Serious Further Offence reviews: Promoting a culture of learning in probation

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HM Inspectorate of Probation is committed to reviewing, developing and promoting the evidence base for high-quality probation and youth justice services. Our *Research & Analysis Bulletins* are aimed at all those with an interest in the quality of these services, presenting key findings to assist with informed debate and help drive improvement where it is required. The findings are used within HM Inspectorate of Probation to develop our inspection programmes, guidance and position statements.

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Executive summary

Context

Serious Further Offences (SFOs) are specified violent and sexual offences committed by people who were, or had very recently been, under probation supervision at the time of the offence. SFOs are relatively rare, but the impact on the victims and relatives is traumatic, enduring, and can be fatal. SFOs also impact on probation practitioners involved in these cases, potentially leading to feelings of shame and guilt, anxiety, and depression (HMPPS, 2021).

When a supervised individual is charged with an SFO, a review is undertaken, usually by HM Prison and Probation Service (HMPPS), although HM Inspectorate of Probation may be called upon by the Justice Secretary to undertake an independent SFO review in high-profile cases. The stated aim of all SFO reviews is 'to drive up continuous improvement' (HMPPS, 2021, p.1). However, probation practitioners and managers have told us in surveys and interviews that the SFO review process can feel like an exercise of blame and shame.

How best to learn from adverse events is a common concern across organisations involved in safety-critical work (Dekker, 2025a), where significant risks need to be managed and harms avoided every day. It has been found that the structure and process of incident investigations can hamper and prevent learning and improvement, with concerns raised regarding failures to learn from common systemic issues and repeated recommendations. However, many organisations and industries have made important progress by adopting the 'New View' of safety science, grounded in learning from frontline experience, and facilitating psychological safety.

Approach

For this bulletin, we analysed the findings of a survey of probation practitioners and managers (n=245) and obtained the views of ten SFO reviewing managers (SFO RMs) and six senior managers with SFO oversight duties through interview and focus group settings. A broad literature review of the safety science and business studies literature was undertaken, and we interviewed two leading senior academics with expertise in the subject area. The overall objective of the research and analysis was to better understand the issues of blame, learning and growth following SFOs in probation, and to outline key lessons and strategies from other sectors in learning from mistakes and tragedies.

Key findings and implications

- Key findings from the survey were as follows:
    - 39 per cent of all respondents were not satisfied that the HMPPS SFO reviews were helpful, with 30 per cent responding positively to this question
    - 55 per cent did not believe there was sufficient support for staff involved in SFO reviews, with 20 per cent responding positively
    - 45 per cent did not believe that there were sufficient opportunities for staff to learn from SFO reviews, with 23 per cent responding positively
    - of those with direct experience of an SFO review (as a practitioner or line manager), 58 per cent did not believe there was a sufficient learning opportunity for the team as part of the process, with only 15 per cent responding positively.

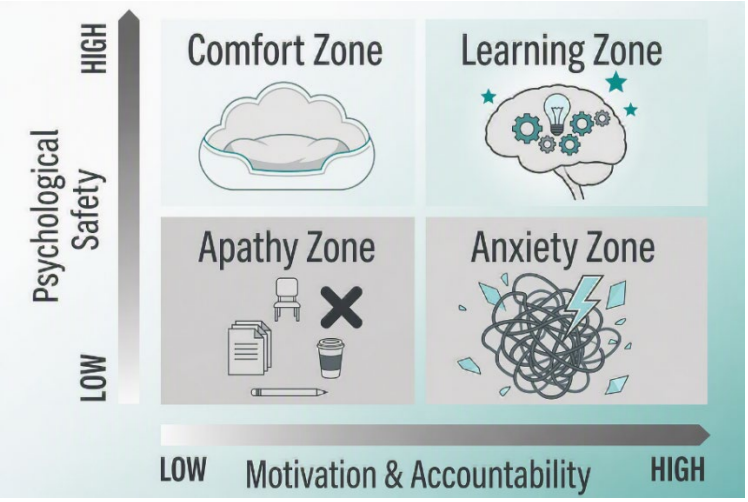
- In their survey comments, probation professionals told us about their anger at the culture of blame which they believed characterised SFO reviews. Probation professionals were frustrated as they felt that the focus upon frontline practitioners masked the organisational and systemic drivers of SFOs.
- In their interviews and focus groups, SFO RMs reported that they were carrying backlogs of SFO cases requiring review, and they believed that the review process was unduly lengthy. In addition, SFO RMs believed that the review process was insufficiently transparent and that this was driving practitioner anxieties and myths about reviews. They were keen to see a more streamlined review process and spend more time with frontline teams passing on the lessons learned from reviews.
- There would appear to be scope for a more evidence-informed approach which engages with the complex uncertainties and risks of everyday work where practitioners balance conflicting goals, rules and imperatives in real time, and where many outcomes are possible in each context and situation. The following five principles of human and organisational performance (Conklin, 2019), which help to operationalise the New View of safety, provide a coherent framework to structure thinking about improving the SFO review process.
    - *Error is normal*. All humans make mistakes, mostly without consequence. To expect perfect performance every day is unrealistic and demoralising for employees. It should be recognised that safety-critical work, such as probation, operates within a VUCA (volatile, uncertain, complex and ambiguous) environment, and that 'human error' is usually the symptom of deeper organisational problems.
    - *Blame fixes nothing*. A blame culture at work provokes defensive behaviour; workers will hide their mistakes and refrain from reporting systemic problems. A blame-free approach is not an accountability-free approach; indeed, blame reduces accountability. Professionals can be held accountable by telling their story, being frank about how things went wrong, and what all in the organisation can learn when facing the same or similar situations.
    - *Context influences behaviour, systems drive outcomes*. The 'Old View' of safety looked for 'bad apples' who undermined otherwise safe and efficient work systems. Adopting the 'New View', practitioner sensemaking should always be considered and understood in the context within which events occurred, with the context being the total work environment, encompassing organisational processes, tools, goals, expectations, resources, training, values, and culture.
    - *Learning and improvement are vital*. An organisational reframing of 'failure' is required where mistakes are treated as valuable learning opportunities. Relationships need to be continually nurtured to support learning and collaboration, with staff openly sharing their experiences and attempting to reconstruct their emotions, choices and actions as they appeared at the time. Beyond finding out what went wrong after an event, a learning organisation should pay attention to both: (i) safety 'signals' and any blind spots; and (ii) the everyday successes of its operations.
    - *Responses matter, especially for leaders*. Constructive reactions engage with the complex realities of everyday work where many outcomes were possible in the context and the situation. Key principles include being evidence-informed, focused upon learning and improvement, and fully inclusive of all those involved in the event,

respecting and recognising the value of differing views. The New View insists that investigations focus upon holistic understanding and clear, feasible, and accountable recommendations which guide the implementation of learning into changes in practice, policy, and systems.

- These five principles offer a guide to thinking about responding to adverse events. While not a blueprint for every workplace, the approach has led to measurable progress in other safety-critical fields, improving both employee engagement and work quality, helping to prevent future adverse events.

- Applying the principles should not be regarded as a simple or quick endeavour; decisive and collective leadership is required, with a commitment to creating an organisational culture of transparency, trust, empowerment, engagement and continuous improvement. A high degree of psychological safety in the workplace is essential (see Figure 1), with all employees feeling able to speak up about their concerns, anxieties and ideas for improvement without fearing punishment or ridicule. A focus upon procedural justice and creating a (restorative) just culture is beneficial, incorporating important learning from 'what goes right' as well as from adverse events.

Figure 1: Factors for high-performing teams (Henschel, 2020; based upon Edmondson, 2014)



- The development of a learning organisation approach in the probation service in Wales, building upon the 'human factors' evidence base, is a promising sign and offers potential learning for the English regions. Such an approach requires effort, resources, and some courage from senior leaders who need to recognise that they cannot know the work-as-done (rather the work-as-designed) as well as their managers and the operational workforce.

- Probation in 2026 finds itself in a situation of relatively inexperienced practitioners dealing with large workloads and caseloads, with some teams having high levels of vacancies and staff turnover. These systemic problems will not be overcome quickly or easily. However, reforming SFO reviews along the lines of the New View of safety, with its concomitant emphasis on trusting relationships and operational empowerment, is a potential way forward, supporting continual improvement and staff engagement, development, morale and retention. Crucially, promoting a culture of learning is beneficial to all: probation practitioners, managers and leaders, and victims and wider society through minimising the risk of future adverse events.

Glossary of key terms

Term	Definition
Accountability	For professionals, being accountable means being answerable for the results of actions and decisions in work practice. Dekker (2014, p.23) cautions against retrospective accountability which leads to blame and creates fear. Forward-looking accountability invites thinking about who will implement improvements and evaluate their effectiveness.
Double-loop learning	Double-loop learning occurs when organisations not only address problems, but reflect on and change the assumptions, priorities, and rules that produced them, supporting deeper learning and longer-term improvement.
Early look report	An initial report produced within 10 working days of SFO notification, summarising key events and immediate management actions.
Enhanced early look report	A more detailed form of an early look review, providing additional analysis of the circumstances surrounding the offence.
Fishbone analysis	A cause-and-effect diagram used to identify and categorise factors contributing to an event, supporting systemic learning.
Hindsight bias	The tendency to believe, after an event, that the outcome was predictable.
Human Learning Systems	A relational approach to public management that enables public services to respond to the complexity of the lives of the people it serves, and the contexts they operate within.
Human Factors (ergonomics)	Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect safety and performance.
Human and organisational performance principles	Five guiding principles for learning from adverse events: error is normal; blame fixes nothing; context influences behaviour; learning is vital; how we respond to failure matters.

Term	Definition
Just culture	An organisational culture that embraces complexity, supports its staff and encourages them to tell their account, and focuses upon learning from mistakes without unfairly blaming individuals.
Learning organisation approach	A management philosophy where organisations continuously transform themselves by facilitating the learning of their members.
Learning review	A structured, blame-free investigation process that focuses on understanding the context of an event and generating practical system improvements.
Learning team	A group-based approach to post-incident learning, involving practitioners in sensemaking and solution development.
Local rationality principle	The idea that people make decisions that make sense to them at the time, given their goals, knowledge, and context.
Near miss event	An incident that could have resulted in harm but did not, and which can be used as a learning opportunity.
New View (Safety II)	A modern safety science approach focusing on systemic factors, learning, and resilience rather than individual blame.
Old View (Safety I)	A traditional safety model that attributes adverse events to individual failings or 'bad apples'.
Outcome bias	Judging a decision based on its result rather than the quality of the decision at the time it was made.
Psychological safety	A workplace climate where employees feel safe to speak up about concerns, mistakes, and ideas without fear of punishment or humiliation.
Restorative just culture (RJC)	An advancement of the Just Culture concept that combines systemic learning with restorative practices, allowing for those involved in adverse events to express remorse, seek forgiveness, and restore trust.
Root cause analysis and RCA²	A structured method of problem solving used to identify the underlying causes of faults or problems. An enhanced approach to root cause analysis has been developed, known as RCA² (Root Cause Analysis and Action). Key principles for the approach include being system-focused, action-oriented, and non-punitive.

Term	Definition
Safety clutter	The accumulation of rules, procedures and documentation that do not contribute to safety and may hinder effective work.
Situation–Background–Assessment–Recommendation (SBAR)	A structured communication tool used to convey critical information clearly and efficiently.
Second victim	A professional who experiences emotional distress (for example, guilt or shame) after being involved in an adverse event.
Sensemaking	The process by which people give meaning to their collective experiences, especially after unexpected events.
Serious Further Offence (SFO)	A specified violent or sexual offence committed by an individual under probation supervision or within 28 working days of supervision ending. All SFO qualifying offences carry either a maximum sentence of at least 14 years' imprisonment or an indeterminate sentence.
SFO review	A formal process to examine cases where an SFO has occurred, aiming to identify lessons for improving probation services and preventing future incidents, while providing relevant information to victims and/or their families.
SFO reviewing manager (SFO RM)	A senior probation officer responsible for conducting SFO reviews, including case analysis and interviews.
Shared mental model	A common understanding among team members about how a system works or how tasks should be performed.
Significant incident learning process (SILP)	A learning-focused review methodology that engages those involved in incidents to understand what happened and why.
Volatile, uncertain, complex, and ambiguous (VUCA)	An acronym describing challenging work environments like probation services.

1. Introduction

The focus of this bulletin is upon how probation services can learn and improve practice following serious further offences (SFOs). SFOs are specified violent and sexual offences committed by individuals who were, or had very recently been, under probation supervision at the time of the offence. All SFO qualifying offences carry either a maximum sentence of at least 14 years' imprisonment or an indeterminate sentence (HMPPS, 2021).

SFOs are relatively rare: less than 0.5 per cent of individuals under probation supervision are charged with a SFO (HMPPS, 2021). However, SFO notifications and convictions have increased consistently over the last few years (Ministry of Justice, 2025a) and the harm resulting from SFOs is of the highest order; murder, rape, or other violence and harms from which it is difficult or impossible to recover characterise SFOs. While responsibility for committing an SFO rests with the perpetrator, these offences can undermine public trust in criminal justice and probation services. In addition, the professionals involved in a SFO are often adversely affected (Syed, 2015) – feelings of inadequacy, depression and despair are common reactions among professionals involved in a SFO case, irrespective of the circumstances of the offence.

Learning from activities and mistakes that lead to SFOs, or near misses, can thus be seen as a moral and strategic imperative for probation. HMPPS aims to fulfil that duty through the SFO review process. In certain high-profile cases, HM Inspectorate of Probation may be asked by the Secretary of State for Justice to undertake an independent SFO review – these are published on the Inspectorate website.

Formally, the objective of all SFO reviews is to learn from the circumstances surrounding the offence and help prevent future similar incidents in the future, while also providing relevant information to victims and their families (HMPPS, 2021). A distinct serious incident notification process is used within youth justice; this process falls outside the remit of this bulletin.

