

# Full Joint Reinspection of Youth Offending Work in Bromley

An inspection led by HMI Probation



# Foreword

This inspection of youth offending work in Bromley is one of a small number of full joint inspections that we are undertaking annually with colleagues from the criminal justice, social care, health and learning and skills inspectorates.

We chose to undertake a reinspection in Bromley as a result of poor outcomes in their previous inspection in 2015.

The youth offending partnership in Bromley had made positive progress since the last inspection. Governance and leadership arrangements were strong. There was a high degree of visibility of, and commitment to, youth offending work within the local authority. Important foundations had been laid which should enable the further improvement and long-term stability of youth offending work in Bromley. Many aspects of case practice had improved considerably; although there was still some way to go to achieve the quality of practice that both partners and the Youth Offending Service (YOS) aspired to. The contribution of team and operational managers to developing and maintaining the quality of practice was not fully effective. We were pleased to find that work to address education, training and employment difficulties had maintained its previous high quality.

The recommendations made in this report are intended to assist Bromley YOS in its continuing improvement by focusing on specific key areas.

A handwritten signature in black ink, appearing to be 'G Stacey', with a long horizontal flourish extending to the right.

**Dame Glenys Stacey**

*HM Chief Inspector of Probation*

*June 2017*

## Key judgements



## Summary

### Reducing reoffending

*Overall work to reduce reoffending was satisfactory.* Assessments, and reports for courts and youth offender panels, were generally good. Planning for work to reduce offending required further improvement. Custodial cases needed to be treated as a single integrated sentence. The transfer of cases to or from other YOTs was not done well. Education, training and employment outcomes were good.

### Protecting the public

*Overall work to protect the public and actual or potential victims was satisfactory.* Assessment of the risk of harm to others had improved considerably. Referrals to Multi-Agency Public Protection Arrangements were made as required. The internal multi-agency risk management forum was not sufficiently effective. Management oversight arrangements were not always effective.

### Protecting children and young people

*Overall work to protect children and young people and reduce their vulnerability was satisfactory.* Many aspects of this work had improved substantially, particularly assessment and planning within the YOS, and its delivery of suitable interventions. Joint work with children's services remained inconsistent. Management oversight and the risk management forum were not always effective. The service provided by the YOS nurse was valuable and used well.

## **Making sure the sentence is served**

*Overall work to make sure the sentence was served was good.* Assessment of diversity factors was good but more attention needed to be given to plans to address barriers to engagement. Engagement with children and young people and others in assessment and planning had improved considerably. Response to non-compliance with the sentence, and to other incidents, was appropriate. The basic skills tutor service was valuable and was used well.

## **Governance and partnerships**

*Overall, the effectiveness of governance and partnership arrangements was satisfactory.* Governance and leadership arrangements were generally strong. There was good local commitment to youth offending work. A broad range of partnerships were in place. Education, training and employment partnerships were particularly effective. There were difficulties with some health related arrangements. The use of data was underdeveloped. Operational management in the YOS was not sufficiently effective. Improvement plans were ambitious and appropriate.

## **Interventions to reduce offending**

*Overall work on interventions to reduce offending was satisfactory.* When interventions had been delivered this was done well. Interventions were based on the needs of the individual case, which was a substantial improvement from the previous inspection. It was sometimes unclear what work had been delivered. Not enough effective use was made of the custodial period of sentences.

# Recommendations

Post-inspection improvement work should focus particularly on achieving the following outcomes within 12 months following publication of this report:

1. reoffending should be reduced
2. the proportion of children and young people who receive a custodial sentence should be reduced to the national average or below
3. the quality of case management practice should be improved. Case records should clearly record and evaluate work that has been completed in individual cases
4. planning for risk of harm and safeguarding work should be of good quality; as should planning to address identified diversity factors
5. managers should be effective in improving the quality of practice, providing good quality oversight, and making sure that the required services are delivered
6. joint work with children's services should protect children and young people (both those known to the YOS and others associated with them), and reduce their vulnerability. This should be supported by strong and effective escalation arrangements, with staff and managers in each organisation who understand each others work well. Children's services should make an effective contribution to the work of the Management Board and the partnership
7. assessment, planning and work to address emotional and mental health needs should be of good quality, and meet the needs of children and young people known to the YOS
8. assessment, planning and work to address substance misuse should be of good quality, meet the needs of children and young people known to the YOS, and be supported by effective partnership arrangements
9. arrangements for the transfer of cases between YOTs should secure continuity of services, the protection of the public and the safeguarding of children and young people
10. current and localised information should be developed and used to enable the Management Board to provide effective oversight, and managers to improve the effectiveness of quality assurance arrangements.

Please note – throughout this report all names referred to in the practice examples have been amended to protect the individual's identity.

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# Reducing reoffending

# 1

# Theme 1: Reducing reoffending

## What we expect to see

As the purpose of the youth justice system is to prevent offending by children and young people we expect youth justice partners to increase the likelihood of successful outcomes by undertaking good quality assessment and planning, deliver appropriate interventions and demonstrate both positive leadership and effective management.

## Case assessment score

Within the case assessment, overall 75% of work to reduce reoffending was done well enough.

## Key Findings

1. The quality of assessment was good, but not enough attention was given to reviews.
2. Reports for courts and youth offender panels were generally of good quality.
3. Planning for work to reduce offending often required improvement.
4. It was sometimes unclear what interventions had been delivered. When interventions were delivered then work in the community to reduce offending usually met the needs of the case.
5. Education, training and employment (ETE) outcomes were good.
6. Co-location of police officers in the YOS was not yet fully resolved, although progress had been made.
7. Not enough attention was given to cases being transferred into or out of Bromley.
8. Custodial sentences needed to be treated as a single integrated sentence.

## Explanation of findings

1. It is essential, in order to lay foundations for future work, that sufficient effort is made at the start of the sentence to understand why the child or young person offended, and what may help reduce that. These assessments were generally good. Case managers also described to inspectors a good understanding of the children and young people with whom they worked. Speech, language or communication factors linked to offending were not considered sufficiently. Evidence was sometimes too descriptive, with insufficient analysis of its impact. Assessment of ETE needs was good. Staff and partners made sure that comprehensive and up to date ETE information was available in the case record.
2. Pre-sentence reports (PSRs) are the main means by which the court is informed about offending and other factors to assist with sentencing. We inspected 21 PSRs. All except three were good enough. Sometimes not enough attention was given to the clarity or appropriateness of the proposal, and to including sufficient analysis of risk of harm to others. The YOS had plans to further improve the quality and conciseness of its PSRs. YOS officers in the youth court were well informed about cases that were due to appear, although at the time of the fieldwork IT access limited their ability to undertake further checks. Unusually, children and young people were not provided with details of their next YOS appointment before leaving the court.
3. All the referral order reports that we inspected were good, providing valuable information to inform deliberations at youth offender panels. There were, however, two cases where neither we, nor the case manager, were able to locate a report within the case record.



4. Not enough attention was given to reviewing assessments as required. It is important that they are reviewed post-sentence, in order to consider the child or young person's response to the sentence and any other changes that may have arisen. The lack of this was a concern. Other reviews were not timely. In some cases the need for a review following a significant change or receipt of new information had not been recognised.
5. Planning for work in the community to reduce offending was good enough in just under two-thirds of cases. In some cases a plan of work could not be found. More attention sometimes needed to be given to the impact on offending of living arrangements, family relationships, lifestyle and emotional or mental health. Not enough attention was always given to making sure that plans were reviewed, and amended as necessary, in a timely manner. The YOS nurse was the only health practitioner who was regularly involved in the planning process. Plans had a strong focus on ETE. Staff had a good understanding of the importance of securing positive ETE outcomes to help avoid offending.
6. 'Bromley Y' was a borough-wide service providing a single point of access for cases with an emotional or mental health need. It was located elsewhere in Bromley. Good work was evident once referrals had been made and an intervention started. Those we met who had attended the service valued it. Children and young people, however, regularly failed to attend.

