HM Prison & Probation Service

Policy Framework - Notification and Review Procedures for Serious Further Offences

Annex B: - Operational Guidance

SFO Team, Public Protection Partnerships Section, Public Protection Group, HMPPS

Contents

1. Introduction

The purpose of the SFO review is to provide a robust and transparent account of practice by way of an internal management review, including an action plan. In some cases the documents will be shared with victims/victims' families.

In order to improve transparency for victims, HMPPS revised the SFO format in 2018, moving from a process driven approach to a narrative format for all cases notified to HMPPS on or after 1 April 2018. In response to the HMI Probation thematic inspection of the SFO investigation and review process in 2020, HMPPS committed to exploring options for a revised SFO format and the Policy Framework (2021) introduces a new template, Annex D, arising from our experience of work undertaken during the Covid exceptional delivery model and our drive to make the process more effective. **Probation should complete the review on the new template for all notifications submitted to the HMPPS SFO Team on or after 4 January 2022.** The revised format strengthens the focus of the review documents, includes a summary and will be produced "ready to share" with appropriate redactions. Specific guidance for reviewing managers (RMs) about what information should go where in the revised format can be found at Annex D(i). This operational guidance provides further information about what RMs should consider when approaching a SFO review.

Since April 2021, HMI Probation have been involved in quality assuring a random sample of SFO reviews. The operational guidance should be read in conjunction with the HM Inspectorate's quality assurance Standards, Rules and Guidance and Ratings characteristics documents, which can be found here.

This version of the operational guidance includes a number of changes, with the addition of new sections on early looks and Offender Management in Custody (see pages 19-21). We have amended the Guidance in other areas, including on completing reviews to align with the QA standards, contributing to parallel reviews and the period to cover in the review. We have introduced a revised letter to victims offering information about the review, which Victim Liaison Units will send on behalf of the Head of PDU, and we have also updated the internal quality assurance checklist.

2. SFO Notification

2.1 Completing the Notification

The Probation Service (PS) must notify the central HMPPS SFO Team using the SFO notification template (Annex C) when an eligible supervised individual is charged with a qualifying offence (see the Policy Framework for eligibility details).

The Regional Probation Director is responsible for ensuring local arrangements are in place to identify cases at court that are within scope for the SFO procedures and that processes are in place to collect information so that a fully completed notification is submitted to HMPPS SFO Team within 10 working days of the first court appearance.

In cases that are likely to attract significant national public interest, staff should inform senior managers and the HMPPS SFO Team immediately when an supervised individual is charged with an eligible SFO. This will enable HMPPS SFO Team to be able to quickly and accurately inform Ministers and senior officials of the details prior to the information being published by the media.

Where PS court staff do not identify the SFO at the first court appearance, and therefore HMPPS are not notified of the charge within the set timescale, the PS SFO regional team manager must identify the reasons for the delay and agree actions to improve local practice, if applicable. Any follow up actions can be included as learning points in the action plan within the SFO Review.

The SFO Notification contains three parts.

Stage 1

PS court staff should identify SFO cases at court and complete Stage 1. The initial sections of the notification contain factual details about the supervised individual e.g. name, date of birth, address, and details of the alleged SFO. Please ensure the factual information is completed as accurately as possible, including the CRN as this is a critical identifier across a number of CJS systems.

Accurate and timely reporting of court details are of the utmost importance. The PS SFO regional team manager should ensure that court duty staff record the exact details of the SFO charge (and any additional charges) on the notification. The section of the Act under which the supervised individual has been charged should be provided, for example the relevant section of the Sexual Offences Act 2003. A brief summary of the offence should be provided, for example, if the charge is murder, the notification document should describe how the victim died (e.g. as a result injuries inflicted by a blade or a firearm); where the offence happened (e.g. in the home, the street, a public house); when it happened (the time and date) and other relevant circumstances (e.g. following an argument); the relationship between the supervised individual, victim and other witnesses; how it happened; and the alleged motivation or reasons, where known.

Stage 2

This should be completed by PS court staff and provides examination of the case allocation process and should be completed in all cases where the sentence commenced before unification on 26 June 2021, in order that any issues about appropriate case allocation can be identified for contextual purposes and addressed in the full SFO review, as relevant. There is no expectation that any learning is taken forward in the action plan.

Stage 3

The region managing the supervised individual at the time of the SFO must complete this section, usually the regional SFO Team, unless local arrangements have been agreed (see below for guidance on National Security Division cases). Stage 3 should include details of the supervised individual's status, supervision details and confirmation from a locally identified manager, usually the regional SFO Team manager, that the case qualifies as an SFO.

Some elements of the notification may require careful checking to ensure all relevant information given is accurate. These include:

- 3.2 - Has another PDU or probation region, former NPS division or CRC been involved in the management of the supervised individual during the current sentence? This relates to transferred cases and cross border arrangements.

- 3.2 - Table for community order/suspended sentence order. This table has space for one order (row 1), with up to 4 requirements (final column - Rows 1-4). Staff should enter further information in the space below.

- 3.2 - Table for post release licence. This table has space for 2 types of licence, so that where HDC is running alongside a licence supervised by the probation region, it can be identified by including the specific HDC period and the substantive licence period separately. The start and end dates of both the licence and the period on post sentence supervision (PSS) should be included.

- 3.2 - Additional Information. Please provide details of any recalls or parole board involvement in the case, specifically dates and outcomes.

- 3.2 - Specific questions about the supervised individual's circumstances e.g. was the supervised individual subject to electronic monitoring. Please provide details of key components of inter-agency involvement. Early factual briefing to HMPPS senior management, MOJ press office and Ministers can often provide an essential role in ensuring that SFO cases, and the role of practitioners and probation regions, are presented in a fair an accurate light.

- 3.3 – Previous convictions. In the first two tables please provide the number of all previous convictions up to the point of the index offence(s) and the type of convictions. More detail should be provided in the final table about *only those* convictions marked with an * in the second table.

- 3.4 - MAPPA and other reviews e.g. SCR, LCSB. Past experience has shown that the findings of any parallel review can often comment on probation practice, and it is essential that the HMPPS SFO Team are aware of the potential for such information to be placed in the public domain in order that an agreed media response can be established.

- 3.6 - Confirmation. The PS regional SFO manager should complete this section to determine whether it qualifies as a SFO review or not.

The notification must be checked for accuracy and signed off by the regional SFO Team manager or individual locally identified to sign off notifications.

Email addresses for the regional SFO SPOCs can be found at the end of section 2.3 of this guidance.

Cases where more than one region has been involved:

Where a supervised individual has appeared at court within another jurisdiction and is charged with an SFO, or was being supervised by another region at the time the alleged SFO occurred the following applies:

- Probation court staff covering the area in which the supervised individual appeared for the SFO identify the supervised individual and notify the local SFO SPOC responsible for the management of the case. The court staff in the covering area complete Stages 1 and 2 (where the supervised individual was sentenced prior to unification) of the notification (liaising with other areas if appropriate). The probation region managing the supervised individual at the time the SFO was committed must complete stage 3.

The supervising region must complete stages 1 – 3 of the SFO notification if notified that one of their supervised individuals has been charged with an SFO by a court outside of England and Wales; there is no requirement for courts outside of England and Wales to do this. If the PS is aware that an supervised individual has appeared before a court in another jurisdiction, a notification should be completed, signed off and submitted to HMPPS SFO Team, in accordance with local arrangements. The PS should liaise with the court regarding the offences if the wording differs from the offences on the SFO qualifying list and should seek advice from HMPPS SFO Team to confirm if an offence qualifies as a SFO.

Within three working days of receipt of a SFO notification, HMPPS SFO Team will confirm if the case meets the SFO criteria, and whether or not it will be dealt with as high profile. In cases that have qualified for an automatic review, the probation region managing the supervised individual at the time of the SFO must ensure the regional Victims team is sent a copy of the notification and that the Witness Care Unit (WCU) is notified using Annex G.

National Security Division (NSD) cases

Court staff must identify NSD cases at stage 1 of the notification process and once stages 1 & 2 are complete, send the notification to the NSD SFO SPOC at nsd.sfo@justice.gov.uk, who will

arrange for completion of stage 3. The NSD will then take responsibility for all further stages of the SFO process, including completion of the early look and SFO review, in line with the SFO policy framework and this guidance.

2.2 Early Looks

Probation Instruction 2018 06 implemented an “early look” into practice to ensure the PS completes a prompt and thorough management report in order to identify whether there are any issues which might require an immediate management response.

A RM from the regional SFO Team should complete the early look on a nationally agreed template. The early look must be signed off by the regional SFO Team manager (except in high profile cases and cases with serious practice concerns – see below).

The PS must complete the early look within 10 working days of the SFO notification and in most cases will only be required to examine practice within the 6 month period prior the SFO (unless there is a good reason to explore earlier practice), informed by a review of electronic case records.

The reviewer will send the completed early look to the Head of PDU (where the SFO originated), copied to the Head of Operations.

In high profile and cases with serious practice concerns the Head of Operations is required to personally sign off the early look and must discuss and agree any management action with the Head of PDU, including where indicated a possible investigation under Conduct and Discipline procedures. The Head of Operations must retain a regional early look log. In high profile cases the early look should be copied to HMPPS SFO Team.

Further guidance, including on what constitutes ‘serious practice concerns’ and managing the early look process can be found in the SFO Early Look Guidance issued in July 2021 and available on Equip at 1.1.4.8 (2)

2.3 Communications

Communications should be clear, coordinated and recorded.

PS regions are required to appoint a single point of administrative contact (SPOC) for SFOs, who will be able to access details of cases directly. In order to ensure that all communications between probation and HMPPS SFO Team are clear and there is an audit trail of any communication relating to SFOs kept on file, the regional SPOC should be copied into any relevant emails sent by other probation staff to HMPPS SFO Team about a case. The HMPPS SFO Team will also copy the regional SPOC into relevant emails sent to probation staff, usually RMs, about a particular SFO.

The regional manager of the SFO Team from the supervising region will remain responsible for keeping the relevant Regional Probation Director, or their delegates, updated on individual SFOs.

Notifications and updates of existing SFO cases should be submitted by e-mail to sfo@justice.gov.uk using the GSI network or other Authority approved system, ensuring that the email is marked as 'OFFICIAL-SENSITIVE'.

Each PS region should have a dedicated SFO email address, accessible to all members of staff involved in SFO administration.

HMPPS SFO Team retains a list of email addresses for each PS region's SPOCs, SFO Team Manager, Regional Probation Director and Heads of Operations and it is essential to let HMPPS SFO Team know of any changes.

Each SFO is allocated a national reference number. The following electronic protocol should be used by probation regions: SFO/surname in lower case/initial in upper case/stage) (for example Notification). When the SFO Team have assigned a number, it becomes SFO60001bloggsJstage (for example Outcome).

The PS should open a SFO review file for each case and retain copies of all relevant document, including interview notes, for five years from the date of completion of the review, with any paper records held in line with local records policy. The paper record must include any notes kept by the RM, including notes of interviews with staff. Thereafter, the PS must continue to retain a copy of the SFO review itself in the event the victim/victim's family in automatic cases, makes a retrospective request for information and a redacted copy.

2.3.1 Regional SFO Team email addresses

Each region has a dedicated SFO Team that can be contacted using the email addresses below.

East Midlands	wmps.sfo@justice.gov.uk (NB: this will likely be subject to change).
East of England	EoEsfo@justice.gov.uk
Greater Manchester	gmps.sfo@justice.gov.uk
Kent Surrey and Sussex	ksssfo@justice.gov.uk
London	londonps.seriousfurtheroffences@justice.gov.uk
North East	neps.sfo@justice.gov.uk
North West	NWPS.SFO@justice.gov.uk
South Central	scps.sfo@justice.gov.uk
South West	swps.sfo@justice.gov.uk
Wales	WalesPS.publicprotection@justice.gov.uk

West Midlands	wmps.sfo@justice.gov.uk
Yorkshire and the Humber	YatHPS.SFO@justice.gov.uk

2.4 High Profile Cases

Each PS region must have a process for identifying those cases that are of particular concern and likely to attract public interest These cases are liable to be subject to national media attention. If a case is likely to attract significant public interest or concern, the responsible probation region should send early notice of the expected notification to HMPPS SFO Team as soon as possible and advise the Regional Probation Director or their nominated representative, in advance. The decision to accept a case as potentially high profile will be made by HMPPS SFO Team, who have information about national trends and themes that are of particular interest to ministers or national media and may therefore identify a case as high profile/noteworthy even if not identified as such by the probation region. Many high profile cases go on to generate modest media activity and no further action is required. On occasion, some cases can become the focus of intense media and ministerial scrutiny, and there is a very high impact for victims and families which needs to be responded to as sensitively as possible . Some SFOs will become high profile as the case progresses or at the inquest stage if there has been a loss of life.

Probation regions should follow the early look guidance and also submit the early look to HMPPS SFO Team once completed (see section 2.2). Any identified actions should be progressed, monitored and tracked. Regions should make arrangements to track the subsequent court dates for these cases, and keep HMMPS SFO Team routinely updated. It may also be necessary to expedite the SFO review in line with court dates.

In exceptional cases, when the offence criterion is not met, the case may still need to proceed to a review, for example where there has been substantial national public interest which is reported on the national television news; or where a case is likely to attract national attention or criticism which could impact on national policy or the reputation of the agency.

Examples of cases which would need to be considered as potentially high profile (and should be discussed with HMPPS SFO Team and considered by the manager of the regional SFO Team when responding to question 5 of the notification) are those:

- where a supervised individual with sexual pre-convictions had been released by the Parole Board and is accused of rape
- which involved recall and an offence has been committed whilst a supervised individual is unlawfully at large
- with bizarre offence details which will bring the supervised individual's management, however satisfactory, into the public eye
- cases involving gangs, guns and stabbing

- where murder has been committed on bail or during a period of indeterminate sentence licence supervision where the index offence is murder/manslaughter
- involving terrorism and political extremism offences
- involving multiple agencies where there is a potential for the PS to come under particular scrutiny.
- where early indications show that case management was exceptionally poor
- which fall within a type of supervised individual or offence which attract media or ministerial interest for a specific period

Specific role of the HMPPS SFO Team and high profile cases

HMPPS SFO Team produces a high profile briefing on every case for the Director of Public Protection Group (PPG), within which the SFO Team sits and this forms the basis of the weekly press note sent to Ministers, senior leaders within HMPPS and MoJ and press office.

The press note is sent every Friday to inform them of any high profile cases that are due to appear in Court the following week. It details information relating to the SFO offence, index offence and sentence, any parallel behaviours and reviews and any media interest. Information about the findings of the review, where complete, are kept to a minimum. In high profile cases, a senior manager should ensure regular updates are provided to HMPPS SFO Team, including any new information that comes to light prior to the trial or other court appearances.

Occasionally, the Lord Chancellor or Minister will ask for further information relating to a particular case, and HMPPS SFO Team may need to contact the PS region for more information depending on where the case is in the SFO process.

Based on the information provided by the PS, the Director of PPG prepares Ministerial submissions on significantly high profile cases or where the review has identified very serious practice failings. This will usually include information relating to the findings of the review and the management of the case. PPG will produce the submission in conjunction with relevant PS senior managers and may require further information at short notice to inform such submissions or if the Minister asks follow up questions.

The PPG also respond to Parliamentary Questions (PQs) tabled by Members of Parliament (MPs), and other Ministerial requests for information. They are used to seek information or to press for action from the Government. For SFOs they can often relate to data, but occasionally they may relate to an individual case. PPG has very little time to answer a PQ. In most cases it will be either 24 or 48 hours. To inform the answers to these, HMPPS SFO Team may require quick and urgent contributions from the PS within short timescales, sometimes in a matter of hours, in order to prepare a draft reply.

