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 Cambridgeshire

This report outlines the findings of the recent SQS inspection, conducted from the 24th-26th March 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 20 cases supervised by Cambridgeshire 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 - http://www.justice.gov.uk/about/hmi-probation.

Summary

Overall, we found an enthusiastic, committed and supportive staff team who were working well with children and young people to reduce likelihood of reoffending, address their diverse needs and, thereby, promote effective engagement and compliance with their orders. Some attention needs to be given to work around assessment, planning and reviews. Improving management oversight would help address some of theses issues. Engagement work was an area of real strength, with workers taking a creative yet consistent approach to promoting compliance. Overall, this is an encouraging set of results.

Commentary on the inspection in Cambridgeshire:

1. Reducing the likelihood of reoffending

1.1. Assessment of likelihood of reoffending was sufficient in 17 out of the 20 cases in the sample. A majority of these identified relevant risk and protective factors, and provided an

analysis of the key drivers that underpinned offending behaviour. There was also good evidence that this aspect of work was informed by children and young people's perspectives, for example in the frequent use of self-assessment questionnaires.

1.2. Pre-sentence reports (PSRs) were provided in nine cases, of which six were judged sufficient. The best gave clear analyses of likelihood of reoffending and the young person's offending behaviour. All seven applicable PSRs contained detailed consideration of alternatives to custody. Of the three insufficient reports, we identified deficiencies in their assessment of risk of harm and vulnerability. referral order panel reports were sufficient in three of the four cases inspected.

1.3. Planning to address likelihood of reoffending was good with strong evidence of assessments being utilised effectively to develop initial plans in 18 out of the 20 cases. As one inspector noted: "*Planning was a strong point in this case. The Intensive Supervision and Surveillance (ISS) team…with the case manager produced a comprehensive package of interventions, both restrictive and rehabilitative. Weekly timetables were issued to the young person and…key workers at his accommodation. Liaison between the professionals working with Robin was very good and the management of risk was well supported by the YOS police officer*". This had been identified as an area for improvement in our last inspection, and it was gratifying to see this particular set of positive results.

1.4. Reviews of likelihood of reoffending were slightly less consistent, with 10 out of 13 relevant cases being sufficient. In three cases we found deficits in timeliness of completion and quality. The review practice of simply adding updates to the initial assessment (albeit in a very small number of cases), meant that in those instances the assessment became a densely packed, extended log of entries, lacking in analysis and professional judgement.

1.5. Pleasingly, Cambridgeshire is an area with low custody rates, and there were only two such cases in the sample. Sentence planning for likelihood of reoffending was, in both cases, sufficient.

2. Protecting the public

2.1. When it came to the assessment, planning and review of work to protect the public, we found it to be less effective. In 9 of the 20 cases inspected we judged that there had been insufficient assessment of risk of harm. In these cases, assessments were not always robust and, in particular, failed to take a sufficiently broad approach to risk of harm. An inspector's remark about one case serves as a good general illustration of our findings. They wrote: "*I would have liked to have seen the risks identified in certain of the assessment domains accumulated in the risk of harm section*".

2.2. Relevant risk information such as previous convictions, patterns of offending, or behaviours not directly associated with offending or conviction (for example, aggression at school or at home) had often been identified by case managers, but was not always brought together to inform judgements about risk of harm to others. References to the 'Indicators of Risk of Serious Harm' (RoSH) section of the assessment as the 'trigger' for completion of a dedicated risk assessment may indicate an actuarial approach and over-reliance on it as a prompt rather than as a tool to inform the exercise of professional judgement.

2.3. Assessment of risk of harm in the PSRs inspected was also uneven, with four out of the nine judged as insufficient. In these cases, risk of harm was either incorrectly classified, dedicated assessments were not completed where, in our judgement, they should have been, or the assessment lacked clear evidence for the level of risk identified.

2.4. Plans to address the risk of harm to others were sufficient in three-quarters of the cases. Four out of five cases found to be insufficient lacked a dedicated plan to help manage the risk where one should have been in place.

2.5. Our inspection of reviews of assessments and plans also indicated some inconsistency. Assessment reviews were sufficient in 7 out of 12 cases. The chief deficit of those judged insufficient was that reviews were not taking place as required, particularly in response to a significant change in circumstances. In 4 out of 12 relevant cases, reviews of plans were found to be inadequate as they had not taken place when required. Planning for risk of harm during the custodial period of sentence for the two relevant cases was good enough. There was a single case that met Multi-Agency Public Protection Arrangements criteria, and in this instance planning and engagement were done sufficiently well.

2.6. In just over one-third of relevant cases, management oversight had not been effective in identifying or redressing the issues around assessment, planning and review. Risk and vulnerability panels were reserved for cases assessed as medium and above. While assuring management oversight for such cases, this leaves open the question of how others (as we found) which have been inaccurately or inappropriately assessed as low risk are effectively identified and remedied by managers. That said, there was evidence that the panels were valued by staff and could be effective in mobilising resources and joint agency working. An inspector found, for example, that one meeting: "*…resulted in input from several partnership agencies, (and) good information sharing*".