#### **Quote from a young person about the value of counselling work**

*"I don't handle emotions very well. The YOS sent me to see a counsellor. It has helped me with managing my emotions. It has been useful."*

7. Systems to make sure that case managers were sufficiently aware of health work that had been carried out, and that this was recorded on the case record, were not always effective. Use of a confidentiality clause limited the information provided following substance misuse interventions. It was unclear why this applied. Duplication was caused by recording health information on both a medical system and the case record. There was a lack of clarity about communicating work carried out by Bromley Y to case managers.
8. Custodial sentences normally contain two phases, one in custody and one on licence in the community. These should be treated as one integrated sentence; with planning during the custodial phase reflecting the whole sentence. This was not always the case.
9. Once a plan had been produced for work in the community, interventions delivered were consistent with that plan in over three-quarters of cases. Where they were not consistent the most common concern was that it was unclear what, if any, interventions had been delivered. Where planned interventions had not been delivered there were often no clear reason given for this. Not enough attention was given to the timeliness and quality of reviews of interventions.

#### **Example of notable practice: Reparation responded to the victim's wishes**

**A**bdul stole a motorbike from someone who lived on the same estate. The victim did not wish to be involved in any direct restorative work. He was, however, concerned that parts of the estate needed tidying up. He suggested that Abdul undertook this; which he did as part of his reparation. The victim was pleased that this had improved the estate and made some recompense for the offence.

10. Inspectors formed judgements about the priorities that should have applied in each case, and whether sufficient work was undertaken in these areas to reduce offending. This was always the case with regard to children and young people's attitudes to offending and improving their motivation to change.

The areas where not enough work was done related to addressing family and personal relationships, dealing with substance misuse and addressing emotional or mental health concerns.

11. Sufficient attention was given to reinforcing positive factors in the great majority of cases. This is consistent with the latest theories about why people may stop offending.
12. An appropriate balance was usually struck between work to reduce offending, managing risk of harm to others, and addressing the child or young person's vulnerability.
13. For children and young people in custody, good collaboration with the YOS ETE team made sure that ETE planning for resettlement was prioritised well in advance of release. This work was, however, sometimes frustrated by accommodation difficulties referred to elsewhere in this report.
14. Health workers were willing to meet children or young people at locations away from the YOS, where this was appropriate. There was, however, little evidence of how well children and young people were motivated to attend those appointments that were not statutory.
15. Two full-time police officers were seconded to the YOS. They were based at the police station, although they regularly attended the YOS. This did not comply with Youth Justice Board guidance, which recommends co-location. The difficulties caused by separate locations remained outstanding from the previous inspection. The added value and skills that police officers bring to a YOS extend further than supply of intelligence on children and young people. They can, for example, include meeting children and young people to assist with boundary setting; setting standards for acceptable behaviour; conducting joint home visits; and helping to make sure that information used for breaches is suitable for use as evidence. We were told that resolution of this problem had been agreed, and awaited new IT facilities in spring 2017. Since the inspection fieldwork, the police officers have been given dedicated desks alongside YOS case managers, and begun to locate themselves in the YOS for part of the week. This was positive. There was evidence of two-way intelligence sharing, with relevant police intelligence recorded on the YOS case record, and information from case managers found on the police intelligence system.
16. Overall, work delivered in the community to address reoffending was good enough in just over three-quarters of cases. Where this was not the case, the primary cause was that it was unclear what, if any, interventions had been delivered.
17. Six cases had been transferred into or out of Bromley during the course of the sentence. Insufficient attention was given to making sure that transfers were undertaken in a smooth and timely manner, thereby providing continuity in the way services were delivered. Not enough attention was given, where another YOT was delivering services on behalf of Bromley, to making sure that work was delivered and reviewed as needed.
18. There had been a reduction in the frequency of offending in three-quarters of the cases we inspected. Sufficient progress had been made in addressing living arrangements, where inspectors assessed these as a priority, in all cases. The main areas where insufficient progress was made related to substance misuse (drugs), difficulties in family relationships and emotional or mental health problems. Inspectors judged that just over half of children and young people were less likely to offend compared to at the start of the sentence.
19. In a few cases not enough attention had been given to securing the sustainability of positive outcomes following the end of the sentence, for example through development of an appropriate exit strategy.

### **Strategy developed by a young person to avoid offending**

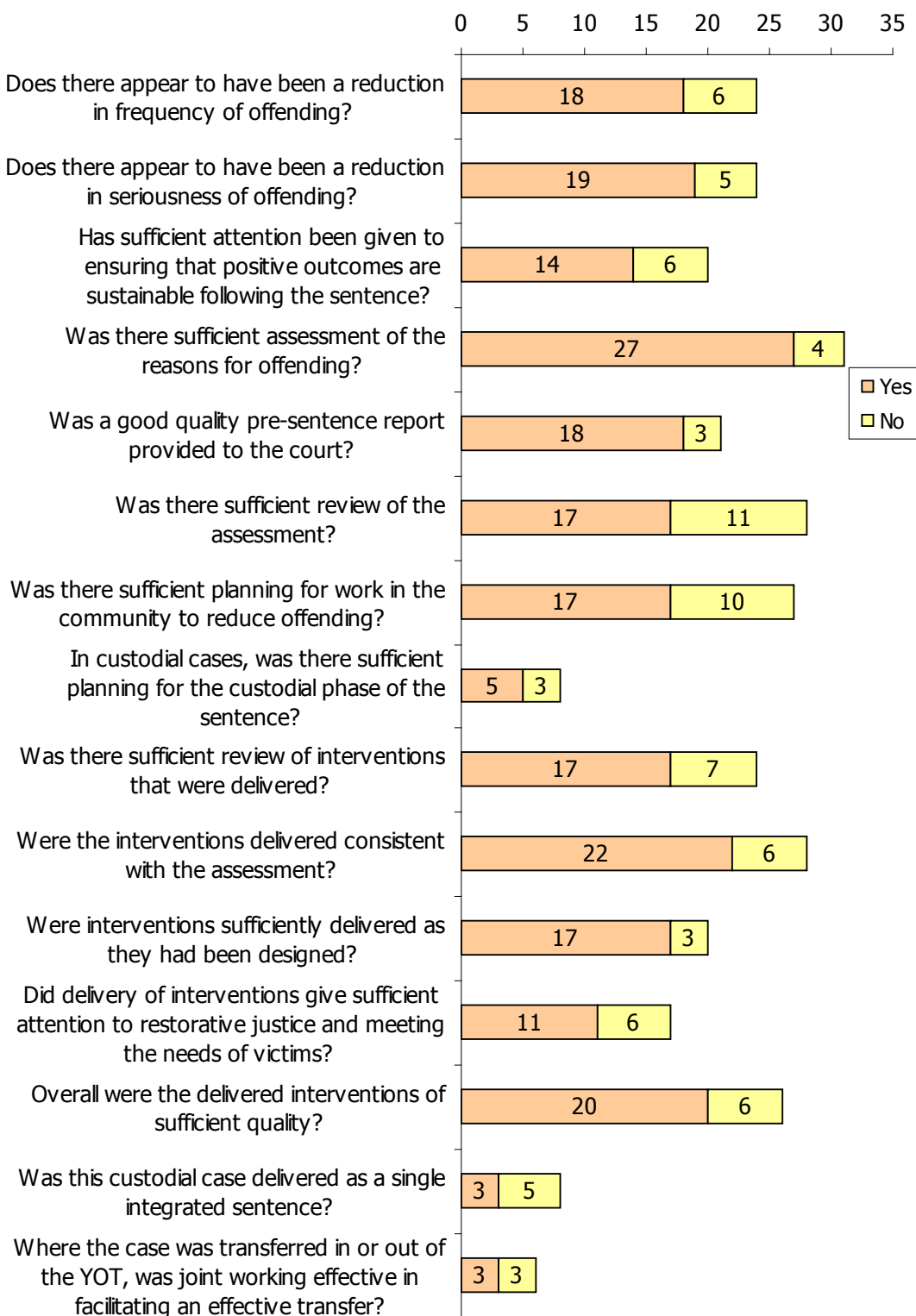
*"To stay out of trouble, so I don't bump into anyone I don't get on with and get into a fight, I get a cab everywhere. That's why I want to learn to drive."*

20. ETE outcomes for children and young people known to the YOS were good. Recent data available to Ofsted showed that the percentage in ETE at the end of their order was 87%; representing 100% of those of school age and 79% of those over 16 years old. There had been sustained improvement since the last inspection. The steady decline in the not in employment, education or training (NEET) cohort benefited from the highly effective work undertaken by the YOS NEET coordinator, as did the increasing range and breadth of bespoke provision available, which enabled good access for most children and young people supervised by the YOS.

## Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 33 cases were inspected. The total answers, however, may not equal this, since some questions may not have been applicable to every case]

### Reducing Reoffending



# Protecting the public

# 2

## Theme 2: Protecting the public

### What we expect to see

Victims, and potential victims, of crime have the right to expect that everything reasonable is done to manage the risk of harm posed by children and young people who have offended. We expect to see good quality assessment and planning, with delivery of appropriate interventions, and positive leadership, effective management and partnership work which reduces the risk of harm to others.

### Case assessment score

Within the case assessment, overall 72% of work to protect the public was done well enough.

### Key Findings

1. Assessment of the risk of harm to others had improved considerably from the last inspection.
2. Planning for work to manage the risk of harm to others sometimes needed improvement.
3. Referrals to Multi-Agency Public Protection Arrangements (MAPPA) were made as required
4. Not enough attention was given by managers to the effectiveness of oversight, nor to cases being transferred into or out of Bromley.
5. The internal risk management forum was not sufficiently effective.
6. Children and young people had a good understanding of the YOS's role to protect the public.

### Explanation of findings.

1. To help protect actual and potential victims it is important that work is informed by good assessment, at an early stage, of what harmful behaviour the child or young person may become involved in, the circumstances in which that might occur, and what may trigger that. This work was of particular concern in the previous inspection. We were pleased to find in this inspection, that the work was done well enough in over 80% of cases. Sometimes not enough account was taken of potential victims, or the assessed classification of risk of serious harm was too low. Reviews were not always undertaken as required, including immediately following the sentence. Some were not timely. Others had not been reviewed following receipt of relevant new information, or following a significant change. Case managers did not always recognise when this may be needed.
2. The assessment should be followed by a plan designed to prevent or reduce the likelihood of the circumstances occurring. Almost one-third of cases, where one was required, did not have a sufficient plan in place. In half of those a plan had not been completed; in others it was unclear. Plans produced under the Asset assessment and planning system were better than those made subsequently. Inspectors commented that some case managers did not understand how to use the AssetPlus planning tool for plans to manage risk of harm to others, and some had not recognised that plans should be completed using this tool.
3. There was sufficient review of plans for work to manage and reduce risk of harm to others in less than two-thirds of cases. In some cases the reviews were late, in some no review had been undertaken, and in others the plan had not been reviewed as required.
4. Interventions delivered to manage risk of harm to others should be consistent with both the assessment and the plan. This happened in just under three-quarters of cases. Where it did not happen planned interventions had not been delivered, with no clear reason given.

5. Overall, inspectors judged that the required interventions had been delivered throughout the sentence to manage risk of harm to others in just under two-thirds of cases. There was no clear pattern to the reasons for this.
6. YOS police officers had a good knowledge of MAPPA. They knew well the children and young people that had been referred into MAPPA. In the cases we inspected, referrals into MAPPA were appropriate; although we were concerned that managers were not always clear about MAPPA.
7. Where cases had been transferred into or out of Bromley YOS during the course of the sentence, joint working with the other YOT had been effective in securing a smooth transfer and continuity of services to address risk of harm in only two out of six cases. Managers did not give enough attention to making sure that transfers were carried out speedily and robustly, to safeguard the protection of potential victims.
8. Not enough attention was always given to managing the risk of harm to identifiable actual or potential victims. Where this was not the case it was because the risks to the victim had not been sufficiently recognised in the assessment or planning.
9. Oversight by managers of risk of harm work was effective in only about half the cases where it was required. The main reasons were that managers had either not recognised deficiencies in assessment or planning, or had not made sure that these were addressed in a timely manner. In some cases there was no evidence that oversight had been provided, even though this was required.
10. Inspectors were concerned about the operation of the internal YOS forum intended to provide multi-agency input into the management of risk of harm for those who posed a high risk of serious harm to others. Evidence from case files, observation, and discussions indicated that this was often unfocused and did not lead to clear direction or actions. There was a lack of evidence within the minutes of these meetings of a consistent holistic approach to managing the risk of harm both to and from these children or young people. Police attended these meetings and provided updated intelligence on the cases being discussed. Additional intelligence held on police systems was, however, generally only researched and provided to case managers on request. Partners from health, education, substance misuse and, until recently, children's services were often absent. The impact was that management of these risks often rested solely with the YOS, instead of being shared.
11. Children and young people we spoke to were often aware of the YOS's role in protecting the public. They understood why additional conditions had been placed on them.

### **Quotes from children and young people**

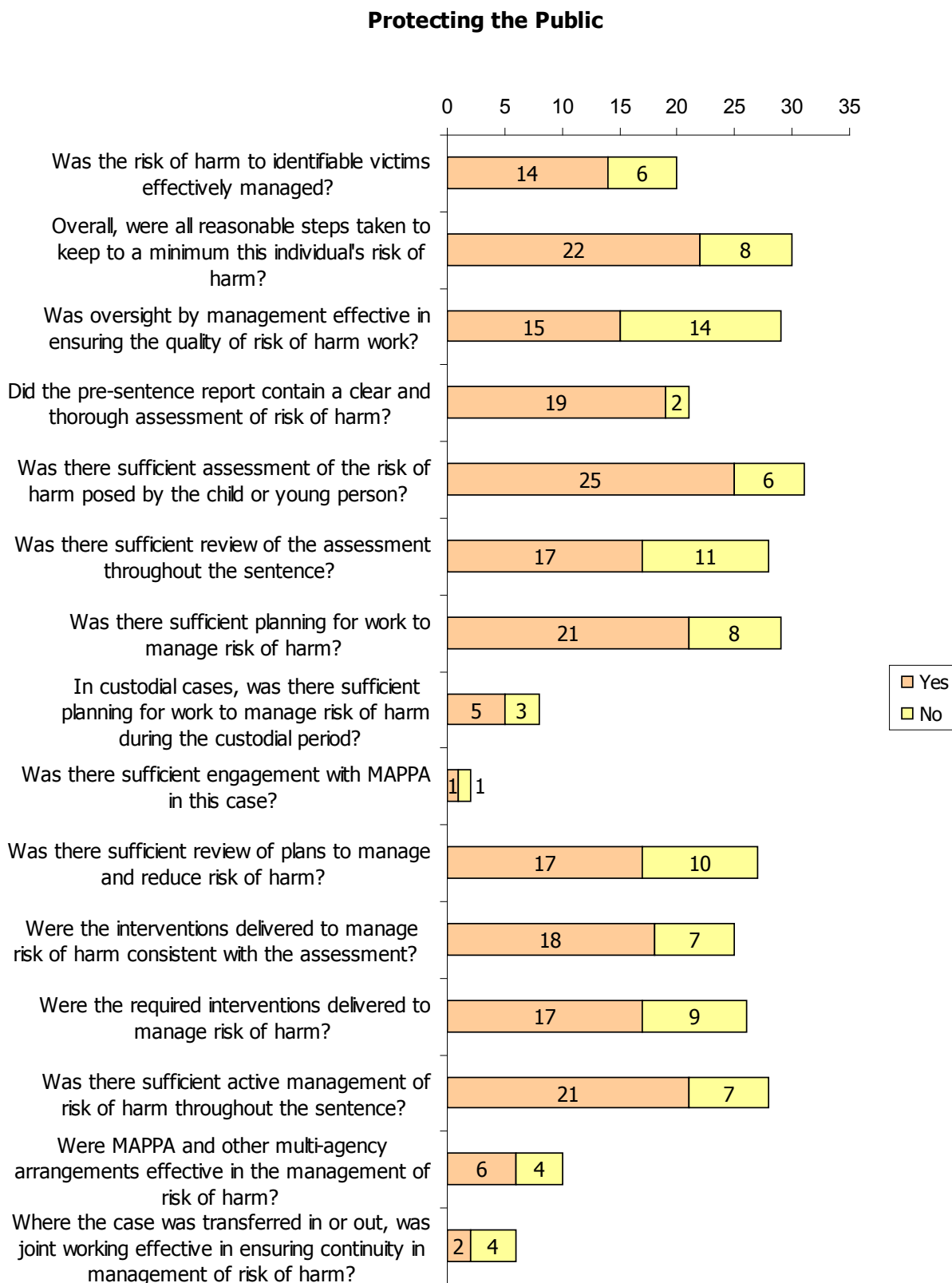
*"I have additional conditions, not to go to 'the park'; because that's where I get into trouble. They're probably right that I will get into trouble there, and I get why I have to have it as a condition."*

*"I've got a condition on my order not to talk to my old mates. That has helped me to stay out of trouble."*

*"I'm on a tag to stop me offending. It helps because I can't go out and do stupid things."*

## Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 33 cases were inspected. The total answers, however, may not equal this, since some questions may not have been applicable to every case]





# **Protecting the child or young person**

# **3**

## Theme 3: Protecting the child or young person

### What we expect to see

Whether the vulnerability of children and young people is due to the consequences of their own behaviour or the behaviour of others, we expect to see that they are kept safe and their vulnerability is reduced. This should be through good quality assessment and planning with the delivery of appropriate interventions, positive leadership and management, and an effective contribution to Multi-Agency Child Protection arrangements.

