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 Hertfordshire

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, to promote continuous improvement by the organisations that we inspect and contribute 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 47 recent cases supervised by the Hertfordshire Targeted Youth Support 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 mixed picture in Hertfordshire. Case managers were committed to providing a good service to children and young people and while we saw some work of a good standard, in too many other cases assessments and plans were insufficient, particularly with regard to managing the child or young person's risk of harm to others and their own vulnerability. With a few exceptions, management oversight arrangements had not been effective in assuring the quality of work undertaken.

Commentary on the inspection in Hertfordshire:

1. Reducing the likelihood of reoffending

1.1 The initial assessment of the likelihood of reoffending in 26 out of 46 cases we saw was completed in time and was satisfactory. In the remaining 20 cases, the initial assessments were not deemed to be of acceptable quality because they contained unclear or inadequate evidence or failed to identify vulnerability or other factors linked to reoffending, emotional/mental health, substance misuse or education, training and employment. In six cases, the assessment was largely a copy of a previous assessment, without being properly updated.

1.2 We consider that it is vital to review periodically what is happening in a child or young person's life as this can change very rapidly. In Hertfordshire, 27 of the cases we saw had reached the stage of needing a review, and 15 had been reviewed properly. The remaining reviews were not good enough because they had not taken place after significant changes, had not updated historic information or were copies of previous assessments without proper updates.

1.3 For the court to make a fully informed decision about a sentence to be imposed on a child or young person, they need the best information from the service. Pre-sentence reports (PSRs) were requested and provided to the court in 31 cases. Just over half were of good quality and had been underpinned by effective management oversight. A few PSRs either were not analytical enough or were based on old assessments of the likelihood of reoffending. Other missing elements included thorough assessments of risk of harm to others and vulnerability.

1.4 After the child or young person receives a sentence from the court, the service must plan how to deliver work to reduce their likelihood of reoffending. These plans were acceptable in 26 of the cases. Plans which were not good enough included those not sequenced according to risk of harm to others or reducing the likelihood of reoffending.

1.5 Planning for work to reduce likelihood of reoffending through the custodial phase of the 13 cases where the child or young person was in custody was adequate in just over half of them. In one case we noted '*An excellent plan for early release on electronic tag was developed after effective reviews of the issues, involving some innovative interventions and a robust multi agency approach. Six appropriate objectives were set and the case manager had a good understanding of sequencing to address risk of harm. Agencies and referrals included in the release plan were: family project to support mother (and other family members), the Adolescent Drug & Alcohol Service for Hertfordshire (ADASH) for support with drug issues, referral for money advice made, referral to knife crime group and to 'crash bang' (a car crime programme), victim liaison work, referral to Y'z Up*[1] *and referral to the health worker for mental health support and counselling*".

1.6 Half of the plans were reviewed satisfactorily in those cases where a review was needed.

2. Protecting the public

2.1. The initial assessment of the child or young person's risk of harm to others was not good enough in 30 of the cases sampled. Sometimes initial assessments and screenings did not take place, relevant previous offences or behaviour were overlooked, victims were

[1] The Y'z Up programme from Watford YMCA includes employability skills, personal budgeting and financial management, four days of work experience, design and delivery of a community challenge (people to raise funds to provide a positive activity for a community group), input around health and lifestyle choices, an Away Day at an outdoor education centre, and a final presentation event for children and young people to showcase their achievements to friends, family and supporters. Children and young people achieve a City & Guilds Level 1 Award in Employability and Personal Development, a Thank You Award for volunteering and an up to date good quality CV.

ignored, staff did not understand risk of harm to others or the nature or level of the risk of harm was unclear.

2.2. In 17 out of the 26 relevant cases, the assessment had either not been reviewed well enough, at regular intervals or following a significant event. Of those 23 plans which should have been reviewed, 20 had not been done well enough. Reviews were either not undertaken, were late, were not good enough or did not take account of new information.

2.3. In 18 out of the 31 relevant cases, PSRs did not contain a thorough assessment of the risk of harm to others.

2.4. Planning to address the child or young person's risk of harm to others was not satisfactory in 31 out of the 38 cases where this was an issue. This pattern was repeated in custody cases, where 10 out of the 13 relevant cases had deficient planning to address the risk of harm to others in the custodial period. In six cases, no formal planning to manage risk of harm to others had been completed and in other cases not enough notice was paid to particular areas such as victims' issues and contingency planning, particularly prior to release from custody. Staff did not always anticipate potential changes in risk of harm to others. They also did not include required interventions in the sentence plans.

2.5. We also noted in one case that '*There has been some good co-working with the schools in this case and this has helped to protect the original victim (who was at the same school at the time) as well as possible future victims (the young person is now at a school where young people who are younger than him are on a separate site). The case manager's insistence on involving school directly in the formulation of the risk management plan is a positive feature too*'.