HMPPS SFO Team regularly receive Freedom of Information (FOI) requests from members of the public, journalists, academics and lawyers. The Freedom of Information (FOI) Act 2000 provides public access to information held by public authorities. Often, requests related to SFOs,

will ask for review or conviction data related to specific offences such as homicides or, in some requests ask for details of index offences for those convicted of a SFO. HMPPS SFO Team also receive bespoke requests that cover broader areas of work in the organisation that are linked to SFOs. These requests involve collaboration with other teams to answer the request and HMPPS SFO Team may also seek contributions from the PS where necessary.

HMPPS SFO Team have 10 working days from date of receipt to provide a draft response. In this time, they must have any data checked by their statistician for accuracy, have the draft signed off by press office and finally approved by the Director of PPG. There are then a further 10 days for the response to be approved by the Data and Compliance Team, Ministers private offices and Special Advisors.

Whilst HMPPS SFO Team do not share SFO reviews or case information under the FOIA, as with a PQ, a request for data is very often triggered by a specific case or cases, and a background document must be produced which may contain relevant information from the SFO review. Often a PQ answer can trigger an FOI request.

Ministers receive correspondence (MC) from MPs, often prompted by their constituents and have to respond within 14 days. PPG will contribute to this response. Additionally, PPG will receive letters direct from members of the public (known as 'treat officials') and must respond promptly. As a result, HMPPS SFO Team may also require the relevant PS region or prison establishment to provide a contribution to the draft reply, and will contact senior managers when further information is required.

2.5 Other Agencies

In some SFO cases, other agencies will be closely involved, particularly the police and establishing joint local strategies with relevant agencies has considerable advantages. The PS should have good liaison arrangements with the communication officers in other agencies.

2.6 Parallel Reviews

Local Safeguarding Children and Adult Boards/Safeguarding Partnerships and Serious Case Reviews or Safeguarding Adult Reviews/ Local or National Learning Inquiries (Child Practice Review in Wales).

Where an eligible supervised individual is charged with an SFO, and a child or vulnerable adult has suffered significant injury or death, the regional senior safeguarding lead manager should notify the Local Safeguarding Partnerships Board or Safeguarding Adults Board. If the case proceeds to a statutory safeguarding review, the PS are likely to be asked to contribute to that review process. The report for the parallel review should be presented as an individual management report (IMR) in line with terms of reference for the review, informed by the SFO review.

There will be cases where the supervised individual and offence eligibility for an SFO is **not** met, but a child or vulnerable adult has suffered significant injury or death. In these cases, where the supervised individual is known to the PS, they should conduct an internal investigation and

complete an IMR. If the case is likely to attract significant national interest, regions should discuss the completion of a SFO review in the public interest with HMPPS SFO Team.

SFO cases involving a Domestic Homicide Review (DHR)

Where an eligible supervised individual is charged with a domestic abuse incident which has resulted in the death of the victim, and once it is known that a homicide is being considered for review, the SFO regional team manager/SPOC for the PS or prison establishment must liaise with the local community safety partnership and designated DHR chair to notify them that the case has triggered an internal review. Each agency contributing to the DHR will be required to carry out an IMR to look openly and critically at individual and organisational practice in the case.

MAPPA Serious Case Reviews (MSCR)

Where an eligible supervised individual is charged with a MSCR qualifying offence and is managed at an Level, the Head of Public Protection should notify the MAPPA coordinator. The local MAPPA Strategic Management Board will commission a mandatory SCR for any supervised individuals managed at MAPPA Level 2 or 3. The Head of Public Protection should make the MAPPA coordinator aware of any cases where a discretionary review might be required, particularly where there has been a homicide and there is no other multi-agency review process.

Sequencing

In terms of sequencing, given the different timescales, the SFO review will normally have been prepared some time prior to the IMR being commissioned, and as such the IMR could be informed by the SFO review documents, and could contain all the relevant information identified within the SFO review. This can also include the relevant learning points identified in the SFO review.

Sharing the SFO review

There may be occasions where the Chair of an independent review requests a copy of the SFO review. The PS should consider how best to support the parallel review and may, in some circumstances, provide a copy of the SFO review to the Chair on the basis that it is not shared more widely. This may be most relevant where the SFO review has been disclosed to victims who may offer to share the review with the Chair or wish to discuss its contents with them and probation regions may consider the implications of partners seeing the report second hand. HMPPS SFO Team are available to discuss individual cases. This should not detract from the value of a bespoke individual management review which will focus on the areas of most relevance for the particular review process.

2.7 Inquests

An inquest is a formal investigation led by a Coroner to find out the identity of the deceased and when, where and how they met their death (by what means and in what circumstances). An inquest is usually held in a Coroner's Court. It is a public hearing, open not only to those directly involved but also to the general public and the media.

The Coroner is an independent judicial officer appointed by the local authority who must have experience as either a lawyer or a doctor.

There may be preliminary hearings – "pre-inquest review hearings" – before the final hearing.

The Coroner hears the evidence afresh at the inquest and conclusions are reached independently of any other reports. An inquest is not the same as a civil or criminal trial, there is no prosecution, claimant or defendant, and it is not an exercise to establish fault or blame or determine criminal or civil liability.

At the close of the inquest the Coroner may also make a report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 of the Coroners (Investigation) Regulations 2013 with recommendations to prevent future deaths.

In certain circumstances an inquest may take place before a jury. This always happens following a death in a prison and sometimes following a death in an AP or where a supervised individual has murdered a member of the public. Jury participation provides an additional safeguard in cases where someone dies whilst under state care or who dies in unclear circumstances whilst required to reside in conditions overseen by the state such as in an AP. This gives public accountability to help to meet the state's obligations under Article 2 European Convention on Human Rights - 'the right to life'

In cases where there has been a loss of life, HM Coroner may request an unredacted copy of the SFO review and this is likely to be shared with interested parties, including the family. The PS may consider providing a redacted copy of the review and request the Coroner share this version with interested parties, although this is a matter for HM Coroner. Recent trends have seen more Coroners requesting SFO reviews and an increased focus during inquests on their findings, judgments and any systematic failings.

Regions must contact Government Legal Department's (GLD) by email at the earliest opportunity following a request for information from the coroner's office and where there has been a serious further offence, copy in HMPPS SFO Team. Each case will be considered on its merits but the usual approach is that lawyers for the PS would advise they take a neutral stance on whether to re-open the inquest. There may be some cases where it is clear that there is no good reason to further examine events in this way and the cost to public funds is therefore not reasonable. Counsel's role is to put information in its proper and operational context. Instruction to counsel is to be facilitative, diligent and proactive, even where probation may be open to potential criticism.

Comprehensive guidance about involvement in the coronial process, including staff being called as a witness is available on EQUIP using the search term "inquests". There is also a video available here that can be accessed using the password "julian".

3. The SFO Review and Action Plan

3.1 The role of the reviewing manager (RM)

The SFO notification and review procedures are intended to provide rigorous scrutiny of those cases where supervised individuals under the management of the PS have been charged with a specified violent, sexual or terrorist offence. RMs are asked to determine whether everything was done which might reasonably have been expected to manage the supervised individual's risk of harm effectively. It is therefore essential that RMs have:

- up to date professional knowledge of risk assessment, risk management and sentence delivery;
- a good understanding of applicable local and national policies, procedures and guidance;
- the authority locally to make recommendations for improvements in policy and practice.

It is the role of the RM to provide a robust and transparent account of probation practice to identify and drive forward appropriately focused learning. This is achieved by the completion of a comprehensive internal management review, including an action plan, which will be shared with victims/victims' families and the Coroner in some cases.

To fully understand practice, the RM is expected to interrogate case records and interview practitioners and managers to establish events and critical decisions made and to identify good practice, missed opportunities and areas for development. The RM's role is to question and challenge practice at all levels and the application and suitability of local, regional or national guidance and policy, to make evidence based judgments and identify the need for learning in order to enhance the future management of cases.

Before writing a SFO review, the RM must be familiar with this guidance and new RMs should complete any local or national SFO training that is available. Line managers can arrange attendance at dedicated training for new and experienced reviewers which includes face to face events and digital resources.

3.2 The period to cover and focus of the review

The starting point of the review should normally be the commencement of the current sentence, this includes examination of the pre-sentence stage where relevant. The review should consider practice up to the date of the SFO or the end date of the SFOs where there are more than one. However, in some cases the scope of the SFO review may be extended. If the supervised individual was in the community for a period of time following the SFO, because either the SFO was undetected or they were under investigation/police bail, and the review has identified significant practice concerns in the period immediately prior to the SFO, then consideration should be given to reviewing practice during the post SFO period. Decisions should be taken on a case by case basis and advice should be sought from HMPPS SFO Team if necessary.

Where possible, the SFO review must cover a period of at least 6 months. If at the point of the SFO, the supervised individual had 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 must also examine practice during that previous sentence. Reviews do not need to cover all previous continuous orders and, where appropriate should go back no further than two years.

It is important that SFO reviews are as concise and focused as practicable, this will help ensure greater accessibility for victims if the review is shared at a later stage. RMs should therefore focus on analysing the most recent significant events, in most cases this will be the 12 months preceding the SFO. RMs should provide summary entries for the earlier stages of sentence and must make professional judgments to determine the need for more focused analysis on events during that period that had a significant impact on risk assessment and case management. For example, it would be appropriate to provide a detailed analysis of a pre-sentence report if it had an impact on the management of the case, a poor proposal or vital information was overlooked which resulted in an inaccurate assessment of risk. In other cases where the PSR was completed some time ago and did not materially affect the management of the case, analysis of the practice may be minimal and a summary of any relevant information from it provided for context only.

Where the supervised individual was serving a particularly long sentence at the point of the SFO, for example a life sentence, it can be helpful to consider grouping any significant events into entries by year, keeping these concise and focussed. RMs should consider more detailed examination of practice from the point of pre-release planning or, where the supervised individual had been managed for a lengthy period in the community prior to the SFO, the focus should be on the 12 months preceding the SFO.

Each case should be considered on its merits. RMs should contact HMPPS SFO Team if they are unclear of the period to cover or what practice to focus on within the review.

Offender Management in Custody

Prison Governors should be familiar with the Public Protection Assurance Tool which addresses the prison's role in the SFO Procedures. Further guidance can be found here in Equip Oversight and Assurance of Public Protection. There will be occasions where the prison may be commissioned to undertake reviews outside the SFO procedures; this policy makes no change to those reviews, which are largely multi agency reviews commissioned under statute or statutory guidance. Information about them is included in the Public Protection Assurance Tool. There may be very exceptional circumstances where there is a commission for the prison to undertake their own management review outside of those multi agency reviews.

The production of the SFO review is the responsibility of the regional probation SFO Teams. They will be responsible for the review of offender management during the custodial period and will not require prisons to provide individual management reviews or to collate data. The RM will be looking at offender management policy, procedures and practice and not prison practice as a whole.

The SFO review should focus on the most recent practice. The RM will focus on the pre-release work, release planning undertaken by the Community Offender Manager (COM) and post-release supervision. The RM will consider the risk assessment completed by the Prison Offender Manager

(POM) as part of the handover to the COM and the quality of the handover itself. Therefore exploration of the custodial phase of a sentence can usually be summarised to include a narrative about sentence progression and any key events. The OMiC case notes that POMs use to record will appear on Delius, as should all the keyworker entries. OMiC case notes guidance can be found in Equip here.

In most cases a review of these records will provide sufficient information. However, there will be some reviews where the RM will need to interview the POM and relevant managers, usually the Head of Offender Management Delivery (HOMD). Interviews will normally only be required in cases where the actions of the POM or their manager had a direct and significant impact on the ongoing management of the supervised individual post release. For example, in some reviews the RM may consider that a sentence plan or a recommendation for progression was very significant and requires an interview with the POM to better understand the approach taken.

The RM will liaise with the HOMD about arranging an interview with the probation POM. If the RM would like to interview the HOMD or there are significant practice issues for the prison, they should first discuss the case with the Regional Head of Service, nominated by the Regional Probation Director to link with the HOMD, who can liaise with their prison line manager, usually the Governor or deputy Governor.

If the supervised individual was located in a prison outside of the home region, the Head of Service will liaise with the relevant Head of Service in that region to support communication with the prison.

If the POM is employed by the prison, the RM should ask the HOMD to arrange an interview with them via their line manager. Interviews for the SFO review will ordinarily involve only the staff members concerned and the RM. If a prison employed POM asks for union attendance at the interview, the HOMD should explore the reason for this request on a case-by-case basis, see Section 9 for further guidance.

By the end of the interview, staff who contributed to the review should have an understanding of how their work will be reflected in the SFO review and any learning for them. The RM should share any significant findings following interviews, and discuss any actions and the implementation of learning with the prison in advance of producing the action plan.

If during the course of the SFO investigation the RM identifies issues about the practice of the POM any related learning should be shared with the relevant line manager to take forward ,if relevant, even if they were not so significant to the review that an interview is required, (the practice of the POM may have developed since then) outside of the SFO action plan. The review should confirm this action has been taken.

In the event that there has been significant learning for the prison and the SFO review is shared with a victim, it is for the Head of PDU to advise the prison via the nominated Head of Service of the date of the meeting and if they would like to discuss how best to present the findings and actions for the prison.

Where more than one Probation region is involved

The probation region managing the supervised individual at the time of the SFO must take responsibility for co-ordinating and writing the review and submitting the completed document to HMPPS SFO Team. There will be occasions where other probation regions, have been involved in the management of a case during the period under review. In such cases, the RM should liaise with colleagues to ensure information is fully incorporated into the review. Staff from other regions must be available for interview. The RM must provide feedback to colleagues on the content of the review and agree any learning points in advance. The RM should provide a copy of the completed SFO review to the relevant SPOC and Regional SFO Team manager. Where a difficulty or difference of opinion between colleagues emerges in such a way that the review process may be undermined, this must be raised with the head of HMPPS SFO Team by the region concerned with a view to seeking a resolution.

If a contracted agency has provided an intervention to the supervised individual, the reviewer should examine their practice in the review.

3.3 What practice to cover in the review

3.3.1 Prompts

Having decided the period to focus on within the review (using the guidance at section 3.2), RMs should use the prompts in this section to help determine the relevant issues that should be considered, analysed and included in the review where relevant.

The prompts have been devised to broadly align with the current HMI Probation inspection standards and the associated case assessment rules and guidance (CARaG), covering the areas of assessment, planning, implementation/delivery and reviewing. RMs should ensure that they are familiar with both documents which can be found at standards and ratings and case assessment, rules and guidance.

The prompts are intended to help guide RMs' thinking and ensure all aspects of the case have been considered. They are not meant to be prescriptive; RMs must make their own judgments about the practice issues that are relevant and significant to each case and should feature within the review and summary. For example, as mentioned at section 3.2, it would be appropriate for a RM to provide a detailed analysis of a pre-sentence report if it had an impact on the management of the case, a poor proposal or vital information was overlooked which resulted in an inaccurate assessment of risk. In other cases where the PSR was completed some time ago and did not materially affect the management of the case, analysis of the practice may be minimal and a summary of any relevant information from it provided for context only.

Assessment

To inform sentencing, a PSR and accompanying risk assessment may have been completed. Following sentence there should have been a detailed written assessment of the likelihood of reoffending and the risk of harm posed to others, completed by a probation practitioner. This should include relevant information, including past offending and behaviour, as well as the impact

on victims. RMs may find it helpful to refer to the Probation Service AQA guidance for more detail about quality expectations in relation to written assessments.