### Case assessment score

Within the case assessment, overall 77% of work to protect children and young people and reduce their vulnerability was done well enough.

### Key Findings

1. Assessment and planning within the YOS for work to safeguard and reduce the vulnerability of children and young people had improved considerably since the last inspection.
2. Joint work with children's services was inconsistent.
3. Oversight by managers, and the work of the internal risk management forum, both needed improvement.
4. The response of the YOS to referrals that were not accepted by children's services needed to be more effective.
5. Not enough use was made of home visits.
6. The YOS nurse provided an important and well used service.
7. The delivery of interventions, within the YOS, to reduce the vulnerability of children and young people had improved substantially since the last inspection.

### Explanation of findings

1. We saw some good work undertaken within the YOS intended to safeguard or reduce the vulnerability of children and young people. One young person said to us: *"I had to go to court. I thought people were after me. I told my social worker but [she] didn't do anything. I then told my YOS worker and she drove me to court, so I couldn't bump into anyone. That was a help"*.
2. There were some examples of effective joint work with social workers from children's services, in cases that reached the threshold for their involvement; but there were too many cases that did not benefit from effective joint work. The effectiveness of the interface with children's services suffered from the difficulties experienced in those services, as evidenced in the Ofsted inspection of services for children in need of help and protection, children looked after and care leavers in Bromley published in June 2016.
3. YOS case managers were invited to children's services safeguarding meetings, such as Child Protection conferences, that involved children or young people known to the YOS. They attended in each of the inspected cases where this was required; although they did not always provide a report. Distribution of the meeting minutes was not timely, which affected the ability of the YOS to make sure that plans and work were consistent.

4. Sufficient effort had been made to understand, analyse and explain the safeguarding and vulnerability needs that applied in the great majority of cases. This was substantially better than in the previous inspection. The main area for improvement was for assessments to draw adequately on information held by other agencies. YOS staff had access to the children's services electronic database. This was, however, difficult to use and key information was easy to miss, even if it was present; and not all staff used it. Insufficient consideration was sometimes given to the risks to other family members of the children and young people subject to a YOS order.
5. Reviews of safeguarding and vulnerability were not as strong as the initial assessments. Less than two-thirds of cases had reviews that were good enough. There were a number of reasons for this, which together indicated that insufficient attention was given to the often dynamic nature of safeguarding and vulnerability concerns.
6. We were particularly pleased to find that, in most cases, there was sufficient planning in place by the YOS, at the start of sentence, for work to address safeguarding and vulnerability needs. This was a substantial improvement from the previous inspection. Where this was not the case the main reason was that a plan had not been created when required. As in other areas of work, there was insufficient review of planning to address safeguarding and vulnerability needs in almost one-third of cases. This was due to a lack of timeliness, plans not being revised as necessary, and reviews not undertaken well enough. The areas in which planning could most commonly be improved were substance misuse (alcohol), care arrangements, and addressing possible emotional or mental health concerns.
7. Where referrals had been made to children's services these were often turned down, even though most were appropriate and the information provided indicated that safeguarding thresholds were likely to have been met. We were told that cases would be escalated if there was a difference of opinion on thresholds or the YOS was otherwise not satisfied with the response. This did not, however, happen in every case where it was required. The YOS did not adequately track cases that had been escalated, and so was unable to demonstrate that this work was sufficiently effective; although it was able to point to some recent cases where escalation had achieved the required outcome. YOS managers did not always understand well enough how children's social care services operated, and how best to engage with them.
8. The required interventions were delivered throughout the sentence, by the YOS, to address safeguarding and vulnerability concerns in just over three-quarters of cases. This was a substantial improvement from the previous inspection; however, in about one-quarter of cases more needed to have been done. The main areas in which not enough had been done were emotional or mental health and substance misuse (both drugs and alcohol).
9. Similar concerns were found about the effectiveness of work to transfer cases in or out of Bromley YOS as had applied to work to manage risk of harm to others, and work to secure the continuity of services to reduce reoffending. For example, in one case where the family had been relocated into Bromley due to gang concerns elsewhere, details of the gang involvement were not received until seven months after the transfer. Not enough attention had been given to making sure that this important information, that could have been vital to keeping the child or young person safe, had been received in a timely manner.
10. There were six cases where the YOS had not done enough, overall, to keep the child or young person safe, or to reduce their vulnerability; although in none of these were they unsafe at the time of the inspection. In each of these cases either planning or assessment had not been good enough.
11. Similar criticisms applied to oversight by managers, and to the work of the internal risk management forum, as applied to risk of harm work. In particular, deficiencies in planning or assessment had not been addressed as required. A representative from children's services now attended the risk management forum; although that had not been the case prior to November 2016. There was not always a clear record of actions arising from the meeting. In those cases where actions were recorded, they often mixed up important or urgent, and other actions. This could mean that the ability of the reader to recognise and focus on the most important actions was hampered.

12. All the case managers we spoke to had a good understanding of the YOS's expectations on them with regard to safeguarding and reducing the vulnerability of children and young people.
13. Infrequent use was made of home visits. These should be undertaken in all cases, as part of the initial assessment and periodically thereafter. They can provide useful context to help understand the child or young person's behaviour and circumstances. In some cases they may also have provided useful safeguarding information.
14. There were good links between the YOS and police school liaison officers. The YOS police officers had a good understanding of the warning signs of child sexual exploitation, having received a number of training sessions on this. Managers recognised that awareness of, and skills to address, child sexual exploitation issues in the YOS more generally required development. The newly formed (January 2017) multi-disciplinary ATLAS team, focusing on vulnerable children and young people in key areas including missing, child sexual exploitation and gangs, was a positive development that was expected to improve arrangements substantially, and should provide support to the YOS. The YOS was represented on the ATLAS Management Board.
15. The YOS nurse was a skilled practitioner who provided a comprehensive service which included weight management, immunisations, sexual health screening, teenage parenting and general physical health. Case managers were confident that she provided them with relevant information they may need to support their work. These services were well used.

