Her Majesty's Inspectorate of Probation

HM Prison & Probation Service

Rules and guidance for the quality assurance of Serious Further Offence reviews

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Information section

Is this case high profile?

The HMPPS central team designates a case as high profile upon receipt of the initial notification. At the point of allocation, the email will contain confirmation of the case's high-profile status.

Where an HM Inspectorate of Probation Inspector considers that a case meets the criteria and has not been confirmed as a high-profile case by HMPPS, the Inspector should contact the senior policy advisor in HMPPS SFO central team, for further discussion. The final decision regarding a case's high-profile status rests with the HMPSS SFO central team

Were relevant staff interviewed to inform the review?

Details of staff interviewed will be set out after the case details.

Relevant staff would include, but are not limited to:

- all responsible officers who managed the case during the period of time under review
- managers with professional oversight of the case
- all probation service officers or trainee probation officers who conducted work in the case as a support to the responsible officer
- the head of the LDU
- staff who facilitated programmes involving the service user.

Where relevant staff on this list have not been interviewed the Reviewing Manager (RM) must give a brief explanation regarding reasons for this. If the member of staff has left the service, the review should provide details of why they left, their manager should have been interviewed to discuss relevant issues and the RM should have considered learning for inclusion in the action.

If staff were unavailable for interview due to organisational reliance on short term agency staff or a high turnover of staff more generally, the RM should have explored this in the review and considered relevant learning for inclusion in the action plan.

If staff were unavailable for interview due to being on long term leave, their manager should have been interviewed to discuss relevant practice issues.

a) Does the review focus only on the supervision period(s) relevant to the SFO?

The SFO review should have addressed work undertaken during an appropriate timeframe. In cases where the service user has been known to probation services for a number of years, only the most relevant periods should be included under the period of the SFO review.

The starting point of the SFO review should normally be the commencement of the sentence on which the SFO was committed. Periods in custody should also be included in the review to examine the sufficiency of probation practice. If, at the point of the SFO, the service user has been managed for a period of six months or less on their current sentence, and this was preceded by a continuous previous period of management, then the review should also examine practice during that previous sentence. If the service user was serving a lengthy sentence at the point of SFO it may be appropriate to include a summary of the custodial

period in the chronology, with more detailed analysis closer to their release, including scrutiny of pre-release work such as parole reports, pre-release planning and implementation, with any key findings taken into the review. Similarly, where a service user has been in the community for a lengthy period of time prior to the SFO, the detailed scrutiny should be on the period leading up to the SFO.

Work undertaken after the commission of the SFO is out of scope for the review, however key events which follow shortly after can be included in the chronology, if they provide relevant context or clarity (PI 06/2018).

Are there any paralleling reviews?

Where it is known, the status of any parallel review will be made clear by HMPPS in the allocation process. However, it is possible that HMPPS are not made aware of other reviews at the time of completing the review.

Case details

The case details should provide the reader with an immediate understanding of some key issues including the assessed level of risk and any changes, who is at risk, safeguarding concerns and domestic abuse issues. This should include a sufficient overview of the history of concerns, circumstances during the review period and any significant changes and include appropriate comment on whether relevant checks/actions were completed to inform the understanding of the risks posed. Case details includes a diversity section which should include all known information available to the reviewer following examination of the case records. The RM should record any diversity issues identified or omitted.

Chronology

The chronology provides a sufficient and accurate account of the key events.

a) Does the chronology provide details of relevant "significant events" in the case reviewed?

The review clearly sets out the significant events in the chronology. Significant events include all actions taken by key probation practitioners and all of the crucial decisions, missed opportunities and good practice examined in the review.

These include but are not limited to:

- pre-release contact, including offender engagement and quality of release planning. Any significant comments made by the Parole Board about release/restrictions
- dates of MAPPA, MARAC, UPW or prison-based risk meetings and key issues/actions arising
- references to the future SFO victim during the course of the supervision, including any prior association or knowledge of victim(s) by offender
- details of contact with the service user
- details of compliance and any corresponding enforcement actions taken
- perceived, alleged or known deterioration in behaviour
- case discussions with other agencies, colleagues or management oversight
- risk assessments, including assessed serious harm level, and any changes with reasons
- use of professional judgement decisions
- consideration of static and dynamic risk assessments
- use of professional curiosity
- missed links between the assessment of offending behaviour and planning work.

b) Does the chronology provide sufficient evidence to support the statements in the review?

The chronology should include a full and accurate account of the case and include sufficient evidence to support an understanding of significant events and related practice i.e. what happened and who was responsible for any related activity. In most situations, summaries of events and related practice are appropriate, without the need for unnecessary detail which does not further the reader's understanding of the case. However, in some circumstances it is necessary for RMs to include more detailed information, particularly in entries related to the following:

- the risk assessment – entries should include clarity about the areas linked to RoSH, levels of risk and imminence, who is at risk and the nature of the risks and the factors that may increase/reduce risk
- risk management plan and sentence plan

- MAPPA actions
- Child in Need (CiN)/ Child Protection Conference actions
- police intelligence
- NDelius management oversight and alternatives to recall entries.

The reviewing manager can choose to cut and paste, where the information supports understanding, but otherwise a detailed description is preferable. For example, where the reviewing manager has recorded that a CiN meeting has taken place, all the relevant actions from that meeting should be added to the chronology.

The above list is not exhaustive. The primary evidence must be available in the chronology to support the analysis, judgement and subsequent learning which the reviewing manager will outline in their review and action plan.

c) Does the chronology include appropriate initial judgements on the quality practice?

The comments column in the chronology must include an examination of the quality of practice and provide clear judgments on sufficiency. The RM should have outlined whether practice met or exceeded organisational expectations, or fell below expected practice standards, with reference to probation instructions and local policy and guidance where relevant. Where relevant, there should be appropriate commentary on significant deficits and omissions to inform the key findings column.

d) Does the reviewing manager appropriately utilise the key findings column in the chronology?

We expect to find the reviewing manager has used the key findings column of the chronology to highlight the following:

- where expected practice has been found
- good practice to be added to the action plan for wider sharing
- deficiencies which require detailed examination in the review.

Evidence of good practice includes work which was particularly effective in the management of the case. Such practice might demonstrate responsivity, creative use of local external services or the use of specialist interventions or effective innovation. Where practice has had to be flexible to be inclusive of a service user's protected characteristics or where a responsible officer has gone 'above and beyond' to improve engagement and/or compliance could be highlighted as good practice.