2.7. We also looked at how well risk of harm to identifiable victims was managed. Improving victim work had been a feature of the previous inspection improvement plan and we were pleased to find that of 14 relevant cases, this element of risk of harm work had been effectively managed in all but one case.

3. Protecting the child or young person

3.1. The initial assessment of safeguarding was sufficient in 14 out of the 20 cases in the sample, with six being insufficient for a number of reasons – vulnerability assessments had not been undertaken, accuracy of vulnerability classification and quality of screening. In some instances, we were unable to find clear evidence for the level of vulnerability stated. In others, assessments did not draw sufficiently on information from another agency or were not satisfactory following a transfer in. These findings were also reflected in the PSR's vulnerability assessments, where three out of the nine cases were judged insufficient.

3.2. Initial plans were found to be sufficient in most relevant cases, although nearly one-third were not satisfactory. As with risk of harm, a number of vulnerability plans had not been completed in cases where this would have been expected. Further historic factors relating to safeguarding (past Child Protection plans, exposure to domestic violence) were not always factored into assessments and consequently their relevance to current vulnerability was omitted. Plans for the two custodial cases were satisfactory.

3.3. Reviews were completed satisfactorily in 7 out of 12 cases. The deficits in the residual five cases included reviews not being completed, lack of timeliness, and a failure to hold a review following significant changes in the child or young person's circumstances.

3.4. As with the previous section, such omissions were not always identified through management oversight processes and procedures. Consequently, they were not effectively challenged or redressed. Of 18 relevant cases, we judged that just over one-third did not have sufficient management oversight.

3.5. We saw some good practice examples of effective safeguarding practice, as in a case where a young person made a disclosure of a suicide attempt (prior to their involvement with the YOS). The inspector found that: "*The case manager quickly assessed the new information and worked with the young person, their parent and YOS health and psychology staff to produce an excellent safety plan. This included a robust contingency plan and out of hours contacts for the parent, as well as comprehensive support for the young person*".

4. Ensuring that the sentence is served

4.1. Practitioners were diligent in their work with young people to secure their engagement and active participation in the work covered during their order. Diversity needs were comprehensively assessed in 17 out of the 20 cases, as was the level of engagement with both children and young people and their parents/carers in order to carry out assessments. Furthermore, all nine PSRs gave sufficient attention to both diversity and potential barriers to engagement. Promoting positive engagement was evidenced in the flexible and creative ways case managers worked with children and young people and parents/carers. For example, home visits were carried out regularly, workers often met with children and young people in venues that were convenient for them and, as noted earlier, good use was made of self-assessment questionnaires. Attention was paid to the health and well-being needs of children and young people in all but 2 out of16 relevant cases.

4.2. These positive findings were also replicated in planning to address diversity-related needs and the removal of barriers to effective engagement. Planning was sufficient in nearly all of the cases inspected and, again, this activity was made more effective by the active involvement of the child or young person and their parent/carer. We also found good examples of work with other agencies to support compliance and secure positive outcomes. In one case an inspector found that: "*…the case manager has managed the transition to Probation well, offering to see Roy fortnightly on a non-statutory basis…The case worker has liaised with various professionals since the transfer to Probation and Roy is now engaging well with his officer…(and) making significant progress*".

4.3. Eleven, just over half of the children and young people in the sample, failed to comply fully with their order. Of these, seven complied after initial difficulties and four failed to comply. The YOS response was sufficient in all but two instances. For the most part, however, case managers were able to appropriately balance welfare, enforcement and public protection concerns.

Operational management

We also found that front-line practitioners and staff felt extremely well supported by their line managers, with all respondents indicating that supervision took place regularly and that supervisors had the skills and knowledge to assess, support, and help improve the quality of work. There was also a generally positive response to training and skills development, with the large majority indicating satisfaction that their needs were sufficiently met to do the job, for future development and for delivering interventions. One-quarter of staff, however, identified a need for further training around speech, language or communication needs. With one exception, all case managers who responded also felt that countersigning and management oversight of risk of harm and safeguarding work as an effective process, perhaps reflecting the value of the risk and vulnerability panels. However, our view was that supervision or quality assurance arrangements made a positive difference to cases in just under three-quarters of cases (11 out of 15 respondents) leaving scope for improvement.

Key strengths

- Assessment, planning and delivery of work to reduce likelihood of reoffending was an area of real strength.
- Work to ensure that children and young people's diverse needs were assessed, and that they were supported to overcome barriers so that they would engage with their orders, was exceptionally good.
- Where risk and vulnerability were identified, the YOS made full use of its own specialist staff as well as working collaboratively and effectively with other agencies.

Areas requiring improvement

- Assessments of risk of harm and vulnerability should make greater use of and evidence, relevant information from previous convictions and patterns of behaviour, in order to improve their quality.
- All assessments should accurately reflect levels of harm and vulnerability and are of sufficient quality.
- Reviews of assessments and plans should be completed when required, particularly in response to significant change.

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 Colin Barnes. He can be contacted at colin.barnes@hmiprobation.gsi.gov.uk or on 07826 905352.

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