HM Inspectorate of Probation

HM Prison & Probation Service

Rules and guidance for the quality assurance of serious further offence reviews

HM Inspectorate of Probation, March 2021 revised September 2023

Contents

Introduction

Following the Secretary of State's request for HM Inspectorate of Probation to take on the new quality assurance process of serious further offence (SFO) reviews from April 2021, we devised a set of quality assurance standards. Inspectors use these standards in the quality assurance process to ensure that we ask the right questions and gather evidence to rate the quality of SFO reviews.

Our quality assurance standards set out the expectation that an SFO review will provide a robust and transparent analysis of practice, provide a clear and balanced judgement on the sufficiency of practice, enable appropriate learning to drive improvement and be suitable to share with victims (or their families) and meet their needs. The quality assurance standards are supported by rules and guidance and ratings characteristics.

His Majesty's Prison and Probation Service (HMPPS)'s SFO quality assurance team has also chosen to adopt our standards, rules and guidance and ratings. This ensures that reviews are quality-assured against the same standards by both HMPPS and HM Inspectorate of Probation and that feedback for improvement is consistent.

Information section

Is this case high profile?

Probation regions identify and notify the HMPPS SFO Team of all qualifying SFOs. HMPPS's public protection team designates a case as high profile on receipt of the initial notification. At the point of allocation, the email sent from the public protection team to the relevant region will contain confirmation that the case is high profile, where applicable.

Where an HM Inspectorate of Probation inspector considers that a case meets the criteria but has not been confirmed as a high-profile case by HMPPS, the inspector should contact the senior policy adviser in the HMPPS public protection team, for further discussion. The final decision on a case's high-profile status rests with the HMPSS team.

Were relevant staff interviewed to inform the review?

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

Relevant staff include, but are not limited to:

- all probation practitioners who managed the case during the period of time under review
- managers with professional oversight of the case
- all probation service officers or trainee probation officers who worked on the case as a support to the responsible practitioner
- the head of the probation delivery unit (PDU)
- staff who facilitated interventions or the delivery of unpaid work involving the person on probation
- approved premises staff, if relevant to the case
- victim liaison unit staff, where applicable
- commissioned rehabilitation service providers
- regional managers and staff.

Where relevant staff on this list have not been interviewed, the reviewing manager (RM) must briefly explain the reasons for this. If a member of staff has left the service, the review should provide details of why they left, and their manager should have been interviewed to discuss relevant issues. The RM should have considered whether any relevant learning needs to be included in the action plan. The RM should consider whether there are sensitive issues regarding being absent from work and should include these in the 'information not for disclosure' column, where appropriate.

If staff were unavailable for interview because the organisation has a high turnover of staff, or were agency staff, the RM should have explored this in the review and considered relevant learning for inclusion in the action plan.

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

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

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

The starting point of the SFO review should normally be the beginning of the sentence during which the SFO was committed. If the person on probation was serving a lengthy sentence at the point of the SFO, it may be appropriate to include a summary of the custodial period in the chronology, with more detailed analysis closer to their release. This will include scrutiny of pre-release work such as parole reports, planning and implementation, with any key findings taken into the review. Similarly, where a person on probation had been in the community for a lengthy period of time before the SFO, the focus should be on the 12 months preceding the SFO.

It may sometimes be necessary to look further beyond the 12-month period, for example if there were clear indicators of risk from previous periods of supervision, or other previous offences/periods on supervision that are relevant and need analysing in the review.

If, at the point of the SFO, the person on probation has been managed for a period of six months or less on their current sentence, and this was preceded by a continuous previous period of management, then the review should also examine practice during that previous sentence.

Work undertaken after the commission of the SFO is outside the scope of the review; however, key events that follow shortly after it can be included in the chronology if they provide relevant context or clarity. The relevant HMPPS guidance on completion of SFO reviews should be consulted.

Are there any paralleling reviews?

In some cases, and depending on the nature of the SFO, HMPPS or partnership agencies could be carrying out parallel investigations, with objectives that are not always identical to those of the SFO review.

When HMPPS knows about a parallel review, it will make the status of this review clear in the allocation process. However, it is possible that HMPPS will not have been made aware of other reviews when it allocates the SFO review.

It can take time for different responsible authorities to decide whether the SFO has met the criteria for a separate review, for example a domestic homicide review or a serious case review. It could be that the commission of other reviews had yet to be confirmed at the point the SFO review was completed, or during the SFO quality assurance process. When the HMPPS SFO team receives notification of another review, it alerts the responsible leads in the public protection group. Other types of review that could be taking place include:

- a child serious case review
- a multi-agency public protection arrangements (MAPPA) serious case review
- a domestic homicide review
- internal human resources investigations.