It is helpful for reviewing managers to identify whether a deficiency is at the individual level, the LDU, regional or a national level in the key findings column and to highlight whether a related learning point has been set. However, this is not a requirement.

1. Analysis of practice

The SFO review provides a robust and transparent analysis of practice.

Judgement

In order to form an initial judgement about this standard weigh up the balance of 'yes' and 'no' judgements for each key question within this section.

1.1 Does the SFO review provide a robust and transparent analysis of assessment in the case?

Judgement

In deciding whether to answer 'yes' to this question, consider the extent to which the review of assessment is above or below the line for each prompt, and whether those aspects that are judged sufficient outweigh those that are not. Where, on balance, the areas below the line outweigh those that are above, consider a negative judgement. One or more areas that are considered below the line may be of such importance that they preclude a judgement of 'yes'.

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

Reasonable action includes, but goes beyond, completing a formal assessment on the appropriate electronic tool (OASys) within a reasonable timeframe. Assessment work will always include the pre-sentence assessment and the initial assessment; however, assessment is a continuous process and will take place work also takes place in supervision meetings, with the service user and when they are in contact with external agencies. Assessment also includes custodial activity such as interventions and home detention curfew (HDC), release on temporary licence (RoTL) and the parole process.

Quality assurers should expect the RM to have considered what preparatory work was undertaken for the completion of the assessment. At a minimum we would expect to see comment given on whether the responsible officer drew information from all available sources. This would include, but is not limited to, assessment by other agencies, including youth offending services and children's services, health providers, specialist assessments and information regarding the custodial part of sentences where appropriate. The reviewing manager should also have considered whether home visits were utilised to inform the assessment of risk, where relevant.

We expect that the RM has scrutinised the accuracy of the assessment of domestic abuse. Domestic abuse is "any incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexual identity. The abuse can include, but is not limited to: psychological, physical, sexual, financial, emotional" (Home Office, 2016). Where there have been no domestic abuse checks made, we expect the RM to have highlighted this and linked it into the action plan.

We expect that the RM has scrutinised the accuracy of the assessment of child safeguarding. Quality assurers expect there to be child safeguarding checks with children's services in all cases where the service user has children, is in contact with children or presents a potential risk of harm to children. Probation staff must ask service users whether they live with or have caring responsibilities for children. Probation staff must also check with children services as to whether children are known to be in contact with the services user and the nature of any involvement. Where there have been no child safeguarding inquires made, we expect the RM to have highlighted this and for it to link into the action plan. A child is defined as anyone under the age of 18 years old (Home Office & Department of Education, 2017).

We expect that the RM has scrutinised the accuracy of the assessment of vulnerable adult safeguarding. Quality assurers expect there to be adult safeguarding information sharing with social services in all cases where the service user is in contact with a vulnerable adult, presents a potential risk of harm to vulnerable adults or is a vulnerable adult themselves. Probation staff must ask services users whether they live with or have caring responsibilities for vulnerable adults. Where there have been no reasonable adult safeguarding inquires made, we expect the RM to have highlighted this and for it to link into the action plan. A vulnerable adult is defined as someone who is 18 years or older who may be vulnerable to abuse or neglect due to the actions on another person (Office of the Public Guardian 2015).

The RM must explore whether the initial risk assessment was timely and sufficiently analysed current and past behaviour to reach informed conclusions about the nature of the risks posed. This includes an identification of which groups might be vulnerable to harm, details about the imminence of risk and the factors that may increase/reduce harm. The RM must make a judgement on whether the assessed risk levels were appropriate

Reasonable action also includes whether appropriate counter-signature was given to the assessments where required. RMs are expected to have commented upon the suitability and timeliness of sharing risk assessments with other agencies, where necessary.

We expect the RM to highlight evidence of good assessment practice where present.

b) Does the SFO review sufficiently analyse crucial decisions? (assessment)

We expect the RM to highlight crucial decisions made in the assessment of the case, and to explore whether those decisions were detrimental or beneficial to the quality of probation practice. Crucial decisions include the 'headline decisions' such as the assessed level of risk of harm and to whom; the impact of not having requested information from other agencies and failure to complete home visits.

We do not require the RM to have made causal links between a practice decision and the commission of the serious further offence. The RM should identify all such decisions and make clear judgements on whether they were supported by reasonable evidence and recorded professional judgements and the extent to which they were effective or detrimental. The review should include commentary on the significance of any decisions made and the impact they had.

c) Does the SFO review sufficiently analyse missed opportunities? (assessment)

Where there are missed opportunities, there will be gaps in the assessment leading to inaccuracies or insufficient information to inform planning and delivery. It is key that

potential missing links between the assessment of offending behaviour/risks and sentence planning or risk management are clearly identified.

An example of a missed opportunity could be a lack of professional curiosity. There is no exact agreed definition, however we find that being professionally curious involves a process of always questioning and seeking verification of the information you are given, rather than making assumptions or accepting things at face value. By doing this, practitioners can avoid some common pitfalls in assessment practice, for example focusing on positive information, accepting a service user's version of their offence or the circumstances of previous convictions and failing to challenge where there are discrepancies with the evidence.

The review should include commentary on the significance of any missed opportunities and the impact they had.

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

If there are deficiencies in practice, we expect the RM to have explored *why* there were gaps in assessment practice, not just *whether* there were gaps in order to inform an appropriately focused action plan. The RM should have explored the reasons behind such deficiencies with the appropriate members of staff in interview and these should be reflected in the review. It is important that the RM has explored deficiencies more broadly than the actions of the case manager, to consider all possible contributary factors.

The RM should have set out clearly the underpinning reasons for any deficiencies in the assessment and considered if the following are relevant:

- issues relating to the culture in the local office or LDU. For example, whether timeliness of assessments was prioritised by middle or senior managers
- whether staff at all levels had received appropriate training
- whether staff at all levels received sufficient management oversight and support
- the sufficiency of countersigning practice
- the sufficiency of the relevant experience, skills and knowledge of all staff.
- workloads levels and the context of this
- issues relating to local or regional processes and guidance and the implementation of national policies
- what impact, if any, national policy such as Probation Instructions had upon the work in this assessment.

We are looking for evidence that the reasons for the key deficiencies have been fully explored, including the views of all relevant staff involved in the case.

e) Does the SFO review sufficiently examine the partnership work with other agencies? (assessment)

In most cases partners, departments or agencies will have had some involvement with the service user. This could have included the provision of information from the Crown Prosecution Service (CPS), domestic abuse call-out information, safeguarding checks and custodial assessments or intelligence. The assessment should include all necessary information and evidence from others.

