Her Majesty's Inspectorate of Probation

Serious Further Offence reviews

Effective practice guide

September 2020

Contents

Introduction 1

Serious Further Offences 2

The Serious Further Offence review thematic inspection 4

Reviews 5

The characteristics of good-quality SFO reviews 5

Part I SFO reviewing: system improvement 7

Good practice illustration: HMPPS Wales 8

SFO reviewing: practice improvement 10

Good practice illustration of approach: London NPS 11

Good practice illustration: Midlands NPS 13

Addressing the common issues in your service: a self-assessment 17

PART II Developing inter-agency cooperation in SFO reviews 19

Developing and managing information to victims in SFO reviewing 20

Expectations of probation staff and/or the wider criminal justice system 20

Vulnerable victims – requirements when sharing the SFO reviews 20

What more needs to be done? 21

Appendix 1: SFO qualifying offences 22

Introduction

Her Majesty's Inspectorate of Probation has a duty to identify and disseminate effective practice.[1]

We test the effectiveness of youth offending and probation provision, and provide assurance. Critically, we make recommendations designed to highlight and disseminate best practice, challenge poor performance and encourage improvement.

This guide is for commissioners and providers, practitioners and managers. It is designed to help them improve the way they conduct Serious Further Offence (SFO) reviews and to maximise the learning from those reviews, and should be read in conjunction with Her Majesty's Prison and Probation Service (HMPPS)'s own guidance.[2]

The first section of this guide highlights effective practice identified during our thematic inspection of the SFO review process at the beginning of 2020. The second, identifies areas, based on the evidence from our review, where we believe there are opportunities for improvement.

I am grateful to all the areas which participated in this review, and for their additional help with the production of this guide. We produce these guides to complement our reports and the standards against which we inspect youth offending and probation.[3] HMPPS manages some of the most challenging and often complex individuals in our society, and SFO reviews have a vital role to play in improving the way this difficult job is done.

I hope this guide will be of interest to everyone working in the probation service and seeking to improve their practice. We welcome feedback on this and our other guides, to ensure that they are as useful as possible to future readers.

Justin Russell
HM Chief Inspector of Probation

---

[1] **For adult services –** Section 7 of the *Criminal Justice and Court Services Act 2000*, as amended by the *Offender Management Act 2007*, section 12(3)(a). **For youth services** – inspection and reporting on youth offending teams is established under section 39 of the *Crime and Disorder Act 1998*.

[2] Her Majesty's Prison and Probation Service notification and review procedures for Serious Further offences (PI 06/2018).

[3] Her Majesty's Inspectorate of Probation's standards can be found here: www.justiceinspectorates.gov.uk/hmiprobation/about-our-work/our-standards-and-ratings

Serious Further Offences

Serious Further Offences (SFOs) are qualifying violent or sexual offences 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.

Background

Although SFOs are relatively rare, their impact is extremely serious. Since 2011, SFOs have been committed by approximately 0.2 per cent of the probation caseload. The review of supervision following these offences has been known as an SFO review since 2003. They were previously known as Serious Incident Reports (SIRs). SFO Probation Instructions (PIs) have gone through several revisions since 2003. 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. The fundamental purpose of providing rigorous scrutiny, however, has remained largely consistent. PI 15/2014 updated responsibilities in the light of the split of offender management between the National Probation Service (NPS) and Community Rehabilitation Companies (CRCs) following the implementation of *Transforming Rehabilitation*. It included reference to the *Offender Rehabilitation Act 2014* (ORA) and introduced a quality assurance framework to be undertaken by the HMPPS SFO team.

SFOs can be very high profile, attracting public and media attention. It is often the reviews subject to media attention that have the most impact. In 2017/2018, there were 626 reviews completed. There is currently no national process to ensure that the learning from lower-profile reviews is captured systematically and used to improve practice and policy.

In April 2018, a revised SFO review process was introduced.[4] '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 have 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.

---

[4] PI 2018-06 - Notification and review procedures for serious further offences.

The new SFO process[5] and review format should enhance action plans and the information provided to victims. Both CRCs and the NPS divisions have processes for disseminating learning from SFO reviews, but learning is not consistently collated at a national level to drive policy improvement. The SFO review model focuses on the work of the probation provider. The current exclusive focus on probation practice restricts the learning for other organisations that may also have been involved in management of the case, except for that small minority of cases which are subject to the separate domestic homicide review or Multi-Agency Public Protection Arrangements (MAPPA) serious case review (SCR) process.

The inspection identified that the best model for providers to identify learning was through the establishment of independent SFO review teams. This separation from the operational line management structure provides a degree of independence and allows reviewers to develop their practice more effectively. Part 1 of this report provides examples of the effectiveness of independent teams.

[5] PI 2018-06 - Notification and review procedures for Serious Further Offences, and PSI 2018-06 Serious Further Offence operational guidance.