In the SFO review, the RM should have referred to these other reviews only to the degree that it is appropriate. The quality assurer should identify whether the review has mentioned other reviews, where they are known about and relevant.

Case details and background information

The case details should provide the reader with an immediate understanding of the key issues, including the assessed level of risk and any changes, who is at risk, safeguarding concerns and domestic abuse issues. This should include a sufficient overview of the history of concerns, the circumstances during the review period and any significant changes. It should include appropriate comment on whether relevant enquiries/actions were completed to inform the reader's understanding of the risks posed. The case details include a diversity section, which should set out all known information available to the reviewer following examination of the case records. The RM should record any diversity issues identified or omitted. Where diversity factors are identified, their significance or impact on the management of the case should be considered throughout the review.

Review of Practice introduction

When undertaking a review, the reviewing manager should be mindful that each case is different, and a one size fits all approach does not apply to SFO reviews. There will be variances based on the nature of the case, risk factors and criminogenic needs. Further, there may be variations in practice between teams, PDUs and regions which need consideration. Each review must be undertaken with this in mind, making the analysis, judgements, learning and accessibility relevant to the individual case.

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

These include, but are not limited to:

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

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

- the risk of serious harm assessment – entries should be clear about the areas linked to risk of serious harm, levels and imminence of risk, who is at risk, the nature of the risk and the factors that may increase/reduce risk
- the risk management plan, contingency plan, and sentence plan
- MAPPA actions

- actions from child in need and child protection conferences
- domestic abuse enquiries and resulting actions (e.g., MARAC)
- police intelligence
- management oversight and alternatives to recall.

The RM can choose to cut and paste entries where the information supports understanding, but otherwise a detailed description is preferable. For example, if the RM has recorded that a child in need meeting has taken place, all the relevant actions from that meeting should be added to the review of practice.

The above list is not exhaustive. The primary evidence must be available in the review of practice to support the analysis, judgement, and subsequent learning that the RM will set out in their review and action plan.

Expected and exceptional practice

The review of practice must include an examination of the quality of practice and provide clear judgements on sufficiency. The RM should have stated whether practice met or exceeded the organisation's expectations, or fell below expected practice standards, with reference to probation instructions and local policy and guidance, where relevant. There should be appropriate commentary on significant deficits and omissions to inform the review.

We expect the RM to have highlighted the following during the course of the review:

- • where expected practice has been found
- • exceptional practice to be added to the action plan for wider sharing
- • deficiencies that link to learning points identified.

Evidence of **exceptional** practice includes work that was particularly effectual in the management of the case and warrants wider sharing across the PDU or probation region. Such practice might demonstrate responsivity, creative use of local external services or the use of specialist interventions or effective innovation. Other examples might include practice that has had to be flexible to take account of a person on probation's protected characteristics, or where a responsible officer has gone 'above and beyond' to improve engagement and/or compliance.

It is helpful for RMs to identify whether a deficiency is at an individual, team, PDU, regional or national level, and to highlight whether a related learning point has been set.

2. Analysis of practice

The SFO review provides a robust and transparent analysis of assessment, planning, implementation and reviewing practice at all levels.

Judgement

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

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

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

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

We expect the RM to have scrutinised the assessment of domestic abuse. Domestic abuse is 'any incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexual identity. The abuse can include, but is not limited to, psychological, physical, sexual, financial, emotional' (Cross government definition, Home Office, 2016 [1]). Where no domestic abuse enquiries have been made, we expect the RM to have highlighted this and linked it into the action plan. Where there are gaps in information, the RM should undertake domestic abuse enquiries when completing the review.

We expect the RM to have scrutinised the assessment of child safeguarding. Quality assurers expect child safeguarding enquiries to have been made with children's services in all cases where the individual has children, is in contact with children or presents a potential risk of harm to children. Probation staff must ask the person on probation whether they live with or have caring responsibilities for children. Probation staff must also check with children's services whether children are known to be in contact with the person on probation and the nature of any involvement. Where no child safeguarding enquiries have been made,

[1] Domestic abuse: how to get help - GOV.UK (www.gov.uk)

we expect the RM to have highlighted this and for it to link into the action plan. A child is defined as anyone who has not yet reached their 18th birthday (Office for National Statistics 2020[2]) The relevant enquiries should be made as part of the review to identify any gaps in information and the significance of these.

