	Children and Families Overview and Scrutiny Committee 2012 **Report from the Director of Children and Families**
For Information	Wards Affected: ALL

Report on the Core Case Inspection of Brent Youth Offending Service by HMIP.

1. Summary

1.1 Brent Youth Offending Service was inspected by Her Majesty's Inspectorate of Probation in September 2011 over a period of four days, the report of that process being published in early December 2011. A full version of the Inspection report is available on the HMIP website (see link below).

1.2 The core methodology was to examine a representative sample of offender cases and to assess whether each aspect of work was done sufficiently well against the criteria established by HMIP. The Inspection did not directly address matters such as strategic and partnership arrangements.

1.3 The Inspection looked at three key practice criteria

- Risk of Harm (This is primarily about Public Protection)
- Safeguarding (This is about the protection of the young person)
- Likelihood of Re-offending

1.4 The judgements 'scale' utilised is described by level of improvement required (so is a deficit model): **Minimum, Moderate, Substantial or Drastic**. Brent scored as follows

Safeguarding Score:	
Score: **65%**	**Comment:** **Moderate improvement required**
Public Protection (Risk of Harm)Score:	
Score: **59%**	**Comment :** **Substantial improvement required**
Likelihood of re-offending Score:	
Score: **62%**	**Comment :** **Moderate improvement required**

2.0 Recommendations

2.1 That the Committee, by noting the content of this report, are aware of both the HMIP Report on Youth Offending Work in Brent and of the Improvement Plan drawn up to address the recommendations made in that report.

3.0 Detail

3.1 HM Inspectorate of Probation is an independent Inspectorate, funded by the Ministry of Justice, and reporting directly to the Secretary of State. This Core Case Inspection (CCI) in Brent is a part of a programme of inspection of all YOS in England & Wales over a three-year period which began in April 2009. Its primary purpose being to assess the quality of practice against HMIP's set criteria

3.2 The Foreword to the report summarised the results thus:

> "Overall, we consider this a reasonable set of findings, with *Risk of Harm to others* and the delivery of interventions requiring particular attention. However, we are confident that if the recommendations in this report are followed the improvement required can be made and sustained."

The preamble also included the following:

> "In Brent we found a YOS working with children and young people from diverse backgrounds and with complex needs, some of whom posed a high *Risk of Harm* to others including involvement in organised gang crime. Due to austerity measures, the YOS had recently undergone changes to its internal delivery structures, with a reduction in staffing levels. However, despite these challenges case managers were keen to improve their assessment and case management skills. The enthusiasm we found among this group of staff should be built upon."

Summarising the results of the service users perspective (young people's) survey the Inspectors commented that:

> "A majority of respondents reported that as a result of action taken by the YOS, some aspects of their lives had improved. In particular, they told us that the YOS had helped them understand their offending and make better decisions".

3.4 It is of note that Brent's scores were close to the National Averages and higher than the average scores for those London YOTS so far published. It is also the case that virtually all London YOTs were found to need Substantial Improvement for the Risk of Harm criteria.

3.5 It must be noted that the way in which these scores are derived is dependent on process driven indicators including the timeliness of completion of documents and their signing–off by managers. It has been argued by a number of sources, including the ADSC London Region, that this approach fails to address what should be the key focus – the outcomes for young people and the community. In addition London YOTs like Brent face the burdens of high levels of young people presenting with serious and complex problems, engaging in higher than average levels of serious offending. The Inspection round in London started in June 2011 at a point when a

number of YOTS were struggling to deal with substantial budget reductions (in Brent's case of almost 30%) and the concomitant re-organisations prompted by those reductions. HMIP rejected calls made by the London Region YOT Managers to postpone Inspections in the light of these issues.

3.6 The detail of the Inspectors findings on the strengths and areas for improvement In relation to each of the criteria examined is appended as Appendix 1.

3.7 The Inspectors made five recommendations as a result of the process and an Improvement Plan to address them has now been agreed by HMIP. Its implementation will be overseen by the London Region of the YJB.

4.0 Financial Implications

4.1 None

5.0 Legal Implications

5.1 None

6.0 Diversity Implications

6.1 None

7.0 Staffing/Accommodation Implications (if appropriate)

7.1 None

Background Papers

Appendix 1 – detailed summary of findings

A full copy of the HMIP Report on Youth Offending Services in Brent's can be viewed on the HMIP website.