The Serious Further Offence review thematic inspection

The SFO review thematic inspection 2020[6] identified that effective reviews and organisational learning requires:

- an effective 'early look' process that identifies any immediate management action in relation to policy or personnel
- a concerted and focused learning approach that is consistently understood across the organisation
- the analysis of probation practice as well as organisational structures and procedures to ascertain learning
- a two-way process in which operational staff involved in cases have access to the review and the opportunity to express their views
- information sharing from other agencies, like the police, to inform reviews. This enables a greater understanding of the management of a case for organisations, and victims and family members alike
- the implementation of quality assurance approaches in each region. These must be timely and systematic, with learning from SFOs disseminated to all levels of the organisation
- that the individual circumstances of victims and victim families are always considered when reviews are disclosed
- that probation providers have processes in place to collate and disseminate relevant learning and actions
- clear lines of accountability, with the responsibility at senior and operational levels clearly identified
- that SFO review learning systematically informs probation training and practice.

[6] HMI Probation. (2020). *A thematic inspection of the Serious Further Offences investigation and review process.*

Reviews

The characteristics of good-quality SFO reviews

We found that the best-quality SFO reviews systematically analysed the probation management of the case; the context of probation practice; and the decisions taken. There is a clear explanation of why events occurred, as well as a description of what had happened and when. This included an analysis of any missed opportunities to improve the effectiveness of supervision, the availability of services and a clear judgement as to whether all reasonable steps had been taken to manage the risk of harm in the case.

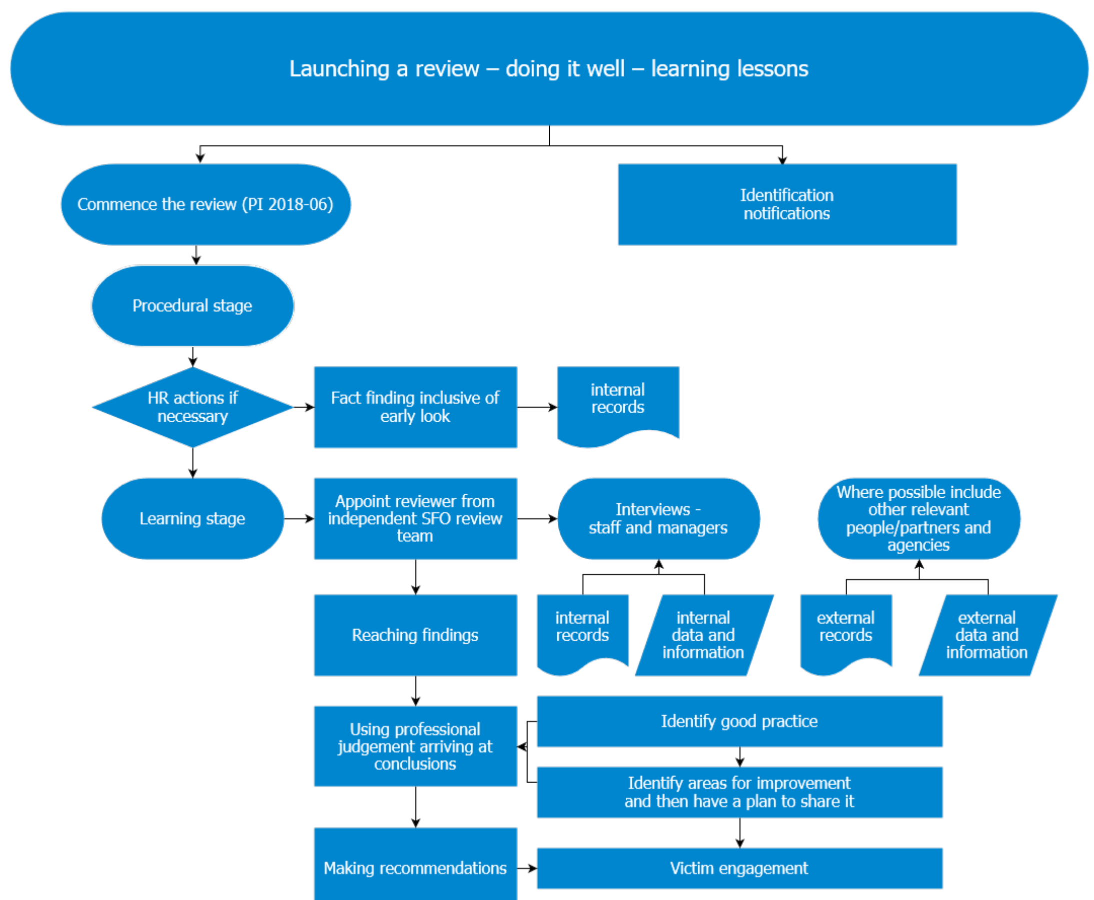
The following are examples of identified good practice:

