Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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From:	Julie Fox, Assistant Chief Inspector
Publication date:	6th November 2013

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

This report outlines the findings of the recent SQS inspection, conducted during 7th-9th October 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 20 recent cases supervised by the Integrated Youth Support Service for Camden. Wherever possible this is undertaken in conjunction with the allocated case manager, thereby increasing the effectiveness as a learning opportunity for staff.

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

Summary

Overall, we found a committed staff group working with a diverse range of challenging children and young people, many of whom lived within the culture of violence associated with gang membership. Staff engaged well not just with the children and young people but, importantly, with their families, with a view to ensuring that change was sustainable after their involvement ended. Assessments and plans were reasonably sound and thoroughly reviewed; although at times management oversight of this work was cursory. Nonetheless, the strong strategic partnerships developed and enjoyed by the Integrated Youth Support Service ensured an effective network of support was in place for children and young people; in many cases, this led to successful outcomes, often 'against all the odds'.

Commentary on the inspection in Camden:

1. Reducing the likelihood of reoffending

1.1. The initial assessment of the child or young person's likelihood of reoffending was sufficient in 16 out of the 20 cases sampled. While all 20 assessments were factually accurate and identified relevant diversity factors, four contained unclear or insufficient evidence and one was completed late.

1.2. New pre-sentence reports (PSRs) were provided to the court in 14 cases; 10 of these were of a good standard. One inspector noted: "*The PSR on this case was of a very high standard, in terms of the level of detail and the quality of analysis of a very complex case*".

1.3. Procedures were in place to check all reports prior to them being submitted to sentencers. However, we found four reports that had been signed off as acceptable, despite containing an inadequate assessment of the child or young person's vulnerability. Similarly, three of the four reports failed to pay full attention to the impact of custody on the child or young person where this was relevant, and two contained inadequate assessment of their risk of harm to others. In one case, the report's 'gatekeeper' (the person who checked the report prior to its submission to the court) had amended the proposal from an intensive community order to a simpler referral order; in the event, the child was given a custodial sentence which, in our view, was more in keeping with the seriousness of the offence than the proposal.

1.4. Plans to reduce the likelihood of reoffending were satisfactory in all five custodial cases and in all but three community cases. Staff had good links with the secure estate and attended sentence planning review meetings, together with family members and other involved professionals, such as social workers, wherever possible. Staff saw, and reaped, the benefit of keeping in close contact with the family while the child or young person was incarcerated.

1.5. Most assessments and plans relating to the likelihood of reoffending had been reviewed well.

2. Protecting the public

2.1. In all but four cases the assessment of risk of harm to others posed by the child or young person was sufficient. Where there were gaps, these arose because the initial screening was inadequate, or the assessment had not taken into account previous behaviours, or the harm had been classified as too low. In one particularly complex case of a 16 year old boy who was violent towards his mother and displayed inappropriate sexual behaviour, the quality of the analysis of the risk of harm was exemplary. The case manager had researched the background to the case thoroughly; this enabled her to complete a comprehensive assessment of, and plan to manage, all aspects of the risk of harm he posed. Reviews of these assessments were sufficient in all but three relevant cases.

2.2. A clear and thorough assessment of the risk of harm to others was included in 10 out of the 14 PSRs. One report omitted to mention that the young person had recently been found in possession of a knife during a police search; this increased both his vulnerability and his risk of harming others.

2.3. There was satisfactory planning to address these risks in 12 out of the 18 cases where this was an issue. Within the last year, an integrated intervention plan had been introduced for community cases and the licence phase of custodial cases. This attempted to improve the cohesion between risk management plans and other plans designed to

address vulnerability and the likelihood of reoffending, by capturing objectives relating to risk of harm, alongside other planned work. Practitioners' views on the new template were mixed. Some found it a useful tool to help the child or young person understand what their risks of harm were and why certain work was needed to reduce these. However, other staff felt inhibited about sharing the contents with the child or young person and preferred to use the original YJB template for risk management planning. Although a laudable initiative, we considered that the new template did not lend itself to comprehensive and robust risk management planning, but instead led to the production of some more limited plans, particularly in the area of contingency planning.

2.4. Nonetheless, we saw positive examples of joint planning and working in complex cases where children and young people had mental health, education and substance misuse needs. In all but one of the four relevant custody cases, there was sufficient planning to address the risk of harm, with some good examples of plans catering for both the custodial and release periods. In the one case subject to Multi-Agency Public Protection Arrangements (MAPPA), the assessment and planning relating to risk of harm was good.

2.5. Most plans to address the risk of harm to others had been reviewed well; there were weaknesses in only three cases, arising through the review not taking place (one case), not being timely (one case) or not being sufficiently thorough (two cases).

