

<i>To:</i>	Morwena Edwards, Chair of Youth Justice Service Management Board
<i>Copy to:</i>	See copy list at end
<i>From:</i>	Julie Fox, HM Assistant Chief Inspector
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## **Report of Short Quality Screening (SQS) of youth offending work in Gwynedd and Ynys Môn**

This report outlines the findings of the recent SQS inspection, conducted from 6th-8th January 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 14 cases supervised by Gwynedd and Ynys Môn Youth Justice Service (YJS). 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 staff team where YJS workers had built constructive relationships with the children and young people who had offended and their families. Good links were in place with other agencies and workers had access to a wide range of resources to help them assess and plan their work. Improvements were noted since our last inspection in work to manage the likelihood of reoffending and to protect the public. Although staff spoke positively about the support offered by their managers, we found that the oversight of work, in particular to safeguard children and young people, was not effective enough. Given the commitment of staff and managers to providing a service to children and young people and the community we anticipate that the good work observed in some cases can be achieved in all instances.

## **Commentary on the inspection in Gwynedd and Ynys Môn:**

### **1. Reducing the likelihood of reoffending**

- 1.1. We look to see if the assessment of why the child or young person has offended is good enough and found that it was in all but two cases. Checks made with other agencies such as schools and Children and Family Services had helped to provide a full picture of the child or young person's circumstances. Eight of the eleven cases due for review had been completed sufficiently well. Where there were gaps, these related to providing an insufficient update of the child or young person's circumstances.
- 1.2. Written pre-sentence reports were provided to the court in four cases and overall these were assessed to be of good quality. In six cases sentencing had been informed by a verbal update to the court, sometimes combined with a short progress report. Where there was no written document, care needed to be taken to ensure that there was always a written record of the advice given to the court on the YJS case file.
- 1.3. Following on from the assessment we expect to see a plan of work to help reduce the likelihood of reoffending. This was in place, and of sufficient quality in all but two cases in the community. In the case of a young person on an order for antisocial behaviour the worker recognised the need for her to develop ties to the local community in order to reduce reoffending. The young person was supported to chair a local residents' meeting to discuss the development of a leisure facility on the housing estate and received praise for her work from a local councillor. This type of creative approach helps children and young people to develop their self-esteem and consideration for others.
- 1.4. Two of the cases in the sample were serving a Detention and Training Order (DTO) and neither had a plan in place to cover the custodial element of the sentence. As both young people were 18 years old at the point of sentence in court they were sent to a Young Offenders Institution (YOI), and treated as young adults as opposed to children. Because the YJS had not completed an initial sentence plan and in these cases the YOI does not prepare one either, neither of these young people had a plan for the custodial part of their sentence. In such cases we would have expected the YJS to undertake this task.

### **2. Protecting the public**

- 2.1. We expect to see a detailed assessment of the risk of harm a child or young person poses to others. This should cover all relevant information, including past offending and behaviour, as well as the impact on victims. We found that this had happened in all but three cases. Where the assessment was insufficient, this was usually because relevant previous offences or behaviour had been overlooked. However, we did agree with the assessment of the level of harm posed by the child or young person in all but one case.
- 2.2. Having assessed the risks, the YJS should put plans into place to manage them. This had been done well in five out of eight relevant cases. Of the remainder, either there was no risk management plan (one case) or the planned response should the risk of harm to others increase was not specific enough.
- 2.3. The risk of harm posed to others can change over time and, therefore, needs to be kept under review. The assessment of risk of harm had been reviewed sufficiently well in seven of the nine relevant cases. Plans to manage and reduce risk of harm to others had been updated as required and we were pleased to see that good use was made of the team police officer to undertake relevant checks on addresses.
- 2.4. We concluded that, where there was an identifiable victim or potential victim, the risk of harm they faced had been effectively managed in only half of the relevant cases (four out

of eight). The nature and level of risk of harm to victims had either not been fully recognised or had been given insufficient attention, particularly in intervention plans. In too many cases these included vague statements such as 'complete offending behaviour work' or 'consequential thinking skills' rather than being tailored to the specific offence and impact upon the victim.