- **Assessment** – the SFO review of the quality of assessment practice should not rely only on the content of assessment tools such as the Offender Assessment System (OASys). Source documents and historical information should be considered and a clear view given as to whether the assessment of risk factors and patterns of behaviour was sufficient to inform the risk management plan. *The SFO review should specifically examine the judgements underlying the assessment as well as the content of assessment processes such as OASys.*
- **Implementation** – the SFO findings in relation to sentence implementation should not focus solely on the delivery of sentence plan objectives and levels of contact. The SFO review should analyse the quality of the professional relationship. For example, is there evidence of the offender manager proactively targeting any concerns or responding effectively to changes in circumstances? *The quality of relationships, as well as the completion of objectives, should inform the judgement on the effectiveness of implementation.*
- **Risk management** – the SFO review of the risk management should not just focus on the written document, but also analyse the effectiveness of its implementation. Was it sufficient to manage the offender concerned? Did specified actions take place, such as routine information exchange with the police? The SFO review should also consider the effectiveness of contingency planning. How responsive was this when risks emerged, and were services, such as approved premises beds, available when required? *Good SFO reviews analyse the practice of risk management and do not focus solely on the risk management plan itself.*
- **Working partnerships** – SFO reviews primarily examine probation practice but offenders are often complex individuals with many agencies involved in their management. In some cases, such as category 1 MAPPA cases, other agencies have statutory responsibilities. SFO reviews should analyse the probation contribution to these partnerships and assess their effectiveness. For example, are the partnership arrangements reliant on informal relationships rather than a formal framework? Is this effective? Did it provide the necessary consistency to manage the offender? *The best reviews assess the effectiveness of the arrangements and their contribution, positive or negative, to the risk management of the case.*

- **Management oversight** – the SFO review of the case must include a view on the effectiveness of management oversight. This will include its frequency and contribution to effective planning and decision making. *In addition, to assessing the quality of management supervision, the best SFO reviews consider the capacity and capability of managers to provide the necessary oversight and support.*
- **Action plans** – SFO reviews will inevitably identify individual practice that must be improved. Action plans nevertheless should not focus solely on individual practitioners. We recognise that procedure and policy change is rarely justified on just one case, but that should not prevent organisational actions being set. For example, SFO reviews may identify obstacles or inconsistencies in key areas such as MAPPA or approved premises. Where necessary, these can be included in action plan objectives. The SFO framework does not allow for actions to be set for other agencies. Reviews, however, may identify gaps in services or failures to respond to probation concerns and referrals. Actions can and should be set to highlight gaps in service to other relevant agencies. *Effective action plans demonstrate an understanding of the case at an organisational as well as individual level.*

Our thematic inspection concluded that it was crucial that the SFO reviews not only analyse the key events, but also focus on learning. This requires that their completion is underpinned by a structured and balanced approach. SFO teams producing the highest-quality reports followed a consistent process (see Figure 1).

Figure 1



Part I
SFO reviewing: system improvement

The local probation providers that Her Majesty's Inspectorate of Probation inspected have processes in place to prioritise, collate and disseminate learning consistently from SFO reviews. The implementation of action plans is prioritised. At national level, while some high-profile cases have resulted in policy changes, there is no systematic analysis of SFO review findings to drive policy.

Local 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.

SFO reviews in Wales, for example, are completed by the public protection and approved premises team, which consists of four quality scrutiny managers (QSMs) 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 demystify the SFO process.

The team systematically records all learning and actions from the 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 in HMPPS Wales 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 important 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' ('Wales Learns') meetings – quarterly meetings that include practitioners and examine cases in detail and can be used to ensure that action plans are achieved.

Good practice illustration: HMPPS Wales

Left to right: **Amaladipa Remigio**, Head of Public Protection and Approved Premises, **Liz Bowen**, Deputy Head, **Kirsty McDowell**, Deputy Head of Public Protection.

Learning and dissemination – systems and models to promote changes

The HMPPS Wales Public Protection team explain their approach:

> *"In Wales, quality and scrutiny managers (QSMs) are often recruited directly from probation delivery units (PDUs) on a rolling basis, and generally stay for a period of 2–4 years. This process works well as it ensures that QSMs have fresh and up-to-date operational experience, but also take away with them valuable SFO learning which they embed in other parts of the business.*

> *"QSMs are actively encouraged and supported to approach SFO interviews and feedback with impartial objectivity, to ensure that practice is rigorously assessed and learning points are identified correctly. The process, however, is also seen as an opportunity for collaboration with offender managers, senior probation officers (SPOs) and PDU heads to develop action plans which are jointly agreed as achievable and proportionate. Throughout the interview and feedback process, QSMs encourage practitioners to review their own practice, and generate ideas and thoughts which help shape SFO action plans which are meaningful to them and promote positive change.*

