Inspection of Youth Offending Work
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From:	Julie Fox, HM Assistant Chief Inspector
Publication date:	16th July 2014

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

This report outlines the findings of the recent SQS inspection, conducted from 23rd-25th June 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 Barnet Youth Offending Team. In each case 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.justiceinspectorates.gov.uk/hmiprobation/.

Summary

Overall, we found that there had been a significant improvement in performance in all aspects of the work of the YOT since our last inspection in September 2011. Previously we had found several areas of practice requiring substantial improvement. An action plan to deliver the necessary changes had been put in place and we now have confidence that Barnet has a well performing YOT. These improvements have been delivered in a very challenging environment, most notably against a backdrop of increasing gang related activity in the borough. The cases we have inspected, which were broadly representative of the whole caseload, consisted of children and young people who were extremely vulnerable, while at the same time often displaying behaviour indicating that they posed a significant risk of harm to others. All cases in the sample were assessed by the YOT as having at least a medium level of vulnerability or risk of serious harm. No case was assessed as presenting low levels of vulnerability and low risk of harm. Developing structures and a culture that are able to manage these issues requires highly skilled staff, good leadership and the contribution of all partners. Barnet YOT has, to a great extent, achieved this.

Commentary on the inspection in Barnet:

1. Reducing the likelihood of reoffending

1.1. The initial assessment of the child or young person's likelihood of reoffending was sufficient in all 20 cases inspected. All assessments were timely and covered all the relevant factors. Most assessments were very thorough. An inspector commented that *"There was excellent work in a complex case where the child's medical condition had directly impacted on their likelihood of reoffending"*.

1.2. Pre-sentence reports (PSRs) were prepared in 14 cases. Some of these were actually described as breach reports, although we judged that they were in fact comprehensive enough to be described as full PSRs. Of these, 12 were judged to be of a good quality.

1.3. Nearly all PSRs offered the sentencing court a range of credible proposals, with the pros and cons of various sentences described. Staff displayed a keen awareness of the courts' attitude to specific offences. In the two instances where we judged the PSR to be of a lesser quality, there had been an insufficient assessment of the risk of harm. Overall, we felt that management arrangements had been effective in ensuring the quality of most PSRs.

1.4. There was sufficient planning undertaken to minimise the likelihood of reoffending in all but two cases; in those, there was no evidence of a written plan describing the work that would be undertaken. Planning included the use of a variety of techniques. For example, one case manager had found material relevant to a particular individual from the media, a BBC documentary, and used this to work with the child on their own behaviour.

1.5. There was a review of the likelihood of reoffending in 12 of the 16 relevant cases. In four cases, there had been no review following significant changes in circumstances that should have prompted one.

1.6. There were several custodial cases where despite attending planning meetings, YOT staff had not been provided with, or were not able to obtain, initial training plans from the relevant institution. Managers were aware of this issue but had been unable to resolve it satisfactorily.

2. Protecting the public

2.1. In nearly all cases, there had been a sufficient assessment of the risk of harm the child or young person presented either to a specific victim or general members of the public. Over a third of the cases in the sample had been assessed as presenting a high risk of serious harm. Inspectors judged that in two cases the assessed level of risk of serious harm was too low.

2.2. We were pleased to note that case managers usually based their risk of serious harm assessments on both actual convictions and the supporting evidence in the Crown Prosecution statements, which in several cases included details of what were seriously aggravating factors.

2.3. There had been sufficient planning to manage the risk of harm posed by the child or young person in nearly all cases. We found that there was a specific risk management plan in all but one case where the YOT had assessed that it was necessary. We saw six cases where the child or young person was subject to a detention and training order. Despite the absence of sentence planning documentation from the institution in many of these cases, inspectors judged that the YOT had in fact ensured that there was sufficient planning to manage the risk of harm posed by the child or young person in five of these.

2.4. Although no cases in our sample met the criteria for management through Multi-Agency Public Protection Arrangements (MAPPA), there were nevertheless a significant number who presented a high risk of serious harm that required a joint approach to the management of this level of risk.

2.5. Strategic managers and staff in Barnet were aware that the borough has a significant issue with gang related activity. Part of the response to this issue had been the development of a 'high risk and gangs' panel which was regularly attended by the local MAPPA coordinator. There was evidence in the cases we saw that this was an effective way of sharing information and developing joint plans to manage the risk of serious harm presented by relevant children and young people. Staff were confident of their ability to present their cases to the panel and understood the importance of a joint approach to the management of risk of harm.

