To: Shafique Shah, Chair of Birmingham YOS Management Board
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From: Alan MacDonald, Assistant Chief Inspector (Youth Justice)
Publication date: 17 February 2016

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

The inspection was conducted from 25-27 January 2016 as part of our programme of inspection of youth offending work. This report is 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

The aim of the youth justice system is to prevent offending by children and young people. Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. We examined 47 cases of children and young people who had recently offended and were supervised by Birmingham Youth Offending Service (YOS). Wherever possible, this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

The published reoffending rate\(^1\) for Birmingham was 30.7%. This was better than the previous year and better than the England and Wales average of 37.9%. Overall, we found some work of good quality in the YOS. Staff were well engaged with the children and young people under their supervision, and their parents/carers, and were working effectively with other agencies involved with their cases. There was scope for improvement, particularly in the planning and review of the work to address the risk of harm to others and the safeguarding and vulnerability of the children and young people.

Commentary on the inspection in Birmingham:

1. Reducing reoffending

1.1. We considered that sufficient advice had been provided to the court in passing sentence in the large majority of the cases we inspected. In three-quarters this was in the form of a full length pre-sentence report (PSR). Almost all of the PSRs were of a good standard, and where relevant paid sufficient attention to appropriate alternatives to custody. In some cases where the child or young person was already subject to supervision a report prepared for a previous occasion was used, while in others the court was provided with a breach report or a verbal update. In seven cases there was no record of any information being provided.

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\(^1\) Published October 2015 based on binary reoffending rates after 12 months for the January 2013 – December 2013 cohort. Source: Ministry of Justice
1.2. We were pleased to see that children and young people, and their parents/carers, were involved in the preparation of their PSR in all but two cases, and almost all reports paid sufficient attention to diversity factors and potential barriers to engagement.

1.3. The quality of reports provided to youth offender panels in the referral orders we inspected was also of a high standard. However, we were concerned that while some initial panel meetings were held promptly following sentence, others were delayed by several months. A shortage of panel members and availability of venues were contributory factors to delays. In at least one case contact was started prior to the panel meeting.

1.4. There was an assessment of why the child or young person had offended in every case we inspected, and in more than three-quarters these were of sufficient quality. The largest area for improvement was in the assessment of the child or young person’s lifestyle, their perception of themselves and others, and their thinking and behaviour. In these areas some assessments contained unclear or insufficient evidence.

1.5. Planning for work in the community to prevent reoffending was insufficient in almost one-third of cases. In some cases no intervention plan had been completed. In others the plan was not sufficiently focused on the assessed needs of the child or young person, or on preventing their reoffending, particularly by helping them with education, training and employment (ETE).

1.6. There was insufficient review of the assessment to prevent reoffending in more than one-third of cases, and of the intervention plan in more than one-quarter. Often this was because assessments and plans had not been reviewed following a significant change in circumstances. However, we saw examples of effective joint working and information sharing with other agencies, particularly some good use of information from the police.

1.7. Thirteen cases in our sample were subject to custodial sentences. In some we were pleased to see good joint working between the YOS case manager and the institution, with joint planning meetings taking place and good levels of contact between the case manager and the child or young person and custody staff. However, in nearly half of the cases there was insufficient planning during the custodial phase of the sentence for work to reduce reoffending. In three cases a custodial sentence plan had not been produced.

1.8. Overall, we assessed that one-third of the children and young people were less likely to reoffend than at the start of their sentence, and only four were more likely to reoffend. In other cases we thought the likelihood was unchanged, or it was too soon to be able to make a judgement.

2. Protecting the public

2.1. The work to understand and explain the risk of harm to others posed by the child or young person was of sufficient quality in most of the cases we inspected. However, planning to manage the assessed risks was insufficient in more than one-third of relevant cases. Areas for improvement included specifying planned responses more clearly, and taking greater account of contingencies. Risk management plans were often too generic and not detailed or specific enough. In five cases no plan had been completed. For those serving custodial sentences, planning for work to address risk of harm to others while in custody was insufficient in nearly one-third of relevant cases.

2.2. We saw some cases that had been wrongly identified as eligible for Multi-Agency Public Protection Arrangements (MAPPA), but others had been correctly referred. Our sample included two cases being managed at MAPPA level 2, of which one required better engagement in the process by the case manager.
2.3. Where there was an identified or potential victim, there was sufficient evidence that the risk of harm they faced had been effectively managed in more than three-quarters of the cases. However, where required the ongoing review of risk of harm to others was insufficient in more than one-third of the cases, and the review of planning to manage risk of harm was insufficient in one-third. In some cases assessments and plans were not reviewed following a significant change in circumstances, and in others the reviews were not of a sufficient quality.

