HM Prison & Probation Service

# Policy Framework - Notification and Review Procedures for Serious Further Offences

Annex D(i) SFO Review Guidance

This Annex provides guidance on how to complete the specific sections of the SFO Review template (Annex D) and should be read in conjunction with Annex B Operational Guidance, which provides wider information on the approach to completing SFO reviews and the required content.

No one SFO review will be the same and your task as a reviewing managers is to make judgments on what practice issues are relevant for inclusion within the review to ensure it provides a transparent analysis of the key aspects of the management of the case.

## Case Information Section

**Details of index offence and sentence:** Set out the date and type of sentence, including release and relevant licence dates in custodial cases. Provide brief details of the index offence(s), with clarity about the nature of the behaviour(s) and the supervised individual's relationship to the victim(s).

**The role of other agencies and details of parallel reviews:** Provide details of:

- any other agencies directly involved in the management of the supervised individual during the period under review e.g. children's services, police, housing, CMHT. These are the agencies who have their own direct responsibility to manage aspects of the supervised individual's risk and/or circumstances, for example the police may be managing a SoR and SHPO and children's services may be involved in safeguarding the supervised individual's children.
- confirmation of any parallel reviews (SCR, DHR etc) and the stage they are at. Where relevant, confirm whether the RM has liaised with the author of the parallel review to inform this review.

You do not need to include details of police/children's services here if they were only involved for the purpose of routine safeguarding checks being made.

**Period reviewed:** Provide clarity about the start and end date of the period under review. For lengthy sentences, this might include an explanation of what early information has been summarised and where the focused examination of practice commences (see Operational Guidance).

**Summary of SFO:** Use sensitive language to set out factual details , including the date and nature of the SFO and brief details (for example, that it involved a fatal stabbing). Be clear about the nature of the supervised individual's relationship with the victim where details are known.

## Interviews

Refer to section 9 of the Operational Guidance for information about planning interviews, staff welfare and effective management of the SFO process.

Set out who was interviewed, their grade and role in the case (including the period they were involved in the case) and the main subjects and issues covered. SFO reviews are anonymous, therefore it is important that individual staff names (or initials/ or any other specific identifier) are not included. Refer to staff using identifiers such as PP1, PP2, SPO1, PDU1 etc. Make a note in this section of

any key staff members that were unavailable for interview, with reasons for this (e.g. long term sickness absence).

## Equality Information

Include all known information about equality and diversity factors identified from the case records, even if the probation practitioner (PP) had not addressed these issues. Please state clearly whether the PP identified, considered and actively managed any pertinent factors, or highlight where there were omissions in expected practice relevant to diversity considerations.

## Risk and Safeguarding Information

The case details and risk and safeguarding information should provide the reader with an immediate understanding of key risk issues. Where insufficient detail is available in the case records about risk/safeguarding issues to inform an understanding of risk, take steps to obtain that information to support the production of the review. This could include contact with the police for information about domestic abuse history, prolific offending and gang related harm and liaison with social care for child/adult safeguarding information. Clearly identify any information you have independently sought to inform your understanding of the case and your judgments.

**Details of groups/individuals at risk, nature of risks and any changes to RoSH during the review period:** Include:-

- a narrative of all assessed risk levels to all groups as assessed at the start of sentence.
- information about why specific groups are at risk and the nature of these risks.
- details of any known adults identified as being at risk and the reasons for this.
- dates of changes to assessed RoSH levels and brief reasons.
- comment on whether the assessed risk levels during the period under review did not account for all known risks and provide a brief understanding of any such additional risks.

**Child and adult safeguarding:** Detail any historical, current or emerging child/adult safeguarding issues to provide the reader with an understanding of all relevant concerns. Include:-

- an understanding of which children or vulnerable adults were either at risk or potentially at risk and why and include details of their ages, relationship to the supervised individual and contact with them.
- details of any referrals to child/adult services, with outcomes provided.
- information about the level of children's services involvement e.g. child protection, child in need and a summary provided of any emerging concerns, and the progress of any intervention during the review period.
- if there were no known concerns, clarify how this was confirmed or state whether checks weren't completed but should have been
- a summary of any safeguarding concerns that arose during the period under review with details of any responsive action that was, or should have been, taken.
- to ensure the review is able to provide a clear understanding of CS risks, you may need to undertake your own checks where this evidence is missing from the case record.

