Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
HM Inspectorate of Probation
1st Floor, Manchester Civil Justice Centre, 1 Bridge Street West, Manchester M3 3FX
0161 240 5336 - www.justiceinspectorates.gov.uk/hmiprobation

To:	Sara Williams, Chair of Brent YOS Management
Copy to:	See copy list at end
From:	Julie Fox, HM Assistant Chief Inspector
Publication date:	28th May 2014

Report of Short Quality Screening (SQS) of youth offending work in Brent

This report outlines the findings of the recent SQS inspection, conducted from 28th-30th April 2014. 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 partner inspectorates 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, promotes continuous improvement by the organisations that we inspect and contributes 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 this inspection was to assess the quality and effectiveness of recent casework with children and young people who had offended. In order to do this, we examined 19 cases supervised by Brent Youth Offending Service (YOS). Wherever possible this was 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 - www.justiceinspectorates.gov.uk/hmiprobation

Summary

Overall, we found that the YOS had worked conscientiously since the last inspection by HMI Probation in December 2011 and had improved their performance. Staff engaged well with children and young people and their parents/carers to develop initial assessments. Planning to address safeguarding and vulnerability during the custodial phase of the sentence was good and in the community, enforcement action was taken appropriately when required. Objectives set in intervention plans were not outcome focused, individualised or written in child friendly language. A focus needs to be given to the timely review of assessments and plans when there is a significant change. Additionally, managers need to ensure that work to address safeguarding and vulnerability is of a sufficient, consistent quality.

Commentary on the inspection in Brent:

1. Reducing the likelihood of reoffending

1.1. The initial assessment of the child or young person's likelihood of reoffending was sufficient in 13 out of the 19 cases in the sample. In most cases the case manager had appropriately assessed the impact of the child or young person's lifestyle on their offending. Similarly, substance misuse issues were assessed well. However, family and personal relationships, employment, training and education assessments as they related to reducing reoffending needed greater and closer examination. Furthermore, offending related vulnerability was often missed and information held by others was not consistently accessed.

1.2. Pre-sentence reports (PSRs) were provided in 13 cases, of which 10 were judged to have been of a good standard and containing an appropriate proposal that was presented well. Arguments against the imposition of a custodial sentence were consistently strong, where this was appropriate. In all the three PSRs where the quality was insufficient this was due to the report writer not adequately taking into account issues of risk of harm and vulnerability. Overall, we felt that management arrangements had been effective in ensuring the quality of the vast majority of PSRs.

1.3. Planning for work to reduce reoffending was sufficient in just over three-quarters of the cases inspected. Areas of work to reduce the likelihood of reoffending had been largely identified. Whilst this is encouraging, objectives in the plans were not outcome focused and written in words meaningful to children and young people. It was often not possible to see from the objectives what changes needed to be made and what progress would look like. A robust plan should also show *how* the objectives will be achieved and the part the child or young person, YOS staff and others will play in achieving outcomes.

1.4. The personal circumstances of most children and young people can change very quickly. As a result, assessments need to be reviewed as different situations arise. We considered that reviews of plans to reduce the likelihood of reoffending had not been done well in 5 out of 14 cases where this was required. These (five) plans were either not done on time or contained significant gaps about personal changes and circumstances.

2. Protecting the public

2.1. Where a child or young person presents a risk of harm to others, we expect to see evidence of this being identified and a plan put in place to manage that risk. In almost three-quarters of cases this assessment was clear and thorough. This established a good foundation for the development of risk management plans. An inspector noted: *"The plan to manage risk was of an exceptional quality and needed to be, given his very high risk of serious harm and high vulnerability. In particular, the case manager had paid attention to contingency planning such as how to manage any potential breaches of exclusion zones. There were several agencies and staff working with the young person and their details had been included in the plan. Interventions were sequenced well, considered the level of dosage and priority to manage the potential for harm"*. Where there were gaps in managing risky situations these mostly arose when relevant behaviour was not given the required focus and the assessment did not make use of information held by other agencies.

2.2. Reviews of the assessment of risk of harm during the course of the sentence were not done well in almost half the cases where this was required. This was disappointing for it demonstrated inconsistencies. Again in these instances, reviews were not undertaken

following a significant change, they were often not timely and sometimes not done at all. Conversely, when they were undertaken they were done very well.

2.3. Planning for work to address risk of harm to others at the start of the sentence was sufficient in three-quarters of relevant cases. This followed a clear and thorough assessment of the risk of harm to others in just over three-quarters of the PSRs inspected. We were also encouraged to see that in four out of the five custodial cases inspected there were good plans in place for work to address risk of harm to others.

2.4. Our inspection of reviews of plans to manage and reduce risk of harm showed some inconsistencies. These reviews were acceptable in 8 out of 12 cases. The main deficit in the four cases was that the reviews were not of a good quality. There was insufficient analysis of all the information available leading to gaps in identifying actions to reduce the risk of harm to others.

2.5. Effective management oversight to ensure the quality of risk of harm work was evidenced in half of the cases where this was required. This demonstrated that some managers were able to provide timely and appropriate oversight and address deficiencies whilst others did not.