> *"SFO action plans are tailored to specific practitioners' learning. By analysing SFO action plans completed over a period time, however, it is possible to see reoccurring trends and themes which merit divisional focus and response.*

> *"In Wales,* ***the best-practice learning group (BPLG) model*** *has been developed and implemented as a way of sharing and promoting learning across the organisation. Each PDU head chairs a local BPLG, which is attended by established practitioner single points of contact, SPOs and a QSM link from the public protection team. Each group organises and undertakes local activity around the Wales BPLG action plan, which is formulated by the public protection team and agreed by the NPS divisional director."*

In addition to SFO learning, the Wales action plan is informed by outcomes from other sources, including local initiatives, MAPPA SCRs, Dysgu Cymru (Wales Learns') events, Domestic Homicide Reviews and Child Practice Reviews.

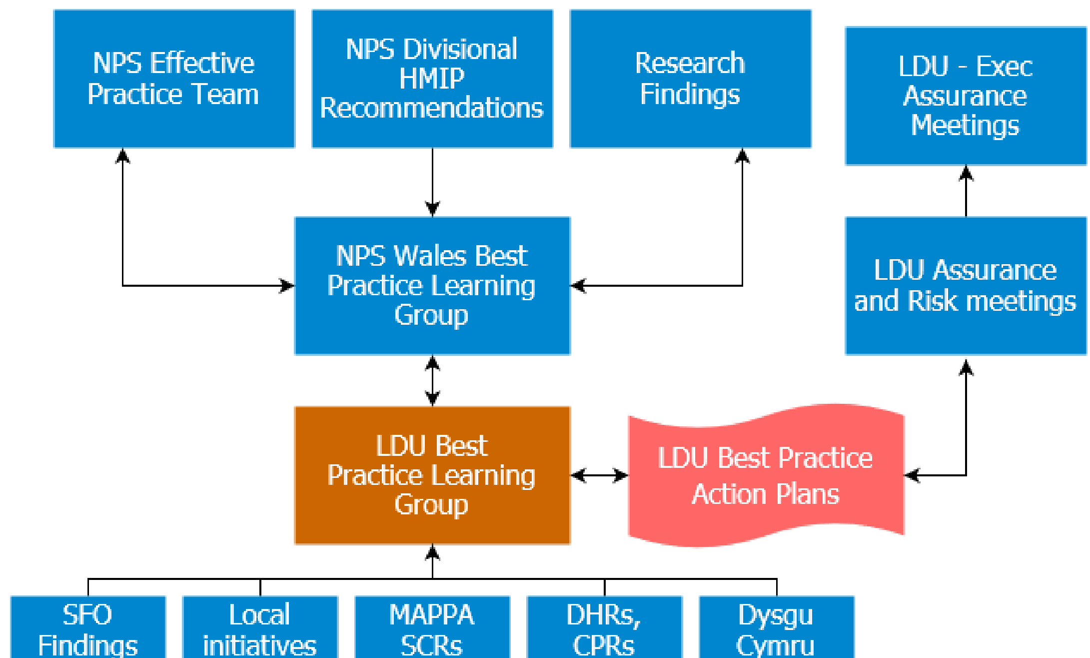
Dysgu Cymru events, are both audit and learning opportunities, organised across Wales NPS, which involve a group of cross-grade staff, analysing practice in relation to a sample of cases. They are a deep dive into practice, and practitioner feedback has been consistently positive about their efficacy and impact. The events are often themed and enable practitioners time and space to reflect on practice. It is expected that outcomes will be discussed at BPLGs, with good practice highlighted and celebrated, and other activities identified to address any learning points at PDU or divisional level.

The overarching objectives of the BPLG model approach are as follows:

1. to provide a robust and evidenced learning and improvement process for the NPS in Wales
2. to support local ownership of learning and improvement processes with dedicated support provided by central teams (including QSMs and the performance and quality team)
3. to develop strong links between local delivery units (LDUs) and QSMs through the delivery of regular and informative QSM briefings
4. to ensure an appropriate balance between the identification of areas for improvement alongside the celebration and sharing of areas of good practice
5. to facilitate national oversight of the learning and improvement processes for the purposes of assurance.

Figure 2

Best-practice learning group model (Wales)



SFO reviewing: practice improvement

SFO review learning should systematically inform probation training and practice development.

Most services inspected by HMI Probation during the thematic inspection of SFO reviews recognised that the SFO review process raised anxieties for staff. The London and West Midlands NPS divisions SFO review teams were especially mindful 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.