The RM should have explored whether there is an effective and efficient mechanism by which probation can request information and receive a timely response. This should include examples of good practice where found. The RM should have reviewed the evidence and information accessible through probation records and could be expected to access information from partner agencies, where the case records are incomplete to inform judgments about practice, significance and impact.

The RM should have outlined clearly which partnership agencies were involved in providing evidence for probation's assessments of the risk of serious harm and likelihood of reoffending. These might include, but are not confined to:

- Police - For intelligence such as domestic call outs, ongoing criminal cases, gang information.
- Children's services - For information on the service user or children to whom they have access.
- Youth offending teams - For where the service user may have been previously known.
- Prisons - For intelligence regarding behaviour in prison and details of any adjudications.
- Mental health teams - For access to assessments and information regarding treatments which might include PD pathway.

In some instances, where there are concerns regarding the practice of partner agencies, the RM should consider a learning point in the action plan to ensure that probation address this issue with the agency.

1.2 Does the SFO review provide a robust and transparent analysis of the planning in the case? (planning)

Judgement

In deciding whether to answer 'yes' to this question, consider the extent to which the review of planning is above or below the line for each prompt, and whether those aspects that are judged sufficient outweigh those that are not. Where, on balance, the areas below the line outweigh those that are above, consider a negative judgement. One or more areas that are considered below the line may be of such importance that they preclude a judgement of 'yes'.

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

Planning actions include start custody/community sentence planning, release planning and risk management planning. Planning work includes, but is not limited to, formal planning on tools such as OASys. Planning work can also take place in supervision meeting with the service user and in meetings with external agencies. RMs are expected to have commented upon the timeliness and quality of the sentence plan and risk management plan. We expect the RM to have considered what preparatory work was undertaken by the responsible officer for the completion of the sentence plan and risk management plan. At a minimum, we would expect to see comment given on whether the responsible officer drew information from all available sources including the self-assessment questionnaire (SAQ), planning by other agencies, including police, health providers, specialist interventions and information

from prison if this was appropriate. Reasonable action would also include whether appropriate counter-signature was given where required.

Evidence could include:

- Release planning: Where a case has included a prison release all planning for this release should be explored, including plans for accommodation, programmes, risk management planning including actions for partnership agencies. This may have involved MAPPA, MARAC or Child Protection Conference planning work. In relevant cases this would include details of parole board decision making and any comments they posit regarding the release plans.
- Risk management plan: In the review the RM should have made a judgement regarding the suitability of the risk management plan, whether it was robust and formed a part of a multi-agency approach. This should include a summary of the risks that it addressed, which agencies were involved and the actions in place.
- Contingency plan: In the review the RM should provide an overview of the most pertinent aspects of the contingency plan so a reader is aware of which actions should have been taken in the event these risks emerged. The RM should have made a judgement regarding the suitability of the plans and if they robustly managed increasing risks or changes of circumstances.
- Sentence plan: The review should include sufficient detail about the sentence plan objectives and how they were to be achieved. It does not need to repeat the full detail given in the chronology. Judgements regarding the suitability of the sentence plan, whether it was specific, measurable, achievable, realistic and timebound (SMART) and if it linked to each identified risk in the assessment should be included. Additional consideration ought to have been given as to whether the planning work was appropriate to offending need, desistance and risk of serious harm.

We expect the RM to highlight evidence of good planning practice where present.

b) Does the SFO review sufficiently analyse crucial decisions? (planning)

We expect the RM to have highlighted crucial decisions made in the planning of the case, and to have explored how those decisions were either significantly positive or detrimental to the quality of probation practice. We do not require the RM to have made causal links however, between a practice decision and the commission of the serious further offence. Sufficient analysis requires the RM to present and assess evidence and reach clear judgements.

Crucial planning decisions include the 'headline decisions' such as referral to an approved premise, referral to MAPPA or contact with the victim liaison unit. Quality assurers should expect to find that the RM has presented and assessed evidence where critical decisions have been made during the planning phases of the sentence.

The RM should identify all such decisions and make a clear judgement on whether they were supported by reasonable and recorded professional judgements, the extent to which they were effective or detrimental and the impact they had on the management of the case

c) Does the SFO review sufficiently analyse missed opportunities? (planning)

Where there are missed opportunities, there will be gaps in planning leading to inaccuracies or insufficient information to inform delivery. It is key that potential missing links between both the assessment of offending behaviour and sentence planning or risk management are

clearly identified, and any links between gaps in planning and the impact on delivery/implementation.

The RM should have identified the missed opportunities and analysed the impact on planning. Missed opportunities may result in planning not focusing on the right areas or sufficient arrangements not being in place to manage risk of harm or reoffending. An example of a missed opportunity in planning could be failing to include structured interventions to address emotional well-being or mental health alongside more obvious risk-related plans.

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

We expect the RM to have explored *why* there were gaps in planning practice, not just *whether* there were gaps, in order to inform an appropriately focused action plan. The RM should have explored the reasons behind such deficiencies with the appropriate members of staff in interview and these should be reflected in the review. It is important that quality assurers find the RM has explored deficiencies outside those of the actions of the case manager. In addition, the RM should be mindful of the workload pressures on, and experience of, the responsible officer and any other staff involved in devising the plans and comment upon these as appropriate.

Quality assurers should consider the following types of evidence (amongst others presented in the review):

- issues relating to the culture in the local office or LDU. For example, whether timeliness of planning was prioritised by middle or senior managers
- whether staff at all levels had received appropriate training
- whether staff at all levels received sufficient management oversight and support
- the sufficiency of countersigning practice
- the sufficiency of the relevant experience, skills and knowledge of all staff
- workloads levels and the context of this
- issues relating to local or regional processes and guidance and the implementation of national policies
- what impact, if any, national policy such as Probation Instructions had upon planning work.

e) Does the SFO review sufficiently examine partnership work with other agencies? (planning)

The RM should have offered evidence, followed by a judgement on the sufficiency of probation's involvement with other agencies during planning work.

The RM should have explored whether there is an effective and efficient mechanism by which probation can request or share information and receive a timely response. The RM should have reviewed the evidence and information accessible through probation records and could be expected to access information from partner agencies, where the case records are incomplete.

