Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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

This report outlines the findings of the recent SQS inspection, conducted during 18th-20th March 2013. We carried this out as part of our programme of inspection of youth offending work. This report will be published on the HMI Probation website. A copy will be provided to partner inspectorates to inform their inspections, and to the Youth Justice Board (YJB).

Context

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

Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. The purpose of the SQS inspection is to assess the quality and effectiveness of casework with children and young people who have offended, at the start of a sample of 14 recent cases supervised by the Youth Offending Service. Wherever possible this is undertaken in conjunction with the allocated case manager, thereby increasing the effectiveness of the inspection as a learning opportunity for staff.

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

Summary

We found that most staff in the Bury Youth Offending Service (YOS) were committed to delivering work of high quality and many aspects of the work were strong. However, we found too many examples where the assessments and plans for work to address vulnerability issues were not of a sufficient standard. In several cases the quality assurance processes had not led to improvements in practice. The challenge for the YOS Management Team is to ensure all staff and managers understand the practice requirements of work to protect children and young people and more cases meet the high standards which some staff demonstrated were possible.

Commentary on the inspection in Bury

1. Reducing the likelihood of reoffending

1.1. There was a timely and sufficient initial assessment of the likelihood of reoffending in 10 of the 14 cases. Where assessments were insufficient, this was because they had not addressed vulnerability issues and had not drawn on all available information. We found evidence that the team consistently used the local assessment and intervention packs at the start of their work with children and young people. These provided a helpful structure for staff in undertaking these tasks. However, they were not being used to good effect by all staff.

1.2. Pre-sentence reports were requested and provided to the court in 10 out of the 14 cases. Seven of these were of good quality. Information in other forms, such as verbal updates provided by case managers, offered enough information for the purposes of sentencing. An inspector noted in one case that, "*This case saw the production of a high quality Pre-Sentence Report. It was analytical and detailed and drew on a number of sources to produce an excellent risk assessment. Risk of harm, likelihood of reoffending and vulnerability were all correctly assessed through a comprehensive and detailed core assessment (ASSET). In addition, the core review (prior to transfer to the Probation Trust) was updated and amended to reflect changes in circumstances of the young person and the progress he had made*".

1.3. Planning to reduce the likelihood of reoffending was sufficient in 12 out of the 14 cases and in all four of the cases that had a custodial element.

1.4. In 7 out of the 11 relevant cases, adequate reviews of the assessment of likelihood of reoffending had been undertaken. Reviews of plans to address reoffending issues were adequate in almost all of the cases.

2. Protecting the public

2.1. There was a clear and thorough assessment of the risk of harm to others in eight out of the ten cases where there had been a pre-sentence report. For the full sample of 14, the assessment of risk of harm to others was of good quality in 12 cases. Assessments of risk of harm were adequately reviewed in almost all of the cases.

2.2. In three out of the ten relevant cases there had not been enough attention given in the planning to address issues of the risk of harm to others. The issues that detracted from the quality of these plans were that they had not been produced or that victims' issues had not been addressed. In all but one of the relevant cases, reviews of the risk of harm had been done to an acceptable standard. In one case we noted, "*This case had a robust plan to manage risk which reflected the issues in the case. In addition, a detailed plan to manage vulnerability was completed to address the evident indicators of vulnerability. The sentence plan was detailed and there was good congruence between the court report, the core assessment, the plan and the work undertaken with the young person. The case was reviewed ahead of schedule, to facilitate an appropriate transfer to statutory Probation Supervision. Good joint sentence planning and liaison was evident between the case manager and the custodial professionals involved in this case*".

2.3. Where there was an identifiable victim, or a potential victim, the risk of harm they faced had been effectively managed in almost all of the relevant cases.

2.4. Management oversight of risk of harm work was effective in over two-thirds of the relevant cases. In some, we saw assessments and plans that were clearly inadequate had been countersigned by managers without addressing quality concerns.

3. Protecting the child or young person

3.1. Only six of the ten pre-sentence reports had adequately assessed vulnerability issues. For the sample overall, only eight (57%) had sufficiently assessed the safeguarding and vulnerability needs of the children and young people. The factors that most often limited the quality of this work were not taking into account relevant previous behaviour and not drawing on all available information. Planning to address vulnerability and safeguarding issues was sufficient in just over half of the relevant cases. Reviews of safeguarding and vulnerability planning were required in 12 cases; this had happened to an acceptable standard in only eight.