It is expected that RMs provide an overview of the areas assessed as being linked to risk of serious harm and reoffending, risk levels, imminence, who is at risk and the factors that may increase/reduce risk in the assessment completed at the start of the review period. In some cases, this will include an understanding of the content of the risk assessment completed at the PSR stage. This will enable the reader to better understand the case and the areas risk management and sentence planning should have initially addressed.

It is for the RM to determine the level of examination given within the review to the PSR and initial post-sentence assessment, having considered the quality/significance of the assessment and the period of practice on which the review will focus. In all cases RMs are expected to provide a full analysis of the quality of the first assessment completed during the more focused review period, with a summary and analysis of any changes in entries thereafter.

Assessment work goes beyond completing a written assessment on the appropriate electronic tool within a reasonable timeframe. Assessment is a continuous process and work also takes place in supervision meetings, with the supervised individual and when they are in contact with external agencies. It is also evident within the custodial setting and includes home detention curfew (HDC), release on temporary licence (RoTL) and the parole process.

Assessments should be well-informed, analytical and personalised, actively involving the supervised individual. The RM must consider whether or not all reasonable action was taken in relation to assessment practice, giving due consideration to the following where relevant:

- Was a PSR and risk assessment completed to inform sentence? What was the quality? Did the practitioner obtain and draw sufficiently on relevant available sources of information? Consider previous probation assessments, other assessments including ASSET if previously managed by the YOS, assessments from health providers, specialist assessments, information on ViSOR, checks with other agencies etc.

- In relevant custodial cases, were clear and appropriate assessments undertaken to inform home detention curfew (HDC), release on temporary licence (RoTL) and the parole process?

- Were post sentence risk assessments sufficient and timely? What was the quality of the assessment completed at the start of the focussed review period?

- Did the practitioner obtain and draw sufficiently on relevant available sources of information to inform initial risk assessments? Consider previous assessments including ASSET if transferred from the YOS, assessments from health providers, specialist assessments, information on ViSOR and information regarding the custodial part of sentences where appropriate.

- Was the written assessment informed by up to date checks with other agencies, including the police about domestic abuse serious group offending (SGO, including gang affiliation)

and serious organised crime (SOC) and social services about vulnerable adult and child safeguarding?

- Did the assessment identify and analyse offending, including current and past behaviour/patterns and convictions? Did it accurately identify the criminogenic needs? Were appropriate specialist tools, assessments and guidance utilised e.g. PD formulation, extremism risk screening tool (ERS), SARA, RM2000, ARMS, HMPPS Risk of Serious Harm guidance. To what extent were supporting assessments referred to within the written risk assessment?

- Did the written assessment clearly and accurately identify and analyse risk of harm to others, including identifying who is at risk and the level and nature of the risk? Did it take into account static, acute and dynamic risk factors? Did it reflect the RoSH summary? Were imminence and factors that would increase and reduce harm clearly set out?

- Did the written assessment describe any specific concerns and risks related to actual and potential victims, including to the victim of the SFO?

- Was the supervised individual meaningfully involved in the assessment of their risks and were their views taken into account? Did the assessment identify their strengths and protective factors?

- Did the assessment analyse the supervised individual's motivation and readiness to engage and comply with the sentence? Was there active consideration of barriers to compliance including assessment of previous breaches or enforcement?

- Did assessment practice include an up to date analysis of the individual's diversity and personal circumstances, and consider the impact these had on their ability to comply and engage with supervision?

- Where a full RoSH analysis was indicated but exempted, was the rationale explained and defensible?

- What was the quality of countersigning practice?

- Was the written risk assessment communicated to all relevant parties?

- Did assessment practice sufficiently focus on keeping other people safe?

Planning

The assessment should lead to clear plans for delivering the sentence in order to reduce the likelihood of further offending. Additionally, where a risk of harm to other people is identified, there should be a plan for managing the risk. RMs must be mindful of the identified risk factors and consider how they are addressed within the plans. Clarity must be provided within the review about the identified risk management activity within the focused review period, including a summary and full analysis of the content of the plan, with an overview and analysis of changes to the plan in entries thereafter. It is for the RM to determine the level of examination given within

the review to previous plans, having considered the quality/significance of them and the period of practice on which the review will focus

Planning should be: driven by the assessment, holistic and personalised and should actively involve the supervised individual. Planning is not limited to the formal assessment tools and also includes preparations for release.

RMs may find it helpful to refer to the PS AQA guidance (search 'AQA' on Equip) for more detail about quality expectations in relation to written plans.

The RM must consider whether or not all reasonable action was taken in relation to planning practice, giving due consideration to the following where relevant:

- In custody cases, was there clear evidence of pre-release planning, including handover to the COM at the relevant point in the sentence? In all cases is there evidence of the COM having sufficient contact with the supervised individual and liaising with the POM appropriately? Is there evidence of MAPPA referral, plans for accommodation, liaison with other agencies? Were all relevant licence conditions included? In relevant cases, did the parole board make specific comments about risk on release and associated planning that needed to be considered?

- What was the quality of the risk management plan (RMP)? Does the plan address all factors identified in the risk of harm assessment?

- Did the plan consider all necessary constructive and/or restrictive interventions to manage the risk of harm? Are additional conditions/requirements proportionate to the risk posed?

- Did the plan make appropriate links to the work of all other agencies involved with the supervised individual, including those related to victim safety and/or safeguarding?

- Did the plan clearly set out the intended frequency of contact with probation and other agencies? Did plans include multi-agency liaison and clearly identify SMART actions for all parties?

- Did the RMP address risks to identifiable victims or potential victims and include sufficient plans relevant to safeguarding children, vulnerable adults and named individuals at risk, including actions to managed DA risk? Did it include appropriate actions to safeguard the victim of the SFO where there were known risks?

- Was there clear evidence of necessary and effective contingency planning to address the breakdown of positive factors and risk escalation issues? Is it clear what the required actions were, in what circumstance they should happen and, who needed to undertake them?

- In MAPPA cases, were timely and relevant screenings undertaken? In level 2 and 3 cases, did probation planning fully reflect the RMP agreed by MAPPA?

- What was the quality of the initial sentence plan?

- Was the supervised individual meaningfully involved in sentence planning, and were their views and, where appropriate, diversity (e.g. maturity and leaning needs) and personal circumstances taken into account? Was their motivation and capability considered. Was the plan outcome focused?

- Did the plan set out how all the requirements of the sentence or licence/post-sentence supervision would be delivered?

- Did the sentence plan set a level, pattern and type of contact sufficient to engage the supervised individual and to support the effectiveness of specific interventions?

- Did sentence planning sufficiently reflect offending and risk related factors and build on strengths, protective factors and supports?

- Did the plan set out the services, activities and interventions most likely to reduce reoffending and support desistance? Was the plan realistic and sequenced effectively?

- In child/adult/victim safeguarding cases was there a specific sentence plan objective to address RoSH?

- What was the quality of countersigning practice?

- Are there links between the gaps in both assessment and planning in the case?

- Did planning focus sufficiently on keeping other people safe?

Implementation

The risk management plan should be implemented as intended, ensuring all required actions are undertaken to protect the public. The sentence plan should lead to the delivery of high quality well-focussed and individualised services which engage the individual.

The RM must consider whether or not all reasonable action was taken in relation to implementation practice, giving due consideration to the following where relevant:

- Was allocation of the case prompt, accurate, and based on sufficient information in respect of: allocation to, the correct organisation upon sentence (in pre-unification cases) and to an appropriate practitioner?

- In custody cases, was the case managed in line with OMiC expectations. In high RoSH cases, is there evidence of omissions/deficits in POM practice that significantly impacted on the subsequent management of the case and which need to be examined?

- What was the quality of the implementation of the risk management plan? Comment on effectiveness and timeliness issues.

- Was sufficient attention given to protecting identified victims and potential victims, including the victim of the SFO where there were known risks?

- Were home visits undertaken where necessary to support the management of risk of harm ?

- Were all rehabilitative and restrictive measures appropriately monitored and addressed?

- What was the quality of communications and information sharing between all relevant staff and agencies? Was the involvement of other agencies in managing and minimising the risk of harm sufficiently well-co-ordinated? In MAPPA & MARAC cases or where there were child safeguarding or IOM meetings, the minutes from the meetings should be examined to determine if all relevant processes were followed. What actions arose from meetings for all agencies and were probation actions delivered?

- Was a timely, pro-active and investigative approach taken by practitioners and managers in relation to information received and new and emerging risks? Was there evidence of professional curiosity? Did staff effectively collect, verify and evaluate information/the supervised individual's account of events?

- Was there appropriate and effective decision making and enforcement practice by staff at all levels?

- If there was evidence of risk escalation, did staff make sound decisions and put appropriate measures in place to mitigate the risks in line with contingency plans e.g. liaison with partnership agencies, use of enforcement or control measures, obtaining guidance from a manager or addressing the risk through rehabilitative intervention? What was the response by practitioners and managers to escalating risk/emerging concerns? Was/should recall have been considered? Were sufficient alternative risk management strategies put in place? Was there scope for alternative action sooner? Were any critical decisions detrimental to effective management of the case? Comment on the risk escalation process (CRC held cases), where applicable.

- Were licence conditions and supervision requirements explained to the supervised individual in a way they could understand?

- Was sufficient focus given to maintaining an effective working relationship with the supervised individual? Were sufficient efforts made to enable the supervised individual to engage and complete the sentence, including flexibility to take appropriate account of their personal circumstances?

- Was the sentence plan delivered effectively? Were the requirements of the plan commenced promptly, or at an appropriate time?

- Was a timely, pro-active and investigative approach taken to the supervised individual's attendance and compliance with all requirements of the order?

- Was action taken to support compliance and was appropriate and timely enforcement action taken if necessary?

- Was the involvement of other agencies in service delivery sufficiently well-co-ordinated?

- Did sentence plan delivery focus on the areas most likely to reduce reoffending and support desistance, with sufficient attention given to sequencing and the available timescales? Did it build on strengths and protective factors and engage key individuals in the supervised individual's life to support desistance and the management of risk of harm?

- Did supervision focus appropriately on managing and minimising the risk of harm to others? Was the level and nature of contact offered sufficient?

- Was line management oversight and support timely and congruent with the risk and needs of the case and the experience, skills and needs of the practitioner? RMs can refer to the Touchpoint Model (search 'touchpoint' on Equip) for detail about expectations from March 2021 forward.

- If the supervised individual was transferred at any point during the sentence, was there a sufficient exchange of information and appropriate action taken to assess and manage any risks relevant to the transfer?

- Was there clear, timely and effective recording of information across the supervised individual's case record? Is there evidence of appropriate professional judgments being made about practice? Were crucial decisions recorded and defensible[1] and carried out?

- Were all reasonable steps taken?

- Was practice in line with expectations? Were national and local policies and procedures followed and appropriate? Are any changes needed?

- Are there links between the gaps in assessment, planning and implementation?

- Does implementation sufficiently focus on keeping other people safe?

Reviewing

Assessment is a dynamic process with significant new events and information leading to the need for review. Plans should also be reviewed frequently to ensure they are up to date. There should also be a regular review of progress and an effective response to changes in the supervised individual's circumstances, behaviour and compliance.

In addition to the prompts below, those in the assessment and planning sections above are relevant here.

[1] Kemshall, H. (1998) Defensible Decisions for Risk: Or It's the Doers Wot Get the Blame. Probation Journal, 45 (2) 67-72, http://prb.sagepub.com/content/45/2/67.abstract

Kemshall, H. (2009) Working with sex offenders in a climate of public blame and anxiety: How to make defensible decisions for risk. Journal of Sexual Aggression, 15 (3) 331-343; http://www.tandfonline.com/doi/abs/10.1080/13552600903031195

Where relevant, the RM must consider whether or not all reasonable action was taken in relation to reviewing practice, giving due consideration to:

- If reviewing was timely?
- If written reviews were completed as appropriate, including following significant events, as a formal record of the management of offending, desistance and harm? What was the quality of written reviews of assessment, the RMP and sentence plan?
- Did reviews take into account all new information? Did they include up to date DA, SGO, SOC and safeguarding checks with other agencies?
- Were they informed by necessary input from/checks with other agencies working with the supervised individual or responsible for the management of risk of harm?
- Did the reviews identify and address changes in factors linked to offending, desistance and harm, including following significant events, with necessary adjustments being made to the ongoing plan of work?
- Was the supervised individual encouraged to contribute to reviewing their progress?
- What was the quality of countersigning practice
- Were written reviews communicated to all relevant parties
- Were professional judgments recorded where written reviews were not undertaken? Were these appropriate?
- Did reviewing practice effectively support the supervised individuals' compliance and engagement? What adjustments were made to overcome any barriers?
- Did reviewing involve appropriate discussion with and input from managers?
- Does reviewing focus sufficiently on keeping other people safe?

3.4 How to write the review

The SFO review template can be found at Annex D with associated guidance at Annex D(i). The action plan template and related guidance can be found at Annexes E and E(i).

RMs must be familiar with the HMPPS and HMI Probation Quality Assurance (QA) standards for SFO reviews introduced in April 2021. The QA standards can be found here and provide a consistent framework for the HMPPS SFO Team and HMI Probation to apply to the content and quality of reviews. The standards are a useful reference tool for RMs to obtain a good understanding of the focus of quality assurance when looking to establish the sufficiency of a review.

3.4.1 Quality assurance standard 1: Analysis of practice

The SFO review should provide a robust and transparent analysis of practice

The analysis of practice requires RMs to identify, examine and make evidence based judgments about:

- whether all reasonable action was taken, including expected practice, crucial decisions and missed opportunities at all levels of the organisation, with particular focus on the management of known risks relevant to circumstances of the SFO
- the reasons for any deficiencies in practice where they exist
- good practice
- the sufficiency of local and national policy and procedures
- the level, nature and quality of multi-agency working, including liaison, information sharing and referrals.

RMs must provide a thorough examination of practice in the areas of assessment, planning, implementation and reviewing. The review should provide details about key events including clear and succinct evidence about what has happened and whether or not all reasonable action was taken, then go on to provide a critical analysis of practice. Focus should be given to the issues pertinent to the case to ensure transparency, including what was done to manage the supervised individual effectively, any crucial decisions and missed opportunities. However, RMs do not have to refer to all aspects of practice if they were sufficient and not relevant to the specific detail of the case management and if they are not required to make sense of the management of the case.

RMs should avoid hindsight bias and distinguish between what was known at the time, what should, or might possibly have been known; and what is now known.

Good practice must be clearly identified, setting out why it has been acknowledged, and any impact it had on the case. It is also important for the review to identify where practice expectations were met in any key areas as this will provide the reader with a more balanced view about what was done well along with any omissions.

RMs should make clear judgments about the sufficiency of practice, policy and procedures and comment on the significance of any crucial decisions and omissions and the impact they had (see victims standard below for further details). Any links between risk and the circumstances of the SFO should be clear. RMs should also explore the reasons for any omissions in practice (see below).

When highlighting deficits/omissions/inaction, RMs should consider the way in which these are described. Where there are clear and significant failings then it is appropriate to say so and use such language. However, RMs should be mindful of using condemning language unnecessarily, for example, it may be more appropriate to say “PP1 did not….” rather than “PP1 failed to”, particularly where the inaction was not considered to be significant.

Exploration of the underpinning reasons (the "why?")

RMs should not just describe what happened but must fully explore and reflect an investigative approach to consider all pertinent underpinning issues in the review to provide reasons for **why** significant deficiencies and omissions occurred. If RMs do not know what caused deficiencies then it will be difficult to identify effective learning in the action plan to ensure they don't happen again.