We expect the RM to have scrutinised the assessment of vulnerable adult safeguarding. Quality assurers expect adult safeguarding information to have been shared with social services in all cases where the person supervised is in contact with a vulnerable adult, presents a potential risk of harm to vulnerable adults or is a vulnerable adult themselves. Probation staff must ask the person on probation whether they live with or have caring responsibilities for vulnerable adults. Where no reasonable adult safeguarding enquiries have been made, we expect the RM to have highlighted this and for it to link into the action plan. The NHS defines vulnerable adults as any adult (person over the age of 18) unable to take care of themselves or protect themselves from exploitation.[3]

As above, the relevant enquiries should be made as part of the review to identify any gaps in information and the significance of these.

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

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

Planning: Planning actions include start custody/community sentence planning, release planning and risk management planning. Planning work includes, but is not limited to, formal planning on tools such as OASys. Planning work can also take place in supervision meetings with the person on probation and in meetings with external agencies.

RMs are expected to have commented on the timeliness and quality of the sentence plan and risk management plan. We expect the RM to have considered what preparatory work the responsible practitioner carried out to complete the sentence plan and risk management plan.

At a minimum, we would expect to see the RM comment on whether the responsible practitioner drew information from all available sources, including the self-assessment questionnaire, planning by other agencies, including the police, health providers, specialist interventions and information from prison, if this was appropriate. Reasonable action would also include whether an appropriate countersignature was given, where required.

Evidence could include:

- **Release planning**: Where a case has included a prison release, all planning for this release should be explored, including the handover from the prison offender manager (POM) to the community offender manager (COM), where relevant, and plans for accommodation, programmes, and risk management planning, including actions for partnership agencies. This may have involved MAPPA, MARAC, or child protection conference planning work. In relevant cases, it would also include details

[2] Child abuse in England and Wales - Office for National Statistics (ons.gov.uk)
[3] Vulnerabilities: applying All Our Health - GOV.UK (www.gov.uk)

of the Parole Board's decisions, and any comments they posit regarding the release plans.

- **Risk management plan:** In the review, the RM should have considered the suitability of the risk management plan, and whether it was robust and formed part of a multi-agency approach. This should include a summary of the risks that it addressed, which agencies were involved and the actions in place.
- **Contingency plan:** In the review, the RM should provide an overview of the most pertinent aspects of the contingency plan, so that the reader is aware of which actions should have been taken if these risks emerged. The RM should have analysed the suitability of the plans and whether they robustly managed increasing risks or changes of circumstances.
- **Sentence plan:** The review should include sufficient detail about the sentence plan objectives and how they were to be achieved. It does not need to repeat the full details in the chronology. It should include analysis of the suitability of the sentence plan, whether it was specific, measurable, achievable, realistic and timebound (SMART) and whether it linked to each identified risk in the assessment. The RM should also have considered whether the planning work was appropriate to offending need, desistance, and risk of serious harm.

Implementation: Reasonable actions during implementation include, but go beyond, implementing the sentence plan and risk management plan, taking enforcement action if there is non-compliance, and proactively managing the risk of harm and risk of reoffending. Additional reasonable actions will include the use of one-to-one supervision and suitable accredited programmes, the use of integrated offender management provision, home visits and multi-agency communication. The RM should have identified any key gaps in delivery practice.

Evidence of implementation activity may include the following:

- **Implementing the sentence plan**: including the timeliness of referrals for interventions and whether a suitable practitioner carried out appropriate offending behaviour work, including, pre- and post-programme work.
- **Taking enforcement action**: including using enforcement where necessary and recording this correctly. Quality assurers should expect to find scrutiny of the actions taken by managers with regards to non-compliance. RMs should also consider the actions of managers when making decisions to recall or not and the time taken to countersign recalls.
- **Pro-actively managing risk**: including whether the responsible practitioner acted in a timely way, when they observed that risk of harm to others was emerging or increasing, to mitigate this risk, by sharing information with partnership agencies, carrying out an enforcement or control measure, seeking guidance from a manager or addressing the risk through rehabilitative intervention. Quality assurers should expect to find scrutiny of the actions taken by managers with regard to risk management.

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

Reviewing: Reasonable action includes, but goes beyond, completing a formal review on the appropriate electronic tool, such as OASys, within a reasonable timeframe. Reasonable action would include evidence of responsiveness to information on an emerging risk of harm

to others and of active review of the assessment, plans and interventions in place. It would also include whether an appropriate countersignature was given on written reviews, where required.

RMs are expected to have commented on the suitability and timeliness of sharing reviewed risk assessments with other agencies, where necessary. RMs should consider whether all relevant information has been reviewed to accurately inform changes to the risk management plan and sentence plan.

