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 Milton Keynes

This report outlines the findings of the recent SQS inspection, conducted during 11th-13th 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 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

Milton Keynes YOT had experienced significant staff turnover during the last 12 months. The restructuring of early help provision resulted in prevention work being moved out of the YOT with the consequent loss of some key staff. There was uncertainty about the position of the YOT itself. Against this backdrop, we found that children and young people were complying with the orders imposed by the courts and that the YOT was working with them to improve outcomes. There were examples of some thoughtful assessments and plans. Overall, however, assessment and planning needed to improve and it was of particular concern that information from children's social care services was not always sought or taken into account at that stage. Management oversight had not always picked up these deficiencies.

Commentary on the inspection in Milton Keynes:

1. Reducing the likelihood of reoffending

1.1. Initial assessments were carried out on time, however the majority (nearly two-thirds) were not judged to be of good enough quality. This was mainly due to unclear or unsatisfactory evidence and failure to draw on information or assessments held by other agencies. In particular, the absence of information from children's social care services was concerning. This also contributed to the inadequate assessment of care arrangements. Home visits did not always take place as part of the assessment which was an omission, particularly for younger children. Additionally, a number of assessments were merely copies of previous ones without being properly updated.

1.2. We judged the quality of almost two-thirds of pre-sentence reports to be good. Where they fell short, it was mainly due to an inadequate assessment of risk of harm to others or because they were not analytical enough. Local management arrangements were largely effective in ensuring the quality, although those judged insufficient had been through that process.

1.3. In over half of the cases inspected, the planning was not considered good enough to help to reduce reoffending. In a number of cases the plan did not reflect the assessment or meet the needs that had been identified by the case manager, including the diversity factors that had been noted. In four out of the six custodial cases inspected, the planning was considered unsatisfactory. Attention was not always paid to restorative justice and victims.

1.4. Conversely, we saw some planning that was thoughtful and reflected the diversity of the child or young person involved. In one case, where literacy had been identified as an issue, the case manager had used cartoon pictures for the objectives and the sentence requirements on the plan. As there were a number of different requirements (including unpaid work and attendance centre), he had given the young person a weekly timetable with the same cartoon drawings on to help him with his appointments. In a very different case, with a child of 11 years suffering a chaotic life and who had a number of other professionals involved, the case manager had, sensibly, identified only one objective to concentrate on which was, in effect, supporting the child.

2. Protecting the public

2.1. The risk of harm that the child or young person posed to others had been assessed well enough in nearly two-thirds of cases. This left four where it was not. In some instances, case managers placed too much emphasis on their impression of the child or young person, rather than evidence such as Crown Prosecution Service papers or behaviour in other settings like care homes or education.

2.2. In some cases, the safety of actual or potential victims was not taken into account. This lack of consideration of the victim was also a feature of risk management planning, which was judged insufficient in over half of relevant cases. As a result, the risk to actual or potential victims had not been effectively managed in six out of ten relevant cases.

2.3. The management oversight of risk of harm work was largely judged to be ineffective because the deficiencies in assessment and planning were not being addressed.

2.4. All the case managers we interviewed demonstrated an understanding of the policies and procedures for the management of risk of harm. In some cases however, the understanding of the process had not resulted in enough thought being given to the implications of behaviour and circumstances.

3. Protecting the child or young person

3.1. In three-quarters of cases there was satisfactory assessment of the child or young person's vulnerability. In those judged not good enough (5 out of 20), relevant behaviour or circumstances had been ignored or not recognised and reviews had not rectified the assessment.

3.2. Planning to address vulnerability was considered good enough in nearly two-thirds of cases. In other cases, there was inadequate attention paid to barriers to engagement or the planned response or contingency planning was unsatisfactory. In four out of the six custodial cases, there was sufficient planning to address safeguarding issues. In one case, however, we saw a planning meeting for a Looked After Child who was remanded in custody which was not attended by either the YOT case manager or the social worker. We consider this unacceptable.

3.3. Management oversight of work to address safeguarding and vulnerability was judged to be ineffective because the deficiencies in assessment and planning had not been addressed.

3.4. All of the case managers we interviewed demonstrated understanding of the local policies and procedures for the management of safeguarding; however, this had not always resulted in vulnerability being recognised or acted upon.

4. Ensuring that the sentence is served

4.1. Barriers to engagement and diversity issues were assessed well enough in almost three-quarters of cases, and children and young people and their parents/carers were properly engaged in most assessments.

4.2. They were not sufficiently involved in the planning, however, and it was disappointing, given the assessments, that planning did not pay enough attention to diversity in over half of the cases. Identified and detailed speech, language and communication needs did not feature in nearly half of the plans. This echoed a finding of the Core Case Inspection in 2011.

4.3. We saw some good examples of work with diversity. One case manager spent several sessions with a young person covering the basics of time and calendar months, after it became clear that he was unable to comprehend either measurement. Overall, we judged that the YOT paid attention to the health and well-being of children and young people.

4.4. In the main, children and young people complied with the requirements of the sentence and where enforcement was necessary the YOT responded appropriately.

4.5. All the case managers we interviewed demonstrated understanding of the local policies and procedures relating to engagement and compliance.

Operational management

All the staff we interviewed were positive about the supervision and support they received and they described the procedures for management oversight as effective. However, we found that in 11 out of 16 cases there was no evidence that staff supervision had made a positive difference to the case. There were a number of processes in place to support staff in the management of cases but there was no evidence that these adequately challenged decisions or assumptions, where necessary, or led to improved practice. We saw a small number of cases where management oversight was not as robustly investigative as the case required.

Areas requiring improvement

The most significant areas requiring improvement were:

i. The quality of assessment; the use of all relevant sources of information/evidence and an *analysis* of that information.

ii. Planning should be based on the assessment and should fully engage the child or young person, their parents/carers and other involved agencies.

iii. Management oversight.

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 YOT 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 Jane Attwood. She can be contacted on 07973 614573 or by email at jane.attwood@hmiprobation.gsi.gov.uk.

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