A well written review will provide a comprehensive exploration of all relevant issues and challenge all relevant staff and processes. RMs should therefore thoroughly investigate practice at all levels of the organisation including the work of probation staff within prisons where this had a fundamental impact on the management of the case and the work of other probation regions where the case has been transferred between regions. This should include interviews with practitioners, managers and senior managers. **Explanations should be sought until there is clarity about the causes of the deficiencies**. This means that RMs should challenge explanations provided by staff and critically explore the validity of them. For example, excessive workloads can be a valid reason for deficiencies in practice, and can be verified using WMT figures, but should not be relied upon to explain issues that may stem from deficits in training, knowledge, understanding and skill. A key consideration should be whether or not practitioners prioritised risk issues.

The review should also go beyond focussing on the conduct of individual members of staff and whether correct procedures were followed, to evaluate whether systems and processes were sound and whether local or organisational structures and local and national policy and procedures supported getting the best outcomes for rehabilitation and public protection.

<u>Exploring practice with practitioners and managers</u>

Where there are deficiencies or gaps in the way the case was supervised, RMs should interview relevant practitioners responsible for the management of the supervised individual. The review should not be confined to examining the practice of practitioners; RMs should avoid taking a narrow focus and should consider if deficits were specific to the case, to the practitioner, or of wider local or organisational concern. The practice of managers should also be examined where they have had, or should have had, direct involvement in practitioner and case oversight and crucial decision making.

Managers have the responsibility to create an environment with clear expectations and in which processes can be followed and policy applied. They should effectively countersign, induct and support new staff, monitor the work of and regularly supervise their staff, ensure they are meeting expected practice requirements, undertake case reviews, provide guidance and make crucial decisions. Managers should also ensure staff have attended mandatory and developmental training and address any concerns that arise or they may express, including workload pressures or other support needs, for example. The role of senior managers should also be examined where relevant, including any crucial decisions around enforcement and management of the case or wider organisational issues or strategic decision making that may have had an impact.

RMs should explore in interview and reflect in the review:

- the role, experience and skills of the practitioners/managers involved. Were there gaps in experience, skills, knowledge, understanding and training?
- why staff involved think the error(s) happened;
- was there anything that should have prevented the error, if so why was it not effective?;
- what was the context - were there things that made the work with the supervised individual difficult or challenging e.g. in crisis, difficulties engaging other agencies
- if resourcing or management decisions made the error more or less likely, how aware were managers of the issue and what was their response?
- how did individual practitioners deal with any workload issues?
- whether there were gaps in the provision of management oversight and support? Staff supervision notes should be used to determine levels of supervision/support where possible.
- if practice issues identified were confined to the case or were of wider concern at an individual, team and regional level. For example, whether the required level of support for new staff or effective countersigning was prioritised by middle or senior managers across the board. RMs may choose to dip-sample other work of staff to determine if the issues were of wider concern, or conversely, if practice has developed.
- equality and diversity issues, including whether reasonable adjustments had been implemented for practitioners with particular needs or disabilities
- if action needs to be taken to improve practice or if improvements have already taken place

Where gaps have been identified in practice, RMs should explore the practice of those staff with their relevant managers and senior managers (in some cases this may include Heads of Operations) to provide further context about why deficiencies may have occurred. The RM should explore and reflect in the review:

- the views of relevant managers on gaps in the practice of their staff, their general practice, experience, skills, knowledge, understanding and training - with an awareness of manager bias e.g. is their work being checked or is there an assumption they are a good practitioner/manager. It is good practice for RMs to conduct dip samples of practice in other cases to establish if a deficiency identified in the SFO review is of wider concern in relation to more general practice.
- any capability issues - previous or current
- if issues identified in practice are confined to this case or are of wider concern across the individual's caseload, the team, PDU and region

- the need for development and training and related learning to be included in the action plan

Exploring organisational issues and multi-agency working

RMs should also explore with appropriate staff and include in the review, any relevant organisational issues at local, regional and national levels including:

- staff awareness/understanding of, adherence too and the effectiveness of expected practice, processes, systems and guidance and policies in place at all levels of the organisation. Were the right guidance, systems, policies and procedures in place? If so, why weren't they followed? Or were they followed but not sufficient for effective practice? Were there gaps in processes, guidance and policy? Are improvements planned or have they already taken place? Does the RM think organisational processes are appropriate? **RMs shouldn't be afraid to challenge**

- was guidance followed and were appropriate systems used by all staff at all levels?

- issues relating to the culture in the team, PDU or region

- resource, staffing and workload issues and impact. Were managers aware? What was being done to address these? Are they ongoing issues? If workloads were a concern, had the staff member raised this? Use evidence from WMTs where possible. Avoid over-reliance on workloads or organisational changes where there was a fundamental aspect of expected practice missed that was inexcusable.

- interface issues

- effectiveness of and/or gaps in multi-agency working arrangements and information sharing agreements with partner agencies? For example, issues related to referrals, engagement with and liaison/information sharing/joint working between agencies such as the police (DA and SOV cases) and children's services (safeguarding cases). In some cases it will be appropriate for RMs to consider whether or not staff felt able to challenge the decision making of other agencies.

Consideration of organisational issues may include the need to review any critical public protection casework (CPPC) or NSD involvement in the case. For instance, RMs may need to consider interviews with relevant NSD managers to explore decision making in response to referrals. If the examination of this practice identifies any relevant learning, the RM should share and agree the findings and learning with the appropriate NSD manager as part of the review process.

Gaps in probation processes in relation to multi agency working need to be explored with relevant probation staff to inform the need for learning. However, issues that relate to the practice of other agencies do not need to be explored with those agencies for the purpose of the review (but should be used to inform an objective within the action plan to ensure any potential learning is shared with the relevant agency - see learning section for more information).

When commenting on the impact of organisational issues on deficits in practice, RMs should assess the work undertaken in line with the organisation's policy and procedures to consider whether the probation region managed the case in line with expected practice. There may be occasions where probation staff worked in challenging circumstances with high caseloads which RMs considered had a detrimental impact on performance. If this is the judgment made, it is reasonable for the RM to say so and set out the basis on which that conclusion is drawn. RMs should consider the context of practice and be clear about how external factors impacted on the ability of practitioners, often capable ones, to do their job. In these cases, the review needs to provide an effective examination of the issue, which is fair to the staff member, and to consider how wider resourcing issues have been, or are being, addressed or managed. A good level of engagement with senior management is required to determine any learning or actions for the individual practitioner and / or the organisation. If a RM thinks organisational standards were not achievable, the RM would be expected to set out why in the review, and the extent to which defensible decisions were made in the face of a particular set of constraints. It is important to maintain sight of what expected standards were, even if there were times when they could not be met.

Once the underpinning reasons for omissions have been identified, the RM should be in a good position to consider if action is needed to improve practice or if improvements have already been made and if instead, practice needs to be monitored to ensure they are embedded into practice (see learning section).

3.4.2 Quality assurance standard 2: Overall judgements

The SFO review should provide a clear and balanced judgement on the sufficiency of practice

Once "the why?" has been established, RMs must ensure that they provide clear judgements within the SFO review on the sufficiency of practice in relevant areas. To achieve this, RMs must make clear and fair evidence based and well balanced conclusions to determine whether or not practice met required standards. Good practice, expected practice and any deficits should be commented on to achieve balance. Judgments must be definitive where possible, stating what was and wasn't done well and must be informed by:

- the views of all relevant staff about the case and practice expectations – It is important that RMs' judgments about practice are fully supported by a detailed examination and reflection of the explanations provided by all relevant staff. Where appropriate, RMs must robustly challenge the views of staff to inform their own professional judgement regarding practice.

- consideration of practice of staff at all levels - the RM must make sufficient judgments on the practice of staff at all levels. This includes ensuring there is evidence and exploration of management oversight, structured supervision, training and appropriate support in place for all staff. The RM should have also explored and made judgments about decision making at all levels.

- analysis of systemic or procedural factors in relation to probation practice and decision making – the RM should provide a summary of relevant systems and/or procedures and make judgments on any related issues that impacted on the management of the case.

- evidence of good practice – the RM should make reference to areas of practice that are considered to go above and beyond practice expectations.

- identification of practice that needs to be addressed through staff performance or discipline, where necessary. It is crucial for both the internal management review and the victim's understanding, that the RM makes clear judgments on the relevant areas that were linked to staff performance and provides assurances that action is being taken.

- examination of and judgment on the content of probation policy - An analysis of probation policy by the RM will allow key areas of improvement to be identified, which could inform changes necessary to address deficits.

- Examination of and judgment on probation practice - the RM 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. RMs should also refer to the early look (if completed) and any remedial action already taken, to inform judgments about the need for further development.

- conclusions on partnership working to inform the action plan - the RM must have clearly identified all partnership agencies 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 agencies that might provide support with; substance abuse, mental health, mentoring or other types of assistance. The RM should explore and make judgments on the quality of referral processes, communication of risk assessments and plans and effective information sharing. The RM should review the evidence and information accessible through probation records and where appropriate should access information from partner agency records, where the case records are incomplete, to inform their judgments. For example, in a case where there were known DA risks but the RM could find no evidence of police checks being undertaken in relation to the new partner (who later became the victim of further offending), the RM would not be able to make a fully informed judgment on the impact of the absence of checks, without first establishing what DA checks at the time would have uncovered. Checks by the RM could also include contact with the police about DA history, prolific offending and gang related harm and liaison with social care for child/adult safeguarding information. The RM must clearly identify the information they have independently sought to inform their understanding of the case and their judgments.

3.4.3 Quality assurance standard 3: Learning

The SFO review should enable appropriate learning to drive improvement

The intention of the SFO review is to explore the standard of practice, including when cases have been managed well, sometimes in difficult circumstances. Where judgments have been made that there have been critical omissions, a thorough exploration of "the why?" will enable RMs to identify what needs to be done to effect change and improve future practice.

The review

RMs should identify the need for learning within the SFO review, this should be linked to the key findings. If RMs considers a deficiency does not warrant an action plan objective, (e.g. because training has already taken place or a staff member's high caseload has been reduced), then this should be clearly stated in the review. The review should also identify any actions already taken/underway to improve practice, including any actions identified in the early look that have been prioritised. The RM should consider the progress in delivery of those actions when determining what ongoing actions are still outstanding e.g. if successfully delivered, the impact of such actions may need to be monitored.

The action plan

A well informed action plan is arguably the most important component of the SFO review. The action plan must address all critical areas of concern identified in the analysis, giving particular attention to the issues underpinning the deficits. For example, excessive workloads may have contributed to poor assessment practice, so the plan would need to set out how workloads are being or will be, addressed and monitored. The review should have commented on the organisational response to addressing the issue. Reviews should identify the need for learning, which should then be translated into appropriate actions in the plan for sharing good practice and improving practice for:

- staff at all levels – this should include practitioners and managers. This includes any staff on long term absence and the plan should be clear about how learning will be taken forward upon their return. It should also include learning for staff from other regions or staff working in prisons, who may have been involved prior to/in a case transfer during the period under review. The learning and measurements for progress should be discussed with that region prior to inclusion in the plan and the review should clearly reflect those discussions.

  Where a review has uncovered a significant issue relating to practice such as a fundamental gap in a member of staff's understanding of case management e.g. the PP did not understand safeguarding policy and did not know how to make a CS referral, the RM must consider if this would have impacted on other cases the practitioner managed and must consider the inclusion of a learning point for remedial action e.g. an audit of all relevant cases where appropriate to identify and correct any related significant practice issues.

  Where the review has identified good practice, RMs should avoid simply including actions to feedback to the individual practitioner; feedback should have formed part of the review

process and been provided to staff and managers during interviews or subsequent communications. Sharing good practice should be with a view to supporting practice development in the wider team/organisation.

If concerns are identified about a member of staff's practice and they no longer work for the 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 evidenced.

- the organisation at local (team or PDU), regional and national levels - including actions related to local service level agreements, referral processes, formal and informal lines of communication and national policy. 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 need for action at a national level should be 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 an option where it is clear the change required cannot be achieved without national oversight or input. Any national learning should be agreed with the suitable owner (usually the relevant policy lead) prior to inclusion in the plan ; and

- multi-agency working -actions should aim to improve the way in which probation staff work with other agencies. For example, where a review uncovers issues related to ineffective probation systems in place to liaise with other agencies then this should also be addressed with the inclusion of a learning point for probation senior managers to take forward. Actions should also address the need to liaise with other agencies to share learning where it has been found that the actions of another agency (such as YOT, children's services, the police or mental health agency etc.) have impacted on the management of the supervised individual and the risk of harm. A learning point should be included that requires a senior manager to take the findings forward with that agency, be clear of their response and to evidence an outcome. For example, if the review identified a critical decision by children's services not to take any further action following a referral by probation, and the supervised individual then went on to harm a child, a learning point should be included for senior managers to bring this to the attention of CS and to understand what action they will take as a result.. RMs should not make recommendations that are beyond the scope of the PS to carry out.

If an area of practice, policy or guidance has already been addressed or is underway prior to forming the action plan then the RM should consider the need to include an action to monitor its progress.

The action plan must also:

- contain sufficient developmental activity to affect change - RMs must focus on ensuring that all relevant learning is identified and is translated into developmental actions **that seek to achieve change** and can be progressed and monitored to ensure errors are not repeated in the future. Developmental actions may include, but are not limited to, training, briefings, reflective discussion, revisiting, revising or producing and disseminating guidance or structured input from a quality development officer. Actions should effect

change rather than just measuring improvement by expecting a practitioner to "follow guidance" that was in place when the deficit occurred. For example: If PP1's risk assessment was not sufficient, the action needs to be more than just quality assuring a further selection of assessments . The RM needs to consider what needs to happen or change for the quality of their risk assessments to improve. If they weren't performing to the required standard why would they suddenly do so now without some kind of intervention? What intervention would best help?

- It may be appropriate in some case not to include developmental activity for particular areas of learning and to instead include dip sampling or audit activity as an action. This could apply to those cases where caseload checks are needed to establish the extent of concerns (if this could not be done by the RM during the investigation and interview process), if action is already underway or has been completed (e.g. in high profile cases where the early look identified learning to take forward and those actions have been successfully delivered), or if managers identify that deficits in this case were an anomaly. In such cases monitoring may be the only action required at that stage to ensure change.

  Timescales for the delivery of actions must be reasonable and must take account of any need for immediate action e.g. where there are significant concerns about understanding of fundamental practice issues, need for whole caseload audits etc.

- identify effective measures for evidencing progress/outcomes – It is important for RMs to differentiate between the area for improvement, the developmental actions that need to be taken to achieve change and the method and timescales by which the progress and impact of the intended action is to be measured to ensure that it is embedded into practice. Methods for evaluating the success of actions must include clear measures for managers to evidence change, for example caseload audits with clarity about the scope of the audit/sample, including the numbers of cases to be reviewed and the aspects of practice they will seek to evidence and the timescale for the audit. It should be noted that attendance at training is an action, not a measurement of change – where the action relates to training, the methods to measure progress should include future audit activity to show learning has been embedded into practice. Actions for managers and the organisation may also require auditing activity to monitor change.

- include all areas of good practice that warrant being shared more widely - be that locally or nationally, to improve general practice. This should include areas of work that were particularly effective in the management of the case and demonstrated responsiveness, innovation or 'over and above' actions e.g. arranging an emergency professionals meeting in response to risk information or holding a joint meeting with the supervised individual and the approved premises manager to ensure a collaborative approach to enforcement and promoting compliance.

  RMs should not include practice that has met expected standards where policy/procedure have been correctly followed, unless there is something about how someone achieved this in very difficult circumstances that others could learn from.