The RM should have also looked at the planning work by probation Through the Gate staff in the run up to release and have made clear judgements on whether or not the correct

interventions were identified against the complexity of need, as well as level of risk. It is expected that the RM has examined MAPPA eligible cases, whether they were being managed at the suitable level and which agencies had actions that arose from these meetings. This is also the case with child protection conferences or child in need meetings and their subsequent plans. The RM must have considered the input or otherwise of partnership agencies in the forming of licence conditions, where they exist.

The RM should have outlined clearly which partnership agencies were involved in providing evidence for probation's planning. These might include, but are not confined to the following:

- Police - To agree a trigger plan, discuss licence conditions, confirm suitability of proposed addresses.
- Children's services - To inform which programmes could be available for a service user who may have a child.
- Prison - To confirm release dates and identify which programmes had not been completed in custody. The RM should have examined the planning practice of the Prison Offender Manager (POM) in custody which might include sentence planning and planning for specific offence-focussed or risk-focussed work. The RM will need to explore the OMiC status of the service user where necessary and whether they were reallocated to the Community Offender Manager (COM) appropriately. The RM should decide whether it is necessary to interview the POM. Any learning identified from deficiencies in their practice ought to be agreed with the prison in advance of inclusion in the action plan.
- Mental health team - To plan additional assessments or treatments, which might include ongoing work with the PD pathway.

In some instances, where there are concerns regarding the practice of partner agencies, the RM should consider a learning point in the action plan to ensure that probation address this issue with the agency.

1.3 Does the SFO review provide a robust and transparent analysis of implementation in the case? (implementation)

Judgement

In deciding whether to answer 'yes' to this question, consider the extent to which the review of assessment is above or below the line for each prompt, and whether those aspects that are judged sufficient outweigh those that are not. Where, on balance, the areas below the line outweigh those that are above, consider a negative judgement. One or more areas that are considered below the line may be of such importance that they preclude a judgement of 'yes'.

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

Reasonable actions during implementation include, but go beyond, implementing the sentence plan and risk management plan, enforcing non-compliance and proactively managing the risk of harm and risk of reoffending. Additional reasonable actions will include the use of one to one supervision and suitable accredited programmes, the use of integrated

offender management provision, home visits and multi-agency communication. The RM should have identified key gaps in delivery practice where they exist.

Evidence of implementation activity may include the following:

- Implementing the sentence plan: including the timeliness of referrals for interventions and whether appropriate offending behaviour work including, pre and post programme work was undertaken by a suitable responsible officer.
- Enforcing non-compliance: including the use of enforcement where necessary and the correct recording of this. Quality assurers should expect to find scrutiny of the actions taken by managers with regards non-compliance.
- Pro-actively managing risk: When risk of harm to others were observed to be emerging or increasing did the responsible officer act in a timely way to mitigate these risks, by sharing with partnership agencies, carrying out an enforcement or control measure, seeking guidance from a manager or addressing the risk through rehabilitative intervention? Quality assurers should expect to find scrutiny of the actions taken by managers with regards risk management.

Quality assurers are looking to find that all reasonable actions taken during the implementation phase have been given critical consideration. We expect the RM to highlight evidence of good practice where present.

b) Does the SFO review sufficiently analyse crucial decisions? (implementation)

The RM should have examined all the 'headline decisions' that had a significantly positive or detrimental impact on probation practice. We do not require the RM to make causal links however, between a practice decision and the commission of the serious further offence.

Quality assurers should expect to find that the RM has presented and assessed evidence where crucial decisions have been made during the implementation phase of the sentence. Examples of a crucial decision in the delivery of a case would include:

- decision to respond to a change in risk with a change in reporting frequency
- decision to increase or decrease use of drug testing
- decision to explore recall and its alternative, such as an AP placement, in response to an increase of risk.

The RM should have identified all such decisions and made a clear judgement on the extent to which they were effective or detrimental and the impact they had.

c) Does the SFO review sufficiently analyse missed opportunities? (implementation)

The review should have explored whether or not there were missed opportunities during the implementation of the risk management and sentence plans and subsequent intervention.

Where relevant, the RM must have examined missed opportunities to enforce, to seek further information from other agencies when a risk of harm to others has increased, a failure to verify information with other agencies, to follow the contingency plan, or to seek managerial advice.

Other examples of missed opportunities are:

- failure to demonstrate professional curiosity

- failure to undertake a home visit
- failure to act to safeguard a potential victim
- failure to follow-up concerns with a drug test.

The RM should have explored whether appropriate staff of any grade, failed to follow up on professional concerns by seeking additional evidence using home visits, drug tests and/or communication with other professionals or people known to the service user.

The review should include commentary on the significance of any missed opportunities and the impact they had.

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

We expect that the RM has explored *why* there were gaps in implementation , not just *whether* there were gaps in order to inform an appropriately focused action plan. The RM should have explored the reasons behind such deficiencies with the appropriate members of staff in interview in preparation for the review. Quality assurers will expect that the RM has explored deficiencies outside those of the actions of the case manager. In addition, the RM should be mindful of the workload pressures on, and experience of, the responsible officer and any other staff involved in implementing the sentence, and comment upon these as appropriate.

The following are areas to which the RM should have given consideration:

- Issues relating to the culture in the local office or LDU. For example, whether the quality of delivery was prioritised by middle or senior managers.
- Whether staff at all levels received sufficient management oversight and support.
- The sufficiency of countersigning practice.
- The sufficiency of the relevant experience, skills and knowledge of all staff.
- Workloads levels and the context of this.
- Issues relating to local or regional processes and guidance and the implementation of national policies
- What impact, if any, national policy such as Probation Instructions had upon delivery in this case.

Quality assurers should find sufficient exploration of the underpinning reasons for any deficiencies in delivery practice where they existed.

e) Does the SFO review sufficiently examine the partnership work with other agencies? (implementation)

Quality assurers will expect to see sufficient examination of the involvement of partner agencies in the implementation of the sentence.

The RM should have identified the partners or other agencies involved in the case and confirmed the level and nature of their involvement. The review should consider the quality of communication and information sharing by probation with the relevant other agencies. The RM should have reviewed the evidence and information accessible through probation records and could be expected to access information from partner agencies, where the case records are incomplete.

It is expected that the RM has examined MAPPA eligible cases, whether they were being managed at the suitable level. Minutes from such meetings will reveal which agencies had actions which arose from these meetings. This is also the case with child protection conferences or child in need meetings. The RM should have explored whether probation actions were carried out.

The RM must have considered the input or otherwise of partnership agencies in the implementation of licence conditions, where they exist.