**Domestic abuse (DA) or stalking :** Include a summary of historical, current or emerging DA risks and the details of any known individuals at risk covering:-

- reported behaviour as well as convictions and clarify whether the PP completed the required DA checks to inform their assessment of DA and/or stalking risks or confirm any omissions in assessing these risks.
- to ensure the review is able to provide a clear understanding of DA risks, you may need to undertake your own checks where this evidence is missing from the case record.
- where there have been numerous victims, it is important that this section clearly differentiates between them and assigns identifiers such as P1, P2 etc.
- details of any relatives at risk of DA should also be provided.

**Specialist risk assessments:** Provide brief details of any specialist assessments/structured professional judgments undertaken, when they were carried out and any key issues to note/recommendations made. Include comment about the absence of required specialist assessments where relevant. In historical cases this may include a separate ARMS or RM2000 but in most cases will relate to other current specialist assessments such as SARA or Extremism Risk Guidance (ERG), which identify risk factors and risk levels that should feed into OASys but are still recorded distinctly. A summary of a PD formulation can also be helpful.

**Subject to Sex Offender Notification Requirements and/or a SHPO?:** Include the status and length of any SoR/SHPO, why they were imposed and provide details of the specific prohibitions. The focus in all these questions is on the period under review rather than post SFO e.g. make it clear if the supervised individual had no history of sexual offences and therefore no SOR requirements until they were sentenced for a SFO that is sexual in nature.

**Serious group offending/organised crime/child sexual exploitation:** Include a brief summary of historic, current and emerging SGO/gang/serious organised crime/CSE concerns and an understanding of related multi-agency working where relevant. Comment on whether the PP sought or shared potential risk information in this regard to inform an assessment of the risks.

**MARAC/IOM:**. Include details of any referrals to, or involvement of IOM or MARAC during the period under review, including any significant actions from meetings/reviews and the role the IOM police played in managing the case. Comment if a referral was warranted but the PP omitted to complete one.

**MAPPA including details of, and reasons for, changes to MAPPA level during the review period:** Identify the MAPPA level at the start of sentence, whether there were any changes as the case progressed, when these were and why the changes were made. Ensure the assessed MAPPA level at the time of the SFO(s) is clear. Detail any omissions in practice in this area.

## Overview of History and Circumstances Relevant to Risk

The purpose of the overview is to provide the reader with a summary of the supervised individual's background, offending history and relevant personal and social circumstances linked to key risk factors. It should provide:

- an understanding of the supervised individual's previous convictions, patterns of offending and critical factors linked to risk

- context to support an understanding of the key areas of risk and need that should have been assessed, planned for and managed as the case progressed.

Consider summarising information from the relevant sections of the needs assessment. Where relevant you may need to comment on any risk factors/circumstances that are unclear due to missing information. An example entry is included below.

**Overview of History and Circumstances Relevant to Risk**

AB was 23 years old at the time of sentencing for the index offence. After early convictions for driving matters as a youth, a more concerning pattern of violence and drug related offending started to emerge. Police and probation records provided information about his involvement in gang activity in his late teens and there was evidence he routinely carried a knife, which he claimed was for 'self-protection'. The most recent gang checks during a previous community order in 2018, indicated that since he had moved to a nearby Borough he was not considered to be an 'active' gang member but was known to be on the periphery of a named gang and to continue to associate with members of it. There was a lack of clarity about his gang nominal status at the start of sentence as the OM did not complete up-to-date gang checks.

AB had experienced a difficult and chaotic childhood, characterised by domestic abuse within the home but in more recent years he had lived solely with his mother in what was considered to be a stable and supportive environment. He had held a number of short term, casual jobs as a labourer and evidenced some commitment and motivation to return to education, although past attendance on college courses had been short lived. While he spoke of wanting to move away from his past lifestyle, it was apparent he struggled to let go of the financial rewards it brought him and that acceptance from his peers was integral to his self-worth. Previous risk assessments highlighted entrenched attitudes about the use of violence to resolve conflict and that his loyalty to his friends and gang affiliations was critical in sustaining his pattern of offending.