Where possible, RMs should formally handover the action plan to relevant colleagues so they are clear on the issues raised by the review, the learning identified and how to progress it.

Finally before signing the action plan off, the RM should consider if it is thorough, clear and SMART and designed to effect change and improve practice.

Multi agency learning panels

HMI Probation intend to hold periodic multi-agency learning panels, attended by all agencies involved in the management of the supervised individual, to share findings, promote collaborative learning from SFO cases and to influence improvements at local and national levels for all agencies.

3.4.4 Quality assurance standard 4: Victims and their families

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

The SFO review is first and foremost an internal management review, although sharing information with those most affected by serious crime is a crucial element of the SFO process – it provides information to certain victims about how a supervised individual was managed by probation and what action has been taken or is planned to address any shortcomings identified in the review. Guidance about sharing reviews with victims is available at section 10 below and on EQUIP 1.1.4.8.7 (1). It is important that the SFO review is transparent by analysing all relevant issues and is accessible to meets the needs of victims. RMs must therefore ensure that the review:

- includes sufficiently accessible language
- is written sensitively to account for the impact on victims
- sufficiently explains the significance of deficiencies and missed opportunities and the impact these had
- sufficiently and transparently focuses on practice relevant to the circumstances of the SFO
- presents sufficient judgments with examples used as evidence to support these

Accessibility and sensitivity of language

The style and tone of language used in all SFO reviews needs to be carefully considered to ensure it is sufficiently accessible and sensitive to account for the impact on victims and their families. Given the review is intended to be an account of the case that is easily digestible for victims/victims' families, too much descriptive content should be avoided.

The document should be clear and concise as it will need to be easily understood by a wide range of professionals as well as the victim/victim's family and in some cases the Coroner. Therefore, reviews should be free from jargon to ensure they are accessible. Any acronyms need to be spelt out in full the first time they are used and should be included in the case specific glossary (see section below). A brief explanation of key terms or processes may need to be included in the review (supported by the glossary) so the 'lay' reader can follow the narrative e.g. the purpose of a risk management plan, the nature of risk escalation and when it applies etc. When referring to 'risk' this will require qualification, for example, 'risk of serious harm', 'risk of harm to others' and 'risk of harm to self. 'RMs should use the active, rather than passive, voice e.g. rather than "a

timely assessment was completed" say "PP1 completed a timely assessment". The word grammar check can be set to assist with this (go to advanced settings to activate this).

Sensitivity should be shown in all SFO reviews. They must be 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.

RMs should ensure the language used to describe practice is measured and not unnecessarily emotive. Where practice was insufficient or fell below expected standards it is right to clearly state this but unless practice was exceptionally poor/egregious, it is not necessary to use more critical language or routinely refer to 'failings'.

Reference to the SFO and the victim

The victim will be aware of the circumstances of the SFO, so any description of the SFO should be factual and avoid unnecessary detail. However, care should be taken to personalise the behaviour rather than relying on the often detached and professional language we are used to. Consider the use of the Judge's comments, if they are available at the point of writing, as these are often more expressive and personal in their account of the offence and contain a level of judgment that we would not routinely demonstrate when completing reports. Avoid using expressions like 'the commission of the offence'

In the interests of security when sharing the documents, victims should be referred to using their initials or anonymised further. The senior manager sharing the review should recognise that this may appear insensitive and explain to the victim or family why this approach has been taken.

Reference to the supervised individual

Reviews can refer to supervised individuals using their full name or initials but, to safeguard against potential loss or wider sharing when reviews are shared outside of the organisation, the review should be amended to show random initials only in the redacted copy to be shared with the victim/victim's family. Again, the victim/their family will know the supervised individual's name but providing a copy of the review to them raises additional information security concerns which can be mitigated to an extent through anonymising identifiers.

Victims of previous/index offences

Any reference should be anonymous, therefore allocating a clear identifier is most appropriate i.e. "A", "B". This approach works well when there are a number of victims and, in domestic abuse cases can be used to identify partners, helping to clearly differentiate between them.

Referring to staff

As above, clear anonymised identifiers should be given. In respect of gender pronouns, RMs should confirm with staff how they wish to be referred to. In cases where the staff member could be easily identified through their gender, e.g. the only male PP in the team, the RM should use gender neutral language.

Examples of other areas that might require additional care and sensitivity are set out in the HMIP RaG.

Impact and significance

RMs must consider and include commentary on the impact and significance of any deficiencies identified in case management so the reader can understand if it was fundamental to the case or if it didn't materially affect overall management. RMs must be clear what they are trying to tell the reader. The reader should not be left second guessing whether the findings were critical or not. Consider the progression of the case - was there a fundamental flaw with a particular aspect of practice that impacted throughout e.g. wrong risk level? If the 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. For example:

"The initial risk assessment in this case was insufficient. There was a lack of consideration given to all areas of known risk, particularly the supervised individual's substance misuse. As a result, neither the risk management plan nor the sentence plan addressed key risk areas and no contingency arrangements were identified. This meant that when the supervised individual disclosed a lapse into cocaine use, the PP's response was weak based on their limited understanding of the supervised individual's past pattern of substance misuse.

Sufficient and transparent focus on practice relevant to the circumstances of the SFO

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 to the 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 any known adults at risk identified, was appropriate safeguarding action taken, was there multi-agency liaison? 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.

Presentation of sufficient judgments with evidence to support them

The RM should set out their judgements on the sufficiency of practice on assessment, planning, implementation and reviewing practice, in a way that is accessible, transparent and meaningful to the victims. Judgments should be supported by clear evidence, with brief explanations to support understanding for a wider audience. 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.

4. Glossary

A case specific glossary of all key terms must be submitted with every SFO review. The glossary will serve to ensure there are clear explanations of all relevant terms. Some standard information has been included in the glossary template e.g. OASys, sentence requirements, risk management plan, sentence plan, licence etc. When completing the review the RM must amend this template to make it case specific e.g. add any additional terms specific to the case and the organisation/division/area. It could include, but is not limited to, the following:

- Specific risk assessment and sentence planning tools
- Interventions e.g. named programmes
- Partnership agencies
- Local risk management meetings
- Local forums/initiatives/joint working arrangements

As well as adding definitions to the standard template, any terms not used within the review should be removed from the template. RMs could consider using bold font type the first time a word/phrase is used in the review to indicate that there is further detail within the Glossary.

The glossary must also reference the documentation/records the RM has examined as part of the SFO investigation e.g. current case file, NDelius records, OASys assessments etc. and should be clear where the RM has been unable to obtain relevant information.

The glossary must contain a list of all practice guidance that informed the review where this is not nationally issued or part of a policy/practice framework, is not readily available on EQuiP and which could not be easily located in archives at a much later date. For example, specific guidance about former CRC policies and procedures.

5. Quality Assurance

5.1 Internal quality assurance and countersignature

Regional Directors must ensure the SFO review is countersigned. This responsibility may be delegated to an appropriate senior manager – the countersigning manager (CM) - who should be independent of the line management of the case.

Prior to sign off the CM should be assured that a manager (usually the Head of the regional SFO Team) has undertaken rigorous internal quality assurance and that, as part of this process, the Head of PDU has had the opportunity to read the review and comment on factual accuracy issues.

Internal quality assurance and countersignature should ensure that:

- the review covers the appropriate period and is written in clear and accessible language, to be understood by a wide range of professionals, the victim/victim's family and possibly the Coroner

- the review is thorough, investigative and transparent, highlighting everything that was done which might reasonably have been expected to manage the supervised individual's risk of harm effectively in the areas of assessment, planning, implementation and reviewing, in line with local and national expectations, policy and guidance.

- clear judgments are made and are supported by evidence

- deficits and good practice are reflected and the underlying reasons and significance and impact of omissions have been explored with all relevant staff.

- appropriate learning has been identified and reflected in the action plan and the organisation can commit to improvements and actions arising from the review.

- the review is focused upon the ways the organisation can learn from what happened rather than apportioning blame.

- a factual accuracy check has taken place

A checklist has been devised to assist with the internal quality assurance and countersigning roles and can be found at Appendix 4.

If the manager undertaking internal quality assurance or the countersigning manager still have questions about aspects of practice or other concerns about content after reading the review documents then these need to be addressed before submission to HMPPS.

Where a review identifies that there has been very poor practice, the CM must indicate when signing off the review, any consideration given to instigating capability/poor performance or disciplinary procedures.

When countersigning the action plan, if the actions of staff in another region or establishment are assessed to be significant, the CM should include information to confirm what action has been taken to agree the learning or how it will be shared moving forwards.

The CM should not sign off and send a review to HMPPS SFO Team until they are satisfied that the content is of the expected quality.

CMs should also consider DPA advice at section 7 about necessity, proportionality and impact when signing off the review or prior to wider sharing.

5.2 External quality assurance: The role of the HMPPS SFO Team and HMI Probation

Prior to 1 April 2021, HMPPS SFO Team quality assured all SFO reviews. HMI Probation (HMIP) now have a role in the quality assurance (QA) process and will assure a random sample of 20 per cent of completed reviews to an agreed set of QA standards, which are accompanied by Rules and Guidance and new QA ratings. HMPPS SFO Team also quality assure in accordance with these documents, copies of which can be found here. HMIP will notify probation regions where the SFO review has been allocated to them for quality assurance and will provide the feedback direct to them.

HMPPS SFO Team will QA the information provided in SFO reviews and will not normally refer to other source material, however if this is required on occasion then the team will advise the region in their feedback that that nDelius records or other case details have been accessed by them to assist with the QA validation process.

Quality assurance will consider whether a robust, transparent and accessible review has been completed, whether the key issues have been identified and if there is appropriate analysis of and evidence based judgements made on the sufficiency of practice in the areas of assessment, planning, implementation and reviewing. The QA includes checks that an appropriate action plan is in place. The QA process will consider similar issues to those set out in the internal quality assurance checklist (Appendix 4)

Feedback from HMPPS SFO Team will be provided in a narrative format and will comment on each specific QA standard, including the style, language and content of the report in terms of its accessibility and sensitivity to victims.

The QA will also consider if all review documents have been appropriately countersigned to a sufficient standard

HMPPS SFO Team may comment on redaction and disclosure issues although it is the responsibility of the region to ensure the review is suitable for sharing, is compliant with the DPA and GDPR, and contains all the information that can be legally shared with the victim.

Regular benchmarking events take place between HMIP and HMPPS SFO Team to check that standards are being applied consistently. HMI Probation also intend to undertake benchmarking sessions with regional SFO Teams.

5.2.1 QA Ratings

Deciding on ratings is not an exact science and whilst each case is considered individually, HMPPS SFO Team and HMIP use the QA rating characteristics framework (RCF – found at HMI Probation QA Standards) as a guide to assessing quality. Each review will be rated and scored according to how it has met the expectations of each of the four QA standards (see the RCF for more detail about expectations and scoring) in the areas of analysis, judgment, learning and victims and families. Each of these standards will be rated as either outstanding, good, requires improvement (RI) or inadequate. The scores available for each of the four standards are as follows:

Outstanding = 3 points

Good = 2 points

Requires Improvement = 1 point

Inadequate = 0 points

The scores from each of the four standards will then be totalled to give the review a composite/overall quality rating.

0 – 2 points	Inadequate
3 – 6 points	Requires improvement
7 – 10 points	Good
11 -12 points	Outstanding

HMPPS SFO Team and HMIP will provide narrative feedback about the review, which will include details of and reasons for these ratings, to the Head of Operations (copied to the Head of PDU, regional manager of the SFO Team and SFO SPOC) that will either:-

- endorse the content of the review on the basis of the evidence provided, rating the content as “outstanding” or “good” – some minor amendment may be required locally; or

- rate the review as “requires improvement” or “inadequate” and confirm what changes will need to be made to some or all of the document set; and

- require a resubmission of the review in some cases

5.3 Action to take on receipt of QA feedback

The feedback received from HMPPS SFO Team and HMIP will clarify if and what further action is required following quality assurance; this will be dependent on the ratings given. QA staff from HMPPS SFO Team and HMIP are available to discuss the feedback with RMs where any issues are not clear:

Composite rating of 'outstanding' or 'good'

- In most cases with a composite rating of 'outstanding' and 'good', where all individual standards also receive these ratings, no further work will be required.

- The RM will be required to undertake further work on receipt of QA feedback where the review has been rated as 'good' where one of the standards has been rated as requires improvement. The additional work to improve the quality of these reviews must be prioritised.

- A review rated as good will only need to be resubmitted to the HMPPS SFO Team or to HMI Probation in cases where:

    - the standard relating to victims and their families has been rated as requires improvement or inadequate and a request for wider sharing has been made. In such cases, the review documents must be resubmitted for further QA prior to sharing.

    - any of the standards have been rated as requires improvement and it is a **high profile case.** In this instance, the review documents must be resubmitted to the HMPPS SFO Team or HMI Probation usually within 28 days.

Composite rating of 'requires improvement'

- The RM will be required to undertake further work on receipt of QA feedback where the review has been rated as 'requires improvement'. The additional work to improve the quality of these reviews must be prioritised and reviews will need to be resubmitted to either HMPPS SFO Team or to HMI Probation to the following timescales:

    - within 28 days when it is a high profile case

    - prior to wider sharing with victims or exceptionally any other individual or body. 20 days must be allowed for QA to be completed and further work to be done as required before a date is set for the review to be shared

Composite rating of 'inadequate'

- The RM will be required to undertake further work on receipt of QA feedback where the review has been rated as "inadequate" and must resubmit the review to the HMPPS SFO Team or HMI Probation, within 28 days, for further QA.

5.4 Resubmissions

The team undertaking the QA will request a resubmission in the circumstances set out above. RMs must highlight changes to the review documents in a different font to allow for amendments to be easily identified.

The RM (when making the changes) and the manager undertaking the internal QA must refer to the latest QA feedback and systematically work through the document to confirm whether or not all relevant areas of the feedback has been responded to appropriately and if the review appropriately addresses the issues raised. It is the responsibility of the Regional Director (or delegated other) to ensure that the review is improved to a sufficient standard;

The feedback for cases that require an immediate resubmission will contain a date for the work to have been carried out and the review documents to be returned, this is usually required within 28 days

On receipt of a resubmission, the central team that originally QA'd the case (either HMPPS SFO Team or HMIP) will undertake a further QA of the documents to establish whether:

- they appropriately address the issues raised in the feedback given
- further improvements are required.

They will then provide feedback to notify the Head of Operations that:

- the resubmitted review is to a sufficient quality; or
- the resubmitted review still requires improvement.

In cases where the resubmitted review requires improvement, the Head of Operations should ensure that the identified further work is carried out or, alternatively, provide robust assurances to HMPPS SFO Team about why it is not deemed necessary. If agreement is not reached about the outstanding requirements, HMPPS SFO Team will seek guidance from the Regional Probation Director and Director of Public Protection Group.

Dependent on the specifics of the case, HMPPS SFO Team may request that the review be resubmitted for further QA on completion of the additional work. In other cases, regions may submit a request for a further QA to be undertaken.

6. Action Plan Updates

There is a second part to the action plan template – the action plan update - which regions must complete to provide a progress update against all objectives included in the action plan. This should be completed and submitted to HMPPS SFO Team for screening, six months after submission of the review. The purpose of the update is to provide assurances to senior managers and HMPPS that actions have been undertaken within the required timescales and have either sufficiently affected change or have resulted in the identification of further activity to address concerns. HMPPS SFO Team will track the submission of action plan updates and provide monthly updates to the regional SFO Teams.

