Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

HM Inspectorate of Probation
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Andrew Walters
Chair of Gloucestershire Youth Justice Partnership Board
Gloucestershire Youth Services Team

6th March 2013

Dear Andrew Walters,

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

This report outlines the findings of the recent SQS inspection, conducted during 11th-13th February 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 Ofsted 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 Youth Offending Team. 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 that staff delivering youth justice worked closely and enthusiastically with their colleagues in children's social care services, recent changes in structures having supported close integration between these departments, which in turn led to positive outcomes for children and young people. Staff were good at engaging children and young people together with their parents/carers where appropriate throughout the order. The quality of some assessments and plans could be improved, particularly when reviews were required, as could the efficacy of management oversight arrangements.

Commentary on the inspection in Gloucestershire:

1. Reducing the likelihood of reoffending

1.1. The initial assessment of the child or young person's likelihood of reoffending was sufficient in 12 out of the 20 cases sampled. Four assessments were completed late and in others, the case responsible officer had based their assessment on the contents of a previous one, rather than fully analysing the new offence and circumstances. Some improvements were noted in the quality of those assessments that had been reviewed.

1.2. New pre-sentence reports (PSRs) were provided to the court in seven cases, all but one of which was of a good standard, demonstrating effective local management arrangements for ensuring the quality of reports.

1.3. Plans to reduce the likelihood of reoffending were satisfactory in all but three cases, although two out of the six plans for children and young people sentenced to custody were insufficient. However, custodial sentence plans generally focused on the child or young person's resettlement needs from the outset. In one rather complicated case, the line manager had intervened to help organise release accommodation for a hard to place young man; the comprehensive release plan captured the involvement of all parties in this case, including the social worker.

1.4. Just over half of all plans to reduce the likelihood of reoffending had been reviewed sufficiently well; in some cases reviews were required but not conducted and in one case the review was unsatisfactory.

2. Protecting the public

2.1. In 14 out of the 20 cases the assessment of risk of harm to others posed by the child or young person was sufficient. Where there were deficiencies, these arose because the initial screening had not taken into account previous behaviours, the full assessment of risk of harm was either missing or late, or the assessment was unclear about the different risks that applied during the child or young person's time in custody and after release.

2.2. Five out of the seven PSRs contained a clear and thorough assessment of the risk of harm to others.

2.3. There was sufficient planning to address the risk of harm to others in less than half of the 12 cases where this was an issue, and in only one of four relevant custodial cases. Plans to manage the risk of harm to others did not follow on from the assessment in three cases and contingency planning was weak in two.

2.4. Only half of the plans to address the risk of harm to others had been reviewed sufficiently well. On occasion, risk management plans were not reviewed when children and young people's circumstances changed, for example, when they were first sentenced or when significant events occurred, such as further violent offending. This meant that the plans in place were not always adequate or relevant to the child or young person's circumstances. Cases deemed high risk (including high risk of harm to others, high likelihood of reoffending and/or high vulnerability) were overseen by a well established monthly high risk planning meeting. While this provided welcome additional oversight to the 'critical few' cases, it seemed that managers leading this forum sometimes overlooked the importance of ensuring that plans recorded within the case management system were up to date, comprehensive and relevant.

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

2.6. Management oversight of risk of harm work was effective in 4 of the 12 relevant cases. In two cases, we considered oversight should have been provided, but it was not evident; in others, assessments and plans which we considered insufficient had been countersigned by the manager without addressing the deficiencies.

2.7. Although all staff interviewed appeared to have an overall understanding of local policies and procedures for managing risk of harm to others, we found that some were a little unclear about when Multi-Agency Public Protection Arrangements (MAPPA) applied. Some case records suggested that ineligible cases were being managed under MAPPA when they, quite correctly, were not. This uncertainty about MAPPA had been noted during our previous inspection programme of Core Case Inspections in 2010.

3. Protecting the child or young person

3.1. In the majority of cases, vulnerability and safeguarding needs were sufficiently assessed, and these aspects were fully covered in all the PSRs examined. In four cases, where we judged the initial assessment of vulnerability and safeguarding to be insufficient, this was because of the quality or timeliness of the screening and assessment. The precise nature of the vulnerability was not always clear and relevant behaviour or information from other agencies was not always incorporated into the assessment.

3.2. Reviews of safeguarding and vulnerability throughout the sentence were sufficient in 7 out of 12 relevant cases. Three custodial cases contained insufficient reviews when significant events occurred, such as the child or young person attempting to self-harm or displaying other dangerous or violent behaviour. Other reviews were insufficient as they had not taken place as required, for instance on sentencing, or had failed to provide a comprehensive update on the previous assessment.