The SFO review process in brief

The SFO review process begins when a person on probation has been charged and appears in court for an SFO qualifying offence. The alleged offence must have been committed while the person was under probation supervision or within 28 working days of their supervision period ending. The probation court team will inform the regional and central SFO team of the case. Following the initial court appearance, the SFO review is commissioned. The SFO RM will complete an 'early look' report within ten working days of notification – this document outlines the key events in the case and identifies any immediate management actions required. Such management action may include the invoking of separate disciplinary proceedings (HMPPS, 2021). Depending on the nature of the case, the case may then progress to an enhanced early look.[1]

When a full SFO review is commissioned, this comprises a review of the case documentation, and interviews with the practitioner(s) concerned, their manager(s), and others as required. The role of other agencies in the case is not reviewed. The review process can take several months to complete. The review is signed off regionally as meeting the required standard, and is then quality assured by the Public Protection Group of HMPPS HQ (about 80 per cent of reviews) or by the Inspectorate (about 20 per cent). The Inspectorate's quality assurance standards highlight the importance of the SFO review enabling appropriate learning to drive improvement, encompassing learning at the local, regional and national levels and in respect of multi-agency working (HM Inspectorate of Probation, 2025a). In the 90 reviews quality assured during 2024/2025, it was judged that areas for improvement were sufficiently identified at a

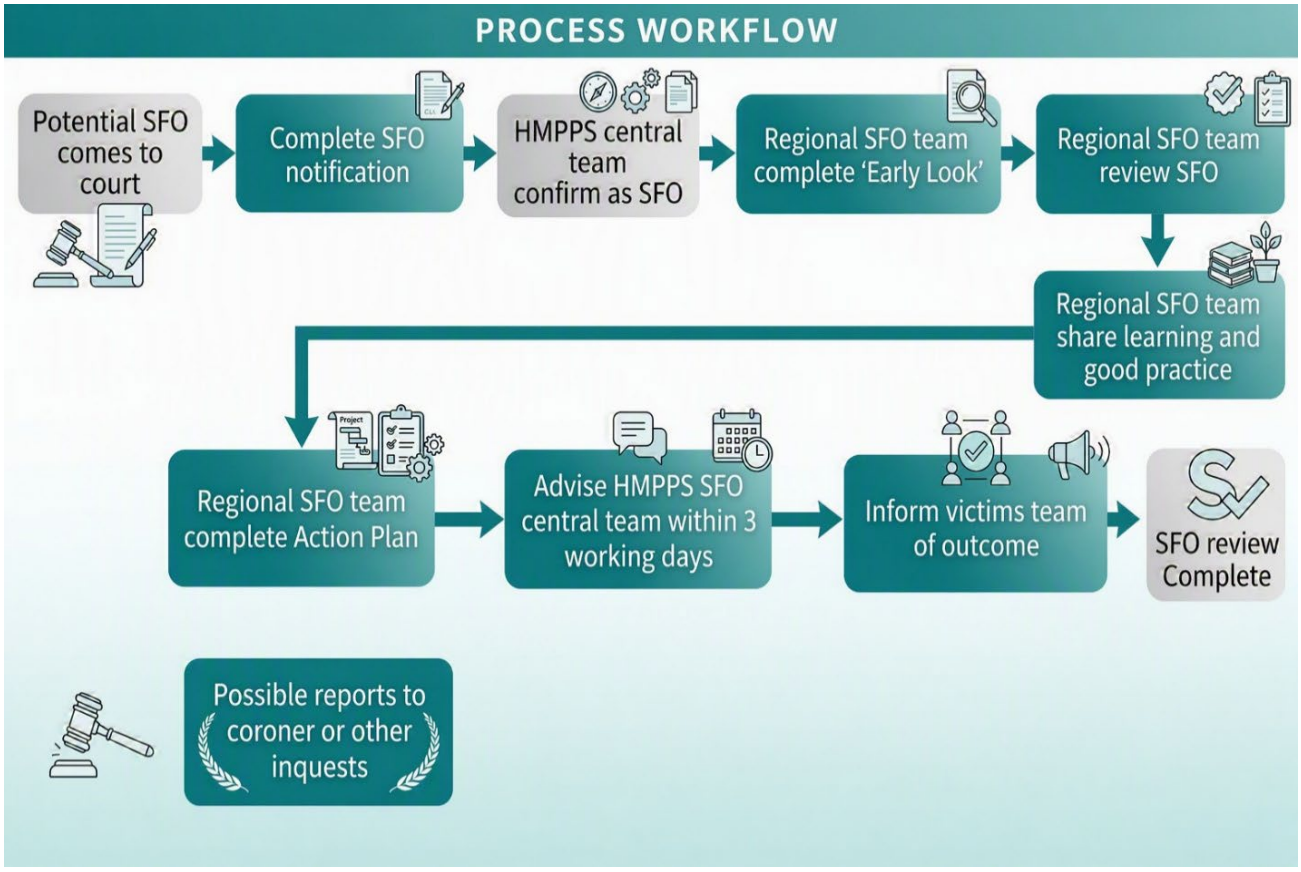
[1] SFO procedures have undergone a number of operational changes since 2021, including the introduction of an early look checklist and enhanced early looks. This bulletin focuses on the broader learning and cultural issues arising from SFO reviews rather than the detailed design of current procedures.

local team or PDU level in 69 per cent of the reviews, falling to 59 and 55 per cent at the regional and national levels (HM Inspectorate of Probation, 2025b).

The SFO review report should also provide victims and/or their families with detailed information on how the perpetrator was supervised, and what actions to improve probation services have been identified through the review. Reviews, in addition, should provide government ministers, and senior leaders within HMPPS and the Ministry of Justice, with an overview of the offence, the key findings, and next steps to address any learning.

Each probation region has an SFO review team comprised of RMs, at the senior probation officer grade, who undertake the SFO reviews, and a team leader. The SFO team is overseen by a senior manager, usually the head of the performance and quality function.

Figure 2: The SFO review process (HMPPS, 2021)



Concerns about review processes

In any safety-critical sector, there is a moral imperative to learn from adverse events, and from near misses and close calls (Dekker, 2025a; Woodier, 2025). Organisations need to understand how safety failures occur, and help managers and workers avoid them in the future. However, concerns have been raised regarding failures to learn from common systemic issues and repeated recommendations. In the world of probation, recent Inspectorate (HM Inspectorate of Probation, 2024) and research (Calder, 2023; Dominey, Calder and Whitham, 2026) findings identify significant fears and anxieties around how SFO reviews are undertaken. As we reported in our 2024 SFOs Annual Report, one probation officer stated as follows:

> *"I have seen a colleague, already devastated by the SFO itself, torn to shreds by the SFO process, to the extent they left the service. SFO carries a heavy emotional weight and whilst I agree that practice needs to be looked at and cases reviewed, so much blame is apportioned that it feels toxic and terrifying. The message appears not to be 'this person committed X crime, how can we work to reduce the risk of this happening?' but rather 'person committed X crime, let's see how many ways we can blame the practitioner for this'." (Probation Practitioner)*

A culture of fear and blame can undermine the capacity of probation services to learn from SFOs and near misses, as staff internalise the need to keep quiet about their concerns. A recent thematic inspection has highlighted similar findings in relation to the national death under supervision policy. While it also offers a framework for learning, its perceived focus on individual failings rather than systemic improvement was hindering engagement. Consequently, the first recommendation within the thematic inspection report was that HMPPS should 'develop a strategy to ensure the death under supervision process focuses on systemic learning and improvement' (HM Inspectorate of Probation, 2025c).

2. Findings

The findings presented in this bulletin are largely based upon a survey of probation professionals (n=245; the majority of whom had direct experience of an SFO), interviews and focus groups with SFO RMs (n=10) and probation senior managers (n=6), and a review of the safety science literature from other sectors. Thematic analysis was used for the qualitative data which was obtained. More details on the methodology can be found in Annex A, with a summary of the survey findings presented in Annex B.

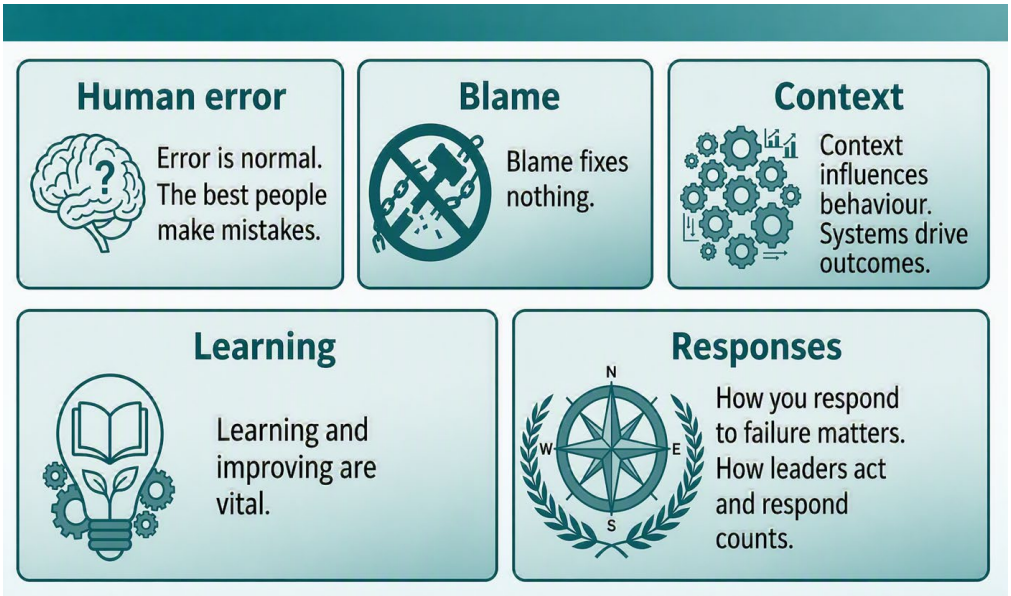
The high-level aims of the research were as follows:

i. to better understand the issues of blame, learning and growth following SFOs in probation
ii. to share lessons from other sectors in learning from mistakes and tragedies
iii. to set out potential strategies to promote a culture of learning from SFOs in probation.

Aligned to the second of these aims, the following sections are structured around the five principles of human performance (see Figure 3), increasingly described as principles of human and organisational performance (HOP), which reflect a body of research and experience clearly synthesised by Professor Todd Conklin (2019), one of the world's leading authorities on learning from adverse events in the workplace. HOP is an operating philosophy that provides a new way of looking at work, focusing on how people and systems interact to shape performance, learning, and improvement. It has been adopted or applied across a range of safety-critical sectors, including healthcare, aviation and transport, construction and manufacturing, and energy.

We examine each of the HOP principles, then consider the extent to which the SFO review process is or could be aligned. Across the principles, further evidence is incorporated in relation to complex systems, (restorative) just cultures, psychological safety, resilience theory, and human factors. The focus of the report is upon maximising and optimising learning rather than upon how information is provided to victims and their families or upon any investigations outside of the SFO reviews' process (e.g. those completed under conduct and discipline policies).

Figure 3: The five principles of human and organisational performance (Conklin, 2019)



2.1 Error is normal

In our working and personal lives, mistakes are often treated as if they were consciously undertaken as a course of action. However, Conklin states that it is highly unusual for people to choose to make mistakes (Conklin, 2019, p.54); making errors is a normal and common feature of all aspects of human life, including our work lives, with even the best, brightest, and hardest working employees making mistakes. As Dr Lucian Leape, Professor at Harvard School of Public Health and a pioneer of safety science in healthcare, stated to the US Congress:

> *"The single greatest impediment to error prevention is that we punish people for making mistakes. Errors must be accepted as evidence of system flaws, not character flaws." (Leape, 1997)*

The work of Professors Sidney Dekker and Todd Conklin outlines a New View of managing safety and conducting investigations after adverse events. Sometimes, this is termed the 'Safety II' model. The New View does not overthrow existing safety science; it builds upon those foundations but addresses conceptual, moral and practical flaws in how traditional safety work (the Old View or 'Safety I') is undertaken. Dekker and Conklin have many decades of practical and academic experience in the fields of healthcare, construction and industry, and aviation. While there are obvious differences across these sectors and with probation, they all involve decision-making, choices and risks which are safety critical.

Dekker and Conklin (2022) begin by critiquing the simplistic notion of 'human error' that underpins much traditional safety work and incident investigation. They emphasise that 'Human error'[2] is an attribution after the fact. To the humans involved in the event – the serious incident at work – it was a normal day at work with the workers engaged in normal behaviours and activities. Quite often what is later described as 'human error' is skilled adaptation to inevitably less than ideal design – as designers cannot anticipate every eventuality and variation in complex safety-critical work.

> 'Complex systems demand adaptation and innovation because the system delivers the unexpected or the unpredictable. In complex systems, sensemaking leads to critical thinking and innovation, which are required for workers to be successful when unpredictable situations emerge.' (Pupulidy, 2015)

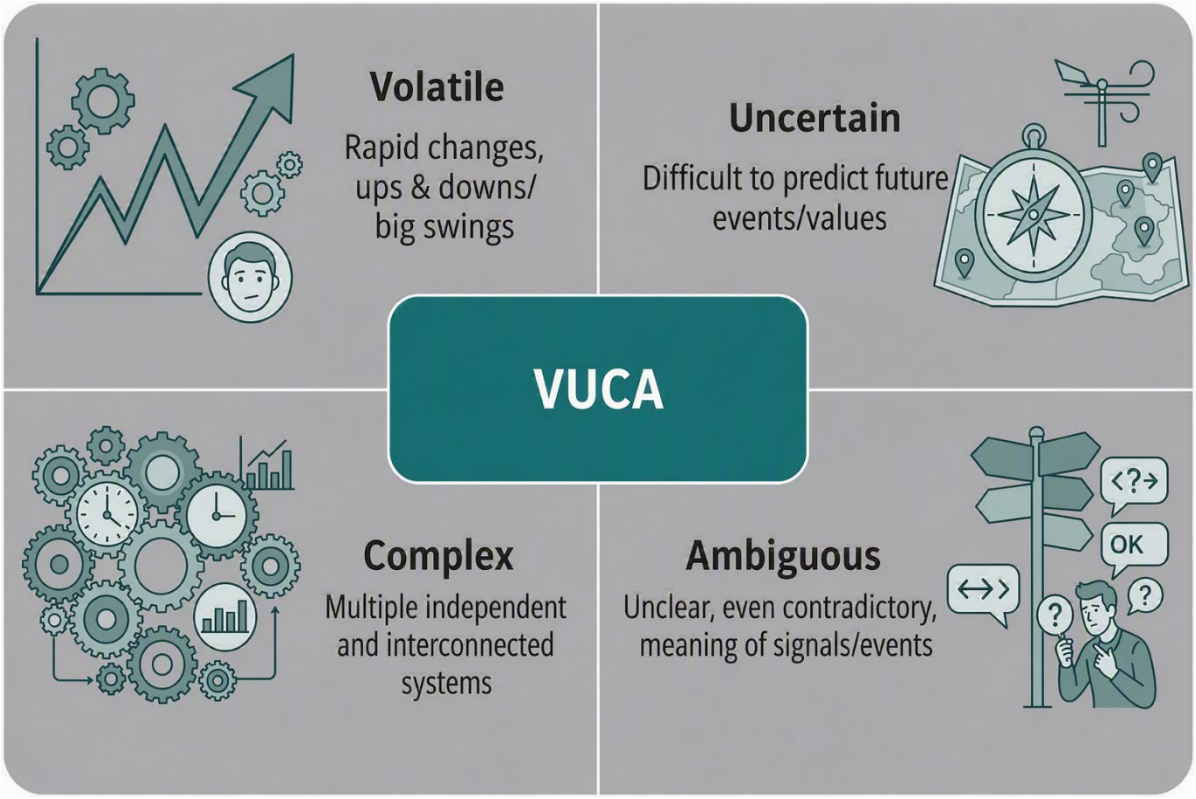
The key to improving safety is for safety professionals, and senior leaders, to understand the complex and dynamic realities of work. Working life is full of adaptations, nuances, workarounds, and sacrifices to get the work done in quite a different way than the idealised working life designed by others. The job of leaders and safety professionals is to understand how work is done and why it differs from work-as-imagined. The question for organisation leaders becomes: 'how well does your organisation's work design accommodate the reality that humans make mistakes'?