If some actions are outstanding at the six month stage e.g. where staff are on leave and learning cannot be progressed quickly, the update must contain additional information on expected timescales. The regional SFO Team must continue to monitor all actions until completion, including liaison with the prison and confirm to HMPPS SFO Team, by way of a further update, when the action plan has been implemented.

HMIP will be focusing on regional SFO work as part of their routine inspections. Prior to an inspection they will request information from HMPPS SFO Team about the region's SFO reviews. This will include copies of QA feedback, action plans and action plan updates from the previous 12 months. This will enable the lead inspector to look at themes and findings as part of the core inspection. HMIP also intend to meet with the regional SFO Team manager to establish their working practices and how they share learning to inform a summary for the lead inspector.

7. The Data Protection Act (DPA)

7.1 Data Protection Act and SFO reviews

The principles of the Data Protection Act 2018 (DPA) can be found at Appendix 1.

The SFO review contains a statement about the legal basis for sharing the information, specifically in relation to victims and families with a legitimate interest. RMs should be familiar with the DPA & General Data Protection Regulations (GDPR); in particular the data protection principles, the various exemptions and take them into account when writing reviews. ” Processing” of data as defined in Section 3 (4) of the DPA means an operation or set of operations performed on information such as collection, recording, alteration, disclosure, alignment or combination of data.

The sharing of data for a SFO review will always involve the “processing” of personal data and special categories of data as defined in Section 3 (2) of the Data Protection Act (DPA) 2018, and Section 35(8) of DPA 2019 respectively. Data processed in the SFO review falls the “law enforcement purpose” as defined in Section 31 of Part 3 of the DPA 2018

Under the DPA 2018, a data controller must ensure compliance with the data protection principles whilst processing personal data; where the processing is for any of the law enforcement purpose, there must be compliance with either section 35(2) or 35 (3, 5) DPA 2018

Under section 35(2) DPA 2018, the processing of personal data for law enforcement purposes may be necessary for the performance of a task carried out for the purpose of a competent authority.

Where data is sensitive and the individual has not consented to sharing, section 35 (5) DPA 2018 will apply and a condition set out in Schedule 8 will need to be met. The relevant condition in Schedule 8 for SFO reviews would be processing is necessary for the exercise of a function conferred on a person by an enactment of law and is necessary for reasons of substantial on public interest (paragraph 1, Schedule 8) and administration of justice (paragraph 2, Schedule 8). Hence sensitive data can be shared as reviews are being used in the course of the administration of justice to inform learning and instil the public’s confidence in the criminal justice system; that errors are being reviewed and addressed, allow for victims to understand that a process has been followed, the background, and any information about the supervised individual that will assist in their understanding of the offending behaviour. The reviews are also part of the function of a Minister.

While the sharing of data falls under the conditions as set out above, the sharing of the data also needs to be **necessary**. Therefore, the specific circumstances of the case must be considered when deciding if the inclusion of the information is necessary to the understanding of the SFO review. Not all information obtained for the review will be considered necessary. It must be considered on a case by case basis.

The information shared must also be **proportionate**. The need to share the information must be balanced and only provided if it enhances the understanding of the case. The information that is shared must be **relevant** and **not excessive** in relation to the purpose for which it is processed (section 37 DPA 2018).

RMs should always consider if it is necessary and proportionate to the understanding of the SFO review to retain the information, it must be relevant and not excessive, if the sensitive information is not necessary to provide context to the case and practice, then it should not be included.

7.2 Redaction/ Removal of information

The SFO review must be written in a style that is immediately accessible and ready to share with victims or other third parties. The new format will include a column for reviewers to record separately , as they produce the report , key information which they think is likely to require redaction/removal . The revised format should reduce the burden of retrospective removal by redaction of sentences or sections in the main body of the text, with the introduction of a column which will be removed in its entirety prior to wider sharing with the victim. However, RMs will also need to consider possible redactions to the information in the background and risk sections of the review prior to wider sharing.

Reviews completed under probation instruction 2018 06 will continue to be redacted for the purpose of victim sharing as necessary.

The RM will need to make judgments on the information they include in the separate column- whether information meets the threshold for redaction will vary depending on the individual case. To reiterate: RMs should always consider if it is necessary and proportionate to the understanding of the SFO review to retain the information; it must be relevant and not excessive. RMs will need to consider the impact of sharing the information; could it place an individual at risk? For example, is there a strong likelihood of reprisals from the victim's family. In general, the legitimacy of sharing information with victims of serious further offences is high. RMs should remember that the general public interest in transparency and the requirement of a public body to demonstrate accountability may often outweigh the rights of individuals. However, the ultimate test will always be whether it is appropriate and proportionate and some information may still need to be removed. It will often be a balancing exercise, weighing up the possible consequences of disclosure for the data subject against any legitimate interest in disclosure - each case needs to be considered on its own merit.

Third party personal information can include that of other living individuals, such as partners, friends, family and associates of the supervised individual, and normally cannot be shared without consent. Psychologist reports prepared by HMPPS staff are not third party information (consent of the author to disclose is not required), although such reports can include personal information of third parties and supervised individuals and you should consider the content in terms of removal by redaction. If the RM considers third party information is vital to the understanding of the review, for example crucial information from the police, the RM should discuss, at the point the review is going to be shared, with their line manager whether consent should be sought.

In order to avoid the need to gain consent for sharing from individual prison establishments, RMs should refer to prisons generically in the review, unless there is a specific reason to name a prison and the RM should ensure that the relevant prison is aware of its inclusion.

In respect of information about supervised individuals, RMs must consider their right to privacy against those most affected by the offence to receive information and in most cases there is a presumption to share personal information provided it is proportionate and necessary to the understanding of the review. It might be appropriate to disclose a history of trauma to provide context and remove specific detail, for example of sexual abuse as a child. If a supervised individual has committed a serious offence of sexual violence, some detail of the supervised individual's own sexual history might be more significant to the understanding of the review. In most cases it would not be necessary and proportionate to disclose medical information. Remember, you will always need to have clear explanation about why information is not being shared.

Personal and or identifying *information about staff* almost always meets the threshold for removal. However, RMs should not remove details of any professional failings by probation staff unless there is a very good reason to do so, as it will undermine the understanding of the review. RMs should remove any personal matters related to background context that is not *directly* relevant; for example, the exact detail of an absence from work, personal circumstances and any information that might identify protected characteristics. In most cases disclosing some information about disciplinary action in response to a SFO would be appropriate to share with a victim but HR advise should be sought and the HMPPS SFO Team may be able to assist..

It is not possible to give guidance that covers every eventuality, as one size does not fit all and the law is clear that decisions need to be made on a case by case basis. Decisions will often be finely balanced. RMs should always clearly record their decisions, and where it is a judgment call, discuss with someone else and ensure a senior manager endorses the redaction log when the review is being shared more widely. The PS will already have formal routes for ensuring adherence to DPA and advice and assistance should be sought as necessary using these arrangements, prior to disclosure to victims.

When there is a request for sharing with a victim, the RM should revisit the removed information and complete a redaction log, recording the arguments for and against withholding the information. Decisions need not be taken in isolation and can be discussed with colleagues or a line manager. The RM's name can be redacted prior to sharing the review with victims/families. Where considered necessary, the supervised individual's name and names of any victims can also be anonymised prior to disclosure, for example where there is more than one victim and to guard against the loss of data – see section 3.4.4 for more details.

All exemptions and the rationale for them must be signed off by a senior manager before the review is shared more widely. **See Annex I of the policy framework "SFO Redaction Log".**

How to redact/remove information

The most secure way of redacting information in reports is to use Adobe Pro; this redacts (blocks out) the text and then removes the underlying material. Alternatively RMs can block out the relevant text with redaction tape, photocopy the report and disclose the copy, not the version with the tape. It is not the best method presentation wise but guards against software that can un-redact word or PDF documents, this cannot occur with Adobe Pro. MoJ guidance also allows for redacted information to be deleted, word “redacted” inserted, a separate document created and converted to PDF. If the text is properly removed before the document is converted to PDF, the removed text cannot be recovered.

The reasons for redactions should be recorded in a separate redaction log which provides a gist of what has been removed for senior manager information and sign off and is an audit should the ICO receive a complaint.

8. Outcome

The Outcome (Annex H) should be sent to HMPPS SFO Team by the SPOC from the region managing the supervised individual at the time of the SFO, copied to the Regional Victim's team in automatic cases, within 3 days of the court sentencing date, or other event which has led to the case being discontinued. SPOCs must ensure that the sentence type and length, not just the conviction is notified to HMPPS SFO Team who provide data based on the type and length of sentences received in SFO cases. Where a supervised individual is acquitted or convicted of a lesser offence, or where the case is discontinued, it will cease to be a SFO and the process will terminate. An outcome must be submitted in these cases. Regions should consider ensuring that any identified learning is still taken forward in cases that are no longer SFOs.

Supervised individuals dealt with under Mental Health legislation.

If the supervised individual is charged but then not convicted, or found not guilty by reason of insanity, of an SFO, but the Court is satisfied that the person did what they are accused of doing, and a hospital order is made under the Mental Health Act 1983*, then the case will be treated as equivalent to a SFO conviction.

(*MHA section 36 (remand for treatment), 37 (hospital order). 38 (interim order), 41 (restriction order).

9. Staff Welfare and Effective Management of the SFO Process

We know from experience that the impact of serious further offending is significant for staff as well as victims, and recognise how stressful it can be for those staff involved. Many staff will find it traumatic and will be particularly aware of the impact on the victim(s). Therefore managers need to exercise good employee care at these times. The review process is not about apportioning blame, it is vital to recognise that risk cannot be totally eliminated when supervising individuals in the community and the focus of reviews should be on developing practice through continuous improvement. There will however be a small number of cases the review process triggered by the SFO, alerts managers to an issue that requires separate disciplinary investigation or the instigation of capability/poor performance proceedings.

In order for staff to have confidence in the process and a degree of closure, regions must have processes in place to provide staff with a clear understanding of the overall findings of the review and in particular, learning that is relevant to them. This should include ensuring that any staff (including managers) involved in the management of a supervised individual who is charged with a SFO notification are made aware when a review is being undertaken, are able to prepare for any interviews and are given feedback about how their practice will be reflected in the review, including any actions for them.

The region should also ensure that any of their staff who are interviewed as part of a SFO review are given a copy of Annex J in the probation instruction "The Serious Further Offence (SFO) review process – information for staff" and pointed to the FAQ resource available on My Learning (further details are listed below).

The review is not a disciplinary investigation or a process for managing poor performance. If an investigation under the Conduct and Discipline policy has commenced, a **separate** investigating officer must be appointed to consider a specific allegation(s) whereas the SFO review will look at practice as a whole. The investigating officer will access the original source material and interview relevant staff, the process is not aligned to the production of the SFO review. If the investigating officer is presenting the SFO review itself is as evidence, a clear rationale for this should be made to the commissioning manager beforehand.

Interviews for the SFO review will therefore ordinarily involve only the staff members concerned and the RM. Any request by a staff member to be accompanied by a trade union representative or colleague, should be considered on a case-by-case basis.

Staff may be particularly concerned at the point the review is shared with victims. It may help them to know that when a redacted review is shared with victims, staff should be aware that the report will be anonymised and that findings from SFOs reviews have been shared in some form since 2013. The line manager and senior manager sharing the review must consider the impact of disclosure on any staff member and if there are particular concerns put in place contingency plans in line with existing staff HR procedures. The region will already have mechanisms in place

for dealing with issues of staff safety and these should be triggered if necessary. If there are exceptional concerns that the impact of disclosure on a staff member is not manageable, contact must be made with HMPPS SFO Team.

SFO FAQ Video

In response to a recommendation in the HMI Probation thematic inspection of SFO investigation and review process and our EFQM self-assessment, HMPPS have produced a generic resource available to all staff following a SFO. The Chief Probation Officer introduces and concludes the resource which is available on My Learning for staff. The attached communication provides detail about the video and the specific issues which can be viewed as standalone sections. This resource was produced informally by staff working within covid-19 restrictions yet is a helpful resource for staff and provides an organisational overview of SFOs and more information about the various stages of the SFO processes.

SFOcomms.pdf

https://mydevelopment.org.uk/mod/scorm/view.php?id=21263

10. Sharing information with Victims

The SFO review is first and foremost an internal management review, although sharing information with those most affected by serious crime is a crucial element of the SFO process – it provides information to victims/victims' families about how an supervised individual was managed by probation and what action has been taken or is planned to address any shortcomings which may have been identified in the review.

HMPPS introduced Victim Summary Reports in 2013, in order to provide victims or their families with information in the most accessible format. However, the existence of a separate report led some victims/victims' families to believe that information was being withheld. As a result victims/victims' families have campaigned for greater transparency and access to the full SFO review. Furthermore, Ministers made a commitment to make SFO reviews more transparent.

PI 2018/06 introduced a narrative style format which has been shared in full with victims/victims' families with only minimal redaction to meet legal requirements. Under the new format introduced with the Policy Framework, the chronology based review will be shared with victims/families along with the action plan. The SFO Review Disclosure Cover Sheet (Annex K) will also need to be completed.

Following conviction of a supervised individual for an automatic SFO, the PS regional Victims Liaison Units (VLU) must offer the victim/victim's family the opportunity to receive information about the review and a redacted copy. The VLO will also send a letter (using the template at Appendix 3) on behalf of the relevant senior manager with a specific offer to meet and share information about the SFO review.

The victim/victim's family is entitled to this information irrespective of whether or not they engage with the Victim Contact Scheme (VCS).

If the victim would like information, the senior manager should:-

- Arrange a meeting with the allocated Victim Liaison Officer (VLO). They will have met the victim/victim's family and have important information about their specific circumstances;

- Read the review and understand the key findings and judgments, any significant shortcomings in practice and the content of the action plan, including a progress update.

- Consider a discussion with the RM to ensure a full understanding of the issues.

- Consider evidence of good practice. Some victims welcome information about what was done well. It is evidence that the PS did adhere to practice guidelines and made sound professional judgments, although how you present this information may differ on a case-by-case basis.

Where the supervised individual has died and there is not an ongoing role for the VLU and a police Family Liaison Officer (FLO) has been assigned to the victim or family, the region should consider liaising with them about the victim's right to information about the SFO review.

There may be occasions when it is appropriate to give consideration to speaking to the victim/victim's family beforehand to discuss the purpose of the visit. Some senior managers have found this to be useful as a preamble to the main visit.

Where there is more than one victim, every effort should be made to co-ordinate the visits to avoid the risk of information becoming widely known before all those affected by the SFO have been visited.

Victims/victims' families who request a copy of the review in advance of a meeting

Some victims/victims' families may request a copy of the SFO review in advance of the meeting. We have consistently found that a meeting to make personal contact, convey the seriousness and importance that we attach to giving a transparent account and to alert victims to headline findings is the most helpful way to proceed. Offering a short meeting to deliver a report, introduce yourself and give a brief explanation of its findings ahead of the victim reading the review and a more in depth follow up meeting, can be a helpful response to such a request. In any event, the review should not be sent electronically because it can be very easy to forward on to others, even inadvertently, and a hard copy should be hand delivered, wherever possible, by the senior manager reiterating the arrangements for the meeting to discuss.

Victims/victims' families who do not want a face-to-face meeting

As set out above it is important for probation regions to do all they can to support a victim to feel able to attend a meeting where information can be shared face-to-face with the victim/victim's family. Every effort should be made to make the meeting feel as accessible as possible for the victim/victim's family- usually the visit will take place at the victim's/victim's family home, although the region should consider alternative venues if requested and increasingly there may be a request for a video call. If so for the reasons set out above, 2 video calls should be set up, one before the report is made available and one after.