#### **Example of notable practice:**

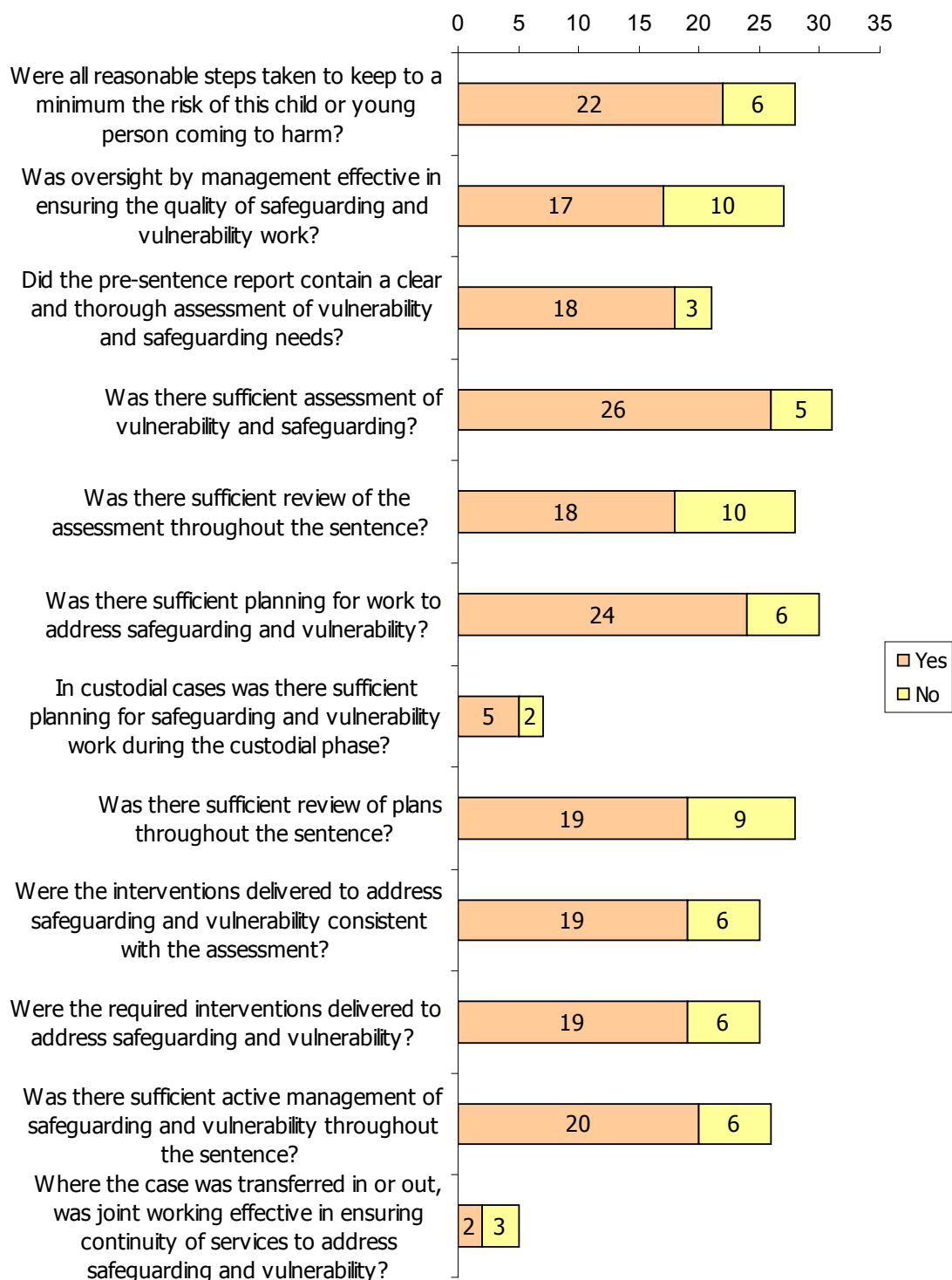
The YOS nurse, who had been paediatric trained, provided a plastic, electronic 'needs sensitive baby' to expectant YOS children and young people to help them recognise when their baby may need feeding, changing and affection. The results were effective, with young males in particular benefitting from the experience.

16. Where Child and Adolescent Mental Health Services were involved with a child or young person relevant information was shared readily. There was, however, sometimes confusion about whether children or young people referred to Bromley Y were, or were not, receiving an intervention or were still awaiting assessment due to non-attendance.
17. Safeguarding and health and safety were considered well at the point that ETE provision was being brokered. All potential placements were visited and risk assessed. Risk assessments were then undertaken by the YOS and by potential providers, including the local college, prior to each placement offer to assure the safety of the child or young person and the safety of others attending or working at the provision.

## Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 33 cases were inspected. The total answers, however, may not equal this, since some questions may not have been applicable to every case]

### Protecting the Child or Young Person



**Making sure  
the sentence  
is served**

**4**

## Theme 4: Making sure the sentence is served

### What we expect to see

Children and young people should serve their sentences as the court intends. We expect that the YOT will maximise the likelihood of successful outcomes by effective engagement with them and their families, responding to relevant diversity factors including paying attention to their health and well-being, and taking appropriate action if they do not comply.

### Case assessment score

Within the case assessment, overall 83% of work to make sure the sentence was served was done well enough.

### Key Findings

1. Assessment of diversity factors and barriers to engagement was good, but more attention needed to be given to planning to address identified needs.
2. Engagement with children and young people, their parents/carers and significant others in both assessment and planning had improved considerably since the last inspection.
3. Responses to non-compliance with the requirements of the sentence were appropriate, as were most responses to other incidents involving the child or young person.
4. The basic skills tutor service provided in the YOS was valuable and was well used.

### Explanation of findings

1. Sufficient effort had been made to identify and understand diversity factors and barriers to engagement with the work of the YOS, in almost three-quarters of cases; although more attention sometimes needed to be given to recognising and assessing the impact of race or ethnicity, and speech, language or communication difficulties. Having identified relevant diversity factors, case managers had not put plans in place to address their impact in almost half the cases where these were required; in particular to address speech, language or communication needs.

### Quote from a parent/carer

*"I have good contact with the YOS. They give me feedback, but I would like to know more as I can provide information on managing my son's risk. I would have liked more feedback in writing, because it would help keep it in my mind, and I can be more vigilant if I spot signs of offending."*

2. It was pleasing to find that there had been sufficient engagement with the child or young person, parents/carers and significant others, when undertaking assessments, in all except one inspected case. Information on the case record indicated that the child or young person and their parents/carers or significant others were sufficiently involved in planning in almost all cases. Both were substantial improvements from the previous inspection. Children and young people and their parents/carers were, however, not always sufficiently involved in the ongoing review of progress throughout the sentence. It was concerning that many of the children and young people we met, while saying that they had been involved in planning, could not explain to us what was in their plan.

3. The majority of PSRs gave sufficient attention to those diversity factors and barriers to engagement that had been identified in the assessment. We saw positive examples of the PSR being discussed with children and young people and their parents/carers; however, more attention sometimes needed to be given to making sure that they understood the PSR in advance of the court hearing.
4. Good attention was paid, overall, to health and well-being outcomes for the child or young person, in particular to the extent that these may act as a barrier to successful outcomes from the sentence, in all except one inspected case where this was required.

### **Example of notable practice: Use of meaningful language supported compliance**

**L**eigh had a history of failure to comply with her sentences. The case manager assessed that this was, at least in part, due to Leigh not understanding what was expected of her. The case manager undertook a series of appointments designed to develop objectives that Leigh understood. Once agreed these were written in words and language that were meaningful to Leigh. The simplicity of the language used helped increase Leigh's level of engagement and her compliance continued to improve. Leigh has not reoffended since being on the current order.

5. A full-time tutor was providing much needed tailored basic skills support, to improve literacy and/or numeracy skills, for an increasing number of children and young people who were hard to place. This was a relatively new post. At the time of the inspection 15 children and young people were receiving support at the YOS. Those identified as potentially NEET, and those who were not engaging in ETE, were prioritised for support. Basic skills assessments were undertaken in these instances. This was a valuable service.
6. Careers advice and guidance was readily available. This was particularly focused on those not engaging in ETE activities or who were seeking placements. Drop-in sessions were held at the local Jobcentre Plus. A small number of young people known to the YOS, including care leavers, were accessing help about potential careers opportunities and job search skills as well as benefit support.
7. Good work had been undertaken to convert statements of special educational needs to Education and Health Care plans. We found positive examples where new requests for Education and Health Care plans were supported for young people in custody.
8. Overall, enough attention was given to making sure that the child or young person engaged with the YOS, and making sure that the requirements of the sentence were met, in all except three cases. Children and young people reported that case managers supported them to attend their appointments.

### **Quote from a young person where the YOS helped them remember their appointments**

*"I get a monthly timetable that I keep in my drawer in my bedroom. They ring me to make sure I'm coming. They also text, and if I'm late they will phone."*

9. There were 14 cases where the child or young person had not complied fully with the requirements of the sentence. The response of the YOS was appropriate in all of these. In nine cases this was sufficient to get the sentence back on track. There were instances in 20 cases where the child or young person had come to the notice of the police, been breached, been convicted of a further offence, or received a custodial adjudication. The response of the case manager to these incidents was appropriate in all except four cases.