Safety-critical work, such as probation, operates within a VUCA environment – volatile, uncertain, complex and ambiguous (Baran and Woznyj, 2021; see also Figure 4) – with many moving parts and interdependencies, and outcomes affected by an array of variables – both known and unknown (Heron and Black, 2023). Crucially, humans do not operate in a linear fashion when undertaking complex high-stakes work. Instead, workers are balancing conflicting goals, rules and imperatives in real time. Moreover, risk of harm within probation is ever-present, and it differs from other sectors due to the dynamic risks and needs within the lives of SFO perpetrators. Consequently, we should not focus upon the impossible goals of 'zero

[2] 'Human error' is rendered in quotes as it is largely an unhelpful and unclear concept for explaining adverse events.

defects' or 'error elimination' but try to create and maintain systems robust enough to detect, prevent or contain the inevitable 'human errors' that mostly have little consequence, but sometimes end in tragedy.

Figure 4: VUCA environments (Acosta, 2021)



We found from our survey and in our interviews with SFO RMs that probation professionals felt that they were being judged by the simplistic Safety I view, with failures by the practitioner ('human error') seen as the primary cause of SFOs and other adverse events without consideration of the organisational and systemic drivers of case failure.

> *"SFO reviews feel like you are being investigated and that it is your fault. There is no support, and you are supposed to carry on as normal with what feels like an axe hanging over your head. There appears to be no empathy from senior managers and no support put in place. I know colleagues who have taken early retirement rather than go through the SFO process." (Probation Professional)*

This quote from a probation professional exemplified the prevailing view that SFO reviews could be experienced as threatening, as an exercise in blaming and shaming, and that the practitioners involved in a review could feel abandoned by the organisational leadership.

> *"As an officer I feel we are made to feel more responsible for the offence than the actual perpetrator, at times, and we are left feeling guilty because we could not predict the future. When SFOs are used as 'training' examples, it is always looking at what the officer did/didn't do (which is, obviously, the point) but the emphasis placed on 'blaming' the officer is clear." (Probation Professional)*

2.2 Blame fixes nothing

While blame may feel emotionally satisfying in the aftermath of an adverse event, it can take up organisational resources while undermining learning and improvement. Conklin (2019, p.58) notes the almost innate human need to believe that bad things are caused by bad people, even if we will not admit to that belief openly in those terms. Controlling that impulse is the first task for leaders and safety investigators, with leaders needing to maintain a focus upon the establishment of connected relationships and a culture of involvement, transparency, learning and improvement. The need for a shift in thinking within the health service was recognised by a previous Health Secretary:

> 'It seems obvious to me that doctors and nurses fear being blamed for a mistake. They fear that they might lose their job, be struck off, be sued or prosecuted; none of which is conducive to being open about how a mistake happened and learning how to avoid it again in the future. This needs to change and clinicians need to be supported not blamed when they are open about what goes wrong. Thankfully things are changing with many great NHS leaders demonstrating that it is possible to create this kind of environment. But I think there are some big structural reforms we can look at to help with the creation of a learning culture' (Hunt, 2022)

Once again, we must remember that it is very rare for an individual to come into the workplace intending to cause or contribute to any harm. Blame can thus be seen as an attempt to make error a choice in retrospect (ibid, p.59). This includes self-blame for adverse events by professionals involved in the case (Calder, 2023; Dominey, Calder and Whitham, 2026), with these professionals experiencing intense guilt, shame, anxiety and depression – studies indicate that rates vary from 10 to 43 per cent in caring professions (cited in Whitham, 2025, p.28; see also Santomauro, Kalkman and Dekker, 2014).

Petrillo and Bradley (2022) emphasise that trauma-informed practice is not just about how an organisation treats people using a service, but also how it values and treats its employees. Care and support for staff are thus a crucial element of trauma-informed practice, with Petrillo and Bradley (2022, pp.21-22) further articulating the specific challenges of probation work: 'practitioners bear witness to traumatic experiences every day. They are often working with people in crisis, exhibiting complex behaviours, and carry a huge professional responsibility to protect people from harm'. Looking across sectors, Santomauro, Kalman and Dekker (2014) highlight the importance of organisations taking responsibility for their employees and helping them to become resilient in the face of possible trauma, which in turn helps organisations as a whole to become more resilient.

However, in our survey of probation professionals, most respondents (55 per cent) told us that they did not believe there was sufficient support for staff involved in SFO reviews (with 20 per cent responding positively). In their survey comments, probation professionals told us about their anger at the culture of blame which they believed characterised SFO reviews. Probation professionals were frustrated as they felt that the focus upon frontline practitioners masked the organisational and systemic drivers of SFOs. Moreover, they were of the view that organisational leaders displayed little empathy or support for practitioners when an adverse incident occurred. However, this view was not universal, with some probation professionals praising their leaders, managers, their colleagues, and SFO RMs for being supportive and stimulating practice learning from SFOs.

In their interviews and focus groups, SFO RMs reported that probation professionals experienced dread, fear and resentment at being blamed for SFOs (see also Grehen, 2026; Dominey, Calder and Whitham, 2026). The prospect of adverse events when at work is a constant, and inevitable, fear for all those working in safety-critical professions. However, the SFO RMs largely believed that the response to SFOs exacerbated that fear and left staff feeling vulnerable and unsupported.

> *"It is not a learning culture, it is a blame culture, it is fault finding for the practitioner and it is an exercise which seeks to absolve the organisation of any blame." (Probation Professional)*
>
> *"The process generates fear. It is difficult to get an open and honest account of what happened in the SFO. We do not get the nuance of what happened in the case." (SFO RM)*

A key issue, that SFO RMs recognised, was that the SFO review process was viewed as enmeshed with the staff conduct and discipline policy, creating anxiety among staff, and reticence about making disclosures and being fully open with SFO RMs and probation managers. The danger is that practitioners do not feel safe to disclose the full story of all events and choices as they appeared at the time, with the stakes perceived as too high for full openness and transparency.

> *"Staff do believe that an SFO Notification can lead to them losing their job, their profession. This is getting worse, there was always some concern, but it is intense nowadays." (SFO RM)*
>
> *"Over years, SFOs have got a really bad reputation in probation, that we're coming to get people, we're going to find some minor technicality and we're going to sort of take people to the cleaners on it. That's a perception in some PDUs." (SFO RM)*
>
> *"Staff engagement is varied. Some PDUs [probation delivery units] are very negative on SFO reviews, due to practice, culture and leadership issues. We need to be accountable, point out deficits in practice. But conduct and discipline policies create anxiety and fear. Sometimes we do not get the full picture, staff don't want to talk to us, then we are reliant upon file reading. We cannot embed the learning like this, as staff fear conduct and discipline will be used against them. In my experience as an SPO I had a harsh RM, so that experience influences my style of reviewing." (SFO RM)*
>
> *"You know it's always that question when you do an interview, am I going to get disciplined? … I say well, I don't think it meets that kind of threshold, but it's not my decision. What will happen is your senior manager will have a look at this and it will be up to him to make that call." (SFO RM)*

It is stated within the policy framework (HMPPS, 2021) that the SFO procedures are separate from any parallel investigations, including those completed under conduct and discipline policies, and a senior manager with responsibility for SFOs emphasised that maintaining a clear separation was vital.

> *"The problem is that conduct and discipline are interrelated with SFO processes. In ten years, I have one or two outrageous practice incidences which needed immediate suspension. Mostly people are doing their best. But conduct and discipline drive fear. There should not be a direct link to discipline in SFO, as the guidance says. But in practice there is a causal link. Accountability is pushed down. The Accountability and Learning Panels take an early look but the threat of disciplinary action runs through the whole process." (SFO Senior Manager)*

Accountability

A blame-free approach is not an accountability-free approach. One of the aims of reviews is to provide *accountability*, the moral duty of professionals to accept responsibility for their actions, whether good or bad. The New View emphasises individual responsibility; doing work well and safely is a core part of professional identity, autonomy, and pride at work. Workers are accountable for their own actions, but not for the organisational and systemic contexts in which they operate (Dekker, 2025a, p.77); it is unethical to hold someone accountable for situations over which they had little or no control. The competing imperatives facing workers also need to be fully recognised, e.g. safety protocols, efficiency and value for money, operational needs, and service user requirements of timeliness, value and quality.

Dekker (2014) makes a distinction between retrospective and forward-looking accountability, with the latter inviting thinking about who will implement improvements and evaluate their effectiveness. Professionals can be held accountable by telling their story, being frank about how things went wrong, and what all in the organisation can learn when facing the same or similar situations. In this way, practitioners become a 'solution to prospectively harness' rather than a 'problem to retrospectively control' (Dekker and Breakey, 2016).

In contrast, a blame culture reduces accountability. A blaming and shaming response to adverse events will provoke defensive mechanisms, such as hiding or withholding information, denial, obstruction and obfuscation. Organisations receive fewer incident reports, are told thinner stories, and consequently develop fewer learning opportunities – without openness and reflection, there is minimal ability to learn, as recognised by the World Health Organisation (2021):

> 'Since most mistakes are honest failures provoked by poorly designed systems, to blame and punish an individual is unfair and misguided. A culture that is based on blame and retribution will ultimately be unsafe because individuals will be afraid to admit their mistakes and will instead hide them. If a culture of blame and fear is dominant in a health organization, it is quite impossible to have a meaningful programme of patient safety.'

The findings from the survey of probation professionals indicate a mixed picture – 48 per cent of respondents said that they felt safe raising concerns and issues with managers, while 23 per cent did not, and 43 per cent felt that the probation service encourages staff to speak up about problems and issues which affect public protection, with 26 per cent disagreeing.

Psychological safety

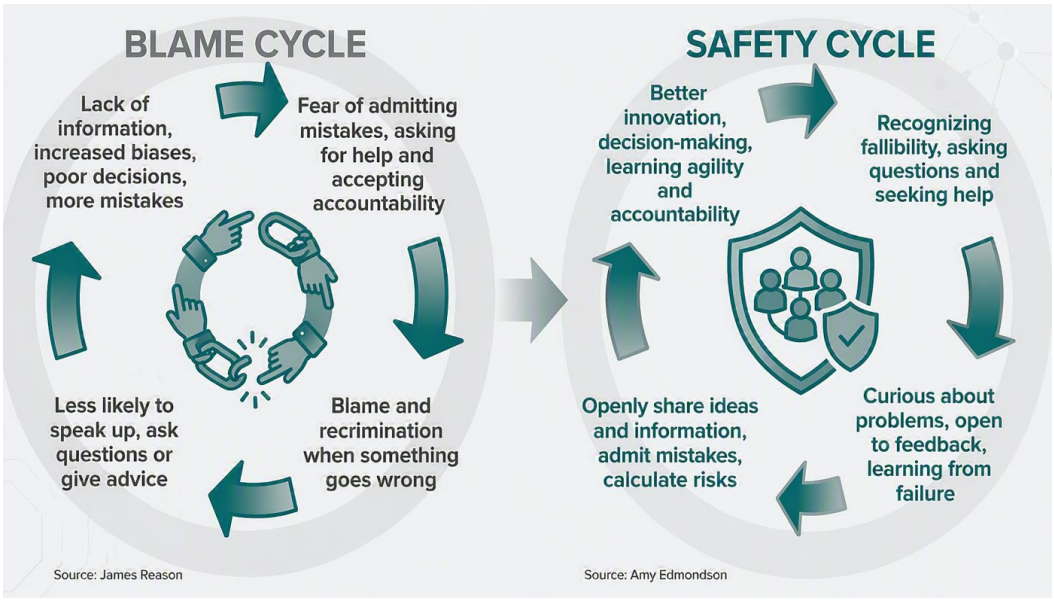
As set out above, blaming workers for adverse events that were driven by systemic and organisational deficits can undermine the ability of leaders to address those deficits due to workers being deterred from reporting their concerns about safety and other operational

realities. Kemshall (2021) highlights how blame cultures are a feature of 'dangerous' organisations, and how these cultures 'can inhibit learning and consequently errors can recur'.

> *"We send Action Plans, but learning is not possible with the anger and fear. It stops learning. Practitioners feel blamed and are not in the mode for learning. We scrabble around to get the evidence, but the process does not do what we want it to – even for victims. Learning is diluted. There are some positives but they are a drop in the ocean, there are some impacts from our work but there are better ways to do it." (SFO Senior Manager)*

In her research into medical errors, Edmondson (2018) describes how clinical teams with the highest performance and quality levels also had the highest levels of medical error reports. This apparent paradox is resolved through Edmondson's concept of 'psychological safety'. Workers who experience low interpersonal risk from humiliation and punishment in reporting their concerns and ideas to managers are more likely to report mistakes and make suggestions for improvement. This creative process had occurred in the highest-performing clinical teams, with staff members feeling safe to speak up, but not in those teams with poorer performance where low levels of error reporting stemmed from a sense of threat if they used their voice. Psychological safety should thus not be seen as a 'perk' for employees and organisations; it is the precondition for problem-solving, learning and improvement (Edmundson, 2018). As further set out in Figure 5, there are clear advantages from moving away from a blame cycle to a learning cycle.

Figure 5: Blame cycle vs safety cycle (Acosta, 2022)



Edmundson (2024) reports how the promotion of psychological safety in various sectors has been advanced through blameless reporting. For example, the adoption of a blameless approach to incident reporting by the US Federal Aviation Authority in 1983 allowed any employee to report an incident or concern anonymously. The Aviation Safety Reporting System (ASRS) captures the chain of events, the human factors involved, and the corrective actions undertaken. Operated by NASA, the subsequent analysis and improvements identified are credited with contributing to a 40 per cent reduction in aviation errors (Edmundson, 2024, p.115).