The RM should comment on whether there was sufficient active monitoring of the individual's level of compliance or engagement. Responsible practitioners should be regularly reviewing whether the approach they are taking has had the desired impact and should identify what has been effective and what has been achieved, as well as any work that is still outstanding. We expect the RM to comment on the quality/appropriateness of adjustments made to overcome any barriers to compliance. We would not always expect to see a formal written review of compliance or engagement but would hope to find evidence in the contact log. In cases where compliance has been good, little or no reviewing will be required.

If there was no formal review of the case, for example if the person on probation was charged with a new offence or following the completion of a programme or other significant change, we also expect the RM to comment on whether this was appropriate.

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

b) Does the SFO review sufficiently analyse crucial decisions?

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

We expect the RM to have highlighted crucial decisions made in respect of planning, and to have explored how these were either significantly positive or detrimental to the quality of probation practice. Crucial planning decisions include the 'headline decisions', such as referral to an approved premises, referral to MAPPA, or contact with the victim liaison unit.

Examples of a crucial decision in the delivery of a case would include a decision to:

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

These examples can also be relevant in the reviewing phase of case management, and would also include a decision to:

- change the levels of risk, groups/individuals identified as at risk, or content of the sentence plan or risk management plan.

Quality assurers should expect to find that the RM has presented and assessed evidence where critical decisions have been made during all phases of the sentence.

We do not require the RM to have made causal links between a practice decision and the commission of the serious further offence. The RM should identify all such decisions in order to make clear judgements (see judgements standard) on whether they were supported by reasonable evidence and recorded professional judgements and the extent to which they were effective or detrimental.

c) Does the SFO review sufficiently analyse missed opportunities?

Where there are missed opportunities, there will be gaps in the assessment leading to inaccuracies or insufficient information to inform planning and delivery. It is key that potential missing links between the assessment of offending behaviour/risks including any changes to a person's risks and needs, and sentence planning or risk management are clearly identified. Similarly, any gaps in planning and the impact on delivery/implementation must be highlighted. Reviewing should include an accurate analysis of changes that apply in the case and not simply a description of what has changed. The RM's analysis should lead to identifying changes required in the risk assessment, sentence plan and risk management plan.

An example of a missed opportunity could be a lack of professional curiosity. Being professionally curious involves a process of always questioning and seeking verification of the information you are given, rather than making assumptions or accepting things at face value. By doing this, practitioners can avoid some common pitfalls in assessment practice, for example focusing on positive information, or accepting an individual's version of their offence or the circumstances of previous convictions and failing to challenge where there are discrepancies with the evidence.

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

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

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

Other examples of missed opportunities include a failure to:

- undertake a home visit
- act to safeguard a potential victim
- follow up concerns with a drug test
- refer to MAPPA, MARAC or other relevant multi-agency forums.

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

The RM should have sufficiently examined any relevant changes in the case and considered whether there were any missed opportunities to review the risk assessment, sentence, and risk management plans in response to these. This may include key information not being

obtained to inform reviewing, or a failure to verify evidence. The RM should also have considered whether:

- reviewing practice was sufficiently analytical
- all tools for storing and sharing information, for example ViSOR and VCMS, were used appropriately to enable effective reviewing
- there were any missed opportunities to seek management oversight, including senior management where relevant, for example in making decisions about enforcement
- management oversight was effective.

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

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

If there were deficiencies in practice, we expect the RM to have explored **why** there were gaps in practice, not just **whether** there were gaps, in order to inform an appropriately focused action plan. The RM should have interviewed the appropriate members of staff to explore the reasons for the deficiencies, and these should be reflected in the review. It is important that the RM has explored deficiencies more broadly than the actions of the case manager, to consider all possible contributary factors. In addition, the RM should be mindful of the workload pressures on, and experience of, the practitioner and any other staff involved in implementing the sentence, and comment on these as appropriate.

The RM should have set out clearly the underpinning reasons for any deficiencies in the management of the case and considered whether the following are relevant:

- issues relating to the culture in the local office or PDU, for example whether middle or senior managers prioritised timeliness of assessments
- whether staff at all levels had received appropriate training
- whether staff at all levels received sufficient management oversight and support
- the sufficiency of countersigning practice
- the sufficiency of the relevant experience, skills and knowledge of all staff
- workload, and the context of this
- local or regional processes and guidance and the implementation of national policies
- the impact, if any, of national policy such as probation policy frameworks on the work in this assessment.