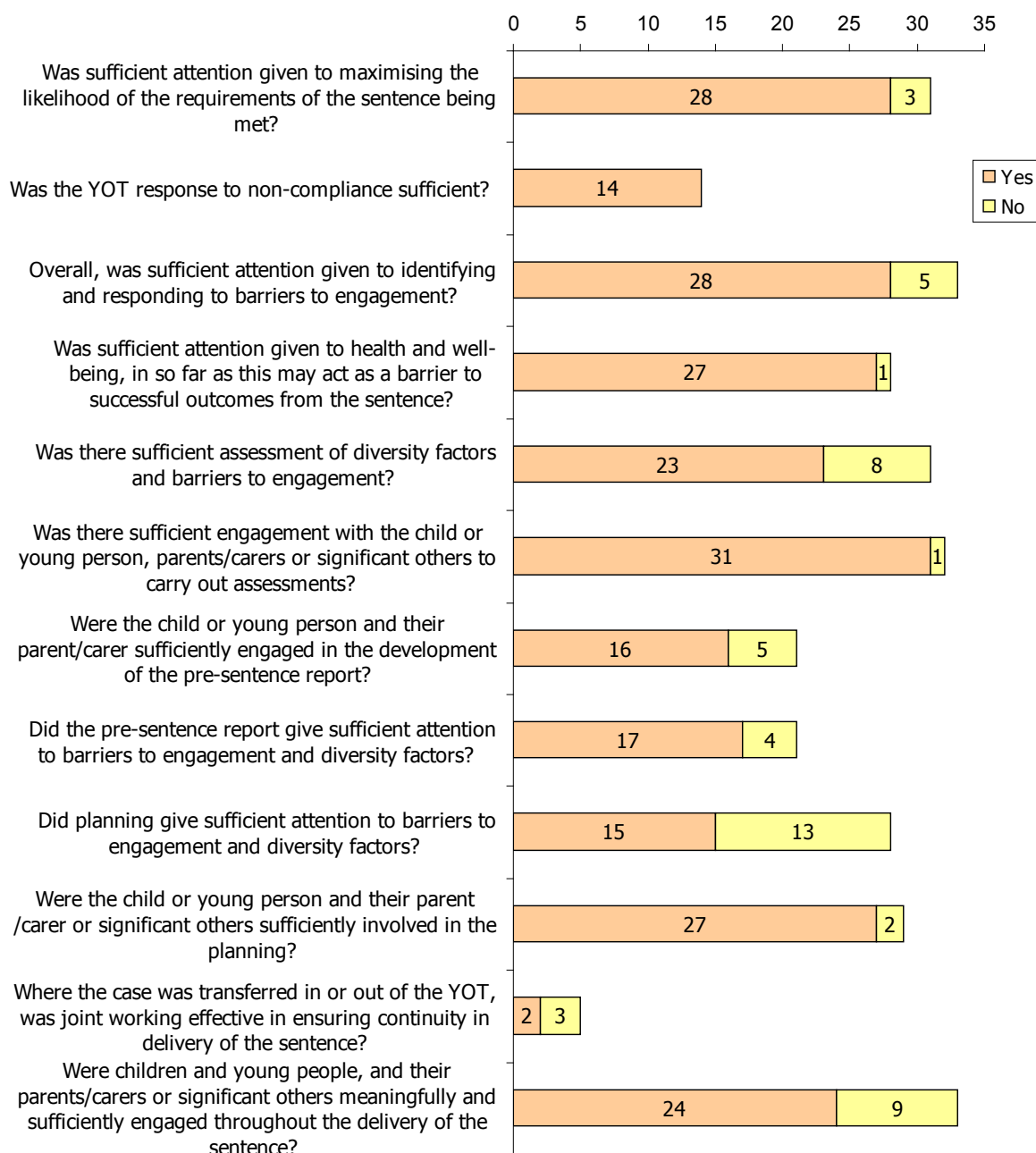


10. All case managers had a clear understanding of the YOS's expectations for supporting effective engagement and responding to non-compliance. More attention could have been given where breach had been considered, including at youth offender panels, to clearly agreeing and recording actions intended to prevent recurrence.

## Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 33 cases were inspected. The total answers, however, may not equal this, since some questions may not have been applicable to every case]

### Making Sure the Sentence is Served



# **Governance and partnerships**

# **5**

# Theme 5: Governance and partnerships

## What we expect to see

Effective governance, partnership and management arrangements are in place. These enable the YOT to meet national and local criminal justice and related objectives, and to deliver and maintain good quality services.

## Key Findings

1. Governance and leadership arrangements were strong.
2. There was good commitment to youth offending work from senior officers and councillors.
3. A broad range of appropriate partnerships were in place; although there were operational difficulties with respect to health arrangements and joint working with children's social care.
4. ETE partnerships were particularly effective.
5. Improvement plans were ambitious and broadly appropriate.
6. The use of current localised information by the Board and managers was underdeveloped.
7. Operational management within the YOS was not sufficiently effective.

## Explanation of findings

### 1. Leadership and governance – offending is reduced and other criminal justice and related objectives are met

- 1.1. The awareness of and commitment to youth offending work, at senior levels in the local authority, was impressive. The Chief Executive chaired the YOS Management Board. The elected member portfolio holder for children's services also attended. This was appropriate. The understanding of youth offending work exhibited by councillors was unusually, and impressively, high. Following the previous inspection, YOS improvement became a standing item on the agenda of the appropriate council scrutiny committee. The work of the YOS was also well linked into other local strategic forums, including the Bromley Children's Board. Despite this, both reoffending and the use of custody remained too high.
- 1.2. Progress on addressing the recommendations of the previous inspection was not initially made as fast as required. Good progress had been made over the past year.
- 1.3. The Management Board was generally well attended, by a broad range of partners. It met frequently. Children's services were notable by their absence from most meetings over the past year. Inspectors were assured that with recent changes to key senior officers that would no longer be the case. The National Probation Service was represented at meetings. Better links were required with the Community Rehabilitation Company.
- 1.4. Health partners, including the Clinical Commissioning Group, were well represented on the Board, at the correct level of seniority. They were active and were aware of the health areas which would benefit from a review of services. Membership by key strategic education leads was strong as was their attendance. The Head Teacher of the Bromley Trust Academy, as a Board member, cascaded information about the YOS to the secondary heads forum. This had helped to improve working relationships with schools.

- 1.5. The Director of Education, who had management responsibility for the work of the YOS, had a good strategic overview. She had a strong vision for the YOS and to further improve joint working. She was well placed to use her position to accelerate development through key partnership groups she chaired or attended. Her influence since she took over responsibility had been considerable.
- 1.6. There was also a separate Temporary Improvement Board. This reported directly to the Management Board and was tasked with addressing the operational performance of the YOS in response to the previous inspection.
- 1.7. The Management Board and the YOS had identified clear, appropriate and ambitious improvement priorities. These had been further developed since the recent arrival of a new head of service. She was a strong leader, was respected by staff and partners, and had rapidly developed a good understanding of the strengths and weaknesses of the YOS.
- 1.8. The development of the Management Board had been supported by training and a local development day. The Youth Justice Board had provided considerable input to both the Board and the YOS. This was important and well received.

## **2. Partnerships – effective partnerships make a positive difference**

- 2.1. The quality and range of information provided to the Management Board had improved considerably. The work of the partnership, however, to improve outcomes, and to make sure that services matched local needs, remained limited by a lack of good quality current localised data available to the Board and to managers. Not enough attention had been given to the quality, usefulness and relevance of data, and to the ability of the Board to understand and interrogate it. For example, reporting of ETE outcomes had improved. The analysis of this was not, however, understood well enough within the Board, meaning that scrutiny and challenge was not fully developed. The Board did not receive enough qualitative information that helped it understand the challenges of practice, and the experiences of children and young people known to the YOS. The YOS had recently recruited a skilled information specialist who could help improve the range and usefulness of data.
- 2.2. An effective fortnightly triage meeting, attended by police officers and YOS managers, considered the most appropriate outcome for children and young people who had been arrested. It offered a valuable opportunity to consider all the circumstances of the child or young person, adding consistency to decision-making, and enabling children and young people to be diverted from the criminal justice system where that was appropriate.
- 2.3. There was no clear system to assist the YOS police officers to identify when children or young people on the YOS caseload came to police attention. Overnight arrests were checked and researched before the information was passed to the YOS the same day. Other police contact was recorded on information notices that were forwarded to the YOS via the Multi-Agency Safeguarding Hub. It was unclear whether this was robust in supporting the ability of YOS case managers to make a timely response to these incidents.
- 2.4. Operational management and oversight of ETE work was robust. Recent positive developments included; improved working with the targeted youth support service; the special educational needs service and the virtual school team; leading to further improvements in outcomes. Partnership working to improve ETE outcomes was strong and effective. Matching children and young people to placements was often challenging given the nature of offences and known affiliations, so risk assessment and safeguarding concerns were prioritised appropriately. Providers generally understood the issues well. They worked effectively with the YOS to provide good support for children and young people for the duration of their placement or sentence, and felt well supported. Providers monitored and tracked individual progress and participation. This information was regularly reported to the YOS, and issues or concerns followed up appropriately.