3.2. Management oversight and quality assurance of safeguarding and vulnerability assessments and plans was effective in less than half of the cases. In Bury, these took the form of monthly case discussions between case managers and their line managers and reviewing cases via Case Planning Forum meetings. Despite these arrangements, in too many instances we saw that clearly inadequate assessments and plans had been countersigned by managers. For example, an inspector noted in one case that, "*Regarding vulnerability, this had been underestimated at the PSR* [pre-sentence report] *stage and this continued through to the initial and review core assessments. This case had numerous indicators of vulnerability including, parental substance misuse and severe domestic violence witnessed by the young person, negative and concerning peer pressure, the young person's substance misuse, previous Children's Services involvement, a lack of educational input and familial involvement in offending. These issues had not been drawn together in the assessment and a robust plan to manage vulnerability had not been produced. The practice deficiencies had not been identified or remedied by line managers*". We noted that there was evidence of regular management oversight and quality assurance input into cases. However, these processes had not helped to identify and address practice shortfalls in respect of assessment and planning for vulnerability issues.

3.3. In our view, there were some staff members who did not have sufficient experience and knowledge to address vulnerability issues in their work with children and young people. We also noted that a small number of staff members did not have confidence in the ability of their managers to offer effective oversight of this work. Our findings would lend some support to these views.

4. Ensuring that the sentence is served

4.1. At the pre-sentence stage and at the commencement of supervision, attention was routinely being paid to assessing the child or young person's diverse needs and identifying barriers to engagement. There was evidence of high levels of involvement of the children and young people, and their parents/carers, in assessment and planning for interventions. For example, we found in one case, "*This case had some good initial outcomes: the young person had secured a place on a training scheme, had not reoffended and had undertaken some work with the YOS health worker to tackle emotional well-being and self-esteem. There had been good liaison with parents by the YOS health worker, alongside recognition of the need to address diversity factors to underpin ongoing engagement and compliance by the young person*".

4.2. In all of the cases we reviewed, sufficient attention had been given to the health and well-being of the child or young person.

4.3. Thirteen of the children and young people had complied with the requirements of their sentence. This was to the credit of practitioners, as many of the children and young people required regular input to secure their engagement in supervision. For those

children and young people who had not complied with the requirements of the sentence, even after steps had been taken to address non-engagement, the response of the YOS was sufficient in all cases.

Operational management

The context for the work we reviewed was that Bury YOS had undergone considerable change in the period leading up to this inspection and staffing levels had fallen considerably. In addition, a range of management services for Bury YOS activities had been brought in from the neighbouring Rochdale Youth Offending Team. While both organisations were retaining their separate organisational identities, they were in the process of consolidating and standardising a number of processes and management activities across the two teams.

We found variations in the quality of work being done by practitioners. Most staff understood local policies and procedures for managing risk of harm to others, vulnerability, engagement and compliance. Most felt they had received the right training to enable them to do their jobs. The majority of staff felt that their managers had actively supported them in their work and had helped them to improve the quality of their work.

Management oversight and quality assurance plays an essential role in ensuring that the harm and vulnerability issues for children and young people are properly managed. We looked for evidence that, where relevant, these processes had helped to ensure the adequacy of work to address risk of harm to others and vulnerability. While we found that management oversight and other quality assurance activities were routinely being undertaken, in too many cases these arrangements had not identified and helped to address practice shortfalls. We, therefore, concluded that management oversight was insufficiently effective. It was not acting as 'a line of last defence', for the quality of assessment and planning work, particularly in respect of vulnerability issues, undertaken by the team.

Outstanding strengths

The following were particular strengths:

- There was good planning and reviews of work to address offending.
- There was routine engagement with children and young people and their parents/carers in carrying out initial assessments and planning.
- The assessments of diversity and barriers to engagement were good.
- There were good levels of compliance and, where needed, effective enforcement of court orders.

Areas requiring improvement

The most significant areas requiring improvement were:

i. assessments, planning and reviews of work to tackle vulnerability and safeguarding needs

ii. management oversight and quality assurance of vulnerability and risk of harm assessments, plans and reviews.

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

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

If you have any further questions about the inspection please contact the lead inspector, who was Joseph Simpson. He can be contacted on 07917 084764 or by email at joe.simpson@hmiprobation.gsi.gov.uk.

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