The RM should have outlined clearly which partnership agencies were involved in providing evidence for probation's sentence delivery. These might include, but are not confined to:

- Police - To agree a trigger plan and contingency plans.
- Children's services - To plan which parenting programmes are available for a service user who may have a child.
- Prison - The RM should have examined the planning practice of the Offender Supervisors in custody which might include sentence planning and planning for specific offence-focussed or risk-focussed work.
- Mental health team - To plan additional assessments or treatments, which might include ongoing work with the PD pathway.

In some instances, where there are concerns regarding the practice of partner agencies, the RM should consider a learning point in the action plan to assure that probation addresses this issue with the agency.

1.4 Does the SFO review provide a robust and transparent analysis of reviewing in the case?

Judgement

In deciding whether to answer 'yes' to this question, consider the extent to which the review of assessment is above or below the line for each prompt, and whether those aspects that are judged sufficient outweigh those that are not. Where, on balance, the areas below the line outweigh those that are above, consider a negative judgement. One or more areas that are considered below the line may be of such importance that they preclude a judgement of 'yes'.

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

Reasonable action includes, but goes beyond, completing a formal review on the appropriate electronic tool, such as (OASys), within a reasonable timeframe. Reasonable action would include evidence of responsiveness to information in relation to an emerging risk of harm to others and of active review of the assessment, plans and interventions in place. In respect of written reviews, it would also include whether appropriate counter-signature was given where required. RMs are expected to have commented upon the suitability and timeliness of sharing reviewed risk assessments with other agencies where necessary. RM should consider whether all relevant information has been reviewed to accurately inform changes to the RMP and sentence plan.

RM should comment on the sufficiency of active monitoring of the level of compliance or engagement. Responsible officers should be regularly reviewing whether the approach they

are taking has had the desired impact, and should identify what has been effective, what has been achieved, as well as work that is still outstanding. We expect the reviewing manager to comment on the quality/appropriateness of adjustments made to overcome any barriers to support compliance. We would not always expect to see a formal written review of compliance or engagement but would hope to find evidence in the contact log. In cases where compliance has been good little, or no reviewing will be required.

We also expect the RM to comment on whether it was appropriate if formal reviewing of the case did not take place, for example if the service user was charged with a new offence or following the completion of a programme or other significant change.

Where there is an evidence that the service user poses a risk of harm to others, we expect the RM to have explored if the review of practice ensured the safety of others. Were necessary adjustments made to the risk management plan, for example, in relation to child and adult safeguarding? The RM should comment on the whether the RO sought information from other relatives or professionals, such as the police, children's services and adult social care, to inform the review and whether they appropriately reviewed the case with a manager.

We expect the RM to highlight evidence of good reviewing practice where present.

b) Does the SFO review sufficiently analyse crucial decisions? (reviewing)

The RM should have examined all of the 'headline review decisions' that had a significantly positive or detrimental impact to probation practice. We do not require the RM to have made causal links between a practice decision and the commission of the serious further offence. However, we do expect commentary to transparently reflect the impact the decision had on the overall management of the case.

Quality assurers should expect to find that the RM has presented and assessed evidence where crucial decisions have been made during the reviewing of the sentence. Examples of a crucial decision in the review of a case would include:

- decision to respond to a change in risk with a change in reporting frequency
- decision to increase or decrease use of drug testing
- decision to make changes to the levels of risk, groups/individuals identified as at risk, content of the sentence plan or risk management plan.

The RM should identify all such decisions and make a clear judgement on whether they were supported by reasonable and recorded professional judgements and the extent to which they were effective or detrimental.

c) Does the SFO review sufficiently analyse missed opportunities? (reviewing)

It is key that potential missing links between changes to a service user's risks and needs and appropriate changes to sentence planning or risk management are clearly identified. Reviewing should include an accurate analysis of changes that apply in the case and not simply a description of what has changed. The RM's analysis should lead to identifying changes required in the risk assessment, sentence plan and risk management plan.

The reviewing manager should have sufficiently examined any relevant changes in the case and considered if there were any missed opportunities to review the risk assessment, sentence and risk management plans in response to these. This may include key information

not being obtained to inform reviewing or a failure to verify evidence. The RM should have considered if reviewing practice was sufficiently analytical. and

We expect the RM to have presented the assessed evidence where opportunities may have been missed that were key to reviewing and to consider the significance and impact on case management.

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

We expect the RM to have explored why there were gaps in reviewing , not just whether there were gaps, in order to inform an appropriately focused action plan. The RM should have explored the reasons behind deficiencies with the appropriate members of staff in interview and these should be reflected in the review. Quality assurers expect to find that the RM has explored deficiencies outside those of the actions of the case manager. The RM should be mindful of the workload pressures on, and experience of, the relevant staff and comment upon these as appropriate.

The following are areas to which the RM should have given consideration:

- issues relating to the culture in the local office or LDU. For example, whether timeliness of reviews was prioritised by middle or senior managers
- the level of professional training the responsible officer had received on reviewing risk of serious harm
- whether the responsible officer had support from managers as required
- whether the responsible officer assigned to the task had the necessary experience of reviewing this service user
- whether the responsible officer was holding an excessive number of cases or being required to complete an unrealistic amount of work
- issues relating to local or regional processes and guidance, and the implementation of national policies
- whether national policy such as Probation Instructions or guidance have had a negative impact upon the work in this assessment.

Quality assurers should find that the RM has sufficiently explored the underpinning reasons for any deficiencies in reviewing practice where they existed.

e) Does the SFO review sufficiently examine the partnership work with other agencies? (reviewing)

Reviewing should feature the involvement and engagement by partners and other agencies. The review should highlight the involvement and responsibilities partner agencies had in relation to addressing the risk of reoffending, supporting desistance and/or keeping others safe. The RM should have examined the quality of communication and information sharing by probation with these other agencies.

The RM should have reviewed the evidence and information accessible through probation records and could be expected to access information from partner agencies, where the case records are incomplete.

The RM should have outlined clearly which partnership agencies were involved in providing evidence for probation’s reviewing work. These might include, but are not confined to:

- Police - Information sharing about reported behaviour and DA concerns.
- Children’s services - To keep probation informed with changes to any intervention in a family or with information that indicates new or increased risk to a child or family.
- Mental health team - To review progress with current interventions and plan additional assessments or treatments, which might include ongoing work with the PD pathway.

Quality assurers are looking to find that the RM has included all relevant input by partnership agencies into reviewing phases of this sentence.

2. Overall judgements

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

Judgement

In order to form an initial judgement about this standard weigh up the balance of 'yes' and 'no' judgements for each key question within this section.

