

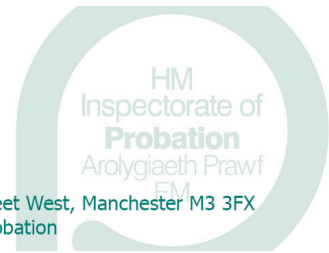


Inspection of Youth Offending Work

Arolygiad o Waith Troseddu Ieuencid

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<i>To:</i>	Neil Davies, Chair of Medway YOT Management Board
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<i>From:</i>	Julie Fox, HM Assistant Chief Inspector
<i>Publication date:</i>	22nd January 2014

Report of Short Quality Screening (SQS) of youth offending work in Medway

This report outlines the findings of the recent SQS inspection, conducted from 16th-18th December 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 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 20 cases supervised by Medway Youth Offending Team (YOT). 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 dedicated and committed staff group working hard to deliver services. The YOT had made progress since the last inspection in 2011. We saw some good assessments in pre-sentence reports (PSRs) which led to appropriate intervention plans. The team had a good understanding of diversity issues and was effective at overcoming barriers to engagement. Compliance by children and young people was good. However, we found that management oversight in ensuring the quality of risk of harm, safeguarding and vulnerability work was not always effective.

Commentary on the inspection in Medway:

1. Reducing the likelihood of reoffending

- 1.1. We were pleased to see a timely and sufficient assessment of the likelihood of reoffending in 17 out of the 18 relevant cases.

- 1.2. PSRs had been written in 14 of the 20 cases and all of them were of good quality. They contained a thorough analysis of the offences, provided the court with relevant information concerning the child or young person and offered a range of alternatives to custody. There was evidence of effective management oversight in the vast majority of reports.
- 1.3. Planning for work to reduce reoffending was variable and only sufficient in 10 of the 18 relevant cases. This was due to a range of reasons including not meeting the needs of the case, not enough focus on the victim, a lack of clarity in the objectives and not sequencing interventions. In two cases a plan had not been produced. We did see evidence of good practice in this area, an Inspector noted: "*There was a detailed assessment linked appropriately to the plan of work, including a very useful speech, language and communication assessment. This helped to identify the type and sequencing of the interventions to be delivered and how and when the contact with the young person would take place*".
- 1.4. Planning for work in custody was sufficient in four out of the five relevant cases.
- 1.5. Reviews of assessments were of good quality and timely in the vast majority of cases. However, while assessments were reviewed well, the subsequent plans to address reoffending were, in some cases, not updated, not focused on the areas that needed intervention or not specific enough regarding the desired outcomes of the work to be done.
- 1.6. We were encouraged to find that all staff were able to demonstrate a good knowledge of the principles of effective practice.

2. Protecting the public

- 2.1. There had only been a slight improvement in this area since the inspection in 2011. The risk of harm posed by the child or young person had been assessed well enough in 10 out of the 16 relevant cases. In four cases the initial screening for risk of harm to others had been insufficient, leading to a full assessment of risk of harm to others not being undertaken when necessary in one case. We also saw two cases where relevant previous offences were ignored and two cases where there was not enough account taken of the victims' issues.
- 2.2. Reviews of risk of harm were insufficient in 5 out of the 13 relevant cases. In three cases this was due to timeliness and in one case there was no review following release from custody.
- 2.3. Planning for work to manage the risk of harm to others was good enough in 7 out of the 13 relevant cases. In three cases no plan had been completed and nor were victims' issues sufficiently addressed. In 9 out of the 14 relevant cases we found that the risk of harm to identifiable victims had not been effectively managed due to assessments, planning and intervention work not being done well enough. However, we were pleased to see that planning for risk of harm work during the custodial period of the sentence was effective in all cases where it was necessary.
- 2.4. We expect to see that managers will identify and ensure that where work is not good enough it is remedied. While we saw evidence of management oversight in the vast majority of cases, we found effective management oversight concerning the quality of risk of harm work in only half of the cases inspected. Despite management involvement with a case, deficiencies were not always identified or acted upon.
- 2.5. Staff we interviewed were aware of local managing risk of harm to others policy and procedure, but there was evidence that this was not always applied in all cases.

