Inspection of
Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

HM Inspectorate of Probation
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Chair of Brighton & Hove YOS Management Board
Brighton & Hove City Council, Brighton & Hove Youth Offending Service

28th November 2012

Dear Chair,

Report of Short Quality Screening (SQS) of youth offending work in Brighton & Hove

This report outlines the findings of the recent SQS inspection, conducted during 05th-07th November. We carried this out as part of our programme of inspection of youth offending work. This report will be published on the HMI Probation website. A copy will be provided to Ofsted to inform their inspections, and to the Youth Justice Board (YJB).

Context

As an independent inspectorate, HMI Probation provides assurance to Ministers and the public on the effectiveness of work with those who have offended or are likely to offend, to promote continuous improvement by the organisations that we inspect and contribute to the effectiveness of the criminal justice system.

Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. The purpose of the SQS inspection is to assess the quality and effectiveness of casework with children and young people who have offended, at the start of a sample of 20 recent cases supervised by the Youth Offending Team. Wherever possible this is undertaken in conjunction with the allocated case manager, thereby increasing the effectiveness as a learning opportunity for staff.

We gather evidence against the SQS criteria, which are available on the HMI Probation website http://www.justice.gov.uk/about/hmi-probation

Summary

Overall, we found a varied picture at Brighton & Hove Youth Offending Service (YOS). The enthusiasm of case managers was a key asset and there was evidence of some highly competent work and effective joint working. However, there were substantial shortfalls in relation to the YOS's management of risk of harm to others, and management oversight arrangements were not effective in improving performance in this area or in ensuring the quality of safeguarding work.

Commentary on the inspection in Brighton & Hove:

1. Reducing the likelihood of reoffending

1.1. We look to see if the assessment as to why this child or young person has offended at this time is good enough. In three-quarters of the 20 cases we looked at, it was. For those where we found gaps, the case manager had not identified relevant diversity

factors, or had not used information from another agency or had not referred the child or young person on to others for specialist assessments, for example, health, education, etc.

1.2. Pre-sentence reports (PSRs) were provided to the court for ten cases. Local management arrangements were effective in ensuring the quality of these in almost every relevant case, and most were of good quality.

1.3. Most sentence plans were done on time and were of a good enough standard, especially for custody cases. In four community cases, there was no initial sentence plan. In most instances sentence plans took the form of paper templates, completed by hand from the perspective of the child or young person. This approach is to be commended in that it encouraged engagement but, in most instances, it did not provide all the information necessary for effective planning.

1.4. Children and young people's lives change very quickly and so their circumstances need to be reviewed on a regular basis. Just over two-thirds of the reviewed assessments and plans had been completed well enough in the cases we inspected. Significant events did not always trigger a review and some were copies which failed to reflect important new information and prompt the implementation of relevant interventions.

2. Protecting the public

2.1. We expect to see a clear, relevant and comprehensive assessment of the risk of harm a child or young person poses to other people at the time of their sentence. We found that this had happened in most of the cases where a PSR had been prepared for the court. However, assessments prepared after sentence were not as good. We were satisfied with the overall standard of the assessment of the risk of harm to others in just over half the cases we looked at. In several, the assessment lacked both detail, such as the inclusion of previous behaviour and relevant information from other agencies, and the essential analysis. As a result, some key triggers and motivators relating to offending, and the potential for further harm to others, were not always identified. We were pleased to note, however, that we agreed with the Risk of Serious Harm (RoSH) classification for all but one case.

2.2. Having assessed the risks, the YOS should put plans in place to address them. We found that initial planning was sufficient in custody cases but that effective initial planning had taken place in fewer than half the community cases we looked at. Some plans lacked the objectives and details to adequately support intervention work or were not clear about when and how these would be implemented.

2.3. Risk of harm is dynamic in nature and needs to be continuously reviewed. Of the cases where this should have happened (14), only half had been reassessed well enough. Planning had been reviewed to a sufficient standard in only slightly more (nine cases).

2.4. Taking account of the needs of victims is not only crucial in helping to keep them safe but also plays an important role in reducing the risk of harm children and young people pose. We found this was not happening as often as it should have been; we expected to have seen evidence that the risk of harm to victims was being effectively managed in 18 of the cases we looked at but found it in only eight.

3. Protecting the child or young person

3.1. In many cases, children and young people who offend will present issues relating to vulnerability and/or safeguarding which need to be properly assessed and planned for. We found that assessments prepared for court, pre-sentence, were more likely to be of good quality than those written at the beginning of the sentence. However, overall, there

had been sufficient assessment of vulnerability and/or safeguarding needs in fewer than three-quarters of the cases we looked at and assessments had been reviewed in less than two-thirds.

3.2. There had been effective planning to address vulnerability and/or safeguarding, and reviews of plans, in about three-quarters of the cases we looked at, with all plans being completed sufficiently well during the custodial phase of the sentence.