We found that effective approaches to completing SFO reviews focused on potential learning. The following organisational practice helped embed this process:

- the completion of a comprehensive early look which addresses any immediate management concerns and helps to ensure that the subsequent review's focus is on learning
- the delivery of staff training about the SFO process provided by the NPS effective practice team. This enables operational staff to understand the process and its focus
- the engagement of the staff involved at the outset. It is important that staff involved are clear about the focus and timings of interviews
- the transparency and openness of the process. It is important that the staff involved can ask questions and that the reviewer responds to any concerns. This should include cases where the report will be disclosed to victims or family members
- telling the staff involved the anticipated timescales for the provision of the review and updating them of any changes. SFO reviews inevitably cause anxiety and concern, particularly for the practitioners involved, and the reviewers make sure they are sensitive to this impact. Attention to good-quality communication should ensure the staff involved are aware of a review's progress
- giving the staff involved access to the completed review. This may require the redacting of some text to protect the identity of other staff members, but they should be informed of the learning resulting from the case.

Good practice illustration of approach: London NPS

Left to right: **Pamela Spring**, Interim Head of Public Protection, **Georgina McGeehan**, Senior Probation Officer, **Sarah Ayodele**, SFO and Complaints Reviewer, **David Edwards**, Senior Probation Officer, **Julia Bateman**, Senior Probation Officer.

Developing a learning culture

Following an SFO, there is often a learning outcome for both operational staff involved in the case, as well as wider learning for all staff. The dissemination of findings from SFOs is a fundamental principle of the process and is required to ensure that learning is embedded across the organisation with the view to improving future practice.

In April 2019, London NPS developed an SFO learning implementation plan to extend beyond the practice in the case, and create an opportunity for local offices and the organisation to understand their strengths and areas for improvement in service delivery. All SFO reviewers in the London NPS SFO team capture the learning themes for each SFO review they produce, to enable these to be reproduced on a divisional database maintained by the SFO team coordinator. The NPS London SFO team provides data from current and previous years to heads of service, highlighting specific learning themes which have been identified from each SFO review arising from the London region, along with overarching regional themes.

> *"A snapshot of the top five most frequent areas of learning provides heads of service with the ability to track the themes and identify whether these areas for improvement recur or reduce over time in comparison with the previous year".*

This assists heads of service with their local management teams and offender managers to determine what the reasons are for the reoccurrence of areas for improvement and explore how these can be addressed in a meaningful way.

> *"This fosters the learning environment intended to be triggered by the occurrence of an SFO which assists those involved to re-evaluate their management of a case and learn new ways to avoid future scenarios for similar cases."*

Heads of service discuss the implementation of the learning from SFOs at monthly critical case discussions with the head of public protection, which ensures that the focus of improving practice remains firmly on the agenda.

This local learning process has been supported by the delivery of half-day briefings to all staff in operations in NPS London. It is based upon the national package compiled by the HMPPS effective probation practice team and is delivered by quality development officers from NPS London's performance and quality team.

Specific sessions for newly qualified officers are also delivered on a rolling basis by the head of service for SFOs. Briefings encourage staff to gain a more informed understanding of the SFO process, dispel myths and explore the learning themes from SFOs, including any recent high-prolife reviews.

In the London region, awareness of learning from high-profile SFOs, along with general learning themes, are raised via the performance and quality bulletin, and as a follow-up discussed at the performance and quality committee meetings.

Effective partnership working between the performance and quality, and SFO teams has strengthened the focus on specific learning themes to support the NPS London quality agenda.

Managing challenging conversations

It is recognised that SFO reviews can be a challenging and potentially overwhelming experience for staff involved, particularly if the SFO resulted in the loss of life. London NPS has developed a process which is designed to enable staff to experience a collaborative, transparent and sensitive approach.

Reviewers read case files thoroughly prior to the initial approach to staff, to understand the roles of those involved and to determine who to interview. Operational NPS staff of all grades and settings are approached initially via email, inviting them to interview. This email sets the scene of what to expect from the process, offers suggested dates for interview and includes an attachment of PI 06 2018, with specific reference to Annex N for staff. The introductory email also provides an indicator of the time span that the SFO review will cover to enable staff to prepare by re-examining their involvement in a case. Responsible officers and SPOs who have written or endorsed assessments, respectively, are encouraged to review these prior to the meeting and familiarise themselves with the case. Occasionally, further contact takes place via telephone if the staff member has any additional questions prior to the meeting.

Reviewers produce the chronology before interviews start, and establish which questions they wish to ask of those involved. During the interview, reviewers start by explaining the SFO process and acknowledging the uncomfortable nature of having another practitioner analyse their work critically. Reviewers will also acknowledge that in every case, regardless of the outcome or experience of the individual, there will always be learning, as this is the reality of the SFO process and part of professional development.

Open questions are used to encourage free discussion. This facilitates a less defensive standpoint and enables wider discussion about the significance and impact of any omission.

Reviewers provide context to specific questions posed to staff, to increase understanding of the greater or lesser focus on omissions or strengths.