The findings from the survey of probation professionals indicate that the organisational culture was not perceived as psychologically safe with regard to SFO reviews, and perhaps in general – the latter being reflected in the recent thematic inspection of the recruitment, training, and retention of probation practitioners (HM Inspectorate of Probation, 2025d; see also Haggar and McDermott, 2025; Robinson et al., 2025). Many practitioners who had been involved in a SFO told us they were not given a proper opportunity to explain their side of the story, and that they were left in the dark about review processes and progress – 38 per cent of the staff survey respondents felt that the review process had not been clearly explained to them (with 35 per cent responding positively). The perceived lack of transparency (see also Dominey, Calder and Whitham, 2026) led some to conclude that the review was unfair to them.

> *"I was not included in a lot of the correspondence. I was not kept well informed about how the process was progressing, when things were due or what would happen next." (Probation Professional)*
>
> *"I was interviewed for a day and a half about my case, at all times I was led to believe that my practice was at fault and it was my fault that the SFO happened." (Probation Professional)*

More positively, several practitioners reported that good communication with SFO reviewing teams helped assuage their doubts and anxieties. As this probation professional explained:

> *"I asked for a conversation with our internal SFO team which was really helpful, but prior to this, it was quite scary and negative. We don't really get told much about SFOs and the learning from them at all, with the exception of very specific cases such as Bendall. I think there's a big gap in terms of the amount of SFO reports that we undertake and the feedback loop into frontline staff." (Probation Professional)*

Just culture and restorative just culture

A *just culture* in the workplace can be viewed as more constructive and effective than a blame culture (Dekker and Breakey, 2016) or 'retributive dead ends' (Dekker, 2022). The just culture concept has become popular in modern management; it is an 'environment of trust where people are encouraged and even rewarded, to provide essential information related to safety' (Amalia, 2019, p. 260). It is seen as preferable to a blame culture in recognising that 'adverse events are an inevitable part of the human and professional experience' and in the sense that it 'focuses on identifying and fixing systemic factors; and strives to prevent harm fairly without placing inappropriate blame on individuals for system flaws.' (LA County Health Agency, 2017).

However, Dekker (2013; 2025) has found that just culture programmes are too often delivered in a mechanistic fashion – sometimes the categorisation is colour-coded as follows:

- *white* for an honest mistake
- *grey* for violations meriting a formal warning
- *black* for intentional recklessness and immediate dismissal.

Some organisations break the categories down further, e.g. at-risk behaviour, repetitive at-risk behaviour, reckless behaviour, and malicious behaviour (LA County Health Agency, 2017). While such breakdowns of the *individual* actions that contribute to safety problems are more nuanced than the Old View of safety, Dekker (2025a) questions who draws the line with such

labelling systems. More fundamentally, such retroactive labelling does not reflect the New View insights that organisational systems and cultures usually drive individual 'human error'.

Dekker (2025a) further argues that leaders cannot buy a just culture off the shelf; rather, it requires sustained cognitive and moral effort from organisational leadership. While leaders may describe their organisation as operating within a just culture, the concept is too often mobilised in ways that legitimise blame and sanction at the individual level, diverting attention from the more difficult but constructive task of examining organisational and systemic issues. A genuine just culture is characterised by this approach following serious incidents:

- asking 'what happened?', not 'who did what?'
- embracing the complexity/uncertainties and not writing simplistic chronologies
- adopting a justice approach that allows workers to tell their account
- moving from backward to forward-looking accountability
- supporting the 'second victims'[3].

> *"A hospital I know has a learning culture. They have Learning Teams – all staff get in the same room – and review near misses from the week. They have permission to discuss what went wrong, what was and what was not working well, and then develop a plan to fix the problems." (SFO RM)*

Dekker and Breakey (2016) highlight the need for just cultures to consider substantive justice, procedural justice, and restorative justice. *Procedural justice* emphasises the importance of employee voice, fairness, and transparency, and has been found to be linked to employee engagement, commitment, and wellbeing (Fitzalan Howard, 2024). Dekker (2025a; see also Dekker, Oates and Rafferty, 2022) argues for organisations to go further and work towards a *restorative* just culture (RJC), with benefits having been identified for practitioners, risk awareness, and organisational learning, as well as economic benefits from increased productivity (de Boor and Kaptein, 2022; Boskeljon-Horst, Steinmetz and Dekker, 2024). The RJC approach is based upon the principles of restorative justice, which are familiar to the world of probation (see, for example. Marder, 2020). RJC is based upon:

- understanding not blaming
- understanding the need for systemic improvement
- enabling restorative conversations and the opportunity for those involved to express how they feel, including feelings of remorse
- ensuring a focus upon the restoration of trust.

RJC is not concerned with absolutes; in a complex work environment, compromise and ambiguity should be recognised, with no single individual account of an incident being accepted as the only true and correct account. Crucially, the restorative approach aims to humanise people and repair harm and restore trust to all. A powerful example of a health organisation's journey to adopting a restorative just culture is provided through Just Culture – The Movie (Dekker, 2023a), where the vision was to refocus upon the importance of relationships and a compassionate approach. It is re-emphasised here that you cannot buy a just culture off the shelf, and you cannot proceduralise compassion, relationships, and trust.

Barriers have been identified to the implementation of a restorative just culture, including organisational hierarchies, the required investment of time and resources, and entrenched beliefs favouring more retributive approaches (Sawin et al., 2023). To help overcome such barriers, Boskeljon-Horst, Steinmetz and Dekker (2024) explored possible commonalities in the conditions for success across multiple cases and industries. The enabling conditions which were

[3] Second victims are safety-critical professionals who suffer emotionally when the service they provide leads to harm. Adapted from: https://secondvictim.co.uk/. See also Santomauro, Kalkman and Dekker, 2014).

identified included leadership expectations, perspectives and responses, encompassing the courage to act restoratively, and the need to fully recognise the impacts upon practitioners and to pay attention to the all-important relationship between practitioners and the wider organisation/leadership. Critically, leaders need to listen and understand, building or rebuilding multi-dimensional trust through restorative conversations which demonstrate serious care about the humanity and health of their people. These enabling conditions are reflected in following ten proposed actions set out by Oates and Mersey Care's OE Team (2022):

- be inclusive
- coproduce
- design your organisation
- create psychological safety
- embed civility, compassion and respect
- understand and learn
- reframe the language
- support wellbeing
- require leadership
- invest in organisational health

2.3 Context influences behaviour

The old and new views of safety and incident investigation

The 'bad apple theory' dominates the standard, traditional, perspective on what causes adverse events. In the Old View, leaders and managers develop organisational systems that would be safe and effective if it were not for human inattention. This view of safety at work, that unreliable people cause reliable systems to fail, was articulated most clearly in the 1930s by Herbert William Heinrich (1931), the founder of occupational safety science. Heinrich postulated that 88 per cent of workplace accidents were caused by 'man failure', that is, 'human error'. However, there is little empirical evidence for Heinrich's claim (Marshall, Hirmas and Singer, 2018).

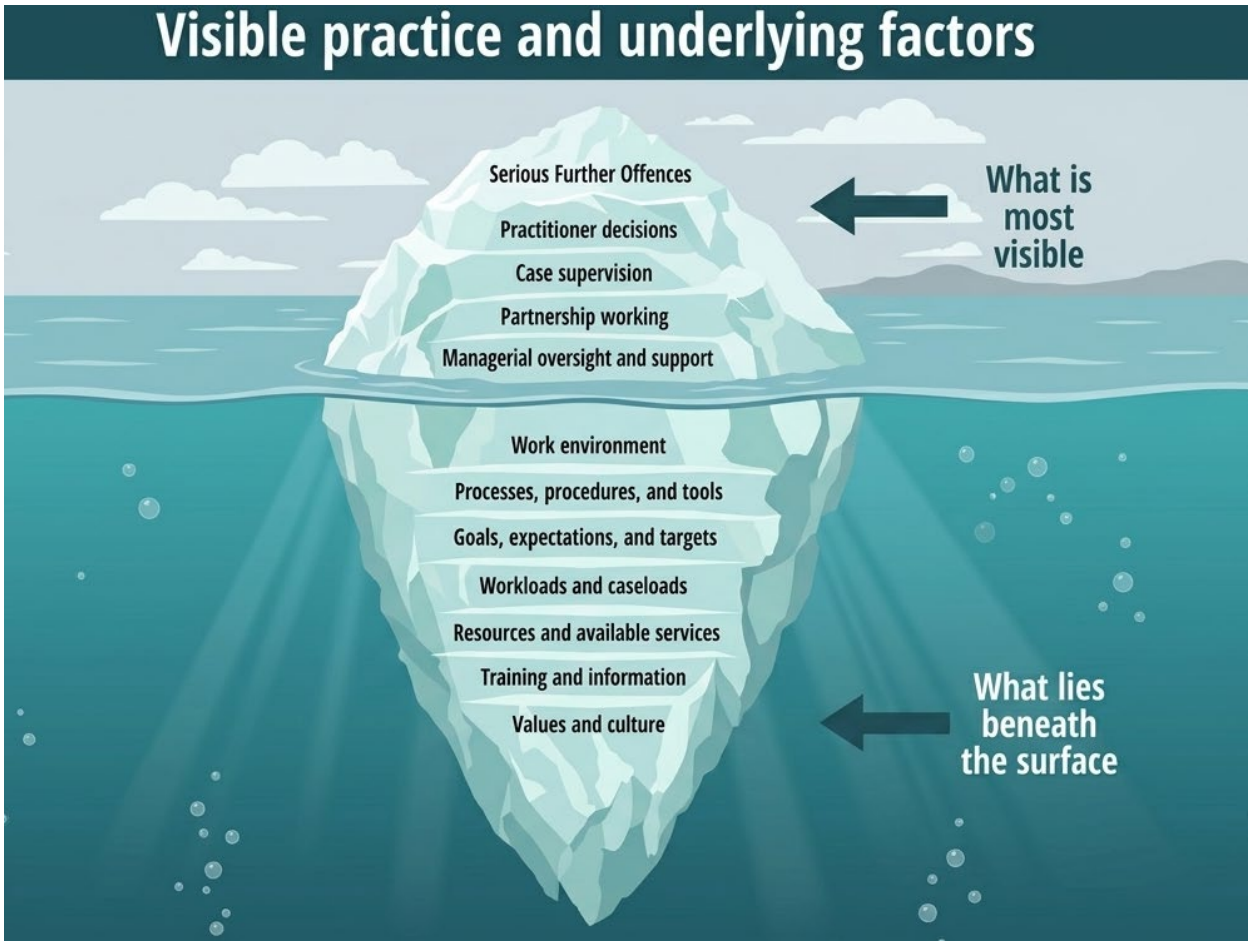
The New View of safety (Safety II) emphasises that it is workers who create safe and effective working environments, as not even the best system designers can deliver processes and tools in an inherently safe condition. Work systems and facilities need to be operated by workers, who are of course humans with all their inherent flaws and frailties, as well as their enthusiasm, creativity and commitment. Organisations need to accept the simple truth that people will make mistakes at work, and work systems need to be robust enough to accommodate that inevitability. It is brittle systems that lie behind adverse events; workers and service users need robust systems that accommodate failures and mistakes; systems that do not depend upon a single person getting an operation right every time day after day. Such an operation can be seen as a brittle system based upon an unrealistic expectation.

'Bad apples' may seem a common sense and intuitive explanation of why adverse events occur, but Conklin (2019) contends from his reviews that the data on incidents will generally reveal a set of factors and systemic drivers (see, for example, Cook, Woods and Miller, 1998), and not a sub-set of accident-prone employees. Similar, Dekker (2024) notes how employees are often faced with poor choices rather than coming to work to make poor choices. Individual differences between humans of course exist; work organisations need to be robust in the recruitment and selection of people with the right attributes to the specific work of the organisation. In the unlikely scenario that an organisation has recruited an unusually ill-suited set of individuals, a review of HR processes would be more profitable than a series of incident reviews aimed at unmasking 'bad apples'.

Sensemaking and double-loop learning

The *local rationality principle* tells us that people do what makes sense to them at that time and in that context (Dekker, 2019), with the 'context' being the total work environment, encompassing organisational processes, tools, goals, expectations, resources, training, values, and culture (see Figure 6). Importantly, safety professionals need to see the world of work through the eyes of the workers, including any competing pressures, e.g. the need to be extra thorough while at the same time being highly efficient. If an unsafe action made sense to any one practitioner, other practitioners may do (and probably *are* doing) the exact same unsafe actions. By understanding *sensemaking* (Pupulidy, 2015) in context, safety investigators, work designers and senior leaders can prevent the safety failure making sense a second time to another set of workers.

Figure 6: Practice within context



Linked to organisational sensemaking, Argyris (2003) distinguishes between single-loop and double-loop learning. In single-loop learning, problems are identified and corrected without questioning the underlying assumptions, priorities, or rules that shape practice. While this may resolve the immediate issue, it leaves the status quo intact and creates the conditions for similar problems to recur. By contrast, double-loop learning involves reflecting on and challenging the assumptions, priorities, and governing rules that produced the problem in the first place, enabling changes to policies, systems, and ways of working that support deeper learning and longer-term improvement.

Root cause analysis and RCA²

Root cause analysis provides a structured problem-solving method to identify the underlying causes of faults or problems. Crucially, care needs to be taken that it does not become a post-hoc construction that identifies a single cause apparent only after the fact, with this analysis becoming decoupled from the context within which the event occurred. In everyday work operations that went well or with little noticeable effect, an investigator of normality would find organisational processes, resources and teamwork that contributed to the expected outcome, so too with poor outcomes. In essence, overly mechanistic and linear explanations of events are ill-suited to complex and dynamic human-centric events.

An enhanced approach to root cause analysis has been developed, known as RCA² (Root Cause Analysis and Action). It was developed by the National Patient Safety Foundation (2016) and has been promoted by the Institute for Healthcare Improvement (2019) to address limitations in standard RCA processes. RCA² recognises that there is seldom a single solution that will address the various system vulnerabilities, and it adds a critical second component – action – recognising that analysis without action is incomplete in terms of implementing sustainable, system-level changes that prevent recurrence. Key principles for the approach include being:

- system-focused – looking for vulnerabilities in processes, not individual blame
- action-oriented – requiring concrete corrective actions, not just recommendations
- non-punitive – the aim is learning and prevention.