PP1 referred to AB having a 'good relationship' with his partner (P1), despite this not being approved of by her family. Two previous police call outs indicated some concerns about volatility in the relationship and the nature of the index offence indicated suspicions and jealousy. The risk assessment touched on some of these issues but there was an absence throughout the period under review of any exploration of P1's circumstances or AB's known contact with young children in his family, to establish whether child safeguarding or any other vulnerabilities were relevant.

In terms of need, AB had a history of cocaine and cannabis use and admitted to having used both at the time of the index offence. AB suffered with depression, for which he reported taking medication, and there had been an episode of psychosis in 2017, thought to be cannabis induced. Risk assessments recognised the link between emotional wellbeing and the risk of serious harm posed but did not offer any further information about this

## Review of Practice

### Event and Analysis of Practice and Context

When completing the main review entries, take a narrative approach and combine the description of what happened in the case, with an analysis of, and judgments on, the sufficiency of practice in relation to the event.

Include in your analysis a detailed examination of the underpinning issues, including the views of staff at all levels, any systemic issues and the effectiveness of policy and guidance where relevant. Use the commentary to highlight crucial decisions and missed opportunities and explore the significance and impact of them.

Consider all relevant practice as the case progresses and how assessment, planning, implementation and reviewing were approached. Include reference to adherence to, or deviation from, local or national expectations and policies in order to place the case in context and to inform the key findings. Be clear about when there was an absence of expected action.

You should use the chronology to create a narrative content which "tells the story" of the case, drawing out pertinent practice issues.

Use accessible language and include brief explanations of practice expectations to support accessibility for a wider audience. Example:

> *PP1 clearly identified the child safeguarding (CS) risks in this case and ensured a 'risk flag' was created on the case record. Risk flags are evident to all staff when accessing the case record and selecting them should provide a summary of pertinent risk information. PP1's summary was detailed and would clearly inform anyone accessing the case record that xx posed a risk of emotional and psychological harm to his children through being exposed to domestic abuse within the home.*

Summarise third party and personal/special category data in this column in a way that ensures the review is "ready to share" with a victim, subject to redactions being agreed. Include the more detailed personal and sensitive aspects of the information in full in the 'information not for disclosure' column (see example entry below).

**OASys/Risk Assessment Entries**

To support accessibility and clarity, include *separate entries* for (i) risk assessment, (ii) RMP and (iii) sentence plan, with brief explanations of the role and purpose of each included for the wider audience. Structure entries around the headings identified below. These align with the OASys Countersigning Checklist issued by EPSIG in December 2020 but have been kept broader to avoid too much technical detail. Refer to the full checklist to ensure the entries capture all relevant information but use your own professional judgment to focus on the most pertinent issues. Avoid numerical reference to specific sections of the OASys assessment, e.g. R6.1 without a description , as this will be meaningless to a wider audience.

Ensure that the entries provide an understanding of both the *content* of the assessment and plans and the *quality* of them. Avoid statements which simply comment on the quality e.g. *"the risk management plan identified all relevant agencies"*; these judgments need to be supported by a brief narrative summary of the evidence e.g. *"these included children's services, the police and the accommodation worker".*

Focus the content on the identified risks in the case. The aim is to ensure a reader understands i) the risks presented by the supervised individual ii) the plans in place to manage these iii) the quality of the assessment and plans and any omissions in them; and iv) if there were gaps, what should have been in place and what impact the omissions had. Make reference to expected practice and quality standards to support judgments where necessary. As with all entries, fully explore any identified deficits in practice with a view to establishing the underpinning reasons for them.

**(i) Risk Assessment**

Briefly explain the purpose and expectations of the risk assessment for the wider audience. Clarify why it was being completed and whether it was timely in line with expectations.

Include summary statements about whether the assessment was fully completed, had sufficient evidence to support the scoring and was informed by all relevant information sources and the SAQ. Was information appropriately included in the INTBDTTO section where necessary?

Some information previously required in the entry relating to the risk assessment should now be captured in the earlier 'overview', specifically an understanding of the offending history and the detail about the history and circumstances related to areas of need identified in sections 2-13. You do not need to repeat the detail here.

**Offence Analysis:** Provide an understanding of the pertinent issues relevant to the index offence(s), the supervised individual's attitudes towards it and the PP's assessment of motivations and triggers. Comment on whether the assessor considered all relevant aspects of the offence(s) and sufficiently analysed the supervised individual's account of it? The reader should be left with an understanding of any significant concerns about denial and minimisation and other attitudes/behaviours relevant to the assessment and management of the case.