2.6. Where there was an identifiable victim or potential victim, the risk of harm they faced had been effectively managed in two-thirds of all relevant cases.

2.7. Management oversight of risk of harm work was evident in the vast majority of cases; however, we considered this was effective in just under half of the 18 relevant cases. Although the local High Risk Panels provided clear guidance on a number of cases, on others, assessments and plans that we considered insufficient had been countersigned by the manager without addressing weaknesses. Some staff interviewed said they would have appreciated more detailed feedback being given to them about the quality of their work.

3. Protecting the child or young person

3.1. There was a satisfactory initial assessment of vulnerability in three-quarters of cases; such assessments were thoroughly reviewed throughout the sentence in all but one relevant case. Staff generally liaised effectively with other specialist services, such as mental health, sexual health and counselling, where required. In particular, those managing young women were alert to their vulnerability to sexual exploitation and sought to prevent this, as necessary, through appropriate referrals.

3.2. Similarly, satisfactory plans were in place to manage vulnerability in three-quarters of relevant cases. Where gaps arose, these were primarily because the planned response was insufficient or unclear, changes in vulnerability were not anticipated or contingency planning was lacking. As with risk management planning, the integrated intervention plan did not help the case manager to address vulnerability issues as effectively as the more comprehensive YJB vulnerability management plan. Effective planning was in place to manage vulnerability within the custodial setting in all but one case.

3.3. Reviewed assessments of vulnerability were more thorough than initial assessments, with only one being deficient due to its content and timeliness. Similarly, reviewed plans to manage vulnerability were more thorough than initial plans in all but two relevant cases. These findings combined to indicate an increase in the quality of work over recent months.

3.4. In direct contrast to the management supervision of risk of harm work, oversight of work to address vulnerability was much better; it was sufficient in almost three-quarters of cases, although in four cases important gaps in assessments and plans were not addressed.

3.5. All staff interviewed had sufficient understanding of local policies and procedures for managing vulnerability and safeguarding.

4. Ensuring that the sentence is served

4.1. Attention had been paid to assessing and planning to address the child or young person's diverse needs and any barriers to engagement in the vast majority of cases. Staff were attentive to the child or young person's health and well-being in all appropriate cases. Similarly, in every case examined, there had been effective engagement with the child or young person, and their parent/carer, to complete the assessment. However, three of the PSRs examined did not sufficiently describe how barriers to engagement would be overcome; this was a missed opportunity, as such barriers had clearly been addressed as part of the initial assessment.

4.2. Learning styles were routinely assessed and taken into account in terms of planning how the work would be delivered. One case manager, having established that the child had a visual learning style, depicted three priority objectives using a simple graphic illustration. The resulting plan was colourful, simple to absorb and focused; it enabled the case manager to talk through with the young child what they would need to do over the course of the order.

4.3. Two-thirds of children and young people complied with the requirements of their sentence, some after initial difficulties; this was a testament to the persistence of case managers, given the chaos which prevailed in many of the children and young people's lives. Where they did not fully comply, the response was satisfactory in most cases.

4.4. Staff were enthusiastic about their ability to make a difference to the lives of the children and young people under their supervision - and were doing just that, both through their own efforts, and their use of an impressive range of support networks.

Operational management

In common with other youth justice organisations, Camden Integrated Youth Support Service had undergone reorganisation over recent months, in order to meet budgetary pressures. The new organisation sought to deliver a holistic service to the whole family, so parenting work was a prominent feature and parents/carers were well engaged with the work with children and young people.

Staff interviewed were generally positive about learning and development opportunities, although some felt that supervision by managers was not always fully effective. Our view was that management supervision and other quality assurance processes made a positive difference to the quality of work in around half of the cases, which left room for improvement.

Key strengths

The best aspects of work that we found in Camden included:

- strong partnership working. Good use was made of a wide range of specialist services to ensure that the best chance of a positive outcome was achieved. Police intelligence was routinely sought and used to help shape judgements about the risks of harm and the likelihood of reoffending by children and young people, with regular information exchange across a wide range of agencies promoting accurate assessment

- finding many examples of staff 'going the extra mile' for the children and young people with whom they worked. Their enthusiasm for their work was palpable and resulted in even the most challenging children and young people making progress while under their supervision.

Areas requiring improvement

The most significant areas for improvement were:

i. the capacity of the integrated intervention plan to support robust planning to manage risk of harm to others and vulnerability

ii. the effectiveness of management supervision to improve the quality of the work, particularly in relation to risk of harm to others.

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

We are grateful for the support that we received from staff in the Integrated Youth Support Service 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 Helen Rinaldi. She can be contacted on 07717 361639 or by email at helen.rinaldi@hmiprobation.gsi.gov.uk.

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