The National Patient Safety Foundation provide the following justification in relation to healthcare:

> 'The actions of an RCA² must concentrate on systems-level type causations and contributing factors. If the greatest benefit to patients is to be realized, the resulting corrective actions that address these systems-level issues must not result in individual blaming or punitive actions. The determination of individual culpability is not the function of a patient safety system and lies elsewhere in an organization.' (National Patient Safety Foundation, 2016, p.2)

The human factors approach

The World Health Organisation explain that a human factors approach to work means that:

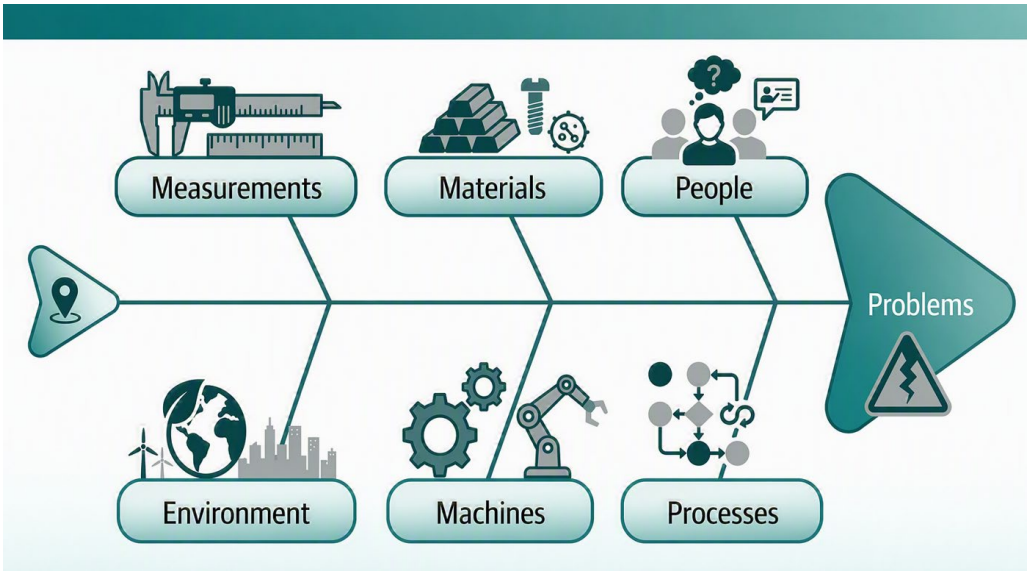
> 'when safety incidents occur, it is important to have a non-punitive culture. Instead of blaming individuals for events, the systems approach focuses on:
> * building systems to reduce potential risks and prevent future errors;
> * building system defences to reduce the likelihood of errors resulting in patient harm.
>
> The overall human factors philosophy is that the system should be designed to support the work of people, rather than designing systems to which people must adapt.' (WHO, 2016, p.5)

There has been significant progress in the probation service in Wales in implementing a learning organisation approach, based upon insights from the human factors evidence base. Research participants told us that they were finalising a staff survey to measure the impact of the human factors approach. A key process within the approach known as *fishbone analysis* (see Figure 7) has been implemented fully in the past two years in the SFO review process in Wales. Fishbone analysis is used to inform the early look reports. It produces a cause-and-

effect diagram which is aimed at enabling investigators to isolate and understand the many potential factors contributing to an event, categorise those factors, and allow them to be considered in team learning sessions. The resulting diagram somewhat resembles the skeleton of a fish, hence the name. In Wales, the analysis is led by the PDU head, assisted perhaps by the deputy or a senior probation officer. Workload and organisational factors are fully considered in the sessions.

> *"The fishbone analysis takes a holistic view, asking, 'what was it like to manage this person?', 'what was going in the PDU and in the team?', 'how did SDS40, Reset, Early Release affect operations?' The fishbone analysis is an opportunity to put the SFO in context." (HMPPS senior manager)*

Figure 7: Fishbone analysis (American Society for Quality[4])



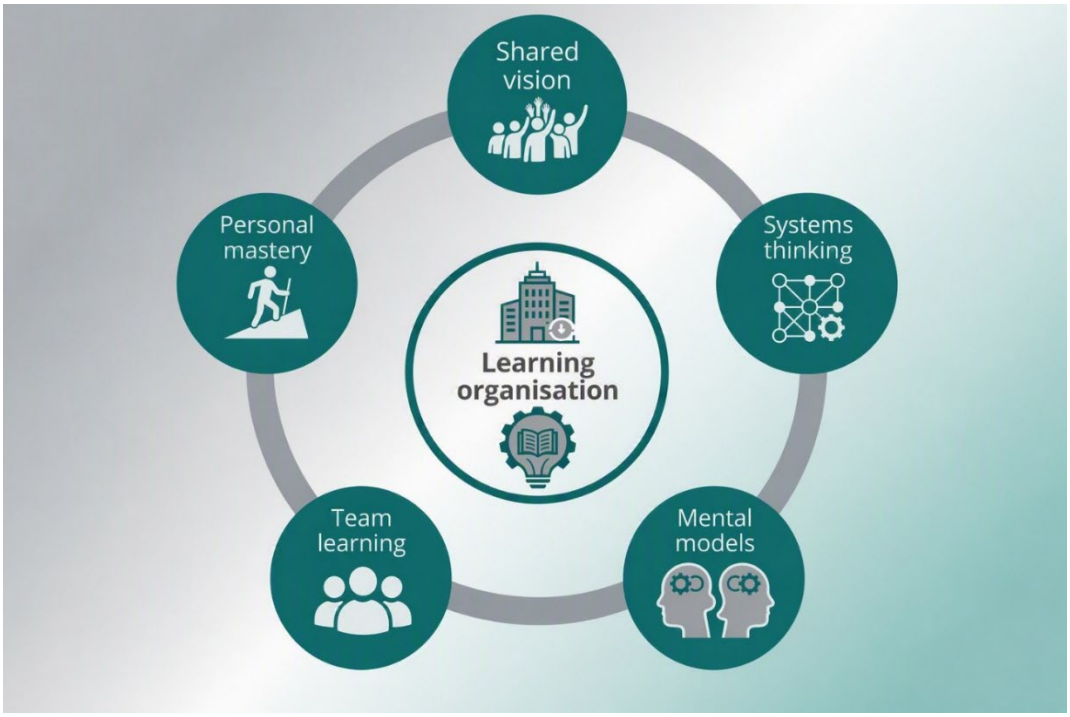
The Wales Probation human factors approach is part of their overall *learning organisation approach*. This approach is most associated with the work of Peter Senge (see Figure 8), a management consultant and academic who promotes a systems thinking approach to organisational leadership. For Senge, learning organisations are characterised by staff members who are interested in their occupation, and are committed to the success of the organisation. He explains that while individual learning and development does not guarantee organisational progress, there can no progress without individual commitment to learning. Organisational leaders must work to facilitate learning for all, removing systemic, cultural and psychological obstacles to that objective. The creation of continual learning environments is similarly promoted through the Human Learning Systems approach to public management, where the purpose of management changes from seeking to control worker behaviour to creating the conditions (including psychological safety) in which people can learn effectively together (Lowe, Wong and Fox, 2025).

Our participants stressed that the success of the learning organisation/human factors approach depended upon continuing leadership buy-in and staff feeling psychologically safe to discuss problems openly. They were optimistic about the future success of the new approach.

> *"Leaders model that it is OK to share when we've made mistakes, that can be a difficult thing to do. We all have to stand up and admit the mistakes we have made in our careers." (HMPPS senior manager)*

[4] https://asq.org/quality-resources/fishbone

Figure 8: Senge's five disciplines of learning organisations (Aliazas and Chua, 2021)



2.4 Learning is vital

Learning is our ability to increase our knowledge and skills, then to deploy those new capacities, and to change our behaviour and thinking through informed reflection. Organisational learning centres around knowledge creation, retention, transfer, and mobilisation to frontline operations. Most organisations want to become learning organisations, but this requires effort, resources, and some courage from senior leaders (Conklin, 2019, p.64) who need to have the humility to accept that they cannot know the work-as-done (rather the work-as-designed) as well as their managers and operational workforce. In terms of learning from SFO reviews, the responses to the staff survey indicate much room for improvement. Notably, 45 per cent of all respondents did not believe that there were sufficient opportunities for all staff to learn from SFO reviews (with 23 per cent responding positively). Of those with direct experience of an SFO review, 58 per cent did not believe that there had been sufficient learning opportunities for their team as part of the process (with 15 per cent responding positively).

The New View emphasises that workplace safety is not the absence of adverse events, but the capacity to operate safely and recover quickly from the unexpected. Organisations adopting the New View report improvements in safety performance. For example, the Australian supply company CHEP[5] reported a 30 per cent improvement in reportable injuries over two years following adoption of the New View. The psychological safety provided by the New View culture improved incident and concern reporting, leading to learning and improved safety.

In their study of mental health settings, Turner et al. (2022) found that adopting the principles of the New View and restorative just culture had improved the quality of incident reporting and clinical reviews of incidents. Staff surveys indicated that trust in management had increased and fear of disciplinary action for making disclosures had decreased. A weekly all-staff triage identified those incidents where formal reviews could potentially offer organisational learning

[5] https://www.southpacinternational.com/hop/how-chep-have-adopted-hop-to-improve-work/

opportunities. Importantly, New View investigations are explicitly not a performance review, or a disciplinary process, or a punitive, blaming or shaming exercise of any kind. Instead, they focus upon learning opportunities for the individual, the team, and the organisation.

The US Forest Service (USFS; Pupulidy, 2017) also adopted the New View perspective. In 2014, the service replaced their standard serious accident investigations with a *Learning Team* approach. USFS had found that the prescriptive model of investigation, adopted in 2003, had not instigated any meaningful change in their operations or policy, and had not reduced the number of firefighters who had died while tackling wildfires. The USFS leadership found that despite using common investigative methods and tools, the resulting reports were simplistic and pointed to 'human error' without understanding how specific failures had occurred and how operations could be improved. The investigations were regarded with suspicion by firefighters as they seemed to assume that staff had *chosen* to err and caused the event, without contextualising the complex balancing of priorities that firefighters have to make in the moment without knowledge of the outcome.

Learning Reviews

The Chartered Institute of Ergonomics and Human Factors (CIEHF, 2020) have set out nine principles for undertaking meaningful investigations into adverse events, all of which have applicability to probation:

1. Be prepared to accept a broad range of types and standards of evidence.
2. Seek opportunities for learning beyond actual loss events.
3. Avoid searching for blame.
4. Adopt a systems approach.
5. Identify and understand both the situational and contextual factors associated with the event.
6. Recognise the potential for difference between the way work is imagined and the way work is actually done.
7. Accept that learning means changing.
8. Understand that learning will only be enduring if change is embedded in a culture of learning and continuous improvement.
9. Do not confuse recommendations with solutions.

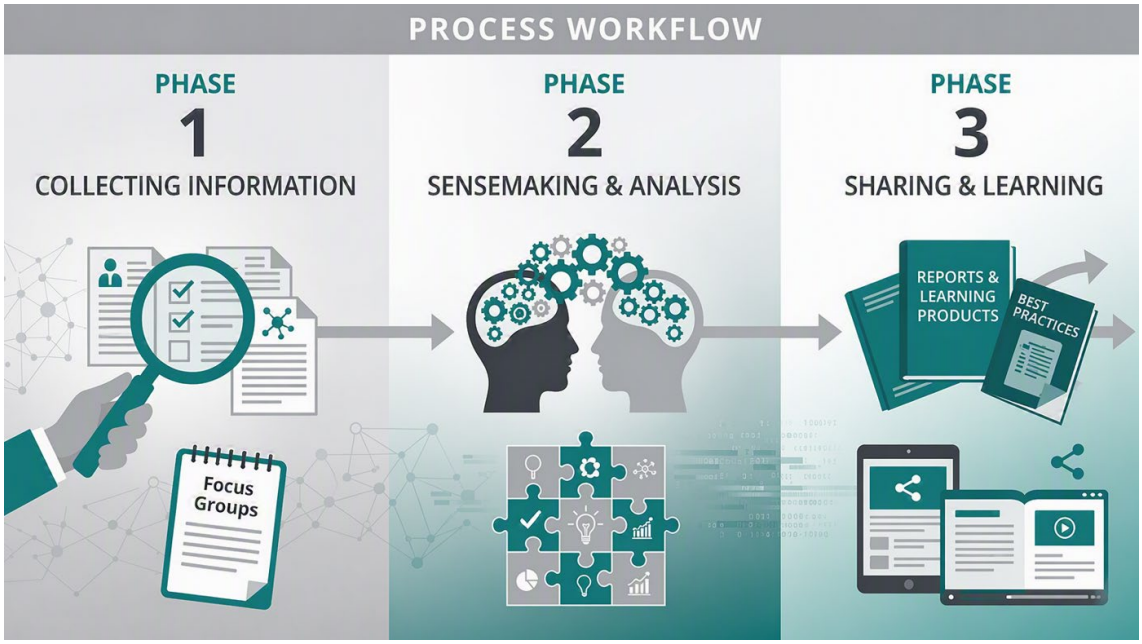
At the heart of the CIEHF principles is the need for investigators to understand and empathise with the situation facing workers at the time of the adverse event. One way to ensure that the complexities and realities are properly captured is to undertake a *Learning Review*. Such reviews were adopted by USFS; they are facilitated by safety professionals but driven by frontline professionals who can explain how work is done in practice and evaluate the practicality of proposed solutions. This is part of completing the design of work utilising frontline workers' profound understanding of the realities of their work. Real learning is then more likely as the learning review avoids hindsight and outcome bias and minimises blame and fear.

The New Zealand Health Quality and Safety Commission's guide to Learning Reviews (HQSC, 2024) begins by affirming the New View that human errors are unavoidable and driven by systems of work. The HQSC recommend that Learning Reviews are not facilitated by subject matter experts, nor should they begin by reviewing the clinical notes and documentation. The facilitators should first talk to a wide range of people involved in the adverse event, letting

them tell their stories in their own time using their own words. Once that understanding of the work-as-done and the circumstances of the event has been developed, then analysis of policy and procedure and performance data should take place.