A full copy of the Improvement Plan can be obtained from anita.dickinson@brent.gov.uk

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Appendix 1

Safeguarding

HMIP Identified as strengths:

- All necessary immediate action was taken to safeguard and protect the child or young person in all appropriate cases in the community. Similar figures were achieved in relation to other affected children and young people in the community.
- Specific interventions to promote Safeguarding were identified in 89% of relevant custody cases.
- In most cases, where necessary, Safeguarding referrals to other agencies had been made.
- There was good evidence that the YOS workers and other relevant agencies (especially ETE/Connexions, substance misuse services, physical health and secure establishments) worked together to promote the Safeguarding and well-being of children and young people. There was less evidence of joint working between YOS workers and children's social care services or emotional and mental health services.
- A vulnerability screening was completed in all cases, and on time in 84%.
- The secure establishment was made aware of vulnerability issues prior to, or
- Immediately upon sentence, in 80% of relevant cases.
- YOS workers had made a contribution to other multi – agency assessments and plans designed to safeguard the child or young person, in 10 of 13 relevant cases.

HMIP Identified as Areas for improvement:

- The vulnerability screening was not completed to a sufficient quality in 37% of cases.
- Whilst the majority of Vulnerability Management Plans were timely only 46% were of a sufficient quality. In some cases the quality was affected by a lack of clarity about the roles and responsibilities of staff and agencies involved with the child or young person.
- There was Insufficient evidence of management oversight of vulnerability assessments and needs both within the community and the secure estate
- Specific interventions to promote Safeguarding were identified in 89% of relevant custody cases. However, these were incorporated in the Vulnerability Management Plan in only 60% and delivered in just over half (56%) of all applicable cases.

Risk of Harm (RoH)

HMIP Identified as strengths:

- An *RoH* screening was undertaken in all 38 cases in the sample and on time in all but five.
- The *RoH* classification recorded by the YOS was correct in 79% of cases.
- Inspectors assessed that there should have been a full RoH analysis in 34 cases. This was done in 97% of cases and was on time in 78% of these.
- In the majority of cases the RoH assessment drew adequately on all appropriate information from other agencies.
- A Risk Management Plan had been completed in all but 4 of the 27 cases that required one.
- Where there were changes in *RoH* factors they were identified swiftly and acted on appropriately in 78% of cases.

- Case managers and other relevant YOS staff contributed effectively to multi-agency meetings in a substantial majority of cases – 88% when the child or young person was in custody and 86% when they were living in the community.

HMIP Identified as Areas for improvement:

- The *RoH* screening was not accurate in 37% of cases and the analysis was not of a sufficient quality in 47% of cases. The main reason for this was that the *Risk of Harm* to victims was not fully considered.
- In the 23 cases where an RMP was completed, nine were not done on time and only 12 were of a sufficient quality.
- In cases that did not require an RMP the need to address potential *RoH* issues had been recognised in 8 of 11 relevant cases; however, action was taken in only five cases.
- High priority was given to victim safety in just over one-third of relevant cases. Full assessments of the safety of victims had not been carried out in 63% of the cases requiring them.
- There was evidence of the effective management oversight of *RoH* in only one-quarter of both the custody and community cases.
- Specific interventions to manage *RoH* in the community were delivered as planned in just over half of the cases and interventions to manage *RoH* during the custodial phase of the sentence were delivered as planned in three of six relevant cases.

Likelihood of Reoffending (LoR)

HMIP Identified as strengths:

- There had been a reduction in the frequency of offending in 69%, and the seriousness of offending in 75% of cases.
- In all cases an initial assessment of LoR had been conducted; it was completed on time in 76% of cases. Good use was made of the information available from other agencies, including children's social care services, the police and educational providers.
- There was evidence of active engagement with the child or young person in 76% of cases, and with parents/carers in 74% of cases.
- The majority of plans or contracts in the community set relevant goals and timescales, reflected the purpose of sentencing and national standards, and focused on achievable change.
- In eight out of ten custody cases there was a custodial sentence plan. All of these were completed on time
- Plans were reviewed at appropriate intervals in all but one case in custody
- YOS staff had been involved appropriately in the review of interventions delivered in custody in all but two DTO cases.
- The YOS worker actively motivated and supported the child or young person throughout the sentence in all but three cases while in custody.
- Based upon the YOS assessment of LoR and *RoH* Inspectors found that the initial Scaled Approach intervention level was correct in all but three relevant cases.
- Appropriate resources had been allocated according to *RoH* throughout the sentence in just under three-quarters of cases in the sample.

HMIP Identified as Areas for improvement:

- The quality of the initial assessments of the LoR was not satisfactory in 37% of cases.

- The learning style of the child or young person had been assessed in less than one-quarter (22%) of the cases.
- The initial assessment was not reviewed at appropriate intervals in 15 of 38 of cases.
- Only three of ten custodial sentence plans sufficiently included factors linked to the child or young person's offending
- The child or young person had been actively and meaningfully involved in the planning process in 53% of cases and parents/carers in 42%.
- Intervention plans were reviewed at appropriate intervals in just under half (49%) of the community cases.
- Interventions in the community were implemented in line with the intervention plan in 53% of cases.
- They were sequenced and reviewed in 45% of cases; and were appropriate to the child or young person's learning style in only 42%. Only half of plans incorporated all diversity issues.
- All requirements of the sentence had been implemented in two-thirds of relevant cases.