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 Newham

This report outlines the findings of the recent SQS inspection, conducted from 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 Newham Youth Offending Team (YOT). 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 that the YOT had worked extremely hard since the last inspection by HMI Probation in 2011 and had improved their performance significantly. That inspection had identified the need for improvements in several important areas of work. Performance is now strong in all four inspected areas (see below), with robust policies underlying effective practice, arising from the previous inspection improvement plan. Staff were committed to delivering high quality services and were supported well in their work. We found effective engagement with an appropriate range of partners and, in general, children and young people were served well by the good quality reports, assessments and plans being produced.

Commentary on the inspection in Newham:

1. Reducing the likelihood of reoffending

1.1. The initial assessment of the child or young person's likelihood of reoffending was sufficient in almost all of the 20 cases sampled. While all assessments were factually accurate, used a broad range of sources of information and identified positive influences on the children and young people, two were not timely.

1.2. In our sample we saw 16 pre-sentence reports (PSRs) and four referral order reports provided by the YOT; 14 of the reports to court were of a good standard and contained an appropriate proposal that was presented well. However, we found two PSRs and two referral order reports which had been signed off as acceptable, despite containing an inadequate assessment of the child or young person's risk of harm to others or vulnerability. In general, we felt that management arrangements had been effective in ensuring the quality of the majority of reports.

1.3. Plans to reduce the likelihood of reoffending were satisfactory in over two-thirds of custodial cases and in almost all of the community cases. We particularly noted that staff saw and utilised the benefits of keeping in close contact through home visits (both singly and joint agency) with the child or young person and their family.

1.4. The personal circumstances of many children and young people change quickly, so assessments need to be reviewed to keep up with different situations. We considered that almost all assessments and plans relating to the likelihood of reoffending had been reviewed well. In a small number of cases we observed the lack of an update to historical information, which meant that assessments and plans did not reflect the current circumstances of the child or young person.

2. Protecting the public

2.1. Where a child or young person poses a risk of harm to others, we expect to see this identified and a plan put in place to manage that risk. In well over two-thirds of cases the assessment of risk of harm to others was sufficient. Where there were gaps, these arose because, for example, the assessment had not taken into account relevant behaviour, or the level of harm posed had been classified as too low. A clear and thorough assessment of the risk of harm to others was included in all but one PSR.

2.2. Reviews of these assessments were also sufficient in well over two-thirds of relevant cases, but again, in some cases, were not fully effective, where some staff had simply copied previous assessments without updating the information.

2.3. Planning to address risk of harm to others was sufficient in almost three-quarters of cases where this was an issue. In one case, a formal plan had not been completed and, in two relevant custody cases, there was not enough planning to address the risk of harm.

2.4. Just under half of the plans had been reviewed sufficiently well; there were weaknesses in seven cases, arising from the review not taking place (two cases), not being sufficiently thorough (two cases) or not amending the plan in response to changing circumstances.

2.5. Where there was an identifiable victim or potential victim, the risk of harm they faced had been effectively managed in just two of the relevant eight cases, mostly because victims either were not identified or included in plans to manage risk.

2.6. We were pleased to see substantial evidence of management oversight in almost all cases. Managers would query the work and, where appropriate, require improvements, which were usually then completed. Inspectors felt that this was due to effective processes in place, such as the 'induction pack'. An inspector confirmed that this pack:

"*included a simple induction checklist to be completed within 15 days of the commencement of the licence or order. This served as a reminder that discussion points such as the breach process, what is good compliance, the behaviour contract and the order or licence had been discussed with the young person. Specialist assessments to be completed included a Drug Use Screening Tool, What do YOU think? (child or young person's self-assessment) and learning styles assessments in addition to the general (Asset) assessment. Also included was a Police National Computer check, planning for home visits and information about supporting intervention services. This list, when completed was then discussed with the team manager in an 'Induction Review' and the minutes entered in YOIS computer system. The pack included photocopies of the various forms and also a booklet for the young person entitled 'A guide to Newham Youth Offending Team, the law and keeping yourself safe'. This useful tool was available for each new case and provided a simple way for case managers to ensure that their assessment was comprehensive and all the relevant enquiries had been fully completed*".

2.7. All staff interviewed had sufficient understanding of local policies and procedures for managing risk of harm to others.

3. Protecting the child or young person

3.1. We considered that staff demonstrated the fullest understanding of the broad nature of vulnerability, which ensured that there was a satisfactory initial assessment of vulnerability in almost all of the cases in assessments and PSRs; although assessments were not always thoroughly reviewed throughout the sentence. However, staff generally liaised particularly well with other specialist services, such as mental health, learning disabilities and substance misuse. We were particularly impressed at the YOT's commitment to ensuring that sentence, vulnerability and risk management plans were shared, not only with other agencies but also with the child or young person, ensuring that all understood the areas of concern and the plans put in place to keep the child or young person, and the public, safe.