- 2.5. The education business partnership based in the youth service had sustained strong working relationships with secondary schools across the borough, providing a broad and impressive menu of work experience and placement opportunities. It delivered a successful mentoring initiative, which matched young people to adults from the world of work. Five young people being supervised by the YOS were working with mentors to raise their self-esteem, and open opportunities and ideas about career pathways.
- 2.6. There was a deficit in the operational management within the YOS of health services. YOS middle managers were not aware of their responsibilities and were not able to provide clarity around some basic areas of healthcare provision. They were unclear about their responsibilities around speech, language and communication needs (SLCN), and about engagement with Bromley Y. As a result there were no effective operational management links with these services.
- 2.7. The Tier three CAMHS practitioner was withdrawn from Bromley YOS in early 2016. It was unclear whether there had been effective consultation about this. The role was replaced with access to a borough-wide service called Bromley Y. The change had, however, caused difficulties and children and young people often did not attend. The opportunity for the involvement of a mental health practitioner in case discussions and case formulation was limited. Plans to bring a well-being practitioner back into the YOS were well advanced. The practitioner commenced work following the inspection fieldwork. This was an important and necessary development.
- 2.8. Case managers and managers in the YOS and children's services did not understand each other's roles well enough. Both would welcome more and varied opportunities to understand each other's work, to improve joint working. Senior managers in children's services and the YOS were not sufficiently sighted on those YOS cases that involved the highest risks to the child or young person, to enable them to jointly assure themselves about the quality of work in those cases.
- 2.9. The YOS continued to work with some children and young people beyond their 18th birthday. It was unclear whether the interface with adult social care services was sufficient to support this work.
- 2.10. YOS managers had raised the need for suitable accommodation provision for 16-18 year olds who present as homeless or are due to be released from custody. Plans were well advanced to increase bed spaces, and hence provide this much needed resource. It was, however, too soon to assess the effectiveness of this.
- 2.11. Having successfully reduced NEET numbers, the YOS was working to develop partnership arrangements with training providers who offered highly flexible and bespoke programmes for some of the hardest to engage. Alternative provision for school aged children had developed well, including for those excluded from mainstream school. Those with complex emotional and behavioural needs were offered personalised programmes in a nurturing and supportive environment.
- 2.12. The YOS held a weekly court and allocations meeting. This helped to make sure that staff were aware of new cases, and the issues arising in them. This, however, was not an effective forum. Important issues that were raised in cases, for example relating to safeguarding or risk of harm, were not always recognised and understood well; nor did the meeting lead to clear, swift and appropriate actions where these were needed to resolve issues.

### **3. Workforce management – effective workforce management supports quality service delivery**

- 3.1. The YOS workforce strategy was based on building, developing and retaining its own staff. This was appropriate in view of previous staffing difficulties. It had led to a stable workforce. The effectiveness of this approach was dependant on managers and more experienced staff having a good understanding of practice and using their skills effectively to develop staff; to challenge, improve and achieve a good quality of practice. Notwithstanding the improvements achieved since

the previous inspection; this was not always done well, and oversight was not always effective. Managers did not always clearly understand safeguarding processes and management of high risk of serious harm.

- 3.2. Some progress had been made in developing quality assurance systems. There was, however, still much work to do to make sure that these effectively supported the work of managers. The recently recruited information officer was a positive development that had the potential to improve the situation considerably.
- 3.3. Cases had sometimes been allocated to staff that did not have the level of skills needed to deal with the complexities of the case.
- 3.4. The YOS nurse received regular, appropriate supervision. The substance misuse worker only received supervision within her agency (Bromley Changes). She did not receive supervision in the YOS, nor three-way supervision. There was confusion about the status of the service level agreement between the YOS and Bromley Changes. The substance misuse worker held a high caseload.
- 3.5. A speech and language therapist attended the YOS one half day per month to offer advice, training and consultation to staff. The service had reduced to this level in 2016. An internal report written in 2016, alongside the reduction, reported the need for continued YOS access to SLCN services. There appeared to be no action taken in response to those findings. Case managers had received training in SLCN, but there was insufficient evidence of this service being used. SLCN were not always responded to as required.
- 3.6. The YOS ETE team comprised a full-time tutor, a NEET coordinator and a part-time education welfare officer. They were supported by a designated special needs worker from the Preparing for Adulthood team. The ETE team was held in high regard by YOS case managers and by partners. There were very good working relationships between case managers and the ETE team. Caseworkers were knowledgeable about their work and had a good grasp of the range and types of provision children and young people were engaging with. The capacity of the team to further develop work for those children and young people who were hardest to engage, or with the most complex needs, was stretched.

#### **4. Learning organisation – learning and improvement leads to positive outcomes**

- 4.1. The NEET worker had robust data about outcomes for children and young people, and explored the reasons when placements for individuals were not successful. This data was used well to inform further developments.
- 4.2. Just over two-thirds of case managers reported that the culture of the YOS promoted learning and development very well. Most reported that their managers were knowledgeable, supported them in their work, and provided effective and appropriate supervision. In some supervision files there was, however, no evidence of structured supervision, clear development plans, or evidence that progress was reviewed.
- 4.3. Most case managers considered that management oversight and countersigning of risk of harm and safeguarding work was effective. These arrangements were, however, often not effective. The understanding of the role of supervising managers was not sufficiently developed.
- 4.4. Over three-quarters of case managers considered that their training and development needs were met. They all considered that they had received sufficient training to support them to respond to SLCN, and to other diversity factors; although further work was required to make sure that the training achieved its desired outcomes.
- 4.5. The YOS had instituted a monthly reflective practice workshop, where case managers could bring any case they wanted to discuss. This operated as a safe place and was valued by those who brought cases to it.

- 4.6. YOS staff had received safeguarding training; although there had not been sufficient evaluation of whether this had provided the level of knowledge and skills that was needed in all cases, including for support staff.
- 4.7. Case managers spoke highly of the new head of service. They were supportive of her ambitions for excellence in the work of the YOS. All staff that we met showed a clear commitment to make a positive difference in the lives of the children and young people they worked with.



# **Interventions to reduce reoffending**

# **6**

# Theme 6: Interventions to reduce offending

## What we expect to see

The work with children and young people to reduce offending should include a broad range of good quality interventions. They should take into account individual need and ability, and be delivered well. They should be monitored and evaluated to make sure they are effective. Where children and young people are working with more than one agency, partnership work should be integrated.

## Case assessment score

Within the case assessment, overall 78% of work on interventions to reduce offending was done well enough.

## Key Findings

1. The selection of interventions was normally based on the needs of the individual case. This was a significant improvement from the previous inspection.
2. Substantial effort had been made to acquire a broad range of interventions. More work was required to make sure that these matched the needs of the YOS and would be used well.
3. When interventions had been delivered, this work was generally done well.
4. There were too many cases where it was unclear what, if any, work to reduce offending had been delivered.
5. Not enough use was made of the custodial period of sentences to commence work to reduce offending.