**Areas linked to risk of reoffending (RoR) and risk of serious harm (RoSH):** Clarify the areas of need linked to RoR and RoSH, you will have used the overview section to provide an understanding of the issues so there is no need to repeat all the details here but comment on whether you agree with the areas identified or highlight any omissions or inaccuracies. Was scoring suitably supported by the evidence throughout?

**Risk of serious harm assessment:** Comment on whether the screening and full RoSH analysis accurately and fully analysed all relevant risks and provide a narrative summary of pertinent identified issues e.g. propensity to carry weapons. Include clarity about what information was used to provide an understanding of relevant risks, for example, child safeguarding. Comment on any significant omissions.

**Risk of serious harm summary:** Provide a summary of who is at risk, the nature of the risk, the assessment of immediacy and, factors likely to increase and reduce risk along with commentary on

the accuracy and quality of the information provided. Clearly summarise the identified risk levels for each category and include your own judgment on whether these were appropriate.

Be clear about what information the risk assessment contained relating to any known child and adult safeguarding concerns and whether this was sufficient and evidenced the practitioner giving priority to the assessment of these risks.

Clarify if relevant specialist assessments or structured professional judgments were or should have been undertaken, the outcome and how they have been used to inform the risk assessment.

**(ii) Risk Management Plan**

Briefly explain the purpose and expectations of the RMP for the wider audience.

Include a summary of the information contained under the four pillars and in the contingency plan along with your judgment on the sufficiency of the content. Be clear about any pertinent omissions and what this meant for the overall effectiveness of the plan. Where there are gaps, set out what alternative plans should have been in place to manage key risks.

**Supervision:** What activities and providers were identified and did they sufficiently address the identified risks?

**Monitoring & Control:** What activities to manage assessed risk factors and keep others safe were included and are they sufficient?

**Intervention & Treatment:** What activities to address assessed risk factors and keep others safe were included and are they sufficient?

**Victim Safety Planning:** Which victims were identified in this section, what plans were in place to safeguard them and are these sufficient? Were there gaps related to specific individuals or groups? Were there clear and sufficient actions relating to any known child and adult safeguarding concerns? Was priority being given to the management of these risks?

**Contingency plan:** Provide a summary of the key planned activity to respond to changes to the identified risks or a breakdown in the plan – who was going to do what in what circumstances? Were all likely indicators for escalating risks included? This is important so the reader is alert to expected practice if risk issues emerge during the review period.

**(iii) Sentence Plan**

Briefly explain the purpose and expectations of the SP for the wider audience.

**Objectives:** Summarise the objectives and the planned activity to achieve them, with clarity about who was expected to do what. Comment on the effectiveness of the objectives, whether they were SMARTA and sequenced effectively and whether they took account of learning needs and addressed all significant risks and needs. Be clear as to whether the plan sufficiently linked with the RMP in addressing child and adult safeguarding concerns.

**Engagement, motivation and capacity to engage:** What is the evidence that the practitioner has worked to engage the individual in the sentence plan and assessed their motivation and capacity to change and factored that into the plan ? Has the assessor considered maturity or the impact of other diversity considerations or personal circumstances (e.g. substance misuse or mental health) on the supervised individual's capacity to engage?

**(iv) Countersigning**

Always confirm whether the risk assessment and plans required countersigning and, where they did, set out the quality of the manager's countersigning practice. Did the countersigning manager identify any relevant quality issues and request additional work or did they sign off an insufficient assessment and plans? Were there factors that impacted on the quality of countersigning practice ?

You do not need to include separate entries for the assessments and separate entries for the plans when examining subsequent reviews; use one entry and simply comment on the content and quality of any changes or the absence of required changes.

**Information Not for Disclosure**

You should be familiar with Section 7 of the Operational Guidance relating to the Data Protection Act 2018 and redaction/removal of information.

Write the SFO review in a style that is immediately accessible and ready to share with victims or other third parties. Use this distinct column to include sensitive information that you consider should be removed prior to wider sharing in order to meet legal requirements. For example, the specifics about a traumatic event in a supervised individual's life, personal details about a staff member's absence where it would not be necessary or proportionate to share, or details of third party information that cannot be shared without consent.