4. Ensuring that the sentence is served

4.1. We expect to see the YOS doing what it can to help children and young people complete their sentences successfully. This will include engaging them and their parents/carers in the assessment and planning processes, identifying and addressing barriers to engagement, and putting measures in place to ensure they comply with the requirements of their sentence.

4.2. Diversity issues and other potential barriers to engagement had been assessed sufficiently well in three-quarters of the cases we looked at and included in the majority of plans. In a couple of cases, the YOS's management of diversity issues had been excellent.

4.3. The extent to which the child or young person and their parents/carers had been engaged by the case manager was variable, with better engagement at the assessment stage than with the planning process.

4.4. Most children and young people complied with their sentences. About half of those who complied suffered some initial setbacks; many were helped back on track by action taken by the YOS.

Operational Management

There had been changes in staffing, including line management, at the YOS in recent months. This had led to gaps in management oversight which coincided with the timeframe of our inspection case sample. There had also been a lack of consistency for some children and young people in who was managing their case. While a change in case manager had led to improvements in the handling of the case in some instances, in at least one case this had had a negative impact on the experience of the child or young person.

We found that there was a variation in the levels of understanding of the members of the YOS staff interviewed about the principles of effective practice and local policies and procedures. In our view, two thirds understood the principles of effective practice, local policies and procedures in relation to safeguarding and half in relation to promoting engagement and responding to non-compliance. One-third understood local policies and procedures for the management of risk of harm.

There were mixed views from the YOS staff interviewed about how well the organisational culture promoted training and development. Some explained that the ongoing restructuring process had had a negative impact on this as they were unsure about their future in the YOS.

Overall, case managers[1] felt that their line managers had, and used sufficiently, their skills and knowledge to assess, and help them improve, the quality of their work. One-third of those interviewed felt they could describe the countersigning/management oversight of their risk of harm and safeguarding work as an active process and, again, one-third felt they had effective and appropriate supervision. Although the numbers interviewed were small, this means that a worrying proportion felt they were not receiving important aspects of management support. Most advised

[1] We interviewed six case managers and one senior practitioner during the inspection, six of whom provided their views about organisational support and culture.

that they valued the chance to reflect on, analyse and receive feedback on their cases, but demonstrated little awareness or appreciation of the YOS management's recently introduced practice meetings which could offer some of these opportunities.

Management oversight plays an essential role in ensuring that where risk exists in a case, it is properly managed. It can take the form of one-to-one sessions between a case manager and their manager, a wider meeting with internal colleagues or with external partners, or the implementation of sound quality assurance processes. We looked for evidence that, where relevant, management oversight had been effective in ensuring the quality of work to address risk of harm to others, vulnerability and safeguarding. We found that a considerable number of cases had not been sufficiently overseen and, in most of these, this had led to deficiencies in the case manager's assessment and/or planning not being addressed. In some relevant cases, there was no evidence that there had been any oversight at all.

Outstanding strengths

The following were particular strengths:

- The YOS's staff were committed to engaging with the children and young people whose cases they managed, knew their current issues in depth and worked hard to help them progress through their sentences. Above all, they retained the belief that the children and young people they worked with could change.
- We found cases in which YOS workers had given particular attention to diversity needs. In one, having identified that a consistent approach would help to improve the engagement of the young person, the YOS worker ensured that appointments were set at the same day and time each week, and that the same interpreter attended to support the young person. In another case, the YOS worker demonstrated a high level of understanding of the speech, language and communication needs of the young person, referring to educational psychology and consequently employing a range of visual interventions to explore factors which could be associated with his offending behaviour.
- The YOS demonstrated that it was capable of excellent standards of joint working. In a complex case, the YOS's assessment of the young person was comprehensive, drawing on information from other agencies to provide appropriate detail and analysis. The Multi-Agency Public Protection Arrangements framework was used well to facilitate effective multi-agency working, taking account of the diversity needs of the young person and ensuring his smooth transition to probation services.

Areas requiring improvement

The most significant areas for improvement were:

i. the assessment of risk of harm to others (which in many cases lacked sufficient detail and analysis),

ii. deficits in planning in community sentences to address the risk of harm to others (with some not supported by specific details as to how to prevent that child or young person hurting others),

iii. reviews of assessments and plans, as a considerable proportion were not reviewed sufficiently well,

iv. insufficient attention to victims and potential victims, during the assessment and planning stages,

v. management oversight, including supervision and quality assurance arrangements.

We strongly recommend that you focus your post inspection improvement work on those particular aspects of practice.

We are grateful for the support that we received from staff in the YOS to facilitate and engage with this inspection. Please pass on our thanks, and ensure that they are made fully aware of these inspection findings.

If you have any further questions about the inspection please contact the lead inspector, who was Vivienne Clarke. She can be contacted on 07795 306910 or by email at vivienne.clarke@hmiprobation.gsi.gov.uk.

Yours sincerely,

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YJB links with HMI Probation
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