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

It is important that the RM's judgments about practice are fully supported by a detailed examination of the explanations provided by relevant staff. We expect the RM to set out what information was obtained during their interviews with the relevant staff. It is key that their 'voice' is heard where appropriate. However, the version of events given by members of staff still ought to be robustly challenged and/or triangulated by the RM, who should provide their own professional judgement regarding the validity of the accounts given.

b) Does the SFO review sufficiently consider the practice of staff at all levels?

We expect the RM to make sufficient judgements on the practice of staff at all levels. This includes ensuring there is evidence of management oversight, structured supervision, training and appropriate support in place for all staff. The RM should have considered the quality of management oversight provided in the case and explored the effectiveness of the oversight and where available, identify good practice.

Where a recall was considered and/or alternatives to recall were put in place, the RM must apply scrutiny to the decision-making process applied by the relevant local manager, and the significance and impact of their professional judgement.

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

Where relevant, the review should include appropriate judgments on any systemic or procedural factors that impacted on the management of the case. The RM should have scrutinised the systems and procedures which influenced practice, and where necessary identify good practice and/or deficiencies. 'Presenting evidence' includes providing a summary of the systems and/or procedures in place and then assessing any identified discrepancies.

'Systems' relate to the objective building blocks of managing service users, which is often underpinned by statute, for example MAPPA.

'Procedure' is linked to policy, with the policy stating the 'what' and the procedure stating 'how'. For example, the policy states that alternative to recalls must be considered in each potential recall situation, the procedure is how different alternatives were considered, who by and how it was recorded.

Quality assurers are looking for whether the review included sufficient analysis of systemic or procedural factors in relation to probation practice and decision making.

d) Does the SFO review sufficiently highlight areas of good practice where they existed?

The RM should make judgments about areas of practice that are considered to go above and beyond practice expectations. Elements of good practice, where it exists, should have been identified and their positive impact examined by the RM.

Evidence of good practice would include work which was particularly effective in the management of the case. Such practice might demonstrate responsivity, creative use of local external services or the use of specialist interventions or effective innovation. Where practice has had to be flexible to be inclusive of a service user's protected characteristics or where a responsible officer has gone 'above and beyond' to improve engagement and/or compliance could be highlighted as good practice.

Where it exists, quality assurors are looking for evidence that the RM identified all examples of good practice and has linked it to the action plan, allowing learning for individuals, and the organisation at either a local or a national level.

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

When exploring and analysing staff contributions and responsibilities, areas of staff performance is likely to be highlighted. It is crucial for both the internal management review and the victim's understanding, to clearly state the relevant areas that were linked to staff performance and provide assurance that action is being taken.

The review should reassure victims that staff will be held to account where necessary and that any learning would be shared more widely where applicable. Care needs to be taken by the RM not to share any confidential or sensitive information which could pertain to an ongoing employment tribunal.

Quality assurers should find that the RM has identified action that needs to be taken to address staff performance, where necessary.

f) Does the SFO review sufficiently link to other reviews taking place on this case?

In some cases, and dependent upon the nature of the SFO, there could be other investigations by HMPPS, or partnership agencies with paralleling but not always identical objectives.

It can take time for different responsible authorities to decide whether the SFO has met the criteria for a separate review, for example a domestic homicide review or a serious case review. It could be that the completion of other reviews had yet to be confirmed at the point of the completion of the review and the QA. Upon receipt of the notification, the HMPPS SFO team alert the responsible leads in the public protection group.

The following are examples of other types of review which could be taking place; Child Serious Case Review, MAPPA Serious Case Review, Domestic Homicide Review and Internal HR investigations. In the SFO review, the RM should have referred to these other reviews only to the degree that it is appropriate. The QA should identify whether or not the review has mentioned other reviews, where they are known about and relevant.

g) Does the SFO review contain sufficient judgement of probation policy to inform the action plan?

It is possible that an RM might identify an issue with the content, rather than the application, of probation policy. An analysis of probation policy will allow key areas of improvement to be identified, which could inform changes necessary to address deficits. Where appropriate this should include good practice. We expect that the RM has made a judgment within the review about systematic and procedural concerns, where they exist which should inform a national objective within the action plan.

h) Does the SFO review contain sufficient judgement of probation practice to inform the action plan?

The review must provide a critical assessment of practice and make clear well-balanced judgments about sufficiency. Judgments made must be supported by evidence; RMs must explain their own thinking, balancing the available evidence and considering any contextual issues.

Where appropriate this should include judgments on good practice. Presenting appropriate and informed judgments in the review will enable the RM to identify key learning for the action plan, to benefit all relevant staff and to ensure improvements to (or the sharing of) practice at a local and organisational level.

Quality assurers should find that the review has identified all areas of concern to inform the action plan. If the RM considered that a deficiency did not require an action point, then clear reasons should have been given. Where a responsible officer has left the service, wider thought should be given to the training, support and management they received during the period under review and whether wider learning points can be identified. Quality assurers should see clear links between every key finding and each action in the action plan, or a clear explanation of any exemptions.

i) Does the SFO review sufficiently come to conclusions on partnership working that informs the action plan?

There is likely to be some level of involvement from other agencies, whether that be at key points of the sentence or routinely through sharing information and/or delivering interventions or services. The SFO review is not expected to directly critique partner agency practice but should explore it in the context of effective multi-agency working.

The RM must have clearly identified all of the partnership agencies which were involved in the assessment, planning, implementation and review of the case during the period under review. Partner agencies include all statutory organisations, but also local partnerships agencies which might provide support with; substance abuse, mental health, mentoring or other types of assistance. The RM should have highlighted the quality of referral processes, communication of risk assessments and plans and effective information sharing

The RM should have explored whether there is an effective and efficient mechanism by which probation can request or share information and receive a timely response. The RM ought to review the evidence and information accessible through probation records and could be expected to access information from partner agency records, where the case records are incomplete.

As with other areas, the RM should have assessed evidence and then concluded with clear judgements.

3. Learning

The SFO review enables appropriate learning to drive improvement.

Judgement

In order to form an initial judgement about this standard weigh up the balance of 'yes' and 'no' judgements for each key question within this section.

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

Judgement

In deciding whether to answer 'yes' to this question, consider the extent to which the review of assessment is above or below the line for each prompt, and whether those aspects that are judged sufficient outweigh those that are not. Where, on balance, the areas below the line outweigh those that are above, consider a negative judgement. One or more areas that are considered below the line may be of such importance that they preclude a judgement of 'yes'.