The column would normally be removed in its entirety prior to sharing with victims/families. At that stage you will also need to consider potential redaction of information included within the background and risk information sections of the review prior to disclosure.

Include a broader description of the relevant information in the 'event and analysis' column to provide a sufficient and reasonable understanding for the victim/family or wider audience in line with guidance in Section 7 of the Operational Guidance.

This approach will provide HMPPS staff with pertinent additional detail about the case as part of the internal management review, as well as ensuring the review provides a sufficient understanding of the case with the column removed.

**Critical Practice Issues (Key Findings) and Identified Learning**

Use this column to highlight the critical issues/deficiencies in relation to assessment, planning, implementation and reviewing by way of a concise summary of each key finding. Identify areas for learning and learning points that will be included in the action plan, along with any action already being taken. Also specify areas of good practice[1] for inclusion in the action plan.

Use the key findings in this section to inform your summary (see below).

[1] Good practice is practice that was particularly effective and warrants being shared as something that others could adopt or learn from.

**Example Review Entry**

| Date | Event and Analysis of Practice and Context | Third Party/Personal Data not for Disclosure- | Critical Practice Issues (key findings) and Identified Learning |
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| 01/03/20 | **Police contacted the NPS about AB's suspected involvement in a serious incident.**<br><br>PP1 was not available and reception staff emailed her a summary of the contact requesting she return the call. It included the information that the police were seeking to arrest AB due to allegations he had been involved in a group attack during which a firearm had been discharged at the victim's home address and threats made to kill him and his family.<br><br>PP1 did not follow up this call prior to the serious offence against the same victim a week later. This significant omission resulted in a missed opportunity to review and manage the risks posed to the victim, who also lived within AB's exclusion zone.<br><br>PP1 should have established the details of the incident and for this to have prompted a discussion with SPO1 about whether AB should be recalled (returned to custody) or, as a minimum, plans put in place to manage the presenting risks.<br><br>During interview PP1 was evidently distressed and did not attempt to minimise this omission but she was able to provide some relevant context. PP1 described | PP1 had experienced the loss of both of her parents within a two month period. She had returned to work following some time off but SPO1 recognised she was clearly still struggling emotionally and was discussing the need for some extended leave just before PP1 went off with no notice the day after this event due to her young child being taken seriously ill and hospitalised. | **Learning point 4**<br><br>SPO1 did not ensure sufficient cover arrangements for cases during PP absence.<br><br>Learning has been set for SPO1 and ACO1 to review cover arrangements and guidance in relation to this.<br><br>**Learning point 5**<br><br>Information on significant risk concerns was lost in the PP's absence – communication arrangements did not safeguard against this. |

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| | an intention to call the investigating police officer back but explained she was dealing with a complicated prison release that day which took up a significant amount of her time. The next day she commenced a period of unplanned absence due to a personal emergency and did not have the opportunity to personally hand over case information/ tasks. PP1 did state that she knew expected practice would have been for her to record the email containing the police information on the case record and return the call on the day . Or, alternatively if she was not able to do this, she should have escalated this to SPO1. She described a context of feeling overwhelmed throughout this period, having experienced a number of difficult life events which had impacted on her wellbeing and performance at work. Shortly prior to being allocated this case, she had returned to work after a short period of absence but, with hindsight, acknowledged she had returned to work too soon. SPO 1 had offered support and PP1 agreed to consider taking some extended leave but the day after this event, circumstances forced this without notice.<br><br>When discussing oversight of PP1's cases during her absence, SPO1 said she was waiting to see if PP1 would return and had not reallocated her cases to the team on this basis. She confirmed that PP1 had not mentioned the outstanding call when she notified her she would be absent. In light of the significant staffing issues explored in the entry above *(not shown in this example),* SPO1 explained that in making this decision she was conscious of the impact of any further caseload reallocations on both staff and supervised individuals. SPO1 did review PP1's high risk cases and arranged appointments with colleagues but the absence of detail on AB's record meant the concerning information about the alleged incident was not evident and the clear indicators of increased risk were therefore missed. Given that SPO1 knew about PP1's situation and the likely | | Guidance put in place to ensure that administrators know what action to take in these circumstances and ensure SPOs are alert to critical risk information, will be monitored.<br><br>**Learning Point 6**<br><br>SPO1 and ACO1's Understanding and application of recall policy framework.<br><br>SPO1 and ACO1 to have a reflective discussion about the recall policy framework and alternatives to recall and view the video resource for senior managers to support recall decision making. |