2.6. In 37 cases where there was an identifiable victim or potential victim, the risk of harm they faced had been effectively managed in 17. Engagement with Multi-Agency Public Protection Arrangements (MAPPA) in the assessment and planning of all four relevant cases was not adequate.

3. Protecting the child or young person

3.1. The initial assessment of the child or young person's vulnerability and safeguarding needs was found to be sufficient in just over half of the cases sampled. Where the assessment was not good enough, this was usually because the vulnerability screening was of insufficient quality, hadn't happened at all or had overlooked relevant information about the child or young person's behaviour. The nature of the vulnerability sometimes wasn't identified or was inaccurate. Assessments of the child or young person's vulnerability and safeguarding needs were not reviewed sufficiently well in 15 out of the 27 cases where a review should have taken place.

3.2. Planning to address vulnerability and safeguarding issues was good enough in 19 of the 39 relevant cases, but 11 cases did not have a formal vulnerability management plan at all, where we thought there should have been one. There were also poorly planned responses or too little attention being given to diversity factors, contingency planning, poor anticipation of potential changes or planning for emotional and mental health, education training and employment, care arrangements and substance misuse.

3.3. Planning to address vulnerability and safeguarding was better in the 13 custody cases, where seven cases had a sufficient plan in place. Overall, plans had not been sufficiently reviewed in 15 cases and in three had not been reviewed at all.

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 in nearly two-thirds of cases. It was then used in 65% of the reports.

4.2 Evidence of good levels of involvement of the children and young people, and their parents/carers was seen in the assessment and planning of interventions and especially in the development of the PSR. In one case we noted '*There was productive engagement with the young person's mother and family. His mother and sister were taken along with the case manager to the young offenders' institute for his initial assessment and although their contributions were valued, he was also seen alone. The case manager made efforts to get the family to support the young person in the community. He had previously lived with his sister and after some information of concern came to light, the case manager made an unannounced home visit with the allocated social worker. The findings resulted in the sister and her children receiving an assessment and subsequent referral to a family project for support. The risk management plan was then changed to enable the young person to live with his mother on release*'.

4.3 The child or young person and their parents/carers had been involved in the assessment and planning of interventions in 27 out of the 47 cases. However, the plans did not always reflect the child or young person's views on priorities.

4.4 Overall, the service gave sufficient attention to the health or well-being of the child or young person where it might act as a barrier to successful outcomes from the sentence.

4.5 The great majority of children and young people had complied with their supervision and this was a credit to the efforts made by case managers including visiting the home and working with parents/carers. In one case we noted that '*the young person has engaged with the order and has not missed any appointments without permission. It is fair to say that he presents as motivated but fails to back this up when it matters, but the case manager…is very much on top of the case and…is encouraging the young person to engage and move forward*''.

Operational management

The cases we inspected were held by Hertfordshire Targeted Youth Support Service[2]; a service which has experienced enormous changes since it was a Youth Offending Team. This transition has not yet ended.

We found that in three-quarters of all cases, staff supervision or other quality assurance arrangements had not made a positive difference, in particular with regard to risk of harm to others (94%) and vulnerability (81%). In some instances there had been no management oversight, despite concerns surrounding the child or young person's vulnerability or risk of harm to others. We found other examples where, rather than providing advice on how to improve, practice managers had signed off insufficient assessments and plans.

We interviewed 21 case managers and they spoke positively about the new management arrangements, stating that their managers had the necessary skills and knowledge to undertake the role. All felt that their training and skills development needs were almost always met. They spoke positively about the availability of training. Despite this, case managers did not demonstrate a good understanding of local policy and procedures to protect the public, and this was reflected in the findings.

[2] Targeted Youth Support is defined as: 'Support for vulnerable young people and their families in need, focusing on support, resolution and multi agency work, through the identification of complex needs to prevent escalation into specialist services'. There are five Targeted Youth Support Teams in Services for Young People (organised on a double district basis) with a remit to work with vulnerable children and young people in need and their families. Each team brings together staff from a range of backgrounds who previously worked in Youth Connexions, Specialist Adolescent Teams, Youth Offending Teams and Independence Support Services (18+ Care Leavers).

Outstanding strength

The following was a particular strength:

- We saw a good understanding of diversity factors for individual children and young people. For example, there was a young person from a multi-racial background – a West Indian father (with whom he was not in contact), a Spanish mother and an Italian stepfather. The case manager was aware of the diversity aspects in this case and had included in her initial sentence plan an objective to get the young person involved with a black and minority ethnic group, both in relation to help fill his free time positively and to help him with issues of identity. His offending had substantially reduced; he spent more time with his parents, and had engaged with supervision.

Areas requiring improvement

The most significant areas for improvement were:

i. Assessment and planning to address the child or young person's risk of harm to others - with attention being paid to relevant offences and behaviour.

ii. Assessments of vulnerability and safeguarding needs.

iii. Review of assessments 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 Targeted 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 Caroline Nicklin. She can be contacted on 07766 290969 or by email at caroline.nicklin@hmiprobation.gsi.gov.uk.

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