3.3. Satisfactory plans were in place to manage vulnerability and safeguarding, with these plans being appropriately reviewed, in around two-thirds of relevant cases. Such plans were not completed in two cases, or on time in a further three. One case responsible officer had recently developed a useful aid for assessing and planning to manage vulnerability, consisting of a 'vulnerability awareness' worksheet. He used the worksheet as a means of checking the understanding of the word 'vulnerability' with the child or young person, exploring past and current situations in which they had either felt or been vulnerable, before drawing up intervention and vulnerability management plans with them.

3.4. As with the planning to manage risk of harm to others, management oversight of vulnerability and safeguarding work was effective in less than half of the relevant cases. This was either because it was required but absent, or deficiencies in assessment or plans were not addressed, or the internal forum (the high risk planning meeting) did not ensure the quality of services.

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 the child or young person's diverse needs and any barriers to engagement in the majority of cases, with learning styles and difficulties being particularly well recognised. Effective use was made of an 'in-house' speech and language therapist, who worked directly with the children and young people, as well as providing guidance to case responsible officers and social workers as to how best to engage the child or young person. Only one interviewee said that they would benefit from more training on how to recognise and respond to speech, language and communication needs.

4.2. In three cases the child or young person's status as a Looked After Child had not been fully taken into account in deciding how best to engage them with their sentence.

4.3. The child or young person and their parents/carers had been involved with the development of the PSR in every case, and with the assessment in all but two cases. This reflected the enthusiasm with which the staff seemed to approach the challenge of engaging the child or young person.

4.4. Case responsible officers gave sufficient attention to diversity needs when planning interventions in almost two-thirds of cases. Barriers to engagement and other diversity factors such as maturity and Looked After Child status, which had been identified as part of the assessment, did not always feature in the plans produced, which seemed to be a missed opportunity. Children and young people, together with their parents/carers, were sufficiently involved in planning in most cases.

4.5. Over three-quarters of the children and young people complied with the requirements of their sentence and where they did not do so fully, the response was sufficient in all but one case.

4.6. Eleven out of the twelve interviewees were felt to have a thorough understanding of local policies and procedures for engaging children and young people, and for responding to non-compliance where it occurred. Staff were clearly committed to – and were – making a difference to the lives of the children and young people under their supervision.

Operational management

The Youth Services Team had gone through a huge amount of change over the last few years, both structurally and due to a high level of maternity absence, with one-third of their 15 case responsible officers being on maternity leave at the time of the inspection. This had led to a high turnover within individual cases, but with little obvious negative impact on children and young people. The team were also experiencing some trepidation about the future, with the majority of the workforce facing transfer to a new employer on 1st April 2013. Nonetheless, most were clear about their priorities and generally felt that the culture of the organisation promoted learning and development.

Staff were also positive about the quality of their supervision by managers, with only one interviewee suggesting this was less than fully effective. We also made judgements about whether staff supervision was making a positive difference: we felt it did in nearly three-quarters of relevant cases.

Outstanding strengths

The following were particular strengths:

- Partnership working was effective. Those eligible for 'leaving care' support (aged 16 and over) benefited from the co-location of case responsible officers with social workers. This arrangement not only fostered a collaborative approach to engaging, assessing, planning and delivering work with this particular age group, but also had a positive impact on multi-agency work with younger children. In one case, a highly vulnerable 17 year old had a social worker from the leaving care team. The intervention plan drawn up by his case responsible officer dovetailed neatly with the other agency plans, including the pathway plan, and oversight of the case was provided by a manager from the leaving care team; this ensured quality of practice on the crucial issue of vulnerability in this case.
- Although the focus of this inspection was on initial assessment and planning, we found many instances of quality interventions being initiated promptly at the start of the order. Early indications were that these were likely to have a positive impact on children and young people. In one case, a valuable deterrent was being provided to a young person via a six week

programme called 'Great Expectations' which allowed them to enter prison and shadow an inmate, in order to gain first hand experience of custody. Another young person who struggled to communicate had been encouraged to volunteer for the young men's group; this enabled boys to develop team building and other life skills over a ten week period. Activities were primarily physical, but also included advice on healthy living, sexual health and relationships. In another case, a useful job vacancy booklet compiled by the employment team was helping the case responsible officer to direct and inform the young person's efforts towards gaining employment.

Areas requiring improvement

The most significant areas for improvement were:

i. the assessment of the child or young person's likelihood of reoffending (which in many cases lacked up to date analysis),

ii. plans to manage the risk of harm to others, with particular attention being paid to those sent to custody,

iii. reviews of assessments and plans at regular intervals and following significant changes in circumstances,

iv. management oversight, including supervision and quality assurance arrangements.

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 Youth Services Team 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.

Yours sincerely,

Julie Fox
HM Assistant Chief Inspector of Probation

Copy to:
Alison Williams, Director of Youth Support
Peter Bungard, Chief Executive, Gloucestershire County Council
Linda Uren, Director of Children's Services
Paul McLain, lead elected member for children's services
Will Windsor-Clive, lead elected member for crime
James Clynch, Business Area Manager YJB
YJB link staff with HMI Probation
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