In some circumstances the PS could consider a telephone call to discuss the findings of the review and any relevant context prior to sharing the review.

If the victim declines any meeting, face-to-face or video/telephone call, and would like a copy of the SFO review only, it should be hand delivered by the senior manager who would have undertaken the visit – they can hand over the report with empathy and understanding and reiterate the offer of a meeting. In these circumstances, the PS must advise the HMPPS SFO Team that they have provided a copy of the review without direct engagement with the victim/victim's family.

Victims/victims' families with additional needs

Arguably all victims of serious offending are vulnerable and they are all entitled to an enhanced service under the Victim's Code. That said, the PS should consider if the victim/victim's family member has additional needs or safeguarding considerations that are relevant to the sharing of

information about the SFO review. This may be due to physical or mental health issues, learning difficulties or experience of trauma.

Probation regions should consider each situation on a case-by-case basis. The WCU may have given the Victim's team information about the particular circumstances of the victim/victim's family which suggests additional vulnerability. For example it may be appropriate to consider asking for permission to contact support workers, other professionals involved in the victim's/victim's family life, including probation workers to gain additional information and help agree an approach – it would be highly unusual circumstances to decide not to disclose to a victim or their family. If the PS consider that disclosing the SFO review could significantly impact adversely on the victim's/victim's family member's well-being, particularly if they have refused consent to speak to or liaise with others, they should discuss and agree an approach with HMPPS SFO Team.

Meeting with the victim/victim's family

The PS must provide the victim/victim's family with a copy of the SFO review to keep. The SFO Review Disclosure Cover Sheet (Annex K) should be completed to introduce the review. Senior managers should consider how to present the report to the victim/victim's family, they are often quite lengthy and it may not be helpful to simply sit there and wait while they read it. Sometimes it can help to walk a victim through the summary of events and signpost them to the key findings. It is important to anticipate some potentially difficult questions and consider an appropriate response.

Saying Sorry

An early and genuine apology can do much good at no cost and on occasions it is clearly necessary. Remember the purpose of sharing information in this way is to provide a proper account of practice and what action has been taking as a result of the review. It is important not to shy away from any failings.

MoJ legal advisors are clear that, under the data protection act, the PS can share information about the review for the purpose of the administration of justice. It does of course need to be **necessary** and proportionate to do so and **any information shared must be relevant in that particular case.** Further information is available in section 9. Legal advisors from GLD can also provide additional advice about disclosure.

Critically, an apology in itself does not confer or constitute an admission of legal responsibility. That said, it is important not to enter into any discussions about legal issues, it is acceptable for the senior manager to say it is not the purpose of this meeting to discuss the issue of legal liability. The increased transparency in the SFO procedures has ministerial support and the potential for more litigation is an accepted risk.

Inquests and sharing information with victims/victims' families

If a possible inquest is pending, the senior manager should be aware that the criminal trial will not necessarily have gone into the same level of detail as the inquest, particularly in respect of systemic failings. It is likely that the inquest will address issues beyond the remit of the SFO review. Therefore it is important that the senior manager makes it clear to victims that the SFO review was an internal management report with a focus on what was known about probation

practice at the time of the review. They can acknowledge that the inquest process may uncover information that puts a slightly different perspective on the practice and the judgments that were made in the review.

After the meeting

Recollections of the meeting will inevitably vary. Therefore, it is essential for the senior manager to make a written record of the meeting and the PS should send a letter to the victim/victim's family summarising what was discussed and any follow-up actions. If the victim/victim's family raises issues which are not directly related to the SFO, a senior manager, not the VLO, should agree to take that forward. It is important to offer a second meeting to discuss any issues that the victim/victim's family has after having time to read the full review – a copy of which should be left with the victim/victim's family.

Additional resource for senior managers

- The Public Protection Group and Effective Probation Practice Group have produced a standalone resource for senior managers to access at the point they are preparing to share information with a victim/victim's family. The resource is presented in video format and is approximately 40 minutes long and comprises:
    - a video clip from Nadine Marshall whose son Conner was murdered by a supervised individual who was subject to probation supervision, in which she talks about her experience of victim contact;
    - contributions from Nigel Byford (Midlands Region) and Andrew Blight (London Region) about their experience of sharing information with victims; and
    - a short power point presentation narrated by Liz Chapman, Head of HMPPS SFO Team which includes information about the legal basis for sharing information, much of the detail is included in this chapter.

If a senior manager in the PS would like a copy of the resource, please contact HMPPS SFO Team at sfo@justice.gov.uk

Victim Liaison Unit contact e-mails

London Region	LondonNPS.VictimContactScheme@justice.gov.uk
East Midlands Region	MidlandsNPS.EastMidlands.victimcontact@justice.gov.uk
West Midlands Region	
Staffordshire	MidlandsNPS.staffordshire.victimcontact@justice.gov.uk
Warwickshire	MidlandsNPS.Warwickshire.VictimContact@justice.gov.uk

West Mercia	MidlandsNPS.WestMercia.VictimContact@justice.gov.uk
West Midlands	MidlandsNPS.WestMidlands.VictimContact@justice.gov.uk
North East Region	NENPS.VLUNorth.Admin@justice.gov.uk
Yorkshire and Humber Region	
Humberside	NENPS.SouthVictim.Unit@justice.gov.uk
South Yorkshire	NENPS.SouthVictim.Unit@justice.gov.uk
West & North Yorkshire	NENPS.WestNorthYorkshire.victimcontact@justice.gov.uk
North West Region	
Cheshire	NWNPS.cheshire.victimcontact@justice.gov.uk
Cumbria & Lancashire	VictimContact.CL@justice.gov.uk
Merseyside	NWNPS.merseyside.victims@justice.gov.uk
Greater Manchester Region	NWNPS.gmvictims@justice.gov.uk
East of England Region	
Bedfordshire	NPS_SEENorthClusterVictimsUnit@justice.gov.uk
Cambridge & Peterborough	NPS_SEENorthClusterVictimsUnit@justice.gov.uk
Essex	SEENPS.EssexNorfolkSuffolk.VictimContact@justice.gov.uk
Hertfordshire	NPS_SEENorthClusterVictimsUnit@justice.gov.uk
Norfolk	SEENPS.EssexNorfolkSuffolk.VictimContact@justice.gov.uk
Northamptonshire	NPS_SEENorthClusterVictimsUnit@justice.gov.uk
Suffolk	SEENPS.EssexNorfolkSuffolk.VictimContact@justice.gov.uk
KSS Region	SEENPS.KSS.VictimContact@justice.gov.uk
South West Region	
Avon & Somerset	BGSWVictimContact@justice.gov.uk
Gloucestershire	BGSWVictimContact@justice.gov.uk
Wiltshire	BGSWVictimContact@justice.gov.uk
Devon & Cornwall	DDCVictimContact@justice.gov.uk
Dorset	DDCVictimContact@justice.gov.uk
South Central Region	SouthCentralVictimContact@justice.gov.uk
Wales Region	
Gwent	WalesNPS.gwent.victimcontact@justice.gov.uk
North Wales	WalesNPS.north.victimcontact@justice.gov.uk

Cardiff and the Vale	WalesNPS.sw1.victimcontact@justice.gov.uk
Swansea/Neath/Port Talbot	WalesNPS.sw2.victimcontact@justice.gov.uk
CWM TAFF MORGANWG	WalesNPS.sw2.victimcontact@justice.gov.uk
West Wales	WalesNPS.dyfedpowys.victimcontact@justice.gov.uk

11. HMPPS SFO Team

11.1 Contact details

Head of Team

Liz Chapman ✉ Liz.Chapman1@justice.gov.uk ☏ 07967 323989

Senior Policy Leads

Daniella Parascandolo ✉ Daniella.Parascandolo@justice.gov.uk ☏ 07967 327016 (Lead for high profile cases)

Zahin Talukder ✉ Zahin.Talukder@justice.gov.uk ☏ 07773 050017 (lead for inquests, action plan updates, SFO bulletin)

Senior Quality Assurance Manager

Sarah Dickson ✉ sarah.dickson1@justice.gov.uk ☏ 07967 326587

Quality Assurers

Vicky Quinn (part-time) ✉ victoria.quinn2@justice.gov.uk ☏: 07967324402

Sharifa Mohamed ✉ Sharifa.Mohamed1@justice.gov.uk ☏ 07812760618

Clare Enfield ✉ Clare.Enfield2@justice.gov.uk ☏ 07976 641261

Bex Raven ✉ Bex.Raven@justice.gov.uk ☏ 07890 398316

Victoria Green ✉ Victoria.Green2@justice.gov.uk ☏ 07890 398312

SFO Admin Support

Philip Cogram ✉ sfo@justice.gov.uk

The SFO Team can be contacted with general enquiries at sfo@justice.gov.uk

11.2 Role of the team

The purpose of the SFO Team is to manage the SFO process to ensure that there is a rigorous system of scrutiny for cases where specified individuals under supervision have been charged with a serious further violent, sexual or terrorist offence so that:

- Areas of continuous improvement to risk assessment and management practice within Probation provision may be identified and disseminated locally, regionally and nationally;

- The public and victims/victims' families may be reassured that HMPPS is committed to reviewing practice in cases where individuals under supervision are charged with certain serious offences; and

- Ministers, Chief Executive of HMPPS, Director of Probation other senior officials and managers and the wider MoJ can be informed by us of high profile cases of alleged serious further offending

The team role includes:

- Administering the SFO process from receipt of notifications through to the final outcome in each case

- Providing help and advice to PS staff where necessary, e.g. qualifying criteria, reporting on sensitive SFOs, completing SFO reviews and action plans. HMPPS SFO Team is available for general advice via email or telephone.

- Quality assurance of SFO reviews completed by the PS

- Monitoring of progress with SFO review action plans – joining up with the HMPPS Effective Practice & Service Improvement Group to ensure the implementation and success of learning is a key focus.

- Development of national policy and guidance relating to SFO Procedures, as well as contributing to the development of policy and practice in other areas of HMPPS

- Tracking high profile inquests

- Events for Stakeholders

- Recording and managing SFO data for HMPPS; collating and disseminating statistics to the PS and other parts of HMPPS for analysis. Answering PQs, FOI requests and ministerial correspondence.

- Ensuring Ministers, HMPPS Chief Executive and other senior officials are informed of high profile cases through timely submissions and/or briefings. Between 1 April 2019 and 31 March 2020 the HMPPS SFO Team received 537 SFO notifications, 49 of those were high profile cases.

- Providing data for the annual SFO conviction statistics which can be found at Serious Further Offences Bulletin 2020 .

- Current area of interest for Ministers – reports in the national papers about SFOs, Ministers asking questions in parliament.

To ensure we can provide Ministers with accurate information it is important that correct information is provided to us in SFO notifications and SFO reviews. We may also need to contact PS regions for further information in cases that attract press and Ministerial interest. This information is often needed quickly.

The SFO Team are happy to provide help and advice to staff involved in the notification, completion and countersigning of SFO reviews.

11.3 Public Protection Partnerships Section

The SFO Team forms part of the Public Protection Partnerships Section, within the Public Protection Group. Other teams in the Section work on policy in relation to:

- Assessment and management of sexual offending

- MAPPA

- ViSOR

- Custodial public protection

- Adult and child safeguarding

- Assessment and management of risk and need

- Risk of serious harm guidance

- Domestic Abuse & Stalking

Appendix 1

Data Protection Act [2018].

General Principles

Section 2 of the Data Protection Act 2018 sets out the general principle that personal data must be processed lawfully and fairly on the basis of consent or another specified basis.

For SFO reviews, personal data may only be processed for law enforcement purposes if it is lawful and fair.

Personal data can only be processed if section 35(2) is met. In the case of sensitive data, at least one condition in Schedule 8 must be met.

Sensitive processing for law enforcement purposes is set out in section 35(8) as:

> *(a) the processing of person data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs or trade union membership;*
>
> *(b) the processing of genetic data, or of biometric data, for the purpose of uniquely identifying an individual;*
>
> *(c) the processing of data concerning health;*
>
> *(d) the processing of data concerning an individual's sex life or sexual orientation*

Section 35(2) - Processing of any personal data

The relevant conditions for SFO reviews for processing personal data are:

> "*35(2) the processing of personal data for any of the law enforcement purposes if lawful only if and to the extent that it is based on law and either—*
>
> > *(a) the data subject has given consent to the processing for that purpose, or*
> >
> > *(b) the processing is necessary for the performance of a task carried out for that purpose by a competent authority".*

Section 35(4) and (5) - sensitive processing

For sensitive processing, either section 35(4) or 35(5) needs to be met.

"35(4)

(a) the data subject has given consent […], and

(b) at the time when the processing is carried out, the controller has an appropriate policy document in place."

"35(5)

(a) the processing is strictly necessary for the law enforcement purpose;

(b) the processing meets at least one of the conditions in schedule 8, and

(c) at the time when the processing is carried out, the controller has an appropriate policy document in place."

The relevant conditions under schedule 8 are:

1.

(a) is necessary for the exercise of a function conferred on a person by an enactment or rule of law, and

(b) is necessary for reasons of substantial public interest.

2. processing is necessary for the administration of justice.

5. processing related to personal data which is manifestly made public by the data subject (any relevant information the supervised individual has made public themselves).

Appendix 2

Disclosure to victims under Probation Instruction 14/2015

The Probation Service will continue to disclose information to victims arising from SFO reviews completed under PI 14/2015. For those cases Victim Summary Reports (VSRs) can still be prepared. They should be a full and accurate summary of the findings from the SFO review:-

- include details from the analysis section of the SFO review document including any identified deficiencies in the management of the supervised individual, the learning points and, most importantly, the remedial action that has been taken to rectify matters for the management of future cases. Corporate issues and systemic issues may be the main points; alternatively, the main points may cover core practice

- in instances where members of staff have undergone capability/poor performance or disciplinary procedures as the result of an SFO review the VSR places importance on giving an open and honest account of what happened and this might include details of remedial action that has been taken to address staff performance. Individual staff names or information which would identify individuals should never be disclosed

The VSR should include the context in which any deficiencies occurred and explain what was done with a supervised individual. Since the original guidance was issued it has become clear that information about the supervised individual can be shared lawfully where it is necessary to do so, to give a proper understanding of what happened and of the practice in the case. This means that the VSR can set out what work was done to manage the supervised individual's risks and address their needs, and this need not be limited to information in the public domain.

The Probation Service should give the victim a copy of the VSR.

Requests for access to the full SFO Review

In most cases to date, a comprehensive VSR, a meeting to discuss it and a follow up letter where necessary, has answered the victim's/victim's family's questions and they have not sought further access to the full SFO Review. However there will be cases where victims request access to the full SFO Review. In light of the change to a position where we routinely share appropriately redacted SFO Reviews with victims/victims' families, the fact that there are already circumstances in which the SFO Review has been shared, and the legal advice that it is lawful to share appropriately redacted SFO reviews, retaining the position where we continue to refuse to disclose reviews is not tenable.

Where victims/victims' families do not feel they have been provided with sufficient information through the Victim Summary Report process, to offer to provide additional detail through another

means such as a more detailed VSR or a bespoke report runs the risk of further undermining the victim's/victim's family's confidence and trust in the process. The process of understanding the findings of the SFO review should not add to the trauma the victim/victims' families have already been through. Therefore where requests for the full SFO are received, arrangements should be made to make the appropriately redacted full review available. The advice on redaction contained in the body of this guidance applies.

Section 9 addresses the legal basis for sharing information with victims/victims' families. Further advice on any request can be sought from HMPPS SFO Team and in particular PS regions who receive requests for access to a review under the Freedom of Information Act should seek advice from the HMPPS SFO Team.