2.4. We were pleased to find that management oversight was clearly recorded in case contact logs. However, we assessed that oversight had been ineffective in ensuring the quality of work to address risk of harm to others in almost half of the relevant cases, primarily because the deficiencies in assessment and planning had not been rectified.

3. Protecting the child or young person

3.1. A considerable proportion of the children and young people in our sample were considered vulnerable. During the period inspected ten had been a Looked After Child (via section 20 or care order) and two had been remanded to local authority accommodation.

3.2. There was sufficient assessment of safeguarding and vulnerability in more than three-quarters of all the cases we inspected. However, in one-sixth of cases the screening or assessment of vulnerability was insufficient. The most significant areas of vulnerability where more attention had been required were in relation to emotional and mental health, living and parenting arrangements, and substance misuse.

3.3. Planning to manage safeguarding and vulnerability was insufficient in nearly half of the relevant cases, either because a vulnerability management plan was not completed, or the planned responses to vulnerability were insufficient. Key areas requiring more attention were emotional and mental health, living and parenting arrangements, ETE, and substance misuse. As with risk management plans, vulnerability management plans were sometimes too generic and not detailed or specific enough. For those serving custodial sentences, there was evidence of sufficient planning to keep the child or young person safe while in custody in only half of the relevant cases.

3.4. Where it was necessary the ongoing review of safeguarding and vulnerability was insufficient in one-third of the cases, and the review of planning to manage vulnerability was insufficient in more than one-third. In some cases assessments and planning were not reviewed following a significant change in circumstances, and in others the reviews were not of a sufficient quality.

3.5. In line with our findings we assessed management oversight had been ineffective in ensuring the quality of work to address safeguarding and vulnerability in nearly half of relevant cases, where deficiencies in the assessment or planning had not been rectified.

3.6. Overall, the YOS gave sufficient attention to the health and well-being of most of the children and young people in our sample, in so far as these acted as potential barriers to successful outcomes from the sentence. We found that in one-quarter of the cases there had already been a reduction in factors linked to safeguarding within the first three to six months of the sentence. In many instances there was evidence of effective communication and co-working of cases with children’s services and other agencies. We were pleased to see the YOS had various review panel arrangements in place.

4. Ensuring that the sentence is served

4.1. Sufficient effort was made to identify and understand diversity factors and possible barriers to engagement in most cases, and in three-quarters the children and young
people, and their parents/carers, were sufficiently involved in the planning of their supervision. However, initial planning could have given more attention to barriers to engagement and other diversity or potential discriminatory factors in nearly one-third of cases. Often identified barriers were not addressed within the plan.

4.2. The engagement of the child or young person with the work of the YOS was maintained and/or improved in two-thirds of cases, and nearly two-thirds had complied with the requirements of their sentence. There was good use of home visiting and joint working with other agencies. Where the child or young person had not fully complied with their sentence the YOS had responded appropriately in most cases.

**Operational management**

We interviewed 33 case managers. Most spoke positively about the quality of support and supervision they received from their managers, but we met 5 staff who felt that they had not received an effective and appropriate level of supervision. Line manager absence may have contributed to this. More than half thought the culture of the organisation promoted learning and development. The large majority of the case managers thought that their training and development needs had been met in relation to their current post, and almost three-quarters that their future development needs had also been responded to.

Most case managers considered they had received sufficient training to deliver the interventions they used in their work, and all but one felt able to recognise and respond to diversity or potential discriminatory factors. In contrast, more than one-third of practitioners thought they required more training to be able to fully recognise and respond to the speech, language and communication needs of children and young people.

**Key strengths**

- PSRs and referral order panel reports, and assessments of why children and young people had offended, were of a good standard.
- Case managers demonstrated good knowledge of, and commitment to, the children and young people under their supervision.
- Good attention was paid to the health and well-being outcomes of children and young people.
- Children and young people and their parents/carers were involved in the assessment and planning of work with them.

**Areas requiring improvement**

- Staff and managers should ensure that in all cases, where required, there is sufficient planning and review of work to manage the risk of harm to others and the safeguarding and vulnerability of the child or young person.
- Managers should ensure that in all cases there is effective oversight of the quality of work to address the risk of harm to others, and the safeguarding and vulnerability of children and young people.
- The YOS should ensure referral order panels are held promptly following sentence.

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 Steve Woodgate. He can be contacted at steve.woodgate@hmiprobation.gsi.gov.uk or on 0778 994 3088.
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Note 1: 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.

Note 2: We gather evidence against the SQS criteria, which are available on the HMI Probation website - [http://www.justiceinspectorates.gov.uk/hmiprobation](http://www.justiceinspectorates.gov.uk/hmiprobation).

Note 3: To request a paper copy of this report, please contact HMI Probation Communications at communications@hmiprobation.gsi.gov.uk or on 0161 240 5336.