We are looking for evidence that the reasons for the key deficiencies have been fully explored, including the views of all relevant staff involved in the case. Quality assurers should find that the RM has sufficiently explored the underpinning reasons for any deficiencies in assessment, planning, implementation and reviewing practice, where they existed.

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

The review should contain sufficient analysis of wider systemic and procedural factors that may have had an impact on practice. For example, new policy frameworks may not have been embedded effectively, which should be explored by the RM. Regions or teams may have adopted their own policies or practices in some areas, and the RM should explore the effectiveness of these and how they influenced the practice in the case. An example of this could be MAPPA level 1 processes, or enforcement practice within a region, PDU or team.

Additionally, wider issues such as staffing, workload and resourcing should be considered, as well as any national or local strategies to address these issues.

Consideration of these factors helps to explore the 'why' behind critical practice decisions and omissions.

f) Does the SFO review sufficiently examine the partnership work with other agencies?

In most cases, partners, departments and other agencies will have had some involvement with the person on probation. It is important that the work with other agencies is scrutinised in all phases of case management.

Assessment

Assessments should include all necessary information and evidence from other agencies, such as information from the Crown Prosecution Service, domestic abuse call-out information, safeguarding enquiries and custodial assessments or intelligence.

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

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

- Police – for intelligence such as domestic abuse callouts, ongoing criminal cases and gang information
- children's services – for information on the person on probation or the children to whom they have access
- youth offending teams – for information if the person on probation had previously been supervised as a child/young person
- prisons – for intelligence on behaviour in prison and details of any adjudications and/or security concerns
- mental health teams – for access to assessments and information on treatments, which might include the personality disorder (PD) pathway.

Where a curfew is being recommended or imposed, the RM should consider whether enquiries were made about domestic abuse and child safeguarding, and if these were

incorporated effectively into the assessment. Where this did not happen, the significance should be explored and analysed.

Planning

Where relevant, the RM should have looked at the planning work by probation staff in custody as part of offender management in custody (OMiC) or any joint planning/communication for non-OMiC cases. This should be considered in the run-up to release, considering pre-release planning and whether or not the correct interventions were identified against the complexity of need, as well as level of risk.

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

The RM should have stated clearly which partner agencies were involved in providing evidence for the probation service's planning. These might include, but are not limited to:

- police – to agree a trigger plan, discuss licence conditions, and confirm the suitability of proposed addresses
- children's services – to provide information on which programmes could be available for a person on probation who has a child
- prison – to confirm release dates and identify which programmes were not completed in custody. The RM should have examined the POM's planning practice, which might include sentence planning and planning for specific offence-focused or risk-focused work. The RM will need to explore the individual's OMiC status, where necessary, and whether they were reallocated to the COM appropriately. The RM should decide whether it is necessary to interview the POM. Any learning identified from deficiencies in their practice ought to be agreed with the prison before being included in the action plan
- mental health team – to plan additional assessments or treatments, which might include ongoing work with the PD pathway.

Implementation

Quality assurers will expect to see that the RM has examined whether partner agencies were sufficiently involved in implementing the sentence.

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

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

The RM should have stated clearly which partner agencies were contributing to the delivery of the sentence. These might include, but are not limited to:

- police – to undertake home visits or specific interventions agreed (e.g., for registered sex offenders (RSOs), integrated offender management (IOM) cases or those with gang affiliations) and, where relevant, effective mechanisms for recording and sharing information (e.g., for IOM cases or RSOs)

- children's services – to undertake relevant parenting programmes or interventions with a person subject to probation supervision who may have a child or about whom there are concerns relating to children, and to agree how relevant information will be shared and reviewed
- prison – the RM should have examined how POMs and offender supervisors in custody implemented the sentence plan; this might include offence-focused or risk-focused work
- mental health team – to undertake additional assessments or treatments, which might include ongoing work with the PD pathway.

Review

Partners and other agencies should be involved in reviewing. The review should highlight their involvement and responsibilities in relation to addressing the risk of reoffending, supporting desistance and/or keeping others safe. The RM should have examined the quality of communication and information-sharing by probation with these other agencies.

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

The RM should have stated clearly which partner agencies were involved in providing evidence for the probation service's reviewing work. These might include, but are not limited to:

- police – information-sharing about reported behaviour and domestic abuse concerns, and reviewing those managed as IOM or RSOs where joint working is part of the sentence/risk management plan
- children's services – to keep probation informed about changes to any intervention in a family or with information that indicates a new or increased risk to a child or family
- mental health team – to review progress with current interventions and plan additional assessments or treatments, which might include ongoing work with the PD pathway.

Quality assurers are checking that the RM has included all relevant input by partnership agencies in the reviewing phases of the sentence.