Appendix 3 Senior Manager Letter to Victims

[Insert Victim Name]
[Insert Victim Address]
(date).

[Insert VLO Address]

Telephone
Email: [Insert VLO email]
www.gov.uk

Date: [Insert date]

Dear XXXX,

I am writing further to the letter you will have recently received from the Victim Liaison Unit offering you the opportunity to participate in the Victim Contact Scheme. If you choose to participate, your allocated Victim Liaison Officer will provide you with information, advice and support throughout the offender's sentence.

You may already be aware that the offender in this case was being supervised by the Probation Service when he/she committed the offence against you/your (state family member). I would like to take this opportunity to say how sorry I am that you have been affected by such a serious offence, and I apologise if any of the information in this letter causes you or your family any further distress.

Most people who are being managed by the Probation Service comply with the requirements of their sentence. However, a very small number commit extremely serious further offences. When they do, the Probation Service reviews what has happened in the cases and completes a report, known as a Serious Further Offence (SFO) review. The SFO review will look at how the Probation Service worked with the offender and, if there was anything that should have been done differently, they will identify what actions need to be taken in future.

As such, I am writing to inform you that a SFO Review has been completed by the Probation Service and you are entitled to meet with myself, as a Senior Manager of the (Region) and a Victim Liaison Officer to discuss the findings of the review. You can choose to receive information about the offender's sentence and / or information from the SFO review. You do not have to make a final decision at this stage, and should you decide that you would not like the information at this time, you are able to request it at any point in the future.

The Probation Service in (Region) is committed to protecting the public and continuous improvement is something that we take very seriously. I would like to assure you that any learning identified as part of the review will be promptly addressed. If you choose to receive information about the SFO review, I can explain this in more detail during a meeting.

If you would like to meet to discuss the SFO review, I can arrange to visit you at home or, if you would prefer, I can identify an alternative venue which is suitable for you. If you respond to indicate that you would like to meet, we will contact you to discuss your preference.

Please email (insert email address) or call (insert name and telephone number), to confirm whether you wish to meet with a Victim Liaison Officer and myself to discuss the review in more detail. If you have any questions or concerns in the meantime, please do not hesitate to contact your allocated Victim Liaison Officer, or the Victim Liaison Unit using the contact details above.

Once again, I would like to apologise if this letter has caused you any further distress.

Kind Regards

Head of Probation Delivery Unit for (insert)

Cc:

Head of Serious Further Offence Unit PS (Region)
Senior Probation Officer Victim Liaison Unit, PS (Region)
Victim Liaison Officer

Appendix 4

Internal Quality Assurance and Countersigning Checklist

The role of internal quality assurance and countersignature

Regional Directors must ensure the SFO review is countersigned. This responsibility may be delegated to an appropriate senior manager – the countersigning manager (CM) - who should be independent of the line management of the case.

Prior to sign off the CM should be assured that a manager (usually the Head of the regional SFO Team) has undertaken rigorous internal quality assurance and that, as part of this process, the Head of PDU has had the opportunity to read the review and comment on factual accuracy issues.

The following checklist has been devised to assist with the internal quality assurance and countersigning roles. Managers completing the internal quality assurance should ensure that they are familiar with both the Operational Guidance and HMIP QA standards and should refer to them as necessary.

Serious Further Offences

Internal Quality Assurance and Countersigning Checklist

Risk and Background Information	Yes	No
Does the review cover the correct period?		
Does the background contain sufficient and clear details of: • the index offence and current order/licence? • a sensitive summary of the SFO? • other agencies directly involved in the management of the supervised individual (SI) and their role and reference to any parallel reviews being undertaken where relevant? • equality information • who has been interviewed and their role. Any staff that could not be interviewed and the reasons for this?		
Is it clear from the details of the initial risk assessment who is at risk, the nature of the risk and what changes, if any, there were during the period under review and the reasons for these?		
Are you clear on the history of any safeguarding, DA, stalking, SGO/gang risks and SOC and circumstances relevant to these during the period under review, including pertinent developments? Are you satisfied that the RM's answers are informed by evidence of relevant checks by the RO or additional checks during the SFO investigation where necessary?		
Is the involvement of MAPPA clear?		
Has the RM provided a succinct and informative overview of the supervised individual's history and circumstances relevant to risk?		
Analysis **The review must provide a robust and transparent analysis of practice of assessment, planning, implementation and reviewing**	**Yes**	**No**
Does the SFO review provide a robust and transparent analysis of assessment in the case? Consider:	☐	☐
Does the review analyse the quality of the assessment completed at the start of the review period (this may include the quality of the PSR where relevant), providing evidence about information used (or any gaps) to inform the assessment (e.g. previous assessments and safeguarding/police checks), risk related behaviour, criminogenic needs, areas linked to RoSH, who is at risk, what the nature of the		

harm is, factors that will increase/reduce risk, imminence and the assessed risk levels? This should enable the reader to understand what areas of risk need to be planned for and managed and what changes in circumstance would be of concern		
Has a clear overview been given of any previous assessments that impacted the management of the case?		
In relevant custodial cases, does the review analyse whether clear and appropriate assessments were undertaken to inform home detention curfew (HDC), release on temporary licence (RoTL) and the parole process?		
Is it clear if the supervised individual was meaningfully involved in the assessment of their risks (and planning), including whether not factors such as their motivation and readiness to engage and comply with the sentence were considered? Does the review analyse the impact of any diversity and personal circumstances?		
Does the review tell you enough about assessment so you understand the risks and any gaps in practice?		
Has countersigning practice been examined?		
Does the SFO review provide a robust and transparent analysis of planning in the case? Consider:	☐	☐
In all custody cases, is there analysis of pre-release planning, including contact with the supervised individual, sharing of information between prison and community based staff, MAPPA referral, plans for accommodation, liaison with other agencies, additional conditions? In relevant cases, does the review provide details of parole report proposals and any significant comments from the parole board about risk on release and associated planning that needed to be considered?		
Does the review analyse and provide sufficient evidence about the content and quality of the RMP to enable the reader to understand the plans in place to manage risk in relation to supervision, monitoring and control, intervention, victim safety and contingency planning. In particular does it reference which agencies were identified and their role, any supports and controls in place, what the planned actions were (including those to manage concerns and risks related to actual and potential victims, including the victim of the SFO where relevant), who was responsible for them and the timescales involved? Has the quality of the contingency plan been examined?		
Does the review analyse and provide sufficient evidence about the content and quality of the sentence plan to enable the reader to understand what plans were in place to address risk, how and when they would be achieved and the intended outcomes? In child/adult safeguarding cases does the review examine if there was a		

related objective to address risk of harm? Are details of the initial level, pattern and type of contact provided?		
Does the review tell you enough about the plans so you understand what needed to be delivered and any gaps? Is the review clear where there are links between the gaps in assessment and planning?		
Does the SFO review provide a robust and transparent analysis of implementation in the case? Consider:	☐	☐
Does the review analyse the timeliness and quality of case allocation to an appropriate RO?		
Does the review sufficiently examine the management of the case during the custodial stage?		
Does the review analyse the delivery of the RMP and SP? Is it clear how plans relevant to the critical risk issues were implemented?		
Does the review consider if sufficient attention was given to the delivery of actions to protect identified victims and potential victims, including the victim of the SFO where there were known risks?		
Does the review examine if a timely, pro-active and investigative approach was taken by practitioners and managers in relation to information received and new and emerging risks? Is there commentary on the evidence of, or absence of, professional curiosity?		
Does the review analyse the use and effectiveness of decision making and enforcement practice by staff at all levels? Is it clear about the response of practitioners and managers following escalating risk/emerging concerns? Does it sufficiently analyse whether or not recall had/should have been considered and any alternative risk management strategies put in place? Does the review examine if there was scope for alternative action sooner? Does the review identify critical decisions that were detrimental to effective management in this case?		
Does the review analyse if sufficient efforts were made to enable the supervised individual to engage and complete the sentence, including flexibility to take appropriate account of their personal circumstances?		
Does the review examine the quality of communications and information sharing between all relevant staff and other agencies and whether or not the management of risk of harm was sufficiently well-co-ordinated? In MAPPA & MARAC cases or where there were child safeguarding or IOM meetings, have the minutes from the meetings been examined to determine if all relevant processes were followed and have actions that arose for all agencies been identified. Is the review clear if probation actions were delivered?		

In relevant cases, are clear details provided about case transfer practice?		
Does the review consider line management oversight, support, advice and decision making and if it was timely and congruent with the risk and needs of the case and the experience, skills and needs of the practitioner?		
Does the review tell you enough about implementation so you understand what was delivered along with any gaps? Is the review clear where there are links between the gaps in assessment, planning and implementation?		
Does the SFO review provide a robust and transparent analysis of reviewing in the case? Consider:	☐	☐
Does the review analyse whether the risk assessment was reviewed in line with expectations, including in response to significant changes? Is evidence provided of any new information used to review the assessment of risk levels based on what was known at the time, including consideration of imminence and relevant risk/protective factors		
Does it analyse reviewing of the RMP (or gaps in reviewing) where circumstances changed, to take account of new risks? Does the review examine if reviewing was informed by necessary input from/checks with other agencies? Is evidence provided of changes to the content of the plan?		
Does it analyse reviewing of the sentence plan in response to progress and change? Is evidence provided of changes to the plan, including any new objectives and changes to reporting arrangements?		
Do you consider there were other events, not identified, that should have prompted additional reviews of the assessment/plans?		
Does the review tell you enough about reviewing so you understand relevant practice and any gaps? Is the review clear where there are links between the gaps in assessment, planning, implementation and reviewing?		
	Yes	**No**

In relation to all of the above standards the following prompts should be considered:		
• Does the review sufficiently consider whether all reasonable action was taken?		
• Does the review sufficiently analyse crucial decisions?		
• Does the review sufficiently analyse missed opportunities?		
• Does the SFO review sufficiently explore underpinning reasons for any deficiencies in practice where they existed?		
• Does the review sufficiently examine partnership work with other agencies?		
Overall, is there clear identification of pertinent risks and relevant commentary on assessment, planning and implementation and reviewing practice relevant to these? Do you understand events and related practice or are there outstanding questions/gaps in your understanding?		
Judgments **The review must provide a clear and balanced judgement on the sufficiency of practice**	**Yes**	**No**
Does the review provide clear and balanced judgments on the sufficiency of practice? Consider:	☐	☐
Has the RM evidenced a sufficiently investigative approach to ensure all relevant staff have been interviewed and the conclusions reached are informed by detailed consideration of all available evidence? Is there sufficient understanding of what went wrong and why to inform a focussed action plan?		
Does the review include the views of all relevant staff about the case and practice expectations? Where explanations are not valid, has the RM evidenced sufficient challenge and drawn their own conclusions? Is there clear evidence of the RM's own professional judgment throughout?		
Does the review sufficiently consider the practice of staff at all levels? Is there sufficient commentary from senior managers to account for their practice (where relevant), any concerns in the practice of middle managers they hold line management responsibility for and to discuss organisational context?		
Does the review include evidence based judgments about the sufficiency of practice? Do you agree with the judgments made		
Does the review include sufficient analysis of systemic or procedural factors in relation to probation practice and decision making? Have organisational expectations been rigorously examined and does the review include relevant judgments about the sufficiency of policy and guidance at a local and national level? Do you agree with the judgments made?		

Does the review sufficiently highlight areas of good practice where they existed?		
Does the review sufficiently identify practice that needs to be addressed through staff performance or discipline, where necessary?		
Does the review sufficiently come to conclusions on partnership working to inform the action plan?		
Learning **The review must identify and capture in the action plan, areas for learning and practice improvement**	**Yes**	**No**
Does the review identify areas for learning and practice improvement? Consider:	☐	☐
Does the review identify good practice (not expected practice) for dissemination?		
Does the review sufficiently identify areas for improvement for staff at all levels? Is it clear where/why learning is not required?		
Does the review sufficiently identify areas for improvement at a local, regional and national level (where relevant)?		
Where relevant does the review sufficiently identify areas for improvement in respect of multi-agency working		
Do the planned actions sufficiently capture the learning and practice improvements? Consider:	☐	☐
Does the action plan include learning to sufficiently address deficiencies identified for staff at all levels? Does it include the learning for absent staff, to be picked up on their return? Where there has been a clear deficit in understanding of practice, has the plan highlighted the need for a wider quality audit of the individual's work/caseload?		
Does the action plan include learning to sufficiently address areas for improvement at a local, regional and national level (where relevant), for example is there a gap in processes/policy/guidance? Does the learning indicate the need for bigger changes? Has national learning been identified where relevant and agreed with the national policy lead?		
Do the planned actions contain sufficient developmental activity to affect change?		
Is the plan SMART and does it provide clarity about how progress/outcomes will be monitored ? For example, are reasonable timescales given for delivery e.g. poor practice or a misunderstanding of practice expectations would require immediate		

action. Are they measurable e.g. use of dip samples and case audits, being specific about the numbers of cases to be reviewed and the timeframe.		
Do the planned actions include sufficient assurances about how learning will be shared with partner agencies?		
Victims and their Families **The review is appropriate to share with victims and meets their needs**	**Yes**	**No**
Have columns been used effectively, clearly setting out the events/analysis, the RM's exploration of underpinning issues and judgments, and the critical practice issues and identified leaning?		
Have details of third party and personal information been included in the "not for disclosure" column, with a disclosable summary included in the event/analysis column?		
Is the language used in the review sufficiently accessible: Is it clear and concise and does it flow well?		
Is the review written sensitively to account for the impact on victims?		
Does the review include accessible explanations of expected practice to support an understanding for the wider audience?		
Does the review sufficiently explain the significance of deficiencies and missed opportunities and the impact these had, to assist the understanding of a wider audience?		
Does the review sufficiently and transparently focus on practice relevant to the circumstances of the SFO, including the management of any known risks to the victim? Is it clear about risk management in the period leading up to the SFO?		
Does the review present judgments clearly, with examples used as evidence to support these, to assist the understanding of a wider audience?		
Is the review robust and transparent or is it likely to leave questions for the victim/families?		
Summary	**Yes**	**No**
Does the summary sufficiently reflect the critical issues relevant to assessment, planning, implementation and reviewing?		
Is the summary balanced, incorporating key deficiencies as well as areas of good practice?		
Is the summary clear about the management of any known risk to the victim of the SFO where relevant?		

Does it reflect any identified themes and include commentary on crucial decisions and missed opportunities?		
Is the summary clear about the significant of crucial decision or omissions in practice and the impact they had on the overall management of the case?		
Does it provide an explanation of the key issues that underpinned deficits and omissions in practice?		
Is the summary clear about action already taken to address critical issues and the next steps to ensure practice improvements?		

Final QA sign off	**Yes**	**No**
Are you assured that the PDU Head has completed a factual accuracy check?		
Are you assured robust internal quality assurance of the SFO review has taken place?		
Has there been exceptionally poor practice in this case? If so, you must refer in your countersigning comments to any consideration given to instigating capability or disciplinary procedures. Where the actions of another region (transferred cases) or agency are assessed to be significant, you should include information to confirm what action has been taken or is planned. Have you done this?		
If you still have questions about aspects of practice or other concerns about content after reading the review documents then these need to be addressed before submission to HMPPS.		
Internal QA completed by: Date : Comments:		

Countersignature	**Yes**	**No**
Has the relevant Head of PDU read the review and agreed its contents for factual accuracy?		
Are you content that all learning, and any implementation issues has been shared and discussed with the relevant senior manager?		

Are you content that the review is a factually accurate and transparent account of the case and related practice and meets the quality required for countersigning?		
Countersigned by: Date : Comments:		