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

We expect the RM to make sufficient judgements within the review on the practice of staff at all levels and identify related learning for the action plan. This includes highlighting learning for individual ROs as well as examining whether there are areas for improvement for managers. The review should have explored evidence of management oversight, structured supervision and appropriate support in place for all staff and considered the quality and effectiveness of this oversight to inform the action plan.

The review should also identify the need for learning for other probation providers involved in the management of the case (where there has been a case transfer) and any such learning should have been agreed with the provider prior to inclusion in the plan.

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

Local level can include individuals, teams, an office or the Local Delivery Unit. RMs should have explored the impact of local service level agreements, referral processes and formal and informal lines of communication. Of consideration is the culture and key priorities at this level. The RM should explore where policy is implemented differently and why. Where staff shortages were a significant deficiency in this review, the management of this ought to be raised at both the local, and potentially regional, level.

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

Regional level is the area managed by a Regional Director, for example East of England. RMs should have explored the impact of regional service level agreements, referral processes and formal and informal lines of communication. Of consideration is the culture and key priorities at this level. The RM should explore whether there is an issue regarding the way in which national guidance is implemented in that specific region and what action is

required to rectify this. This could be due to contextual issues specific to that region at that specific time. If so, the RM should outline exactly how and why they are doing things differently.

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

RMs should consider whether the issues raised in a review suggest areas for improvement at a national level. However, this is rare, and the starting point should always be to consider the interpretation and application of national policy at a local and regional level in the first instance. RMs should not use national learning as a 'catch all', but as a final option.

National level can include national level agreements, use of tools such as ViSOR, ARMs responsibilities or national agreements on disclosures, learning and development and court procedure. This list is not exhaustive. Where an RM finds potential for national level learning contact should be made with the SFO HMPPs team in the first instance to ensure they are achievable and to identify a suitable owner for the planned action to be agreed with (PI 06/2018).

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

The intention is not to analyse the practice of partnership agencies, but to consider the way in which probation staff work with other agencies and to consider if there are areas that require improvement, which can be taken forward by managers in the probation service.

The RM should have outlined clearly which partnership agencies were involved in the case. RMs should have explored the impact of local service level agreements, referral processes and formal and informal lines of communication. Of consideration is whether there is an effective and efficient mechanism by which probation can request information and receive a timely response.

Partner agencies might include, but are not confined to police, children's services, prison staff, mental health teams and substance abuse agencies. RMs should explore attendance at and contributions towards local MAPPA, local MARAC and local child protection conferences/child in need meetings.

We are looking for the review to discuss multi-agency working which has highlighted the potential for probation practice improvement at local, regional and national level where it is applicable. The review should also consider where there is potential learning for other agencies to be taken forward with them by probation senior managers

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

Judgement

In deciding whether to answer 'yes' to this question, consider the extent to which the review of assessment is above or below the line for each prompt, and whether those aspects that are judged sufficient outweigh those that are not. Where, on balance, the areas below the line outweigh those that are above, consider a negative judgement. One or more areas that are considered below the line may be of such importance that they preclude a judgement of 'yes'.

RMs can on occasion be motivated to add 'good practice' in the action plan to counter-balance deficiencies. Quality assurers should be mindful that in order to be included, work

should be of such a high standard that it warrants being shared more widely, be that locally or nationally, to improve general practice.

If the reviewer considers a deficiency does not warrant an action plan objective, (e.g. because learning and development has led to an increased quality of practice has already taken place or a staff member's high work load has been reduced), then this should have been clearly stated in the review. If concerns were identified in a member of staff's practice and they no longer work for an organisation, then it is important to consider if the learning need may be wider than that individual's practice. The need for wider learning should be included where appropriate. If an area of practice has already been addressed prior to writing the action plan, then the reviewer should consider the need to include an action to monitor its progress.

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

The planned actions at a local level should be assigned to individual practitioners, teams or LDUs. This includes learning for any staff on long term absence and staff from other areas who may have been involved prior to/in a case transfer during the period under review. The actions should be deliverable locally and may include actions relating to the implementation locally of national policies, procedures and guidance documents or specific training or mentoring for individuals. This could also include identified good practice, which should be shared within the LDU for the benefit of colleagues. Where the review has identified a fundamental misunderstanding/gap in the knowledge of a responsible officer, it will be appropriate for a learning point to be included in the plan for a caseload audit to be undertaken. This will ensure checks are made on the management of other cases held by the responsible officer and that any issues are rectified as a matter of priority.

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

The planned actions at a regional level should be assigned to managers at an appropriate level of seniority to address practice which deviates from national policy or procedure and has been identified as a wider issue for the region. The actions should be deliverable regionally and may include actions relating to the implementation regionally of national policies, procedures and guidance documents. This could also include good practice identified which should be shared within the region for the benefit of all LDUs.

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

Often SFO reviews will rightly focus on the application of national policy at local and regional levels. In some rare instances RMs may need to consider whether there should be national level learning. However, the RM should not use national learning as a 'catch all' section, but as a final option.

National level can include national level agreements, use of tools such as ViSOR, ARMs responsibilities or national agreements on disclosures, training and development and court procedure. This list is not exhaustive. Where an RM finds potential for national level learning contact should be made with the SFO HMPPs team in the first instance to ensure they are achievable and to identify a suitable owner (PI 06/2018).

The action should be agreed with the suitable owner (usually the relevant policy lead) prior to inclusion in the plan and the learning point should be realistic and achievable with a clearly defined expected outcome.

d) Do the planned actions contain sufficient developmental activity to affect change?

The action plan should focus on ensuring that all relevant learning is identified and is translated into developmental actions that can be progressed and monitored to ensure similar errors are not made in the future. Actions are developmental when they include clear interventions with a view to affecting/supporting changes to practice. This may include, but is not limited to, training, briefings, reflective discussion, revisiting guidance or structured input from a quality development officer. The action plan must address all areas of concern identified in the key findings. For example, excessive workloads may have contributed to poor practice, so the plan needs to set out how this is being, or will be, addressed and monitored. Where a review has uncovered a significant issue relating to practice e.g. the RO did not understand safeguarding policy and did not know how to make a referral to children's services, the reviewer must include appropriate developmental activity to address this knowledge deficit. In addition, consideration should be given to whether this would have impacted on other cases and therefore whether an action is required to audit all relevant cases where appropriate to identify and correct any related significant practice issues. In most instances this action will have been picked up as an urgent consideration during the review process and is likely to already be underway prior to the action plan being finalised.