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

g) Does the SFO review sufficiently highlight areas of exceptional practice where they existed?

We expect the review to highlight exceptional practice where it occurred during the review period. This should be across all phases of case management and at all levels.

Evidence of exceptional practice would include work that was particularly effectual in the management of the case. Such practice might demonstrate responsivity, creative use of local external services or the use of specialist interventions or effective innovation. Other examples might include practice that has had to be flexible to take account of an individual's protected characteristics, or where a responsible practitioner has gone 'above and beyond' to improve engagement and/or compliance.

Quality assurors are looking for evidence that the RM identified all examples of exceptional practice, gave reasons why it was deemed exceptional, and, where appropriate, linked it to the action plan, so that individuals, and the organisation at a local, regional or national level, can learn from it.

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

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

The review should reassure victims/families that staff will be held to account where necessary and that any learning will be shared more widely, where applicable. The RM needs to take care not to share any confidential or sensitive information that could pertain to an ongoing employment tribunal.

The RM should be mindful of the impact on staff when completing their review. We expect to see interviews with staff at all levels managed with sensitivity, while also ensuring that any practice issues are raised through the appropriate channels.

2. Overall judgements

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

Judgement

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

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

It is important that the RM's judgements about practice are fully supported by a detailed examination of the explanations provided by relevant staff. We expect the RM to set out what information they obtained during their interviews with the relevant staff. It is key that staff members' 'voice' is heard, where appropriate. However, the RM should still robustly challenge and/or triangulate the version of events given by members of staff and should provide their own professional judgement on the validity of the accounts given. There is an expectation that staff at all levels, including senior leaders in PDUs, regions and nationally (where relevant), will be involved and provide evidence on practice expectations, deficits, and how practice has since changed and any associated improvements.

b) Does the SFO review make sufficient judgements on the practice of staff at all levels?

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

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

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

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

'Systems' relate to the objective building blocks of managing people on probation, which are often underpinned by statute, for example MAPPA.

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

Quality assurers are looking for whether the review included sufficient analysis of systemic and procedural factors in relation to probation practice and decision-making. This includes interviewing relevant leads at a local, regional, and national level, where appropriate.

d) Does the SFO review contain sufficient judgement of probation policy?

An RM may identify an issue with the content of probation policy, rather than how it has been applied. An analysis of probation policy will allow the RM to identify key areas for improvement, which could inform any changes necessary to address deficits. Where appropriate, the effective implementation of probation policy should be included. We expect the RM to have made a judgement in the review about systemic and procedural concerns, where they exist, which should inform a national objective in the action plan.

e) Does the SFO review sufficiently explain the significance and impact of deficiencies and missed opportunities?

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

f) Does the SFO review sufficiently come to conclusions on partnership working?

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

The RM must have clearly identified all of the partner agencies involved in the assessment, planning, implementation, and review of the case during the period under review. Partner agencies include all statutory organisations and commissioned rehabilitative services, as well as other local partner agencies that might provide support with substance abuse, mental health, mentoring or other types of assistance. The RM should have highlighted the quality of referral processes, communication of risk assessments and plans and effective information-sharing.

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

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

g) Does the SFO review contain sufficient judgements throughout to inform the action plan?

The review must provide a critical assessment of practice and make clear, well-balanced judgements about sufficiency. The judgements 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 judgements on exceptional practice. The RM should make judgements about areas of practice that are considered to go above and beyond expectations. Elements of exceptional practice, where they exist, should have been identified and their positive impact examined by the RM.

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

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

3. Learning

The SFO review enables appropriate learning to drive improvement.

Judgement

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

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

Judgement

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

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

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

The review should also identify the need for learning for all probation staff involved in managing the case, such as court staff, approved premises staff, and staff delivering interventions or unpaid work, and where there has been a case transfer. Any such learning should have been agreed with the lead before being included in the plan.

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

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

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

RMs should have explored the impact of regional service level agreements, referral processes and formal and informal lines of communication. They should have considered the culture and key priorities at this level. The RM should explore whether there is an issue with

the way in which national guidance is implemented in that specific region, and what action is required to rectify this. This could be due to contextual issues specific to that region at that specific time. If so, the RM should set out exactly how and why the region is doing things differently.

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

RMs should consider whether the issues raised in a review suggest areas for improvement at a national level. The starting point should always be to consider how national policy is interpreted and applied at a local and regional level. RMs should not use national learning as a 'catch all', but as a final option.