## Explanation of findings

1. The delivery of interventions had made a sufficient contribution to reducing offending in just under three-quarters of those cases where there was sufficient evidence to assess this. Children and young people were generally referred to interventions based on their offending related needs. Case managers considered what type of intervention may be most suitable for each child or young person. These were substantial improvements from the previous inspection. The previously seen overreliance on groupwork for the delivery of interventions, irrespective of its appropriateness in individual cases, had ended. We were, therefore, disappointed to observe one intervention where neither enough attention had been given to its suitability for individual children and young people or enough preparatory work undertaken. Insufficient consideration was given to the suitability of the arrangements for a lone female young person.
2. Where interventions to reduce offending had been delivered, they were usually delivered well. In over three-quarters of cases those interventions delivered were consistent with the needs of the case. There were too many cases, however, where recording of interventions was poor, and where it was unclear what, if any, work had been carried out with children and young people to reduce their offending. In such cases case managers were themselves unable to describe in detail what work had been undertaken. Children and young people were generally less forthcoming than in other inspections in describing the work that had been undertaken with them.

### **Quote from a child or young person**

*"I do nuffin there. Just sit in a room. What's the point? I wish they made me do something that will help me and change the way I behave."*

3. Case managers generally had a good understanding of the principles of effective practice for work with children and young people. Work had been delivered in accordance with these principles in just over three-quarters of cases.
4. The YOS had put some effort into acquiring a range of one-to-one interventions for work with children and young people. The extent to which this was based on analysis of needs was unclear. In particular there were no interventions available within the YOS linked to child sexual exploitation, or to address child or young person to parent violence. Neither was there useful information available to help case managers map children or young people onto the most appropriate interventions for their situation, for example in response to age, maturity or gender.
5. The delivery of interventions should be dynamic, reflecting changes in circumstances and the response of the child or young person to those interventions. The ability to do this effectively was limited by the lack of information recorded that could inform evaluation of progress and subsequent adaptation to the work. It was also dependant on the undertaking of regular good quality reviews of assessment and plans. Recording of interventions delivered had improved in the months leading up to this inspection.
6. In over half of the custodial cases, not enough effort had been made to use the custodial phase as an opportunity to start the delivery of interventions as part of planning for resettlement of the child or young person into the community, or to begin work to reduce their risk of harm to others. This was often linked to the custodial sentence plan not providing a clear integrated plan for the whole sentence.
7. Materials and other resources used in the community for work to reduce offending were of good quality in all except one case. They were normally delivered as their design intended them to be. In combination with the right type of intervention being selected, this should increase the likelihood of the work resulting in positive outcomes.
8. Some children and young people that we met reported that they had previously taken part in a weapons awareness intervention. Their comments about this were positive.
9. Restorative justice was considered in only two-thirds of cases where this might have been appropriate. Reparation was not always given enough priority; although substantial progress had been made over the months leading up to inspection in the range of suitable and timely reparation opportunities available in the YOS.

### **Positive quotations from children and young people on weapons awareness interventions**

*"It's a booklet that we are working through. We look at different scenarios and what would happen, that it's more risky to carry a weapon, than not carry a weapon. It has been useful."*

*"People say they take them out for their own protection . . . but I now know you are more likely to be hurt."*

### Example of notable practice: Reparation also supporting skills development

The bike project was a reparation activity that also aimed to teach children and young people bike maintenance and road safety skills. Bikes that had been recovered by the police, but not claimed, were donated to the project. These were refurbished and made safe, and then donated back to suitable recipients in the community.

This practical intervention was delivered well. It involved team work, problem solving, and use of mathematics and communication skills. It provided positive challenges to the children and young people who attended it, leading to the development of transferable skills that would be of value to both the children and young people, and to the community.

10. Latest research stresses the importance of reinforcing positive factors in the lives of children and young people that may help them to avoid offending. Sufficient attention was given to this, in the delivery of interventions, in almost all cases where it was required.
11. In order for effective work to be undertaken with children and young people, they need to be sufficiently engaged with their sentence and the work of the YOS, and to comply with these. It was, therefore, positive to find that the YOS response to non-compliance was sufficient in all cases, and that sufficient attention had been given to making sure that the child or young person was fully engaged with the work in all except three cases.
12. The work of the YOS with an individual child or young person is normally time limited to the length of their sentence. It is, therefore, particularly important that attention is given to making sure that positive outcomes achieved during the sentence are sustainable following its end, and that a good exit strategy is put in place to support this. While this was the case in just under three-quarters of cases where the sentence had progressed far enough for this to be important, there were six cases where not enough consideration had been given to what was needed to sustain progress.
13. Overall, children and young people spoke positively about their case managers.

#### Quotes from children and young people:

*"[She]'s the best worker I have ever had, [she] is really supportive. [She] will drop me a text in the week to remind me . . . and see how things are going."*

*"Some times I get fed up, and [he] gives me a little push to help me along."*

*"[She]'s put me on the right track. I don't want to let [her] down. She makes me feel there's someone can help me. [She] listens and tells me what [she] thinks."*

# Appendices

# Appendix 1 - Background to the inspection

## Inspection arrangements

The Full Joint Inspection (FJI) programme inspects youth offending work, predominantly in statutory community and custodial cases, in a small number of local authority areas each year.

The majority of the Youth Offending Teams selected for these inspections are those whose performance – based on reoffending rates, National Youth Justice Outcome Indicators and supported by other information, such as recent inspections – is of significant concern. Periodically, we also include high performing areas to establish a benchmark of good practice.

The published reoffending rate<sup>1</sup> for Bromley was 43.1% (with an average number of previous offences per offender of 1.42), compared to 36.3% for the previous year (average number of previous offences of 1.04) and 37.9% for all England and Wales (average number of previous offences of 1.24). Use of custody in Bromley was 0.47 episodes per 1000 in the 10-17 population, compared to 0.36 for all England and Wales.

The primary purpose of the youth justice system is to reduce offending. This is the main theme of the inspection. The other core themes are protecting the public, protecting the child or young person, making sure the sentence is served and governance and partnerships.

## Criteria

A copy of the inspection criteria is available on the HMI Probation website:

<http://www.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/>

## Methodology

YOTs are informed approximately 11 working days prior to the inspection taking place.

Fieldwork for this inspection was undertaken on the weeks commencing:

23 January 2017 and 6 February 2017.

In the first fieldwork week we looked at a representative sample of 33 individual cases up to 12 months old, some current, others terminated. The sample included a number of those who are: a high risk of harm to others, are particularly vulnerable, are young women, or are black and minority ethnic children and young people. Cases were assessed by a team of inspection staff. They examined these wherever possible with case managers, who were invited to discuss their work in depth, explain their thinking and identify supporting evidence in the record. We gathered the views of children and young people, parents/carers and victims linked to the cases we inspected.

We also received copies of relevant local documents.

During the week in between, the data from the case inspections was collated and a picture about the quality of the work of the YOS developed.

The second fieldwork week is the joint element of the inspection. HMI Probation was joined by colleague inspectors from police, health, social care and education. We explored the lines of enquiry which emerged from the case inspections. The leadership, management and partnership elements of the inspection were assessed, with a particular focus on reducing offending.

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<sup>1</sup> The reoffending rate that was available during the fieldwork was published October 2016, and was based on binary reoffending rates after 12 months for the January 2014–December 2014 cohort, and use of custody in the year to June 2016. Source: Ministry of Justice.

We also gathered the views of others, including strategic managers and staff, and observed work taking place.

At the end of the second fieldwork week we presented our findings to local strategic managers, the YOS Management Team, YOS staff, elected members of the local authority, and other interested parties.

## **Scoring Approach**

Details of how our inspection judgements are made can be found on our website.

<http://www.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/>

## **Publication arrangements**

A draft report is sent to the YOS for comment three weeks after the inspection, with publication approximately six weeks later. In addition, a copy goes to the relevant Ministers, other inspectorates, the Ministry of Justice Policy Group and the YJB. Copies are made available to the press and placed on our website.

FJI reports in Wales are published in both Welsh and English.

Further details about how these inspections are conducted can be found on our website in the document *Framework for FJI Inspection Programme* at:

<http://www.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/>

## **Role of HMI Probation and Code of Practice**

Information on the role of HMI Probation and our Code of Practice can be found on our website:

[www.justiceinspectorates.gov.uk/hmiprobation](http://www.justiceinspectorates.gov.uk/hmiprobation)

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

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## Appendix 2 - Acknowledgements

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 Criminal Justice  
Joint Inspection

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