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| | timeframe for her absence, she should not have delayed the reallocation of her caseload, something she acknowledged at interview.<br><br>There were a number of factors in play that contributed to, and provide some understanding of, the failure to act on the police information. SPO1 spoke very highly of PP1, describing her as an experienced, diligent and committed practitioner. Case audits undertaken immediately after this SFO came to light provided supporting evidence for this, with detailed case recording noted as a strength. PP1's management of this case up until this point had been robust. On this basis it is reasonable to conclude that the extenuating pressure PP1 was under in her personal life directly impacted in this instance and therefore I have not included individual learning about case recording in the action plan. That being said, SPO1 agreed safeguards are required to ensure significant information is not missed and she has since implemented a new system which requires administrators to copy the SPO into any emails with information about significant events in a case. I have included a learning point in the action plan to ensure this system is monitored and reviewed. While both SPO1 and ACO1 assured me that caseloads have reduced and staffing resources have been resolved, there is also a learning point for SPO1 and ACO1 to review the expectations for cover arrangements during staff absences.<br><br>The failure to act in this case was significant and meant there were missed opportunities to protect the victim prior to the SFO. SPO1 advised that she would have been unlikely to recall AB even if she had been alert to the police information because he had not been charged at the time, an explanation that demonstrates a lack of understanding of the recall policy framework which requires probation practitioners to consider recall in cases where a supervised individual's behaviour indicates that they present an increased or unmanageable risk of serious harm to the public or there is an imminent risk of further offences being committed. There | | |

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| | is no requirement to await the outcome of police investigations or for the supervised individual to be charged, if the Probation Service is satisfied that the reported behaviour meets the recall threshold. ACO1 agreed that had she been alert to the allegations she would have wanted more information but recall would have been a consideration. As a minimum she considered a return to the approved premises in another Borough would have been the starting point as this would have included additional restrictions and greater monitoring thereby ameliorated the presenting risks.<br><br>In this instance AB was being sought by the police for an incident where a gun was fired inside an exclusion zone and the police were confident he was involved, which was sufficient concern to meet the threshold for immediate recall in line with the recall policy framework. Once the individual is back in custody there is an opportunity to review the risk assessment and management plan and consider what measures could be put in place to manage the risks and whether re-release could be supported in the event that new information became available, a decision be made not to charge, or indeed in the event of a not guilty finding. The decision on whether to support re-release is based on the information as a whole and whether risk can be managed in the community; re-release is not automatic in the event there is no charge or conviction. | | |

## Summary

Provide a short, complete and accurate overview of what you have already written in the main body of your report. Draw together the pertinent findings to allow senior managers in the organisation to readily acquaint themselves with the significant issues, this will support sharing of the review with victims/families. The full chronology will be shared and provides further detail, so the summary *distils the 'headline' findings*. Where appropriate, cross reference particular entries in the chronology which contain further detail.

The summary is narrative in style and should:-

- reflect critical issues relevant to assessment, planning, implementation and reviewing
- provide an understanding of the key underpinning reasons for deficits/omissions
- be balanced; be clear if practice expectations were met and include areas of good practice as well as key deficiencies
- reflect identified themes, for example, if there a fundamental flaw with a particular aspect of practice that impacted throughout e.g. inaccurate risk level.
- comment on crucial decisions and missed opportunities and the impact they had on the overall management of the case.
- be clear and transparent about whether all reasonable action was taken to manage risk, including any areas of known risk that were relevant to the circumstances of the SFO.
- clearly state what, if anything, could or should have been done differently and make final balanced judgments about where practice met or did not meet required standards. In some reviews, where significant elements of practice were of concern, it would be appropriate to conclude that practice as a whole fell below the required standard.
- provide an understanding of any actions already taken or underway, including any remedial action as a result of the early look into the case.
- detail the planned next steps to provide assurances about what action will be taken to share good practice and address all areas of concern, with an overview of when and how progress will be measured.

Avoid:

- the use of headings
- introducing any new information
- a lengthy summary

## Annex K SFO Review Disclosure Cover Sheet

Complete this for all reviews and append it to the review prior to sharing to provide an accessible overview of the review process and case details.