Learning Reviews depend upon the staff involved in an adverse event openly sharing their experiences and attempting to reconstruct their emotions, choices and actions as they appeared at the time. The prerequisite for such openness is a high degree of psychological safety, trust that colleagues and leaders will be compassionate and supportive, and a belief that understanding will be forthcoming; an organisational reframing of 'failure' is required where mistakes are treated as valuable learning opportunities. Sensemaking, analysis and report writing flow from a rich understanding of the whole context of the adverse event. Through the open participation of workers in focus groups, discussing the narratives constructed through initial information gathering, system solutions can be developed, with the final report describing any weaknesses in the system where management action is required. Crucially, relationships need to be continually nurtured to support learning and collaboration.

Figure 9: Learning review process – a phased approach (New Zealand Health Quality and Safety Commission, 2024)



Dekker (2005b) highlights the importance of learning beyond serious incidents and the value from encouraging different and dissenting views to identify earlier safety 'signals' and any blind spots. Creating internal challenge networks or cross-functional groups which include frontline workers are set out as two potential options, with a focus upon pursuing honesty and openness over any pretence that perfection is achievable.

A learning organisation should also be interested in the everyday successes of its operations (Kletter et al., 2020; Dominey, Calder and Whitham, 2026), particularly in sectors such as probation where the everyday work of practitioners to prevent serious harm is largely unseen and invisible. Hollnagel's resilience theory (2014, cited in Dekker, 2025a, p.46) highlights both disturbances and opportunities, recommending that attention is paid to 'what goes right' as well as adverse events. Things go right in everyday operations not through normative compliance to 'work-as-designed' but through the ability of the worker to identify problems and skilfully adapt procedures and processes to emerging situations; this is 'work-as-done'.

The need to identify and share effective practice has similarly been highlighted by McManus (2025) who states that 'we hear a lot about what goes wrong but I would advocate that we need to be louder about what goes right because we know that everyday practitioners are building these great safety plans and risk management plans, we are forming trusting relationships and preventing harm, and these are often outside of our formal roles and responsibilities'. An organisation can then fully understand its capacity to safely control and manage risks, and also be progressive in outlook, rather than solely looking backwards at failure (Conklin, 2019, p.70).

Time with practitioners

Organisational leaders must work to facilitate learning for all, removing systemic, cultural and psychological obstacles to that objective. Regrettably, despite learning being the declared primary aim of SFO reviews, SFO RMs told us that they were spending too little time providing learning activities. They reported that problems of understaffing of review teams, a backlog of SFO reviews, and further demands (including quality assurance) meant that they were struggling to make time for transferring learning from SFO reviews to frontline teams.

> *"We spend too much time writing reports rather than delivering Action Plans and driving learning for the frontline." (SFO RM)*

Nevertheless, there were many examples of promising and innovative work at the local level, and some good experiences with the HMPPS central team. There was an appetite among SFO RMs for more collaborative discussion of findings to share insights and experiences with practitioners, drawing together key messages and lessons from recent SFO reviews, and to clarify and assure staff about the aims of SFO reviews.

> *"We meet with Assistant Chief Officers and PDU leads and present the action plan and findings. We give the overview and take questions. We will meet with all concerned and disseminate the learning and why these issues are critical. Face-to-face if possible but Teams as well. Sessions are well attended but not mandatory. We talk about systems change, about the context, not just about 'you', it's not about blame. They are well received. They are surprised that we look at HR data on staffing levels, sickness absence, and Workload Measurement Tool figures. The context of all that was happening, courses, projects etc." (SFO RM)*
>
> *"HMPPS Central SFO Team are very supportive, and we get good feedback, they understand the complexity and staffing issues. Central team give a good steer to go beyond blame and minor practice deficiencies. To look wider than the individual. Such as OASys, where there are routinely gaps in risk assessments, and understanding of risk." (SFO Senior Manager)*
>
> *"We are all assigned a PDU to engage with, we go to local staff meetings and have run professional development days to demystify and debunk SFO myths. We pass on the learning and the key themes from recent SFOs." (SFO RM)*
>
> *"We are trying to be more visible to probation staff. The SPOC (single point of contact) role is helpful, we attend team meetings with SPO and PPs and explain what we are finding." (SFO RM)*

The Probation Service has been facing challenges of excessive workloads and high vacancy rates (see, for example, Public Accounts Committee, 2026), and SFO review teams have not been immune from these difficulties. The SFO RMs emphasised the broad role of their teams, with most SFO RMs reporting that they undertook other duties alongside SFO reviews; they investigated complaints from people on probation and the public, contributed to deaths under supervision enquiries (HM Inspectorate of Probation, 2025c), or assisted police-led homicide reviews where probation input was required. SFO RMs and team leaders told us that they were carrying too many vacancies and had backlogs of cases to review. The impact of this cannot be underestimated, as delays in the completion of SFO reviews impact upon the timeliness of learning and improvement, alongside the obvious impact for victims and their families (HM Inspectorate of Probation 2025c).

SFO RMs told us that they felt under pressure, and at times suffered from stress and anxiety about their workloads. Several questioned the value of conducting full reviews for older cases – where there may be less learning for the contemporary probation service – especially those concerning the former Community Rehabilitation Companies (CRCs) from the *Transforming Rehabilitation* era. Consideration could thus be given to whether there is potential for a different, more streamlined, SFO review process for some older cases, while recognising the importance of providing an account for victims and relatives.

> *"I am not writing just one report. I am writing ten at the moment and am covering for two staff vacancies. It's relentless, more keep coming in and we have a backlog going back years. I have been working on a SFO from a CRC, reconstructing what the policy and practice situation was at that time in the EDM [exceptional delivery model]. Finding the relevant documents was difficult, so I used personal networks." (SFO RM)*
>
> *"There is a backlog, my last case was a CRC one from four years back. The Prioritisation Framework from PPG [public protection group] focuses upon high profile cases first and sentenced cases. That helps." (SFO RM)*

More generally, it needs to be ensured that there is a strong focus upon identifying and then taking forward the most critical learning. Dekker and Conklin (2022) highlight the phenomenon of 'safety clutter' (ibid, p. 105); the accumulation of documents, rules and procedures over time, which though done in the name of safety, do not contribute to safety – and may even undermine safe working by overburdening and distracting the frontline from their core tasks (see also Dekker, 2025b). They conclude that the way to deregulatory and improve safety at work is to ask workers what rules and requirements are actually getting in the way of doing work safely and effectively, then use that insight to experiment with reducing and streamlining processes.

Transparency

One obstacle to collaborative learning was felt by SFO RMs and their senior managers to be the lack of transparency in relation to SFO reviews. Recipients of a full SFO review are limited to the head of the PDU, the regional probation director, senior staff at HMPPS HQ, Ministers, and for a random twenty per cent of cases, the Inspectorate will receive the full unredacted review report. Following receipt of the review report, PDU heads will summarise only the action plan for their teams – it was felt that this feedback could be depersonalised and decontextualised. Victims, and/or their relatives, obtain a redacted version of the full review report and the action plan, which is presented by a senior probation manager, often the PDU head alongside a victim

liaison officer. The probation frontline team where the SFO occurred thus receive the least information about the contents of the review. A senior trade union official remarked as follows:

> *"It's all very hush-hush. The lack of transparency creates anxiety among staff, a 'rumour mill' starts up as to who is involved and what will happen." (Trade Union official)*

The limitations to transparency were seen as a source of anxiety for probation professionals, already fearful about being solely blamed for an adverse event without an appreciation of the full context including staffing and workload pressures. Where there is limited openness about what is being considered, rumours and misconceptions can develop about the intended purpose of SFO reviews. SFO RMs reported that this was undermining their ability to gain the trust necessary to undertake learning activities with practitioners.

> *"The main challenge of SFO is the lack of transparency and that hampers learning. I get why we are asked to do a full review but the impact of the lack of transparency is to make the process meaningless." (SFO RM)*
>
> *"The process lacks transparency. Probation professionals cannot see the full HMPPS review; we rely upon PDU leaders to cascade the key points and the action plan. Practitioners do not see the full rationale for the actions. This is understandable as individuals need to have confidential info protected. But it means that the action plan is just done to you." (SFO RM)*
>
> *"We want to find out what went well, what went wrong, but the process does not aid learning… We can't share SFO reports with the people involved. What is cascaded attends to the negative and misses the good points of the work done." (SFO RM)*

Learning from the best: aviation

Arguably the strongest safety culture in our time is the aviation industry who have achieved a remarkable safety record given the inherent dangers from highly explosive fuel and defying gravity. The Rail Health and Safety Board (2024) outline the following success factors for aviation learning:

- A detailed understanding of the event and its causes/contributory factors is absolutely key. This is the seed from which everything else grows. If this is wrong or partial, learning will be ineffective.
- This requires an open reporting culture, including an honest exchange during investigation that can be based on trust via a Just Culture. This leads to a strong reporting culture.
- It also requires a robust scientific taxonomy, not simply a list that includes everything anyone has ever noticed or thought of. The taxonomy should be layered from 'surface factors' that are factual in nature to deeper systemic issues that may include structural aspects of how the business operates. For recurrent incidents or clusters, going deeper is key.
- There should be fast, collective responses and sharing of information within and across companies.

- There should also be a multi-media approach to 'spreading the word' and embedding learning into training, and hence into behaviours, beliefs, and attitudes ('norms').
- There must be feedback on whether the changes are working or not. An operational focus group gives feedback on the fitness-for-purpose of the resolution, and later on, its effectiveness.
- There should be a coordinated reaction and response in high-level agencies and stakeholder consortia on common issues.
- 'Targetology' is to be avoided. Here, particular performance metrics are set as goals but have perverse and counter-productive outcomes.
- There must be a generally healthy safety culture, founded on strong professional cultures. This generally leads to high performance at the micro level and commitment to resolve issues at mesa and macro levels, resulting in a safety learning culture.

2.5 Responses to failure matter

Differing reactions to failure

Typical reactions to failure, especially failure that leads to serious harm, can be retrospective, blaming, judgemental and highly focused upon the event and its immediate precursors. This approach, though emotionally understandable, explains nothing about the adverse event as it is riddled with hindsight bias and outcome bias (Cook, Woods and Miller, 1998).

A more constructive reaction will engage with the complex realities and uncertainties of everyday work where many outcomes were possible in the context and the situation. The very same workplace behaviours, choices and decisions will often have led to good or neutral outcomes, and the adverse event can be the result of undertaking ordinary work on an ordinary day. To avoid judgementalism, and outcome and hindsight bias, it is important to get 'inside the tunnel' with the worker (Dekker, 2014). That is, to understand the ambiguous and incomplete information the workers had at that point in time, and the multiplicity of available choices and possible outcomes. Safety investigators, and organisational leaders, need to understand the system, context and situation within which the worker operated. That deeper understanding enables learning and improvement and mitigates blame and hindsight and outcome bias.

> 'Our challenge is to avoid focusing upon finding blame for the event that just occurred. Our job is to understand and explain the event so that we can look forward at other conditions and similar circumstances that exist in our organisation and place controls and safeguards to thwart the next event in a sustainable way. Don't find blame, fix systems.' (Todd Conklin, 2019, p.62)

The College of Policing (2013) offer evidence and practice-informed principles for understanding how police officers make risk decisions in complex, critical and uncertain situations. The key message is that incident reviewers should not be led by the outcome of the decision(s) made and should be realistic about the ability of the police to prevent all harms. Risk is inherent in critical policing situations – risk cannot be eliminated – and attending officers can only be expected to make reasonable judgements in the moment. This is true also of probation work where assessments can be made of the probabilities rather than the certainties of particular outcomes.

> 'Rather than focusing on the outcome, assessments of decisions should concentrate on whether they were reasonable and appropriate for the circumstances existing at the time. If they were, the decision maker should not be blamed for a poor outcome.' (College of Policing, 2013)

New View safety investigations

In New View safety investigations, all those involved must be able to tell their story without fear. Investigators must continually check they understand the standpoint of the participants. Constructing a timeline may be useful, on the proviso that the chronology reflects how the situation and actions looked to different participants at the different stages of the unfolding event. Investigators should ask what cues, expectations, available knowledge and influences the organisation (policies, procedures, demands and culture) was having on the situation as it developed.

The New View investigation is characterised by asking:

- How did the work look to the participants?
- How did the situation unfold, what cues did they get and when?
- What goals were the participants pursuing at that time (not knowing what the outcomes were going to be)?

Investigators (and report readers) must adopt a certain humility, and accept that there will be incomplete data, disagreements between participants, and inconsistencies in and between accounts. In reality, both the causes of bad outcomes and the possible solutions are often uncertain and contested, and it is important to recognise all the uncertainties and complexities involved. The benefits from obtaining diverse accounts have been further highlighted as follows:

> 'An investigation can never uncover one true story of what happened. That people have different accounts of what happened in the aftermath of failure should not be seen as somebody being right and somebody being wrong. It may be more ethical to aim for diversity, and respect otherness and difference in accounts about what happened as a value in itself. Diversity of narrative can be seen as an enormous source of resilience in complex systems, not as a weakness. The more angles, the more there can be to learn.' (Dekker, Cilliers and Hofmeyr, 2011)

The New View aims to provide a resource to facilitate intervention in the system to prevent the recurrence of behaviours that led to bad outcomes. Dickens et al. (2023) criticise serious case reviews (SCRs) of child abuse cases for failing in their overt purpose of improving practice by working to covert purposes of attempting to 'dissipate public outrage, deflect attention from underlying causes, and distort understandings of the work by making it seem straightforward'. This confusion of purposes is echoed in the SFO reviewing teams' complaint that there were too many audiences for the single SFO review report.

The New View insists that investigations focus upon holistic understanding that can lead to tangible improvements, avoiding 'predictable, banal and repetitive' analysis and recommendations (Wood, 2016, p.8). The importance of clear, feasible, and accountable recommendations, which guide the implementation of learning into changes in practice, policy, and systems, has been further highlighted by Ball, McManus and Monaghan (2025). Their

analysis focused upon safeguarding reviews, and they identified the following recurring issues in the formulation of recommendations:

- lack of clarity – including a frequent lack of implementation detail
- language – encompassing non-assertive language, non-actionable verbs, and a heavy use of buzzwords (e.g. 'holistic', 'person-centred', 'professional curiosity') without the 'how' of change
- follow-up and accountability measures – monitoring and evaluation steps often missing, such as the 'how' to understand progress and impact
- feasibility – recommendations often skipped root-cause analysis and assumed resources/funding/services would materialise.

A lack of 'professional curiosity' by individual practitioners has been highlighted in many serious incident reviews. For example, in their analysis of child neglect reviews, the Social Care Institute for Excellence found that 'professional curiosity is all-too-often lost and seemingly small incidents or concerns not fully explored' (SCIE, 2020). Dickens et al. (2022) critique this approach to professional curiosity, noting that workloads, caseloads, and organisation scheduling severely limit contact time, preventing relationship building and constricting the ability of professionals to engage in such professional curiosity. Those practitioners that did spend more time with families to ask more questions and gather more information, did so in their own time against organisational policy. However, relying on goodwill and unpaid work is unsustainable.

