Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

HM Inspectorate of Probation
6th Floor, Trafford House, Chester Road, Stretford, Manchester M32 0RS
0161 869 1300 www.justice.gov.uk/about/hmi-probation

To:	Jill Beaumont, Chair of Oldham Youth Justice Management Board
Copy to:	See copy list at end
From:	Julie Fox, Assistant Chief Inspector HM Inspectorate of Probation
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Report of Short Quality Screening (SQS) of youth offending work in Oldham

This report outlines the findings of the recent SQS inspection, conducted during 8th-10th April 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 Oldham Youth Justice 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 lot of good work being carried out by Oldham Youth Justice Service. Engagement of children and young people and their parents/carers was a priority and clearly evident. Successful resettlement was given prominence with children and young people in custody very well supported. Good assessment of offending-related factors, including individual need and barriers to engagement, together with plans which followed the assessment, underpinned the work. Improvement was necessary in assessment and planning to manage risk of harm to others; however, particularly the protection of actual and potential victims. Planning to manage vulnerability also required attention. Management oversight was not evident and needed to be formalised.

Commentary on the inspection in Oldham:

1. Reducing the likelihood of reoffending

1.1. Initial assessments were carried out on time and were judged to be of good enough quality in all but two of the cases. There was a good level of thoughtful analysis of the information in most of the assessments.

1.2. We judged the quality of all of the pre-sentence reports (PSRs) that we saw to be good. They contained a thorough analysis of the offences before the court and relevant information about the child or young person. Report authors offered suitable and proportionate proposals, where necessary as an alternative to custody. Where they fell short, it was mainly due to the assessment of the risk of harm to others. While PSRs generally contained the correct categorisation of the risk of harm posed, we found the analysis to be perfunctory and formulaic, and likely to be unhelpful to sentencers. Local management arrangements were largely effective in ensuring the quality of PSRs but this did not extend to stand-down reports.

1.3. In the vast majority of the cases inspected, the planning was considered good enough to help reduce reoffending. Plans generally followed the assessment of the reasons a child or young person had offended and included the appropriate areas of work to be carried out. We did not consider that they were particularly useful to the child or young person however, because they had not been involved in the planning. In four out of the six custodial cases inspected, the planning was considered satisfactory.

1.4. There was close working with partner agencies, particularly within the family support services, which demonstrably benefited children and young people. For example, when it was recognised that the deterioration in a young person's relationship with his father was directly linked to his offence, a referral was made swiftly to the Family Intervention Programme to help with family work.

1.5. All of the case managers whom we interviewed demonstrated a good understanding of the principles of effective practice.

2. Protecting the public

2.1. The risk of harm that the child or young person posed to others had not been assessed well enough in nearly half of the cases inspected. In some cases relevant previous convictions or behaviour had been ignored and patterns of offending had, therefore, not been recognised.

2.2. In a small number of cases, insufficient attention had been paid to victims or potential victims. There was an over-concentration on the definition of *serious* harm which, in some instances, left harmful behaviour unassessed. Reviews were not considered good enough in over half of the cases.

2.3. There were a small number of cases where plans had not been prepared even though the risk had been assessed as medium or above. Where plans had been produced, they were not focused clearly enough on the actions that needed to take place. Of more concern, in five cases there was insufficient evidence that the risk posed to an identifiable or potential identifiable victim had been effectively managed. This was largely due to deficiencies in the assessment and/or planning, although in some cases it was due to a failure to identify or recognise a victim or potential victim.

2.4. The management oversight of risk of harm work was largely judged to be ineffective because the deficiencies in assessment and planning had not been addressed. The

arrangements for the *formal* management oversight of assessment and planning needed to improve.

2.5. All the case managers we interviewed demonstrated an understanding of the policies and procedures for the management of risk of harm to others; however, there was some evidence that the processes around risk of *serious* harm had impacted detrimentally on this aspect of work.

3. Protecting the child or young person

3.1. In three-quarters of cases there was a satisfactory assessment of the child or young person's vulnerability. In those judged not to be 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 over two-thirds of cases including four out of the six custodial cases. Plans had not been produced in five community cases where they were needed.

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. Again, the arrangements for management oversight of this aspect of work needed to improve.

3.4. All the case managers we interviewed demonstrated understanding of the local policies and procedures for the management of safeguarding.

4. Ensuring that the sentence is served

4.1. Working with diversity was a real strength within the service. Barriers to engagement and diversity issues were assessed in most cases. For example, in one case a young person had revealed that he was deaf in one ear but refused to wear a hearing aid. As a result, his behaviour could be loud and appear intimidating. The case manager had reflected this in his assessment and sentence plan and had shared the information with other relevant professionals.

4.2. Children and young people and their parents/carers were properly engaged in all but one assessment and in the preparation of all the PSRs we inspected. Reports paid good attention to individuality of the child or young person in all cases. It was the policy of the service for PSR authors to go to court with those children and young people who were at risk of custody which we consider to be good practice.

4.3. A particular strength was the Integrated Resettlement Support (IRS) service provided to children and young people in custody. This commenced at the point of sentence and concentrated on accommodation and education, training and employment. The case manager remained involved alongside the IRS worker and all children and young people in custody received monthly visits. Parents/carers were well supported during this period too, often being transported to meetings and being visited at home to promote continued contact and engagement.

4.4. Given this, it was disappointing that children and young people and their parents/carers were not always sufficiently involved in the planning. Despite this, diversity needs were largely factored into plans by case managers. Overall, we judged that the service paid good attention to the health and well-being of children and young people.

4.5. The YOS's engagement and compliance policy had been recently reviewed to improve its effectiveness. There was a lack of consistency among case managers in respect of

enforcement, suggesting that the policy was not yet fully embedded. In a small number of cases, we judged that the response to non-compliance had not been good enough. Recording of judgements about failed appointments contributed to this. Conversely, we saw some very good judgements made, balancing engagement with enforcement.

4.6. All of the case managers we interviewed indicated that they understood the local policies and procedures relating to engagement and compliance, although it would seem that the inconsistencies belied this somewhat.

Operational management

Most of 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 14 out of 18 cases there was no evidence that staff supervision had made a positive difference. There were a number of processes in place to support staff in the management of cases. Managers were visible and available to case managers; however, the evidence of formal management oversight was not there and the deficiencies in assessment and planning in important areas of work demonstrated that this was more than just a recording issue.

Key strengths

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

- Timely and thoughtful analysis and assessment of offending-related factors.
- Resettlement support.
- Engagement of children and young people and their parents/carers.
- Work with diversity.

Areas requiring improvement

The most significant areas for improvement were:

i. The assessment of the risk of harm to others should take into account all previous relevant convictions and behaviour, and identify actual and potential victims.

ii. Planning for the management of risk of harm to others should be action-focused and prioritise protecting actual and potential victims.

iii. Where vulnerability has been identified, action-focused planning should be in place.

iv. Formal management oversight.

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 YJS 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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