Staff are given an opportunity to explain their usual practices in completing tasks. For example, a reviewer may ask, “what would be your usual approach to safeguarding in this sort of case?”. This enables consideration of any capability concerns and the context of the omission.

In addition, reviewers outline HMPPS’s expectations for best practice. Exploration of potential learning points tend to evolve naturally from case discussion and avoid any unexpected findings.

The viewpoints of the staff member are actively sought, and reviewers express interest in establishing what it was like to manage the case, what they might have done differently and what they considered to be important events, were there any specific constraints affecting their practice.

Good practice illustration: Midlands NPS

Left to right**: Tracy Clarke**, Senior Probation Officer, **Marion Page-Smith**, Senior Operational Support Manager

An effective approach to learning and staff engagement

Since its inception in June 2017, the Midlands NPS SFO team has been keen to allay some of these anxieties and embed a learning culture into local SFO practice, and, as such, has implemented the following practices, processes and interventions into its work over the past three years.

One of its first decisions was to have face-to-face introductions with as many of their colleagues as possible, while sharing information about the SFO process and learning from recent high-profile cases in the Midlands area. They did not want to be another 'unknown factor' for already anxious practitioners.

To this end, they attended two middle managers' events, delivering workshops on the SFO process and providing managers with a victim's perspective. The SFO team developed a 'learning from high-profile cases' workshop. This workshop used anonymised cases to focus on learning and emphasise the team's inclusive, open approach to conducting SFO reviews. They delivered over 40 workshops to over 600 participants, including heads of service, probation officers, SPOs, a member of the national HMPPS SFO team and probation services officers. While this was a big commitment, in terms of time and energy, they believe that it has reaped rewards in terms of staff engagement and reassurance. Considering the success of these workshops, the SFO team presented a series of workshops to approved premises staff, focusing upon the SFO process and the vital role that approved premises colleagues play in risk management. They have gone on to develop a Professional Qualification in Probation-specific workshop, and this is being delivered to all trainees in the division on a rolling basis. The SFO team is represented on various working and champions groups, maintaining our profile and ensuring that we contribute to wider development and learning.

Benefits of the approach

The fact that it is a specialised team has enabled it to develop consistent practice across the unit. This includes taking a considered approach, with team members introducing themselves to practitioners and managers, and providing information about the process prior to interview. The team is mindful of the impact of the SFO

interview and offers interviewees a choice of time, location and method. This responsive approach does not negate the need to have difficult conversations often, and the team is honest about the fact that an SFO review does lead to additional scrutiny and consideration of an individual's practice. It is keen to explore not only what happened, but also why, and to contextualise practice. This reassures practitioners, who report feeling 'heard' in the process. The team is clear that there will be nothing in the review which has not already been discussed with the individual concerned. The team explains that it is also looking for wider learning, whether this be for an SPO group, LDU or the wider division. SFO reviews and actions plans are discussed with the LDU head or deputy prior to submission to the national SFO team, for quality assurance. This enables the swift implementation of any initial learning points.

The team is eager to identify and share examples of good practice, and provides immediate positive feedback where this is appropriate and often asks LDU heads and deputies to reiterate this feedback to practitioners and managers as part of the SFO action plan. This recognises good practice while fostering a sense that the SFO team is not only looking for 'what went wrong'. It is seeking to develop this aspect of its work and is currently developing a 'positive news' bulletin to share this information and learning more widely across the division.

The team is keen to continue to learn and improve. It offers all interviewees the opportunity to provide written feedback regarding their experiences of the reviewing manager and the wider SFO process. It has developed good working relationships with the national SFO team, and its members are active participants in national meetings and workshops.

The SFO review manager explains the approach in practice:

Tracy Clarke, Senior Probation Officer.

What we do

"As a Band 6 deputy head, it is my responsibility to manage the SFO process and ensure that the policy is followed, that the action plan is shared with the relevant staff and that any learning is followed through into practice with teams and individuals. It is also my responsibility to make sure that staff involved in the SFO process are clear about their role and encouraged to cooperate fully with the SFO team during their investigation. It is essential that I support staff in their knowledge of the process and any implications for them and their practice, as well as for the organisation."

How they do it

"The SFO team routinely meet with staff groups to share their role and answer any questions. Myths and fears can emerge around SFOs, and so it is important to share the detail of the policy so that staff understand the practicalities of what will happen if one of their cases commits an SFO. This includes the need for staff to understand the organisational implications of an SFO, together with possible media interest. If a case has not been managed well, they also need to understand that they could be taken through the disciplinary or capability process.

For all SFOs, timely notification and action are necessary. I have oversight of any new SFO immediately, so that I can allocate the 'early look' report and support the author of this document. I quality-check these reports, as they form an important first check of the case, and will highlight any immediate concerns or actions which need to be taken. I allocate an offline SPO to support the offender manager during this first stage and subsequent processes, as this can be a stressful time for them and their manager.

