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 Hartlepool

This report outlines the findings of the recent SQS inspection, conducted during 13th-15th May 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 Hartlepool Youth Offending Service. 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 very positive picture in Hartlepool. The Youth Offending Service (YOS) can be rightly proud of the substantial progress it has made since our previous inspection in 2011. Staff were well supported, committed and were delivering high quality services. They produced good quality assessments and plans and had ready access to an appropriate range of services. There was scope for further improving the quality of the work by ensuring that plans fully reflected the breadth of the issues that had been identified in the assessments undertaken in the cases.

Commentary on the inspection in Hartlepool:

1. Reducing the likelihood of reoffending

1.1. There was a timely and sufficient initial assessment of the likelihood of reoffending in 13 out of the 14 cases.

1.2. Pre-sentence reports were requested and provided to the court in 7 out of the 14 cases. All 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 was a high profile case involving a serious offence. As part of the PSR process, to help inform sentencing, the case manager was instrumental in ensuring that an assessment of the young person's mental health was undertaken. This assessment was subsequently used to inform decisions on the management of the young person during the custodial phase of his sentence. It also helped to establish, at an early stage, priorities for work to address ongoing risk of harm issues*".

1.3. Planning to reduce the likelihood of reoffending was sufficient in 11 out of the 13 relevant cases; this included both of the cases that had a custodial element.

1.4. In 11 out of the 12 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 all seven of the cases where there had been a pre-sentence report. A good quality assessment of risk of harm to others was seen in 11 out of the 13 relevant cases. Assessments of risk of harm were adequately reviewed in all but one of the cases.

2.2. In two out of the ten relevant cases, there had not been enough attention given to planning to address the potential risk of harm posed to others. The issue that detracted from the quality of those plans was that they were not timely. There was appropriate engagement with Multi-Agency Public Protection Arrangements in the single case where this was required. In all but one of the relevant cases, reviews of the risk of harm had been done to an acceptable standard. In one example we noted: "*In this case the young person presented with a range of complex risk of harm and vulnerability factors. These included; substance misuse, fractious family relationships, attention deficit hyperactivity disorder, negative peer influences, self harm and she was seen as being vulnerable to sexual exploitation. The case manager undertook a comprehensive assessment of these issues and produced an effective intervention plan. There was evidence of a multi-agency response to this young woman's needs and the case manager coordinated the work. The case manager and the YOS nurse worked closely together and involved other workers, e.g. YOS engagement officers and police officers. The case manager secured funding for the young person to attend an activities programme. There was clear evidence of positive engagement with the young person and her family and progress was being made in tackling the issues that were linked to the risk of harm that she posed to others*".

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

2.4. Management oversight of risk of harm work was effective in over three-quarters of the relevant cases.

3. Protecting the child or young person

3.1. Six of the seven pre-sentence reports had adequately assessed vulnerability issues. For the sample overall, all but two had sufficiently assessed the safeguarding and vulnerability needs of the children and young people. The factors that had detracted from the quality for these two cases were that either the screening or the assessment had not been timely. Planning to address vulnerability and safeguarding issues was sufficient in just

over three-quarters of the relevant cases. Reviews of safeguarding and vulnerability planning were required in 12 cases; this had happened to an acceptable standard in ten. In one case we noted: "*This plan clearly and accurately reflects the circumstances of the case, the actions that are to be taken, why and by whom. It is also clear that the case manager is working effectively with several different agencies to ensure that the risk of harm posed by the young person is being reduced and that she is being safeguarded from the factors that make her vulnerable. These include measures to address housing needs, substance misuse, possible sexual exploitation and employment. Factors which might trigger an increase in the risk of harm, or of vulnerability, have been identified along with clear contingency plans to tackle them should they arise*".

3.2. Management oversight and quality assurance of safeguarding and vulnerability assessments and plans were effective in more than three-quarters of the cases. In Hartlepool, staff had ready access to managers to discuss case issues. We noted that there was evidence of regular management oversight and quality assurance input into cases and this had had a positive impact on the work being done. Staff also made good use of the 'Risk and Vulnerability' planning forum, to help them to identify priorities along side partner agencies and to review progress.

3.3. In our view, staff members had sufficient experience, knowledge and support to enable them to effectively address vulnerability issues in their work with children and young people.

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 assessments and in planning for interventions. Whilst we found that attention was being paid to including diversity issues in case planning, we noted that many of the plans did not fully reflect the depth of work that had been done on those issues. On that basis there is the potential to further improve the quality of the work done by case managers by ensuring their plans convey the full scope of the work they are doing.

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. Eight 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 presented with complex issues and demonstrated challenging behaviour. Many required regular input to secure their engagement in supervision. Case managers showed persistence in dealing with compliance issues and were innovative in their approaches to securing the engagement of children and young people under their 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

We found that Hartlepool YOS had responded to their previous inspection by implementing a range of measures aimed at improving the quality of their work. This included co-locating the team with relevant partner services and developing practice guidance for work that tackled risk of harm to others, vulnerability and compliance. Case managers had welcomed these developments and had incorporated them into their practice. Staff reported that they were well trained and supported in

their work and that they were clear about what was required of them. We found that staff were aware of the principles of effective practice and of the local policies and procedures that related to addressing risk of harm, vulnerability and compliance in their work with children and young people.

Case managers also valued the improved arrangements for management oversight of practice and, in particular, the development of the forum for practitioners to collectively review risk of harm and vulnerability issues. We saw evidence of these arrangements in use and noted the positive contribution they had made to the quality of work being undertaken by staff.

Key strengths

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

- There was routine engagement with children and young people and their parents/carers in carrying out initial assessments and in case planning. This was often in the face of challenging circumstances and we noted the determination and persistence shown by staff in this respect.
- The assessments of risk of harm and vulnerability issues were of good quality and reflected the skills and experience of staff and the organisational support that underpinned their work.

Area requiring improvement

The most significant area for improvement was:

i. In all cases, assessments, plans and reviews of work to tackle risk of harm and vulnerability should be timely.

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 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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