> 'What was evident in the examples where professionals did persist, challenge and exercise curiosity was that they had to follow their instincts and 'make time' to do so, often going over and above the allotted time permitted by their agencies.' (Dickens et al., 2022, p.70)

Similarly, Phillips et al. (2022) highlight the structural, relational and emotional barriers within probation to the enactment of professional curiosity, as well as the need to recognise that it is hard work, requiring significant emotional labour. To support and enable probation staff to enact professional curiosity, they state practitioners need: (i) time and space to ask the right questions, analyse and act; (ii) time and space to develop relationships with people on probation; and (iii) emotional support (see Figure 10). The significant workload and staffing pressures impacting probation over recent times have clearly made it more difficult for staff to find this all-important 'time and space'.

Figure 10: Practitioner requirements for exercising professional curiosity (Phillips et al., 2022)

Time and space to ask the right questions, analyse and act	Staff need to be given the time to ask the right questions and know when someone may or may not be being truly compliant as this makes it easier to be professionally curious. Moreover, staff need time to digest, analyse and act on the answers that comes from deeper and more searching questioning.
Time and space to develop relationships	Staff need the time and space to be able to develop good working relationships with people on probation so that the right questions are asked at the right time, limiting the damage that might occur as a result of asking intrusive questions.
Emotional support	Emotional support should be provided for staff when it comes to dealing with the answers from the difficult and searching questions they are being required to ask.

An example of the New View approach

The Health Services Safety Investigations Body (HSSIB) was founded in 2023 to investigate patient safety concerns and provides a strong practical example of the New View approach. Their key principles for investigation emphasise maintaining a blame-free stance, being evidence-informed, focusing upon learning and improvement, and being fully inclusive of all those involved in the event (HSSIB, 2023). The creation of HSSIB is covered within Complexity of Failure – The Movie (Dekker, 2023b), which sets out the journey within healthcare where staff had previously felt fearful of being honest, and where fear had been driving poor feeling and poor relationships.

Health Services Safety Investigations Body: How we investigate

- HSSIB do not attribute blame or liability in our investigations.
- HSSIB underpin investigations with the most appropriate and robust safety science methodologies.
- HSSIB investigations take a system perspective and aim to reduce the likelihood of incidents happening.
- HSSIB involve patients, families, and healthcare staff in our investigations.
- HSSIB consider how to improve care for those subjected to health inequalities in all our investigations.
- HSSIB will have a multidisciplinary team approach to investigations using skilled investigators.
- HSSIB involve appropriate subject matter advisors in our investigations.
- HSSIB recommendations will be impactful and will work with the system to ensure there is maximum effect.
- HSSIB will be open and transparent about how they work whilst protecting the disclosure of specific evidence that they gather during the investigations.
- HSSIB will undertake investigations in a timely manner, and in the most cost-effective way.

Ideas for improvement

In terms of improving the organisational response to SFOs, various recent developments are worthy of note. As highlighted previously within this report, there has been a focus within Wales upon a learning organisation approach, which has included the use of fishbone analysis within SFO reviews to help understand the many potential factors contributing to an event. A further initiative, led by the Inspectorate, has been the development of SFO multi-agency learning panels, aiming to promote collaborative learning in those cases where multiple organisations were involved. Such panels have also been used recently within the dynamic inspections of public protection.

The SFO RMs and team leaders had several further ideas for how to improve the SFO review process to better support staff, and to better promote organisational learning.

Default to the early look report format: A recurring suggestion was to adopt the early look report format as the default report format.[6] Many RMs contended that most SFOs do not present valuable opportunities for wider learning, and that a relatively concise account of the case and a timeline could help victims and/or relatives to understand what happened, while identifying any improvements at the operational level. Those SFOs that the proposed short format report identified as revealing potential wider learning opportunities would then be pursued in a full review, which would be multi-agency when appropriate. RMs were concerned that limiting SFO reviews to the role of probation neglected the interactions of all the agencies involved in a case, impeding fuller understanding.

> *"The early look could be used as a triage for full review. A full review is mandatory for offences such as murder, but we do not necessarily learn from simply the offence. The offence drives full reviews, not the opportunities for learning. We should have discretion and produce enhanced early looks rather than full reviews as standard – change the terminology to reflect that. The few cases that could benefit from a full review as they exemplify learning opportunities could follow the HMIP template which is much clearer." (SFO RM)*

Experiment with new review formats: At the time of writing this report, HMPPS had introduced a revised SFO review process and template aimed at addressing the current backlog, the findings from which will be evaluated to further inform the longer-term review of the SFO procedures. The Inspectorate intends to report on the findings from this backlog recovery approach, and the quality assurance of the reviews written on the revised template in its 2025-2026 SFOs Annual Report (HM Inspectorate of Probation, 2025b).

Some interviewees were keen for HMPPS to experiment further with progressive inquiry formats which move beyond individualisation and blame to take a systemic view of adverse events. Some mentioned a trial in a probation region with the SILP (Significant Incident Learning Process) format. SILP is often used in safeguarding practice reviews. In one of her reviews, Pettitt (2025) commends SILP as a format which 'engages frontline staff and their managers who were involved with the families in question, avoids hindsight bias or individual blame, identifies opportunities for improvement within systems for safeguarding children and promotes good practice.' The review format generated actionable system-focused recommendations and avoided oversimplification and stigmatisation.

> *"[A Probation Region] is trying to learn lessons from health and children services. The SILP looks promising. Everyone is in the room, including probation*

[6] This suggestion aligns to some of the recent changes to the SFO process as part of a backlog recovery plan.

> *practitioners. SILP is based upon Appreciative Inquiry principles[7]. They examined a Near Miss, the case was not a SFO, it did not reach criteria because it was not high risk … we need to get away from finger pointing." (Senior Manager)*

Capture action plans nationally for SFO and all adverse events: In one region, the team had developed a simple Excel spreadsheet which captures every action plan recommendation and organises them thematically. The team hoped that this would be adopted as a national approach to identify recurring key issues which can be improved upon.

> *"The themes tracker which our ACO pulls together is useful to develop regional themes. Not sure if this a national initiative. It helps us understand all the threads." (SFO RM)*

Other interviewees wanted to spend more time investigating other important events through which probation could learn how to improve delivery. As set out earlier, the Inspectorate has recently recommended that HMPPS should 'develop a strategy to ensure the death under supervision process focuses on systemic learning and improvement' (HM Inspectorate of Probation, 2025c)

> *"We could do more with Near Miss, Death under Supervision and conditional SFOs." (SFO Senior Manager)*

Most of all, SFO teams wanted to see a transformation in how probation learns from adverse events. There was an appetite to move away from any blame culture and become a learning organisation. As set out in this report, the five HOP principles could offer a guiding philosophy and a conceptual foundation for helping the Probation Service towards a more rounded and evidence-informed review process.

> *"Why don't we start by saying 'you are not to blame'? How can practitioners be blamed for serious further offences. The perpetrator is responsible for the crime. We are miles behind other sectors. A safe environment creates learning. Practitioners want to share their story of working with that person and what work was like at that time. Psychological safety has not been communicated nationally. The human factors approach allows workers to cognitively unload, to tell the interviewer what they're carrying, what are the burning issues that they need to say before they can talk about the incident." (SFO RM)*

[7] Appreciative Inquiry has a focus on identifying strengths and successes to drive positive change and innovation. It encourages individuals and teams to build on their strengths, fostering positive dialogue and forward-looking strategies.

3. Conclusion

The Probation Service in England and Wales is currently struggling to deliver the high-quality service desired by all those working in or with the service. The destabilising *Transforming Rehabilitation* era (2014 – 2021), followed by the difficult unification of probation services during the Covid-19 pandemic, has left frontline probation services in a situation of "too few staff, with too little experience, managing too many cases" (in the words of our Chief Inspector, Martin Jones (BBC News, 2025)). According to the Probation Scorecard (Ministry of Justice, 2025b), only two of the twelve regions are operating at a 'good' level; all others 'require improvement' or are 'inadequate'. In our 2023 to 2025 inspections, all PDUs were assessed overall as 'requiring improvement' or 'inadequate'.

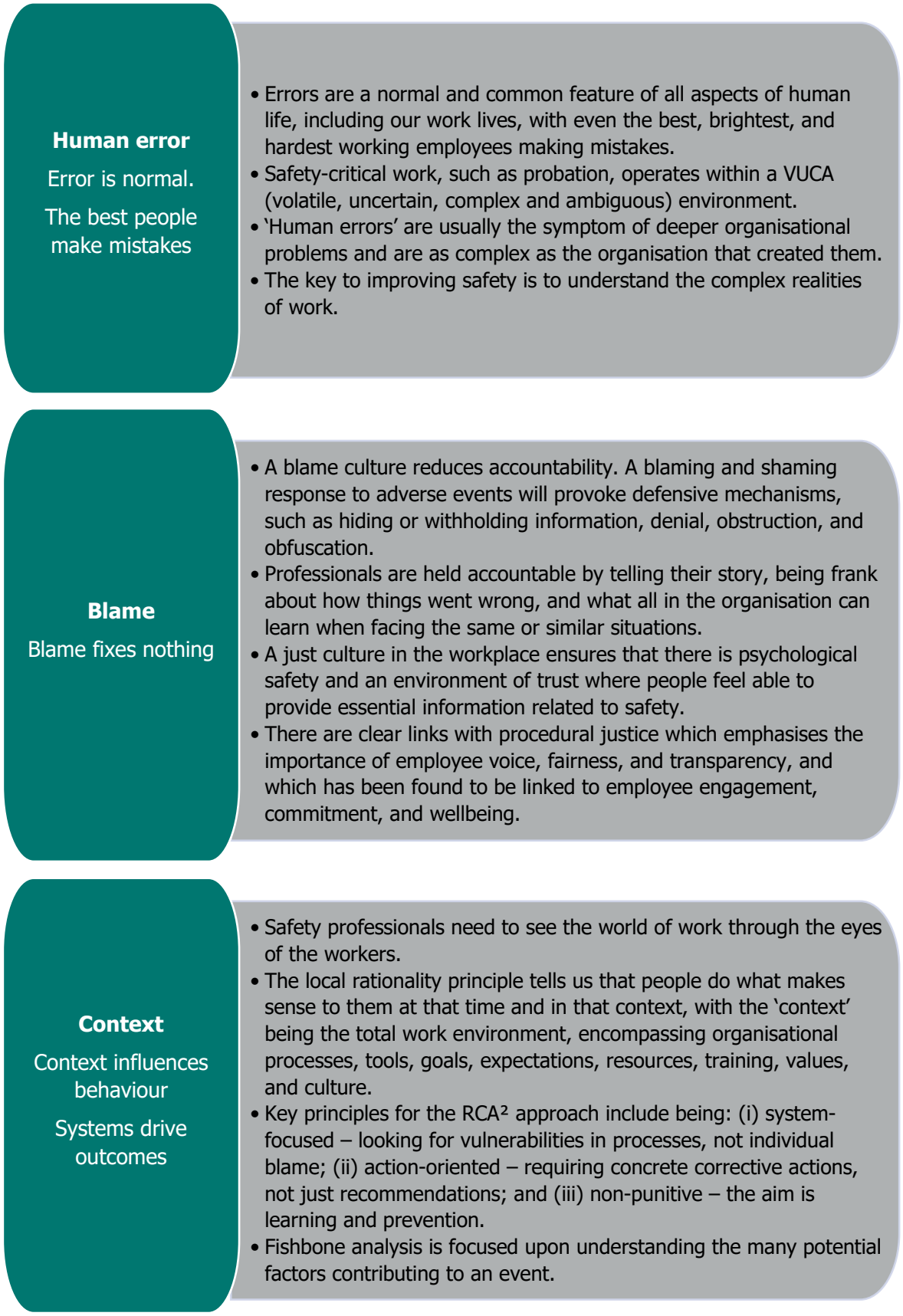
More positively, recent recruitment campaigns have been successful in attracting new trainees (HM Inspectorate of Probation, 2025b), while the financial boost for probation in a three-year £700m p.a. funding package is a welcome recognition of the importance of probation work. At the same time, the National Audit Office reminds us through its October 2025 report on building an effective and resilient Probation Service, that there remains a long way to go, concluding that 'the significant gap between actual and required capacity and slow progress in improving productivity means the challenge it faces is huge' (see also Public Accounts Committee, 2026).

The nature of SFO reviews is a major area of concern for probation practitioners, managers and leaders. SFO reviews are intended to encourage learning but are too often experienced as punishment and blame, and perceived to be failing to engage with the complex and dynamic realities of everyday work where practitioners balance conflicting goals, rules and imperatives in real time and where they are dealing with probabilities rather than certainties. As we have seen, other sectors have been in the same position as probation and moved to differing ways to meaningfully understand adverse events and learn and improve their safety culture.

Many organisations are adopting the New View of safety; increasingly their safety professionals and incident investigations are informed by the five HOP principles (Conklin, 2019), restorative just culture (Dekker, Oates and Rafferty, 2022; Dekker, 2025a), and psychological safety (Edmondson, 2024). Leaders in these organisations understand that blame and punishment deter learning and improvement, and that failures and errors cannot be fully eliminated, but the organisation can move forward by understanding what happened and how recurrence can be avoided. There is a clear focus upon both transparency and restitution. Psychological safety, a worker's confidence that they can speak candidly to managers and colleagues about problems and concerns, is the bedrock for sound safety reviews, and safe and successful business practice in general (Edmondson, 2018).

As set out in this report, the five HOP principles offer a guiding philosophy and a conceptual framework for helping the Probation Service move towards a more rounded and evidence-informed review process (see Figure 11). The New View and the HOP principles do not discard what we know already about risk and safety. Safe and effective services value and use the evidence base to establish rules, guidelines, protocols, and best practice documentation. The New View builds upon existing knowledge, complementing existing frameworks through reframing the questions we ask ('what happened?' rather than 'who did something wrong?') and refines the methodologies of safety professionals. Moreover, the New View expands the purview of safety work by leading us to better understand how work-as-done differs from work-as-designed, grounded in the experiences of frontline staff.