The 'early look' report is shared with the offender manager and their manager as soon as it has been completed. Once the full review is completed by the SFO team, the author will discuss it with me prior to the report being issued. I will then share the review with the SPO of the offender manager, making sure that they are clear regarding the actions to be taken and the timeframe. If the review has positive comments about the work of the offender manager, I will arrange to meet with them to discuss these in person and thank them for their work. If an offender manager is distressed by negative comments, I will offer to meet with them to support them. The broad principles of the action plans are shared and discussed in full managers' meetings, making all efforts not to identify the practitioners. The SFO review will then be disseminated down to teams. Organisational policies are reviewed, revised and reissued, when relevant, and incorporated into the action plan."

The impact we have had

"Since the formation of the SFO team and the delivery of the SFO awareness training, the knowledge and confidence within teams about the process have improved. Anxiety remains when an SFO is identified but the fear is less. Staff are engaged with the process, and ready/prepared to meet with the team to discuss the case. The approach of the SFO team needs to be highly professional and yet sensitive to the needs and anxieties of the offender managers and managers. This greatly helps confidence and communication.

SFOs are frequently part of our discussions, either on a case-by-case basis or when we are discussing general practice principles.

When considering a recall decision, we often work back from "How would our decision look if there was an SFO investigation?". It is common parlance. It is very much a learning experience for offender managers and managers."

How we have made a difference

"Practice has changed in the way that staff supervise the service users and, more specifically, record the contacts on nDelius. Professional judgement and management oversight recording are frequently used to explain and capture discussions and evidence risk assessments. Managers have reported back that

staff who have action points from an SFO will change or refine their practice and share this with colleagues in case discussions. There is open dialogue within teams.

'Early look' authors are gaining more confidence in the writing of their reports, and team managers of the relevant case are very open to working with them at that very first stage. The early look is the first indication of whether work needs to be done, and is a respected and well-used document.
Staff welcome positive feedback regarding their practice, as well as areas on which to improve. The knowledge that good practice will be acknowledged is found to be enabling for all those involved."

Barriers and challenges

"Fear of the process and disciplinary action is the greatest barrier. This is slowly being reduced, as staff are clear about the process and the transparency of the discussions and reports. Offender managers and managers are included throughout and if there are issues with practice, these are discussed and managed."

How do we improve the management and supervision of service users?

"The current management of the SFO process allows us to acknowledge that we can all make mistakes; it is how we learn and improve our practice that matters. Confidence in the quality of the SFO review process and in being heard means that staff are willing to take on the learning, which has a positive impact on their management of service users."

Minimising delays

"The 'early look' report gives immediate feedback on practice, which means that any errors in the management of a case can be quickly rectified. All deadlines for SFO enquiries are strictly adhered to, as the swift notification of actions is very important."

Addressing the common issues in your service: a self-assessment

The inspection of the SFO review process by Her Majesty's Inspectorate of Probation found some common issues. Look at your service and consider if this is the case, and identify actions to address them.

Do your reviews:

- frequently focus on individual practitioner shortfalls? What can you do to balance this? For example, why do the same practice shortfalls occur? What office, team, delivery unit or organisational actions can be implemented?
- encourage reflection and learning? Are your staff clear that the purpose of the SFO process is to review organisational, not individual, practice?
- address learning outcomes for other organisations? if not, could they – and what would you need to do to introduce this?
- engage with partner organisations and make sure that these are informed when a case they are also working with commits an SFO, and that they are aware of the internal review process being triggered?
- address what you deem to be good practice and/or approaches? Is this good practice identified routinely and communicated effectively?
- incorporate independence, openness and transparency?
- have a consistent quality assurance approach?
- cascade into broader learning? For example, is information available on the rates, profiles and impact of SFO locally?

Are your reviews:

- Are they viewed negatively in your or other organisations, and does this undermine their potential for positive learning? What are you able to do to address this?
- Are key messages and learning from reviews routinely emphasised in the organisation's improvement and development approaches?

The SFO review process – improvement opportunities

- Do you use fast tracking and/or prioritise some case types over others?
- Do you have a process for fast escalation of systems issues? What is it, and what impact is it having locally and nationally?
- Is your local approach efficient? If so, how do you know?
- Do you have a process for evaluation of feedback from staff who are involved in an SFO review?
- What are your learning outcomes, and how well known are these across services?
- What do victims feedback on the quality of victim information sharing, and how does this feature in your overall strategic improvement?

Think about how improvements can be achieved from the learning in SFO reviews and how that informs:

- strategic planning
- systems learning and improvements
- practice improvement and training plans
- inter-agency cooperation.

What do you need to stop, start or change to improve adherence to the Probation Instruction, and what can you learn from the highlights of effectiveness in London, Wales and the Midlands services?

How are the learning and recommendations from the SFO thematic inspection[7] being addressed in your service?