2.6. We also considered how well the risk of harm to identifiable victims was being managed. This had been done well in only one-third of relevant cases. Whilst there was some evidence of victim empathy work and letters of apology being written by the child or young person, we were not satisfied that victims had been systematically identified, the risks assessed and plans put in place to protect them.

3. Protecting the child or young person

3.1. The initial assessment of vulnerability and safeguarding was done well in 12 out of the 19 cases in the sample with 7 not being done well for a range of reasons. Not all vulnerability factors were consistently recognised to form a robust assessment to aid planning. Examples of factors that had been missed in one or more cases included information in specialist reports about engagement, physical health, the impact of not attending school and association with adult offenders.

3.2. Reviews of assessments relating to safeguarding and vulnerability were insufficient in 6 out of 15 cases where these were required. The gaps in the six cases primarily occurred because reviews had not been done on time and had not been undertaken following an important change in circumstances. In one case an inspector noted: *"The young person's entry into custody did not trigger a review of the assessment"*.

3.3. As identified in the previous section, these omissions were not identified through management oversight procedures. As a consequence they were not effectively challenged or rectified. Of 11 relevant cases we found that more than half did not have the required level of intervention from managers to ensure the quality of work to address safeguarding and vulnerability.

3.4. Case managers clearly understood local policies and procedures for the management of safeguarding but we did not find evidence of this being demonstrated consistently.

3.5. We were pleased to find that in all four custodial cases there was an appropriate level of planning in place for work to address safeguarding and vulnerability. Case managers had contributed to the custodial plan, the custodial institution had been notified of the safeguarding and vulnerability needs, and plans had been prepared on time.

4. Ensuring that the sentence is served

4.1. It is essential that children and young people and their parents/carers or significant others are actively involved in the development of assessments in order to motivate effective engagement in future work. This was done well and is a clear strength in the Brent YOS. Children and young people were seen alone during the course of the initial assessment and the views of their parents/carers were included in assessments. Encouragingly, there was clear evidence in the development of every PSR that the report writer had engaged the child or young person and their parent/carer.

4.2. The YOS had clear expectations on PSR writers to share and explain the content of reports to children and young people and their parents/carers prior to their sentencing date. We were pleased to find evidence of this having taken place.

4.3. Case managers gave appropriate attention to barriers to engagement and other diversity or potential discriminatory factors at the initial planning phase of the sentence in the large majority of cases.

4.4. Case managers gave sufficient attention to health and well-being outcomes, specifically where they may act as a barrier to a successful outcome from the sentence in over three-quarters of the cases.

4.5. In just over half of the cases, children and young people complied with the requirements of their sentence, some after initial difficulties. This was an encouraging outcome for it demonstrated the dedication of case managers, given the hectic lives of many of the children and young people and the environment in which they were growing up. It was pleasing to see that when enforcement action was required it was carried out appropriately in every case. In a number of cases the enforcement action led to the child or young person re-engaging with the requirements of their sentence. This supported the finding that all staff interviewed had a sufficient understanding of local policies and procedures for enabling effective engagement and responding to non-compliance. One inspector said: *"the case manager successfully engaged the young person by following enforcement procedures closely and making these procedures explicit to the young person. When the young person missed an appointment due to illness, for example, she asked him to provide a sickness certificate from his doctor in the following session. This ensured that the young person was mindful of the importance of keeping his appointments".*

Operational management

Staff had a good understanding of local policies and procedures and of the principles of effective practice with children and young people who have offended. They expressed confidence in their manager's knowledge to assess their work, support them in their work and guide them in improving the quality of their work. However, two of the case managers commented that supervision was not regular and was often cancelled. This would support our finding that staff supervision had not made a positive difference in a third of the cases. Case managers described the countersigning and management oversight as largely effective but there was some evidence to suggest that management instructions were often not followed up. This meant that actions to rectify deficiencies were not monitored effectively.

It was encouraging to find that seven out eight staff interviewed were clear about how the organisation's priorities affected their role. They were not unanimously satisfied that there was a positive culture to support learning and development in the organisation. They identified the need for more up to date training in diversity and recognising and responding to speech, language or communication needs.

Key strengths

- Children and young people and their parents/carers were involved in initial assessments and the development of PSRs.
- Planning for work to address safeguarding and vulnerability during the custodial phase of the sentence was good.
- Enforcement action, when required, was appropriately taken in every case.

Areas requiring improvement

- Objectives in intervention plans should be outcome focused, individualised to the assessed needs of the child or young person and written in child friendly language.
- Reviews of assessments and plans should be completed when required, especially in response to significant change.
- Managers should consistently ensure that work to address safeguarding and vulnerability is of a sufficient quality.

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 Avtar Singh. He can be contacted at avtar.singh@hmiprobation.gsi.gov.uk or on 077969 48325.

Copy to:

YOS Head of Service	*Angela Chiswell*
Local Authority Chief Executive	*Christine Gilbert*
Director of Children's Services	*Sara Williams*
Lead Elected Member for Children's Services	*Michael Pavey*
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