### **3. Protecting the child or young person**

- 3.1. In many cases, children and young people who have offended are also vulnerable themselves and we expect to see that this has been taken into account. We found that just over three-quarters of cases had a sufficient assessment of safeguarding and vulnerability needs. For the remainder, better attention needed to be paid to the initial screening of the child or young person's safeguarding needs; in one case we felt that the level of vulnerability had been underestimated.
- 3.2. Planning to address vulnerability and safeguarding issues was good enough in 7 of the 11 relevant cases. Where there were gaps the reasons for this included missing or late vulnerability management plans and an insufficient planned response should the level of vulnerability increase. Where children and young people are looked after by the local authority this needed to be better reflected within the YJS plan. In one case, assessed as being very high vulnerability, the review dates were set at three monthly intervals which were insufficient, given the level of need.
- 3.3. YJS staff had access to a weekly health panel attended by health workers, the team's speech and language worker and a consultant psychiatrist. The panel's work made a positive contribution to the child or young person's assessment and plan and served as a valuable consultation resource for YJS staff.
- 3.4. Children and young people's safeguarding needs change over time and must, therefore, be kept under review. We found that assessments had been reviewed to an acceptable standard in six out of ten cases. Where gaps were identified, this most often related to a failure to review the assessment following a significant change in circumstances, for example, moving address or renewed substance misuse. The same applied to plans to address safeguarding and vulnerability needs which had been sufficiently reviewed in only one-third of applicable cases. These shortfalls had not been addressed by managers.

### **4. Ensuring that the sentence is served**

- 4.1. Diversity issues and other potential barriers to engagement had been assessed well in all cases. The YJS covered a large rural area and workers were able to provide the right balance between home visiting and office appointments, making good use of community resources. This flexible approach helped YJS workers to engage the child or young person and their parents/carers in the assessment and plan of work.
- 4.2. When inspecting in Wales we expect to see evidence of active and timely screening of the Welsh/English language preference of the child or young person. We were pleased to see that all children and young people were asked about their language preference at the first point of contact with YJS staff. This included their preferred written and spoken language. All those expressing a preference to use the Welsh language were provided with a Welsh speaking case manager.
- 4.3. The majority of the children and young people within our sample had complied with their order. For those who had not, we found that the YJS had responded appropriately in all but one case. This reflected the efforts made by workers, including visiting the home and reminding parents/carers of the importance of working in partnership with the YJS.

## **Operational management**

We look for evidence that management oversight has been effective in ensuring the quality of work to address the risk of harm to others and child safeguarding. This can take the form of one-to-one sessions between a worker and their manager, or a wider meeting with internal colleagues or external partners, as well as the implementation of sound quality assurance processes.

The seven workers we asked felt that their managers had the skills to support them and help them to improve the quality of their work. A number described an open door policy, whereby managers' advice could be sought at any time. However, while managers were accessible, we found that staff supervision or other quality assurance arrangements had been effective in only 4 out of the 11 cases where we would have expected it to have made a difference. Management oversight may have been provided, for example by countersigning work, but in too many cases this process had not identified shortfalls or helped staff to develop their practice.

We found that the vast majority of workers were familiar with local policies and procedures for managing risk of harm, safeguarding, engagement and compliance. The principles of effective practice with children and young people who offend were less well understood by a couple of workers. Just over half felt that they sufficiently understood the priorities of the organisation and how these, in turn, affect their role.

Almost all felt that their training and skills needs were fully met in relation to their current post. A number spoke positively about training received in meeting diverse needs, in particular speech, language and communication; and this was reflected in our findings. When asked about their future development needs, all felt that these were at least partly met if not fully met.

## **Key strengths**

- YJS staff worked hard to help children and young people comply with their court orders. They were particularly good at building relationships with the child or young person and undertaking home visits to help understand issues thoroughly.
- The YJS health panel's contribution to understanding the needs of children and young people and to supporting YJS staff in their work.

## **Areas requiring improvement**

- Planning, specifically:
  - ◆ improving the quality of initial plans to address safeguarding and vulnerability, keeping these under regular review and updating them in response to significant changes in circumstances
  - ◆ ensuring that there is always a plan in place to cover the custodial period of the sentence.
- Reviewing assessments at regular intervals and following significant changes in circumstances.
- Providing effective management oversight and quality assurance of assessment and plans.

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 Helen Davies. She can be contacted at [helen.davies@hmiprobation.gsi.gov.uk](mailto:helen.davies@hmiprobation.gsi.gov.uk) or on 07919 490420.

Copy to:	
YOT/YOS Manager/Head of Service	<i>Stephen Wood</i>
Local Authority Chief Executive	<i>Harry Thomas</i>
Director of Children's Services	<i>Gwen Carrington</i>
Lead Elected Member for Children's Services Gwynedd	<i>Cllr Wyn Williams</i>
Lead Elected Member for Children's Services Ynys Môn	<i>Cllr Ken Hughes</i>
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Head of YJB in Wales	<i>Dusty Kennedy</i>
Head of Oversight and Support for YJB in Wales	<i>Phillip Davies</i>
YJB link staff	<i>Malcolm Potter, Paula Williams, Linda Paris</i>
Estyn	<i>Rachael Bubalo, Linda Howells</i>
Care and Social Services Inspectorate Wales	<i>Bobbie Jones, Nigel Brown,</i>
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