Inspection of Youth Offending Work
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Report of Short Quality Screening (SQS) of youth offending work in Kent

This report outlines the findings of the recent SQS inspection, conducted from 19th to 21st May 2014. 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 this inspection was to assess the quality and effectiveness of recent casework with children and young people who had offended. In order to do this, we examined 47 cases supervised by Kent Youth Offending Service (YOS). Wherever possible this was 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 - www.justiceinspectorates.gov.uk/hmiprobation

Summary

We found that the overall quality of work with children and young people in Kent had improved significantly since we last inspected the YOS in 2011. Enthusiastic staff were working hard to analyse the needs, vulnerabilities and risks of those sentenced by the courts, in order to plan the required work. However, in some cases, the desire to engage effectively with the child or young person, and to respond to their unique needs, resulted in a lack of focus on the victim of their offences and on potential future victims. This gap was not sufficiently addressed through management oversight. Nonetheless, we were pleased to find that an effective overall service was being delivered.

Commentary on the inspection in Kent:

1. Reducing the likelihood of reoffending

1.1. The initial assessment of the child or young person's likelihood of reoffending was sufficient in all but eight of the cases sampled. Only four were considered insufficient, while others were not timely, not completed, or done so late as to be largely irrelevant. The vast majority of assessments of likelihood of reoffending were thoroughly researched, well analysed and covered the child or young person's perspective about reasons for their offending. This area of work had improved considerably compared with our previous inspection in 2011, when only just over half of initial assessments were considered sufficient. However, greater attention needed to be given to reviewing such assessments; only 17 of 29 relevant assessments had been reviewed sufficiently well, which was disappointing.

1.2. Of the 28 pre-sentence reports (PSRs) we examined, three-quarters were of good quality, while a small number insufficiently analysed the child or young person's vulnerability or their risk of harm to others. The court adjourned one case for a speech and language assessment to supplement the PSR. The ensuing assessment was described by the inspector as *"excellent",* particularly since it identified specific ways to maximise the young person's engagement with the YOS. Not surprisingly, those PSRs written by the staff member supervising the child or young person (the case manager) were stronger than those written by someone else, given the case manager's greater knowledge of the child or young person. We suggest the YOS allows report writing by the *relevant* case manager subject to that individual being fully skilled and competent in undertaking this task.

1.3. Planning to reduce the likelihood of reoffending was a real strength of the YOS. This was satisfactory in all of the custodial cases examined and in most of the community cases. Staff had good links with the secure estate and attended sentence planning review meetings, together with family members where possible, as well as visiting in between these meetings to provide additional support to the child or young person.

1.4. The YOS had developed a localised intervention plan, which all inspectors commented upon favourably. We saw many good examples of such plans being written from the child or young person's perspective and in child-friendly language, which clearly simplified the process for the child or young person. The format of the plan had been developed with the benefit of input from the speech and language specialist. These plans linked objectives to the child or young person's likelihood of reoffending, risk of harm to others and vulnerability, although in some cases it was not obvious how planned work would meet the assessed need. Referral order contracts, by comparison with localised intervention plans, were more wordy and unwieldy; they would benefit from revision along similar lines.

1.5. Given the focus on the child or young person, the victim's, or potential victim's, perspective was not always well addressed within intervention plans. There were five instances where this was the case, which left some room for improvement.

1.6. Most plans relating to the likelihood of reoffending had been reviewed well.

2. Protecting the public

2.1. In eight out of every ten relevant cases the assessment of risk of harm to others posed by the child or young person was sufficient. A similar proportion of assessments of risk of harm were reviewed well. Case managers were alert to the need to take other behaviour

into account, as well as formal convictions; this was in stark contrast to our findings on the last inspection.

2.2. Although the victim perspective was lacking in a small number of assessments of the risk of harm the child or young person posed, one case manager had responded particularly well to the need to protect potential victims; the inspector noted: "*Paul was serving a long custodial sentence for serious sexual offences. His mother was keen that two of his teenage friends should be allowed to visit him in custody and was exerting some pressure on the case manager to approve them as visitors. The case manager felt this was wholly inappropriate, particularly since the teenagers thought Paul was serving a sentence for drugs offences. She resisted the pressure, thereby preventing potential victimisation".*

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

2.4. There was sufficient initial planning to address the risk of harm to others in 31 out of the 38 cases where this was an issue. Again, this was a significant improvement compared with the last inspection, when less than half of such plans were sufficient. We saw many positive examples of joint working in complex cases where children and young people had a range of needs, including serious mental health or substance misuse needs. In three-quarters of the relevant custodial cases, planning to address the risk of harm to others was satisfactory.

2.5. Most risk management plans were reviewed thoroughly and there were some positive examples of case managers responding effectively to changes in risk; one inspector commented: "*Susie came to the YOS office in possession of a large knife, telling staff that she intended to use this in an attack on another girl. Staff retrieved the knife, called the police and were supporting the ensuing prosecution. As a result of this incident, the immediate reaction from other professionals working with Susie was to assume that she was unsuitable for lone working. The case manager rejected this notion, as she did not feel at all under personal threat from Susie, largely due to the effective working relationship they had established. With the support of her line manager, she met with the other professionals and persuaded them that the risks were not directed at them but were manageable. This reinforced for Susie that no one was prejudging or giving up on her. Nonetheless, the risk of harm to others was, rightly, reassessed as 'high' in the light of this incident and the plan to manage risk was adjusted"*.

2.6. Management oversight of risk of harm work was evident in the vast majority of relevant cases and found to be effective in seven out of every ten. However, we noted instances where managers had asked for work to be done, but had evidently not monitored its completion. Similarly, some assessments and plans which we considered insufficient had been countersigned by the manager without addressing the deficiencies.