Figure 11: The five principles and key points for SFO reviews



Learning Learning and improving are vital	• An organisational reframing of 'failure' is required where mistakes are treated as valuable learning opportunities. • Learning Reviews involve staff involved in an adverse event openly sharing their experiences and attempting to reconstruct their emotions, choices and actions as they appeared at the time. Relationships need to be continually nurtured to support learning and collaboration. • Sensemaking, analysis and report writing flow from a rich understanding of the whole context of an adverse event, avoiding hindsight and outcome bias. • A strong focus is required upon identifying and then taking forward the most critical learning, avoiding the creation of 'safety clutter'. • Learning must not be confined to finding out what went wrong after an event. A learning organisation should also be interested in both: (i) safety 'signals' and any blind spots; and (ii) the everyday successes of its operations.
Responses How you respond to failure matters How leaders act and respond counts	• Constructive reactions engage with the complex realities of everyday work where many outcomes were possible in the context and the situation. • Key principles include being evidence-informed, focused upon learning and improvement, and fully inclusive of all those involved in the event, respecting and recognising the value of differing views. • The New View insists that investigations focus upon holistic understanding and clear, feasible, and accountable recommendations which guide the implementation of learning into changes in practice, policy, and systems, that can lead to tangible improvements.

Adopting the New View of safety and applying the HOP principles should not be regarded as a simple or quick endeavour. There is no manual that can be readily adopted from elsewhere, and it takes committed and collective leadership to remain focused on learning, removing all obstacles to that objective, and to creating an organisational culture of transparency, compassion, trust, empowerment, engagement, and continuous improvement (see Brophy, 2026 for an overview of transformational leadership behaviours and the Full Range Leadership Model). Looking across sectors, the following have also been highlighted as important for HOP integration (Baker, 2019):

- building education and exposure to HOP principles to facilitate a paradigm shift in thinking
- embedding the principles and operational learning mechanisms into existing processes and practices
- providing training on the principles to all those involved in, or likely to receive, reports of events, failures or mistakes

- maintaining a strong focus on monitoring and evaluation to support continuous and collaborative iteration and improvement
- emphasising forward-looking accountability, with clear ownership for implementing improvements.

The New View values and HOP principles mirror core values of probation in recognising human frailty and failure and in valuing co-production and shared learning with frontline staff and service users. In our conversations with SFO reviewing teams and senior managers, there was a desire for an evidence-informed and forward-looking approach that avoids the perception of hindsight bias and blame. In Wales, there is steady progress towards adopting a systemic understanding of practice problems and adopting the human factors approach to team learning and organisational development. The English regions could follow their lead – this would require effort, resources, and some courage from senior leaders who need to accept they cannot know the work-as-done (rather the work-as-designed) as well as their managers and the operational workforce.

During the period of this research, HMPPS convened a working party to consider how to develop the SFO review process to further the goal of organisational learning and to support staff, and changes had been introduced to address the backlog of reviews. It is vital that the service looks after its staff and creates a supportive environment where wellbeing matters. The New View of safety science and the HOP principles offer a potential way forward, supporting continual improvement and staff engagement, development, morale and retention. Crucially, promoting a culture of learning is beneficial to all: probation practitioners, managers and leaders, and victims and wider society through minimising the risk of future adverse events.

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Annex A: Methodology

The findings in this bulletin are based upon the following sources:

- A survey of probation practitioners (n=245). The survey was distributed via the twelve regional probation directors who were requested to cascade the survey link to frontline probation practitioners. Headline results are reported in Annex B.
- A series of interviews and focus groups undertaken with relevant interested persons, encompassing sixteen probation professionals with current direct involvement in SFOs – ten SFO RMs and six senior managers with SFO oversight. We also interviewed a senior trade union official and two senior academic researchers with a strong publication record in this subject.
- We issued a call for evidence from which we received replies from the Rail Accident Investigation Branch and HM Inspectorate of Constabulary and Fire and Rescue Services.
- A literature review of the safety science and incident reviewing evidence base was undertaken using Google, Google Scholar, selected journals, and institutional websites. Key publications used are cited in the reference section of this report.
- We also benefitted from a commissioned academic advisor, Dr Sarah Crozier, Manchester Metropolitan University, who reviewed our methodology, evidence searching, and final report.

Analysis

Key stages of the analysis were as follows:

- The quantitative survey results were analysed in Excel and the qualitative data was analysed in nVivo. The qualitative data was read, coded and themes were developed for reporting in line with the thematic analysis principles outlined by Braun and Clarke (2006).
- The interviews and focus groups were recorded and automatically transcribed via MS Teams. Codes and themes were developed from the notes, transcriptions and recordings.
- The staff and fieldwork findings and the literature review findings were reported through the lens of the human and organisational performance (HOP) principles (Conklin, 2019).

Ethics

Approval for the research was provided by the HMPPS and Ministry of Justice National Research Committee.

Limitations

This report is grounded in a wide range of evidence; however, the reader should be mindful of the following limitations:

- While the staff survey received 245 responses, this remains a relatively low proportion of all frontline probation professionals in England and Wales, and it is not a random sample. The survey findings thus offer an indicative picture of frontline experience, but the findings cannot be treated as generalisable to all staff.
- The interviews and focus groups with HMPPS staff were conducted by Inspectorate staff members. Although participants were assured that their contributions were anonymous and would be treated in the strictest confidence, it is possible that some individuals may have felt constrained in expressing their views to the Inspectorate. Nevertheless, the themes emerging from the qualitative data suggest that participants engaged openly, and indeed used the opportunity to articulate their experiences and perspectives in candid terms.
- Finally, our study would have benefitted from a more comprehensive examination of how the New View of Safety has been interpreted and adopted across a wider range of sectors and organisational contexts. Such a project was beyond our scope and resources. The cross-sector material presented here is therefore illustrative rather than definitive, drawing on published examples and available literature rather than primary comparative research.

Despite these limitations, the triangulation of the evidence across all the sources provides weight to the key findings and conclusions.

Annex B: Survey of probation professionals

Context

An SFO staff survey was undertaken to provide evidence for the 2024 HM Inspectorate of Probation SFO Annual Report and this research project into building a culture of learning from SFOs.

Approach

The survey was designed by the Inspectorate's researchers and SFO inspection colleagues. The survey consisted of twenty-five questions using 11-point scales, sometimes with accompanying text boxes to allow respondents to briefly explain responses.

The survey was designed in the *Alchemer* online survey app. Regional Probation Directors were asked to cascade the survey weblink and accompanying invitation letter and information sheet to probation professionals. The survey letter indicated that the target audience was 'frontline probation practitioners'.

The survey ran from 25 July to 23 August 2024. There were **245** completed survey responses. We banded responses to the 0-10 scale as follows: 0-3 negative; 4-6 no strong opinion; and 7-10 positive. The respondent narratives were read, analysed and coded in *nVivo* to identify key themes.

Headline findings

The majority of the respondents had direct experience of an SFO, whether as the probation practitioner managing the case (44 per cent), their line manager (14 per cent), or as a colleague (7 per cent). Findings from the banded questions are set out in Tables B1 (questions for all respondents) and B2 (questions for practitioners and line managers with direct experience of an SFO review)

As shown, 39 per cent of all respondents were not satisfied that SFO reviews were helpful (with 30 per cent responding positively) and 45 per cent did not believe that there were sufficient opportunities for staff to learn from SFO reviews (with 23 per cent responding positively). Of those with direct experience of an SFO review (as practitioner or manager), 58 per cent did not believe there was a sufficient learning opportunity for the team as part of the process (with 15 per cent responding positively).

Table B1: SFO survey responses – all respondents (max n=244)

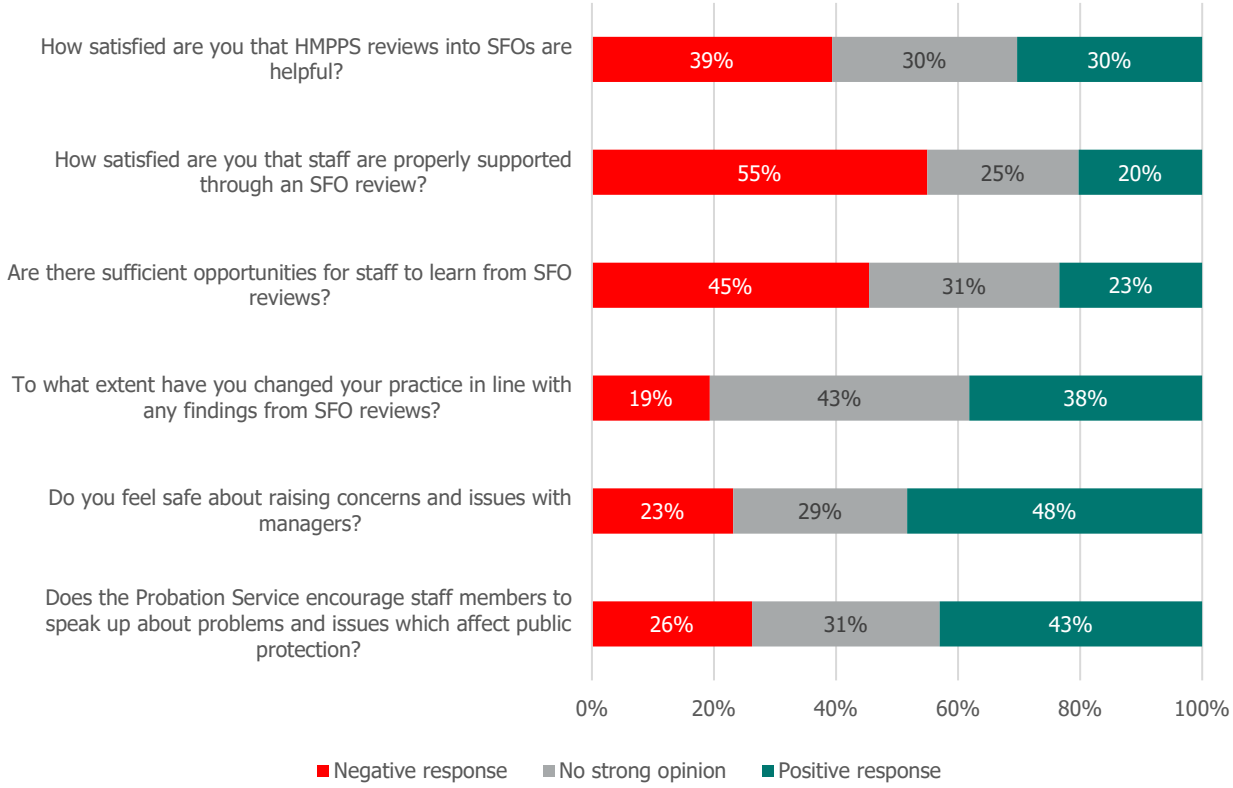
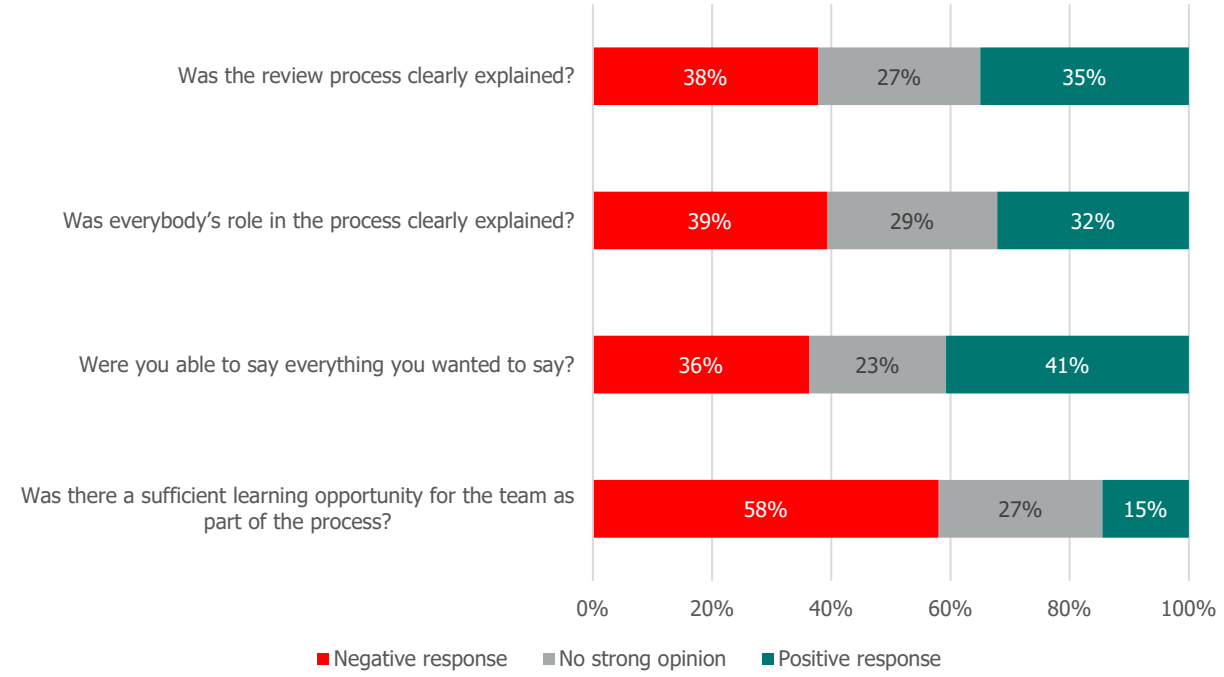


Table B2: SFO survey responses – SFO case practitioners and managers (max n=140)



Respondents were asked to write about their reflections of SFO reviews and learning from SFOs. These were the recurring themes from these testimonies:

- fear about the prospect of an SFO occurring within their caseload
- anxiety and stress about the process and implications of a SFO review
- anger about the blame culture in probation and the interrogatory nature of SFO reviews which responsibilises the individual probation practitioner for organisational failures in resourcing and management
- concerns about the lack of transparency in SFO reviews, with a lack of explanation of the process, and especially about not being allowed to see the full SFO report
- disappointment at the loss of the opportunity to learn from SFOs due to the lack of transparency and blame culture
- concerns about the lack of emotional and practical support from managers and senior leaders during the SFO process
- the negative impact of SFO reviews on team morale and increased workload for colleagues following the SFO report actions
- the lack of realism in SFO reviews, especially the emphasis on the impact of minor administrative errors and omissions which could not have affected the incident, the irrelevance of many post-review actions, and the failure of SFO reviews to address caseload and workload issues.

There were, however, many examples of positive experiences in the SFO review process. These included:

- supportive managers, leaders, and colleagues in the aftermath of an SFO and during the SFO review process
- practitioners learning from SFOs and improving their professional practice following SFO reviews
- practitioners receiving empathy, support and encouragement from SFO review managers.

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