3. Protecting the child or young person

- 3.1. The assessment of vulnerability and safeguarding was satisfactory in the great majority of cases. In one case an inspector commented: "*Vulnerability was informed by a detailed assessment which contained comprehensive information concerning the young person's care history as a Looked After Child and involvement from children's social care services. This enabled the case manager to construct a thorough, focused vulnerability plan to manage the concerns in the case*".
- 3.2. PSRs contained detailed and appropriate assessments of vulnerability in all but one case.
- 3.3. Planning for work to address safeguarding and vulnerability was sufficient in over two-thirds of cases. Where it was not, three cases had no plan and one was not timely. In one case, diversity issues had not been explored sufficiently and in another the contingency planning was not developed enough. Planning for custodial sentences was sufficient in four out of the five cases.
- 3.4. Children and young people's lives can change very quickly and, hence, the work needs to be kept under regular review. While the reviews of vulnerability assessments were of the required standard in 6 out of the 12 relevant cases, in three cases they were not timely and in two cases they were of insufficient quality. Plans to manage vulnerability were reviewed sufficiently in half of the relevant cases. Of those that were not good enough, two were not undertaken at all, and in three cases the review was not timely.
- 3.5. We saw evidence of management oversight in most cases. However, this was effective in only half of the cases. Deficiencies in reviews of assessment and planning were not always identified and, consequently, we saw several cases where assessments and plans were insufficient.
- 3.6. The staff interviewed were aware of local procedures concerning vulnerability and safeguarding.

4. Ensuring that the sentence is served

- 4.1. In order to achieve successful outcomes it is essential to build constructive relationships with children and young people, and their parents/carers. The assessment of diversity factors and barriers to engagement was an area of strength for the YOT. All PSRs and initial plans of work were of good quality. We found that engagement with the child or young person, or parent/carer occurred in all but three cases. Plans incorporated identified diversity issues sufficiently well in 14 out of 16 relevant cases. Health issues were particularly well addressed, with 15 out of the 16 relevant cases demonstrating sufficient attention to this area. The identification of diversity issues and the potential barriers to engagement were well addressed by staff and solutions were effectively built into plans. One inspector noted: "*Overall, the staff had worked well with the young person and interventions were targeted and appropriate. The fact that he complied with the intensive supervision element seems to be a reflection of the dedication of the staff and their adaptation to his communication needs following an assessment of this early on*".
- 4.2. We found well established and effectively used procedures where children and young people did not cooperate with the sentence. In the 12 cases where action to address non-compliance was required, the YOT response was sufficient every time. Staff worked hard to engage children and young people and were successful at building good relationships with those they supervised.

Operational management

All of the staff we interviewed were of the opinion that their line manager had the skills and knowledge to assess the quality of their work. Staff felt supported and felt the Management Team were committed to, and capable of, helping to improve the quality of their work through appropriate supervision. We judged that staff supervision or other quality assurance arrangements had made a positive difference in 12 out of the 20 cases. While there was clear evidence of management oversight and accountability, it was not consistently effective.

The vast majority of staff thought that the organisation promoted learning and development. Most staff felt training provided was appropriate and that opportunities were provided for them to attend relevant courses.

Key strengths

- Good quality assessments of the likelihood of reoffending.
- Good quality PSRs.
- Clear and thorough assessments of vulnerability.
- Excellent engagement with children and young people and parents/carers and understanding of diversity issues.
- Established and effective approaches to achieving compliance.

Areas requiring improvement

- Improving the quality of risk of harm assessments and plans.
- Ensuring victims' issues inform risk management plans.
- Developing a more robust management oversight and quality assurance process.
- Ensuring reviews of risk and vulnerability are completed when necessary.

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 Jonathan Nason. He can be contacted at jonathan.nason@hmiprobation.gsi.gov.uk or on 07768 073286.

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