3.2. An inspector said: "*This was well evidenced in one case where a 17 year old young woman was sentenced to a three month referral order for an offence of theft. Action taken by the YOT in managing this case was very positive in that she was quickly identified as being vulnerable from others. The case manager analysed the presenting behaviour of the young person and cross-referenced this with existing and previous information (from Children's Services and Police) - leading to a swift safeguarding referral, stemming from concerns that the young person was being sexually abused, exploited and domestically abused by her older partner, aged 22. A police investigation confirmed the YOT's concerns, whereupon regular professionals meetings were held to protect this young woman. Children's Services were initially reluctant to accept the need for an investigation, but this was escalated and taken forward by YOT managers. At the point of the inspection, a successful outcome included no reoffending by the young person. Additionally, an investigation was being undertaken by Children's Services, bail conditions were in place to preclude her boyfriend/alleged abuser contacting her, a police investigation was ongoing and relevant referrals had been made to education, training and employment provision and a specialist counselling service".* This is an example where prompt action by the YOT and partnership cooperation has contributed to the protection of a vulnerable young woman.

3.3. Case managers clearly understood what needed to be done to address safeguarding needs and reduce the vulnerability of children and young people. Written plans usually reflected the needs of the case and were sometimes very good, but where gaps in planning arose, these were primarily because the plan was untimely, not linked with other plans or insufficient attention was given to diversity factors. Case managers are expected

to review plans to manage safeguarding and vulnerability, to ensure that they continue to protect the child or young person properly, but in one-third of cases the reviews were not fully effective and case managers did always not ensure the plans were revised as needed.

3.4. Similar to the work to manage the risk of harm to others, management oversight of the vulnerability work was well evidenced and effective in over three-quarters of cases, but in a few cases, some key gaps in assessments and plans had not been addressed.

3.5. All staff interviewed had sufficient understanding of local policies and procedures for managing vulnerability and safeguarding.

4. Ensuring that the sentence is served

4.1. Performance in this area was strong. In the great majority of cases, staff had assessed well and made good plans to address the child or young person's diverse needs and any barriers to engagement. Case managers were attentive to the child or young person's health and well-being in almost all cases.

4.2. Similarly, there had been effective engagement with the child or young person, and their parent/carer, to complete the assessment and the PSRs. The great majority of the reports examined paid attention to how barriers to engagement would be overcome and most had proper plans on how to overcome those barriers. One inspector recognised: "*the care with which alternative locations were found to deliver interventions, or the use of managed attendance; taking account of information from the children and young people and other agencies to support compliance and the safety of children and young people".*

4.3. In almost three-quarters of cases, children and young people complied with the requirements of their sentence, some after initial difficulties. This was a testament to the commitment of case managers, given the chaotic lives of many of the children and young people. Inspectors particularly commended the "*swift and effective compliance processes which ensured that where children and young people did not fully comply; the YOT's response was timely and effective in most cases*". In only two cases had the YOT not undertaken breach action where required.

4.4. All staff interviewed had sufficient understanding of local policies and procedures for supporting effective engagement and responding to non-compliance. One inspector particularly noted the robust arrangements where young people reached the age to be transferred to Probation, confirming that the YOT: "*has a seconded probation officer jointly co-located here and in Probation, who had responsibility for the writing of both youth and adult assessments, and also supporting three way handover meetings*". This assisted young people with a transition at a point where offending is more likely to happen.

Operational management

All staff had a good understanding of the principles of effective practice for work with children and young people who have offended. They understood what was expected of them. They were also positive about learning and development opportunities. We were impressed by the commitment to ensuring that there was a real and positive culture of learning at this YOT, using different initiatives such as the 'bite size' seminars (hour long sessions looking at examples of effective plans, or training staff on delivery around areas such as parenting) and the Interventions Hub (a document containing links to information about current interventions, which are suitable for specific offences or children and young people). Staff were properly supported and encouraged to attend training and then expected to share what they had learnt during team and service meetings. All felt that supervision by managers was fully effective. Our view was that management

supervision and other quality assurance processes made a positive difference to the quality of work in all but three of the cases, which leaves the YOT with a little room for improvement.

Key strengths

- The excellent and broad focus on vulnerability.
- Strong interagency working, including sharing the initial plans with the young person and professionals and the 'professionals' meetings, which ensured the sharing and using of information from children's social care services, education, the police and others.
- The YOT's commitment to diversity, for example ensuring that the children and young people can attend meetings, by the YOT making alternative arrangements regarding location or joint working with neighbouring YOTs, which fostered compliance and the safety of children and young people.

Areas requiring improvement

- The quality of reviews, ensuring that assessments and plans are fully and effectively updated.
- The risk of harm to identifiable victims is managed effectively.

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 Caroline Nicklin. She can be contacted at caroline.nicklin@hmiprobation.gsi.gov.uk or on 07766 290969.

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