National level can include national level agreements, use of tools such as ViSOR, active risk management system (ARMs), or national agreements on disclosures, learning and development and court procedures. It may also include policy and processes relating to interventions and approved premises. This list is not exhaustive. Where an RM finds potential for national-level learning, they should contact the HMPPS SFO team in the first instance to ensure that the proposed action is achievable and to identify a suitable owner.

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

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

The RM should have stated clearly which partnership agencies were involved in the case. They should have explored the impact of local service level agreements, referral processes and formal and informal lines of communication. The RM should have considered whether there was an effective and efficient mechanism by which probation could request information and receive a timely response.

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

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

f) Does the countersignature process ensure the review is of sufficient quality and identifies relevant learning?

The countersignature process should highlight any revisions that need to be made to the review before it is submitted for quality assurance. The countersigner should ensure that all relevant information is included in the review, and that all omissions, critical decisions and areas of exceptional practice are included, analysed and conclude with a sufficient judgement. Additionally, the countersigner should ensure that the review is accessible, and demonstrate that all learning is identified and included in the action plan.

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

Judgement

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

RMs can on occasion be motivated to add 'exceptional practice' to the action plan to counter-balance deficiencies. Quality assurers should be mindful that, in order to be included, work should be of such a high standard that it warrants being shared more widely, be that locally or nationally, to improve general practice.

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

a) Do the planned actions sufficiently address deficiencies identified for staff at all levels in the SFO review?

The planned actions for individuals should be assigned to practitioners, managers, or senior leaders as applicable. This can also include practitioners outside of case management, such as unpaid work staff, approved premises staff or those working in interventions. This includes learning for any staff on long-term absence and staff from other areas who may have been involved in a case before or while it was transferred during the period under review. The RM should consider who is overseeing the action and how quickly this will be implemented.

Actions may relate to the implementation of local or national policies, procedures and guidance, or specific training or mentoring for individuals. These can also include exceptional practice, which should be shared within the PDU for the benefit of colleagues. Where the review has identified a fundamental misunderstanding or gap in a probation practitioner's knowledge, it will be appropriate to include a learning point in the plan to undertake a caseload audit. This will ensure checks are made on the other cases managed by the practitioner and that any issues are rectified as a matter of priority.

The actions should be deliverable locally and may include actions relating to how national policies, procedures and guidance documents are implemented locally, or to specific training or mentoring for individuals.

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

The planned actions at a local level can focus on smaller groups of staff, teams or PDUs. The review should consider whether the actions identified for individuals can be broadened

to include other staff within teams or PDUs, if there is a wider practice issue that requires action. The RM needs to consider who will oversee actions at a local level. The actions may relate to how local, regional or national policies, procedures and guidance documents are implemented, or to specific training for the team/group of staff. They could also include any exceptional practice identified that should be shared with other teams and PDUs within the region.

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

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

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

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

National level can include national-level agreements, use of tools such as ViSOR, ARMs responsibilities or national agreements on disclosures, training and development and court procedures. This list is not exhaustive. Where an RM finds potential for national-level learning, they should contact the HMPPS SFO team in the first instance to ensure that the proposed actions are achievable and to identify a suitable owner.

The action should be agreed with the suitable owner (usually the relevant policy lead) before it is included in the plan, and the learning point should be realistic and achievable, with a clearly defined expected outcome.

e) Do the planned actions contain sufficient developmental activity to effect change?

The action plan should focus on identifying all relevant learning and translating it into developmental actions that can be carried out and monitored to ensure similar errors are not made in the future. Actions are developmental when they include clear interventions with a view to effecting or supporting changes to practice. This may include, but is not limited to, training, briefings, reflective discussion, revisiting guidance, or structured input from a quality development officer.

The action plan must address all areas of concern identified in the key findings. For example, excessive workloads may have contributed to poor practice, so the plan needs to set out how these are being, or will be, addressed and monitored. Where a review has uncovered a significant issue relating to practice, for example the practitioner did not understand safeguarding policy and did not know how to make a referral to children's services, the reviewer must include appropriate developmental activity to address this knowledge deficit. In addition, the RM should also consider whether this would have had an impact on other cases and therefore whether an action is required to audit all relevant cases, where appropriate, to identify and correct any related significant practice issues. In most instances this action will have been picked up as an urgent consideration during the

early look stage of the review process and is likely to already be underway before the action plan is finalised.

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

Learning points must be specific, measurable, achievable, relevant and time-bound (SMART). Simple errors should be dealt with simply. More complex matters (for example, where systems or processes have not worked) may require team or organisational solutions. Timescales must be reasonable and must take account of any need for immediate action, for example where there are significant practice concerns about fundamental issues such as understanding risk, recall processes or the need for case audits.

