Inspection of
Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

HM Inspectorate of Probation
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Chair of Hounslow Youth Crime Management Board
Hounslow Youth Offending Service

28 November 2012

Dear Chair,

Report of Short Quality Screening (SQS) of youth offending work in the London Borough of Hounslow

This report outlines the findings of the recent SQS inspection, conducted during 12th–14th November. 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 Ofsted 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

Overall, we found that the majority of initial assessments and pre-sentence reports (PSR) were sufficient. Assessment of diversity factors could be improved. The quality of many initial plans and reviews of assessments and plans were not good enough. Management oversight was taking place but was not yet effective. Children and young people and, where appropriate, parents/carers were not involved in the planning process.

Commentary on the inspection in the London Borough of Hounslow:

1. Reducing the likelihood of reoffending

1.1. In all except one case there was a timely and sufficient assessment of the factors that were associated with why the child or young person committed the offence. There were a number of examples where case managers had accessed a wide range of sources of

information to inform the assessment including *What do YOU think?,* a self-assessment completed by the child or young person. There was evidence in some cases of well thought out and structured analysis with a rationale for scores in each section of the assessment.

1.2. Reviews of the likelihood of reoffending should take in to account any change of circumstances in the child or young person's life or the impact of any work completed with them. However, in a number of cases reviews were not completed or were simply a copy of the previous assessment.

1.3. PSRs were provided to the court in 11 cases and generally they were of a good quality. There was not always evidence in the case file that a report had been quality assured before it was submitted to the court. All reports gave sufficient attention to appropriate alternatives to custody which were well argued.

1.4. Plans to reduce the likelihood of reoffending were sufficient in the majority of cases, although less so for those children and young people sentenced to custody. Five plans did not focus on how to reduce the likelihood of reoffending or give enough priority to it. In 13 cases where a review of the plan was required six were not completed.

2. Protecting the public

2.1. In five cases the assessment of risk of harm to others posed by the child or young person was insufficient. This was because the case manager had not taken into account relevant behaviour of the child or young person, for example behaviour at school, which would have contributed to the analysis of risk of harm and the accuracy of the assessment. Risk of harm assessments did not address the risk to actual or potential victims and case managers had not taken the safety of victims into account.

2.2. In all 11 PSRs there was a clear and thorough assessment of the risk of harm to others.

2.3. A child or young person's risk of harm to others is not static, it can change. There are certain significant changes that are associated with an increase in risk of harm, for example an increased use of alcohol or drugs. We found that reviews of risk of harm were insufficient because they had not been completed when required and, therefore, there was no current assessment of the child or young person's risk of harm; or there had been a significant change or incident which should have triggered a review of risk of harm and the review was not completed.

2.4. Plans should include actions to minimise the risk of harm to others posed by the child or young person. Risk management plans were insufficient, mainly because planned responses if the risk of harm increased were passive (for example - review risk of harm, arrange a risk management panel, update the plan) and did not actively contribute to protecting the public. Plans could have been proactive, for example by including action to set up mechanisms to gather information, via the YOS police officer or other professionals, about the child or young person or where they lived so that any changes in risk of serious harm could be assessed quickly and action taken if necessary. Reviews of plans were either not completed or of insufficient quality. It was not clear from reading the review whether actions in the first plan had been completed or progressed.

2.5. There was sufficient engagement with Multi-Agency Public Protection Arrangements (MAPPA) in the assessment and planning in one case. In another case the referral to MAPPA was not timely.

2.6. Management oversight of risk of harm work was not effective because assessments and plans had either not been countersigned or if they had been countersigned they were judged by the inspection team as insufficient.

3. Protecting the child or young person

3.1. In the majority of cases there was a sufficient assessment of vulnerability and safeguarding which was reflected in PSRs. In five cases either the vulnerability classification was inaccurate or there was insufficient liaison with children's social care services. In three cases the vulnerability classification had been reduced from medium to low with no rationale recorded for this change and no management involvement. Reviews of safeguarding and vulnerability throughout the sentence were not sufficient either because reviews had not taken place or were not timely.

3.2. In one-third of cases sufficient planning had not taken place for work to address safeguarding and vulnerability because vulnerability management plans were not completed or timely. In seven cases reviews of initial plans were either not undertaken or were of insufficient quality.

3.3. Management oversight of this area of work was not effective because deficiencies in assessment and planning had not been addressed or oversight was required but not provided.

4. Ensuring that the sentence is served

4.1. In six cases there was insufficient assessment of diversity factors and barriers to engagement mainly in relation to speech, language and communication needs. However, we were pleased to see that diversity issues were addressed in PSRs.

4.2. Engagement with the child or young person and parents/carers is essential to ensure an accurate assessment and PSR. This had occurred in the majority of cases. However, such involvement was less evident with the development of initial plans, in particular the child or young person's views about what should be a priority were not reflected in plans. Plans were not written in a child friendly manner and tended to be a list of actions for the case manager, for example 'referral to substance misuse' or 'Case worker to have joined up working with Social Worker'.

4.3. In over one-third of cases insufficient attention had been given to the health and wellbeing of children and young people because agencies did not coordinate their work well. There were two cases where it was evident that a multi-agency approach had been adopted by the case manager and there was good quality communication between them and other professionals. However, we also found examples where the case manager had not spoken to a social worker, or core documents from other agencies were not on the case file, which included cases of children and young people who were Looked After Children.

4.4. Over half of the children and young people complied with the requirements of the sentence and in cases where they did not fully comply, the response of the YOS in six out of nine cases was sufficient.

4.5. Effective practice emphasises the importance of the quality of the relationship between the case manager and the child or young person. Developing a working relationship takes time but the benefit is that positive change is more likely. The inspection team noted that in a significant number of cases the child or young person had been supervised by at least two, and often three or four case managers, in just three months.

Operational management

We found that the majority of the staff we interviewed had a sufficient understanding of effective practice, local policies and procedures for the management of risk, safeguarding and responding to non-compliance. They understood the priorities of the organisation. Not all staff felt they received

effective and appropriate supervision. Countersigning/management oversight was not viewed as an effective process. However, the majority felt that their manager actively helped them improve the quality of their work.

The last inspection, in June 2011, identified management oversight as a concern. We found evidence of management oversight in almost every case. The quantity of management oversight had increased but there was room for considerable improvement with the quality or effectiveness of that oversight.

Areas requiring improvement

The most significant areas for improvement were:

i. the involvement of the child or young person and where relevant parents/carers in the creation of the plan to reduce likelihood of reoffending,

ii. to include actions which protect the public and address victims' safety in plans to manage the risk of harm to others,

iii. greater assessment and inclusion of diversity factors in plans,

iv. the quality of management oversight and staff supervision,

v. reviews of assessments and plans at regular intervals and following changes in the child or young person's life or progress against previous targets or actions.

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 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 Nigel Scarff. He can be contacted on 07766 422290 or by email at nigel.scarff@hmiprobation.gsi.gov.uk.

Yours sincerely,

Julie Fox
HM Assistant Chief Inspector of Probation

Copy to:
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Sherry Malik, Director of Children's Services
Councillor Lily Bath, Executive member of Children, Youth & Families
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