What support and training are required to bring about further improvements?

How can you make better use of the learning and support from the HMPPS national and local performance and quality teams or their equivalents?

How will you harness the support and engagement of other relevant agencies?

[7] Thematic inspection of the Serious Further Offences investigation and review process. May 2020.

PART II
Developing inter-agency cooperation in SFO reviews

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. 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. It also means that victims and victim family members, may only receive partial information on a case.

This potential loss of multi-agency learning should be addressed in future policy developments. Only a small number of SFO review cases currently meet the criteria for multi-agency reviews such as DHRs and MAPPA serious case reviews. We would therefore like to see an enhanced multi agency review approach for SFOs which incorporates contributions from other agencies in line with the DHR and MAPPA SCR frameworks. The enhanced SFO framework could include:

- the setting of criteria for multi-agency reviews. This could include a tiered approach with multi agency SFO reviews being reserved for selected cases
- the coordination of reviews with other agencies to eliminate duplication.
- provision to ensure that all MAPPA managed probation offenders who are convicted of serious offences (murder, attempted murder, rape, attempted rape and sexual assault of a child) are subject to a multi-agency review
- provision for the appointment of an independent chair to oversee/undertake SFO reviews.

The development of a multi-agency approach would require collaboration with existing MAPPA strategic management boards, safeguarding and community safety partnerships. As a minimum, arrangements should be established to ensure relevant SFO learning is always shared with strategic partners.

Developing and managing information to victims in SFO reviewing

Expectations of probation staff and/or the wider criminal justice system

Since the revision to the guidance, PSI 2018 -06, victims and their families should be provided with relevant information on how the offender was supervised, and any shortcomings, and crucially how action to drive improvements has been, or will be, taken.

Where victims are entitled to feedback, and upon receipt of confirmation that the notification meets the SFO criteria, the NPS or CRC staff must notify the witness care unit that the victims are eligible for information about the SFO review.

This is an opportunity to communicate and deliver high-quality services to victims. Providers should seek to engender trust, transparency, confidence and assurance in the service, and seek continually to improve their services to victims of crime.

In carrying out their function in line with the guidance probation staff, SFO reviewing staff should:

- notify witness care units (after the notification of SFO eligible cases) of those victims eligible for information about the SFO review upon conviction. Victims can then confirm their wish to receive a copy of the review. It is the responsibility of the victim liaison officer to communicate this to the relevant NPS or CRC senior lead[8]
- upon conviction, share the review, identifying the systemic and operational issues, in a transparent and accessible way. They should offer an opportunity to victims to give feedback to the review agencies, to explain how the disclosure of the review has helped and or supported them or not.

Vulnerable victims – requirements when sharing the SFO reviews

- The early and effective identification of vulnerability of victims or victim family members is critical.
- A comprehensive vulnerability and needs assessment should be in place for each victim.
- The ‘needs assessment’ should identify what support the victim needs and any referrals to relevant victim support services.

[8] Victims have the right to a copy of the full review, with suitable and appropriate redaction of information which cannot lawfully be shared. (See SFO Operational Guidance (Annex B). *Providers must consider any redactions in accordance with the Data Protection Act 2018 and General Data Protection Regulation 2018.*)

- It should be identified who is delivering the support, when will it start and for how long. Coordination with victim services should take place in the disclosure of the review.
- The review feedback should be delivered by well-trained, empathic and accountable staff, assisting victims to understand the review and its implications.

What more needs to be done?

Training for staff, including victim liaison officers and senior public protection staff, needs to be designed and delivered, and focused on the needs of victims if it is to help facilitate effective service delivery.

There needs to be a more focused and timely approach to inter-agency working – no one organisation can, or should, be expected to get it right for victims in isolation.

Appendix 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 a firearm with intent to endanger life (section 16 of the *Firearms Act 1968*)

Use of a firearm to resist arrest (section 17(1) of the *Firearms Act 1968*)

Possession of a firearm at the time of committing or being arrested for an 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*). [N.B. 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 the 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*)
[N.B. 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 the safety of an aircraft (section 2 of the *Aviation Security Act 1982*)

Other acts endangering or likely to endanger the safety of an 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 the influence of drink or drugs (section 3A of the *Road Traffic Act 1988*)

Endangering safety at aerodromes (under 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 offences

Rape or assault by penetration (section 1 or 2 of the *Sexual Offences Act 2003*)

Intercourse with girl under thirteen (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 thirteen 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 S*exual 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 S*exual 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 *Sexual Offences Act 2003*)
[Note: only where penetration is involved]

Care workers: Sexual activity with a person with a mental disorder (Section 38 *Sexual Offences* Act 2003)
[Note: only where penetration is involved]

Care workers: causing or inciting sexual activity (Section 39 *Sexual Offences Act 2003*)
[Note: only where penetration is involved]