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

If a staff member is absent from work, the plan should be clear about how learning will be taken forward on their return. The timeframe should be considered and how actions will be prioritised.

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

When the actions of another agency (such as a youth offending team, social care, the police, commissioned rehabilitative services, or mental health) have impacted on the management of the individual, a learning point should be included that requires a senior manager with sufficient authority, to take the learning forward with that agency/partner. The probation service should not make recommendations that are beyond its remit to carry out.

4. Victims and their families

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

Judgement

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

From the outset, the review should be written with the victim or their family in mind as a potential audience, as they could request access to the document following conviction. The RM should adopt a transparent and accessible approach, to minimise the need for further revisions should a request for access be made.

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

RMs should be conscious of the tone and accessibility of their writing. They should think about the reader of the report, both members of staff and victims/families, and tailor information appropriately. The review should be written in plain English. Sentences should be short, uncomplicated and in the active voice. RMs should avoid writing in the third person, as this does not indicate ownership of findings and corresponding actions. They should take care to use grammar correctly; in particular, they should never use single inverted commas to suggest that something is untrue. Where a RM believes something is untrue, they should state this clearly. The case-specific glossary should be included to aid the lay reader's understanding. The glossary does not replace the need for clear descriptions in the review. Acronyms should be used sparingly and be written in full the first time they are used. References to 'risk' require qualification, for example 'risk of serious harm', 'risk of harm to others' and 'risk of harm to self'. The term 'person on probation', or another appropriate identifier, should be used rather than 'offender', however this may be relevant to use in some circumstances.

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

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

Any SFO is a distressing and regrettable incident. It is necessary and appropriate that the review is written in a way that does not add to the distress of the victims/families, directly or indirectly, who may read the review. Thought should be given to the language used to describe the details of both the index offence and the SFO.

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

We expect to see sensitivity shown in all SFO reviews. This includes careful use of information or intelligence that is potentially inaccurate or malicious, or for any reason

irrelevant to the assessed risks and the SFO. The types of SFO noted below offer some guidance on which areas might require additional care and sensitivity:

- Gang-related crimes: in some instances, the victim of the SFO is a member of a gang, where the SFO crime was a retaliatory act. The RM must show sensitivity in not attributing blame to the victim/s or disclosing information that might lead to an increased risk of serious harm to the recipient of the review. They should be cautious when naming gangs in these reports.
- Domestic abuse: the review may highlight situations where a victim of domestic abuse made choices that could be viewed by a lay person as failing to protect themselves. Professionals in the criminal justice service are fully aware that people subjected to domestic abuse routinely make decisions while under duress and while suffering from reduced self-esteem and self-worth. Additionally, some victims of domestic abuse choose to placate the perpetrator of abuse as a self-defence mechanism. Sensitivity must be shown not to attribute blame to the victim of domestic abuse. Victims are not responsible for the actions of their abusers.
- Child sexual abuse: in cases where children have been sexually abused or exploited, the RM must take care when referring to any of the children's actions that could be taken out of context or misinterpreted by the recipients. They must show sensitivity in not attributing blame to the victim. Children are not responsible for the actions of adults.

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

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

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

The RM should use the review to set out clearly their judgements on the sufficiency of practice throughout the period under review, in a way that is accessible and meaningful to the victims/families. The review should be sufficiently transparent about all key findings. Evidence to support these judgements should be presented in an accessible way, with brief explanations to help a wider audience to understand it. The RM should include examples to illustrate judgements to allow victims/families to understand why certain decisions have been made. Reviews should avoid detailed examinations 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.

The RM should be mindful of the potential impact of the SFO review process on staff who were involved in managing the case. The analysis of and judgements on their practice should be robust and transparent without including opinion or unsubstantiated evidence.

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

e) Does the review only contain information that can be shared?

The review should be immediately accessible and ready to share with victims or other third parties.

RMs should make judgements on whether it is necessary, relevant and proportionate to include information in the review. The sharing of information should support the reader's understanding of the SFO review and how the person on probation was managed. The review should not contain information that could place staff, the person on probation, or others at risk. Therefore, the RM should determine what information should be considered for redaction prior to any wider sharing.

f) Is the review concise, informative, and accurate?

The review should be concise but include all relevant information. It is crucial that the review contains accurate information relating to probation practice and policy and is checked for accuracy at the countersigning stage. It is also important to recognise that policy and practice may have changed since the review period; therefore, the review should include an accurate account of what was in place at the time, as well as what has since changed (where relevant) and the impact of any changes.