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

Learning points must be Specific, Measurable, Achievable, Relevant and Time-bound (SMART). Simple errors should be dealt with simply. More complex matters (e.g. where systems or processes have not worked) may require team or organisational solutions. Timescales must be reasonable and must take account of any need for immediate action e.g. where there are significant practice concerns about fundamental issues e.g. understanding risk, recall processes, need for case audits etc.

It is important to differentiate between the area for improvement, the actions that are to be taken to achieve change and the method by which the progress and impact of the intended action is to be measured. Effective measures of improvement include dip sampling and audits of specific work/cases. Where these methods are utilised, the impact column should set out the number of cases to be sampled or the scope of the audit, with clarity about what aspects of practice will be focused on and what indicators of positive change it is seeking to find. It is also good practice for the plan to include details of any further action to be taken where findings from audits do not confirm evidence of sufficient progress.

If a staff member is absent from work, the plan should be clear about how learning will be taken forward upon their return.

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

Where learning has been identified for another probation provider e.g. the NPS in a CRC review, the learning and measurements for progress should be agreed with that provider prior to inclusion in the plan. It should be clearly stated how the actions have been agreed and shared.

Where the learning is regarding probation's multi-agency working practices, this must be taken forward by a manager of sufficient authority to approach leaders in other agencies to discuss improvements.

When it has been found that the actions of another agency (such as a YOT, social care, police or mental health) have impacted on the management of the offender, a learning point should be included that requires a senior manager to take the learning forward with that agency. The NPS or CRCs should not make recommendations that are beyond their scope to carry out.

4. Victims and their families

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

Judgement

In order to form an initial judgement about this standard weigh up the balance of 'yes' and 'no' judgements for each key question within this section. Where, on balance, the areas below the line outweigh those that are above, consider a negative judgement. One or more areas that are considered below the line may be of such importance that they preclude a judgement of 'yes'.

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

RMs should be conscious of the tone and accessibility of their writing. RMs should think about the reader of the report, both member of staff and victims, and tailor information appropriately. The review should be written in plain English. Sentences should be short, uncomplicated and in the active voice. Care should be taken to use grammar correctly, in particular single inverted commas, which should never be used to suggest that something is untrue. Where a RM believes something is untrue this should be clearly stated. The case specific glossary should be included to aid the lay reader's understanding. Acronyms should be used sparingly and be given in full in the first instance of use. When referring to 'risk' this requires qualification, for example, 'risk of serious harm', 'risk of harm to others' and 'risk of harm to self'. The term 'service user' should be used rather than 'offender'.

The language used in the action plan should be outcome-focused and proportionate to the findings in the view.

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

Any serious further offence is a distressing and regrettable incident. It is necessary and appropriate that the review is written in a way which does not add to the distress of those victims, direct or indirect, who may read the review. Thought should be given to the language used to describe the details of both the index offence and the serious further offence.

The victim is the person legally identified as the direct victim of the SFO crime committed by the service user. There can be more than one direct victim in each SFO. In the tragic incidence where death has been caused, the victims will be identified as the direct relatives of the deceased.

We expect to see sensitivity shown in all SFO reviews. This includes careful use of information or intelligence which is potentially inaccurate or malicious, or for any reason irrelevant to the assessed risks and the SFO. The types of SFO noted below offer some guidance on which areas might require additional care and sensitivity:

- Gang related crimes. In some instances, the victim of the SFO is a member of a gang, where the SFO crime was a retaliatory act. Sensitivity must be shown, not to attribute blame to the victim/s or to disclose information which might lead to an increased risk of serious harm to the recipient of the review. Caution should be given to naming gangs in this report.
- Domestic homicide. In cases of domestic murder, the review may highlight situations where the victim made choices which could be viewed by a layperson, as failing to

protect themselves. Professionals in the criminal justice service are fully aware that people subjected to domestic abuse routinely make decisions whilst under duress and whilst suffering from reduced self-esteem and self-worth. Additionally, some victims of domestic abuse chose to placate the perpetrator of abuse as a self-defensive mechanism. Sensitivity must be shown not to attribute blame to the victim. Victims are not responsible for the actions of their abusers.

- Child sexual abuse. In cases where children have been sexually abused or exploited, care must be taken when referring to any of the children's actions which could be taken out of context or misinterpreted by the recipients. Sensitivity must be shown not to attribute blame to the victim. Children are not responsible for the actions of adults.

c) Does the SFO review sufficiently explain the significance of deficiencies and missed opportunities and the impact these had?

The review must consider the impact and significance of any deficiencies identified in case management, so the wider audience can understand if it was fundamental to the case or if it didn't materially affect overall management. Reviewers must be clear what they are trying to tell the reader and not leave it for the wider audience to interpret the relevance of the judgements. For example, if a review reports that an action had not been taken in line with expectations, the review must then consider what impact this had on the management of the case and if it was significant overall. Reviews should be transparent about where omissions in practice or detrimental crucial decisions undermined the effective management of risks.

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

The SFO review is first and foremost an internal management review, although sharing information with the victims of automatic SFOs is a crucial element of the SFO process. RMs should be mindful of the circumstances of the SFO and the issues likely to be of concern to the victim and ensure that appropriate attention is given to pertinent areas of risk. The victim/victim's family should be able to read the review and follow the key themes of the case through the key findings and into the conclusion and action plan. For example, where the SFO involves repeat victimisation or relates to a known risk e.g. domestic abuse, the RM must have clearly highlighted this and thoroughly examined whether there was sufficient assessment, planning and management of these risks e.g. were the known adults at risk identified, was appropriate safeguarding action taken, was there multi-agency liaison. The conclusion section of the review should be clear about whether, during the period under review, all reasonable action was taken to manage any areas of known risk that were also relevant to the circumstances of the SFO.

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

The RM should use the review to clearly set out their judgements on the sufficiency of practice in each of the sections of the review (assessment, planning, implementation and review) in a way that is accessible and meaningful to the victims. The review should be sufficiently transparent about all key findings. Evidence to support these judgments should be presented in an accessible way, with brief explanations to support understanding for a wider audience. The RM should include examples to illustrate judgements to allow victims to understand why certain decisions have been made. Reviews should avoid detailed examination of the minutiae of practice, which would not be easily understood by a wider

audience, for example, reference to the various numbered sections of an OASys risk assessment.

Quality assurers should find that the RM presents clear and concise judgements supported by evidence.