3. Protecting the child or young person

3.1. There was a satisfactory initial assessment of vulnerability in over three-quarters of cases, although such assessments were thoroughly reviewed throughout the sentence in a slightly lower proportion of cases. Generally, staff liaised effectively, where required, with other specialist services, such as mental health and children's social care, and took a broad perspective on what made children and young people vulnerable. This was both pleasing to note and in contrast to the last inspection. In the ten cases where we judged the initial assessment of vulnerability and safeguarding to be insufficient, this was for a range of reasons, including delays in completing the screening and assessment or other issues relating to quality.

3.2. The most frequent cause of reviews of vulnerability being deficient was their not having taken place when a significant change occurred in the child or young person's circumstances, such as being sentenced or moving accommodation.

3.3. Satisfactory plans were in place to manage vulnerability and safeguarding in less than two-thirds of relevant cases, although some more conscientious case managers completed plans to manage even low level vulnerabilities, which was impressive. Where gaps arose, these were for a range of reasons, including the planned response being insufficient or unclear, planning being delayed or contingency planning being lacking.

3.4. Effective planning was in place to manage vulnerability within the custodial setting in all but two of the custodial cases.

3.5. Reviewed plans to manage vulnerability were more thorough than initial plans in all but four relevant cases; this demonstrated a significant improvement since the last inspection including over recent months.

3.6. Management oversight of vulnerability and safeguarding work, although generally evident, was less effective than that in relation to risk of harm work; it needed to improve as it was effective in only 19 out of 32 relevant cases. This was primarily because deficiencies in either plans or assessments of vulnerability were not addressed, which some staff attributed, at least in part, to the upheaval caused by various reorganisations within the YOS. However, the following case demonstrated very effective work to protect one young man, well supported by management. The inspector commented: "*Management oversight was effective in this case. The initial assessment was quality assured, with recommendations for improvements being made and followed up. Unpaid work had been ordered by the court, despite not being recommended in the PSR due to the young man's vulnerability (he was considered rather naïve, having been coerced into the offence by peers). The case manager liaised closely with the probation trust regarding the placement they would give to him, ensuring they understood his diverse needs. The case manager then took him to both his unpaid work assessment interview and to his first work sessions. A potentially huge obstacle was overcome through this proactive approach".*

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 great majority of cases. This was in marked contrast to the previous inspection when the needs of some groups of children and young people had not been recognised or addressed. Attention was paid to the child or young person's health and well-being in all but three cases.

4.2. Case managers often made good use of the self-assessment questionnaire *What do YOU think?* to inform their assessments; one practitioner had revised the language within this survey to make it more personal and relevant to children and young people. Case managers were clearly skilled at adapting their approach to suit the individual. One worker (a student social worker) was in the process of gaining the help of a traveller to assist with engaging and motivating a young man from this community who had particular communication difficulties.

4.3. In another case, the inspector commented: "*Tony's previous engagement with the YOS had been poor so the case manager knew that he would not be easy to motivate when he received a new community order. She set very clear boundaries for Tony (and for his mother) and took the opportunity of having a student social worker co-work the case with her. This had the effect of enabling a 'good cop, bad cop' approach which was paying dividends. While the case manager monitored his compliance, the student had developed an effective working relationship with Tony, enabling him to open up to her about a range*

of issues, including his anger and other factors relating to his offending. For the first time in Tony's involvement with the YOS, he was making positive changes, including beginning to recognise that there was more to life than smoking cannabis. After initial non-compliance, he had completed his unpaid work hours, had started group work and was attending regularly. At the time of inspection, he had not reoffended".

4.4. Almost three-quarters of children and young people complied with the requirements of their sentence, some after initial difficulties. This was clear evidence of the tenacity of case managers, given the chaos which prevailed in many of the children and young people's lives. Where they did not fully comply, the response was satisfactory in all but two cases.

Operational management

In common with other youth justice organisations, Kent YOS had undergone a number of reorganisations over recent years and months, primarily in order to meet budgetary pressures. This had led, understandably, to some staff feeling less clear about their understanding of the priorities of the organisation. Nevertheless, only one interviewee thought that the culture of the organisation did not promote learning and development sufficiently well. Most felt that the YOS offered good training opportunities, although these were mostly designed to equip them to do their current job, rather than focusing on their future development. Others bemoaned a lack of training in both assessment and intervention skills to deal with children and young people who sexually offended.

Nearly all staff interviewed were very positive about the quality of the supervision they received from 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 22 of 38 relevant cases, which left some room for improvement.

Key strengths

- The quality of assessments and plans produced by Kent YOS had improved significantly since the last inspection. The locally adapted intervention plan was child-friendly and aided positive engagement with children and young people.
- Partnership working was strong and supported effective intervention planning, as in the following example noted by one inspector: "*A sentence planning meeting was arranged shortly after Teresa's release from custody and chaired by a senior manager from the YOS, given the complexities of the case. A range of parties attended including Teresa, her parents, the case manager, the social worker, a social work student, the resettlement worker from the prison, a youth justice worker and the YOS police officer. Between them, they managed to engage Teresa in the process and produced an effective plan for further work with her in the community. As a consequence, Teresa's compliance with her licence had been generally good*".
- While relationships between young people and their case managers were healthy, these did not interfere with case managers' ability to enforce court orders; case managers achieved the delicate balance between welfare and enforcement with sensitivity and skill.

Areas requiring improvement

- Management oversight should be improved in order to ensure that assessments and plans maintain a perspective on the victim or potential victim, while retaining a clear focus on the need to safeguard the child or young person.
- Managers should monitor cases more systematically to ensure that assessments of likelihood of reoffending are reviewed well and in a timely fashion.

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 Helen Rinaldi. She can be contacted at helen.rinaldi@hmiprobation.gsi.gov.uk or on 07717 361639.

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