2.6. Reviews of the risk of harm posed by the child or young person had been undertaken in three-quarters of relevant cases. The plan to manage the risk of harm presented had been reviewed in all but three relevant cases.

2.7. Management oversight of work to protect the public was effective in nearly all cases.

3. Protecting the child or young person

3.1. The initial assessment of vulnerability and safeguarding was well done in 16 of the 20 cases in the sample we inspected. In the four cases we assessed as having an insufficient assessment, the main reasons for this concerned the emotional and mental health of the child or young person or the arrangements for their care.

3.2. Suitable plans to manage safeguarding and vulnerability issues were put in place at the start of orders in 18 out of the 20 cases we inspected. An inspector commented in one case where a 17 year old girl had been subject to domestic violence from several partners that "*There was a strong focus on developing healthy relationships to ensure that she was able to identify what she wanted from a relationship and protect herself in the future"*.

3.3. We found consistent evidence of good multi-agency working with Children's Social Care including joint planning meetings undertaken as required. All case managers were aware of local policies and procedures as well as the rights of Looked After Children. Case managers ensured that these children and young people received the support to which they were entitled.

3.4. In one case the YOT worker ensured that a vulnerable child was placed in a secure children's home rather than being released into the community after a custodial sentence, as there had been insufficient progress for them to be released safely. At the time of the inspection, work was in hand to manage the transfer into the community near the end of their supervision, to ensure they could be managed safely. In another, the YOT had liaised with housing services through the gangs and high risk panel after shots had been fired at the home address of the child to ensure that the family had a safe address.

3.5. Reviews of assessments of safeguarding and vulnerability were not undertaken in 3 of the 16 cases where these were required. For example, in one case there had been no review following release from custody.

3.6. In most cases, management oversight was sufficient to ensure that the case managers were supported in ensuring children and young people were kept safe, even in very challenging circumstances.

4. Ensuring that the sentence is served

4.1. We judged that in every case, the case manager had actively involved the child or young person, and where appropriate their parents/carers, in the assessment process and the development of a plan to tackle their offending. This high level of engagement was also carried through to the development of a plan. Staff used the inputs of the children and young people to ensure that plans were relevant and jointly owned.

4.2. All PSRs paid sufficient attention to diversity factors and any potential barriers to engagement. This meant that the work started with the best possible chance of the case manager successfully facilitating the necessary changes in behaviour. Good use was made of the *What do YOU think?* self assessment questionnaire in most cases.

4.3. Managers had recently produced a compliance and enforcement policy. Case managers had a clear and consistent approach to enforcement that was robust but fair. In seven cases in the sample the child or young person had not fully complied with the requirements of the order. In each of these cases the YOT took action to either ensure that the child or young person did comply, or returned them to court. There was clear evidence that case managers carefully explained to children and young people what they had to do to comply, and the difference between acceptable and unacceptable reasons for non-attendance.

Operational management

Barnet is a relatively small YOT with only five case-holding practitioners. Inspectors found that each of these staff had a good understanding of both the principles of effective practice and key local policies. Case managers understood the organisation's priorities as they affected their role. Staff considered that their managers had the necessary skills to support them and help them to improve the quality of their practice. They felt that the quality assurance and countersigning of their work was generally an effective process, although some thought that the level of oversight was perhaps too intense leading to a loss of confidence in their own professional skills. We agree with this assertion.

Most staff felt that they had the necessary skills to recognise and respond to most diversity or potentially discriminatory factors, although two felt they would benefit from training around the speech, language or communication needs of children and young people.

At the time of the inspection, several staff who were experienced YOT practitioners, with a limited knowledge of the particular system used by Barnet YOT, were not as confident with their recording of assessments and plans as they needed to be. The complexity of the system meant that it was not sufficient to expect staff to intuitively understand what was required. This had been an ongoing problem recognised in the previous post inspection action plan. Although there was an acknowledgement of the problem, and attempts had been made to provide specialist training, until very recently, it had not been possible to identify a suitable expert to help the YOT improve staff understanding.

Key strengths

- The YOT had ensured that it was supported by all of the relevant partners in protecting the public from the risk of serious harm presented by a significant proportion of the children and young people it supervised. The high risk and gangs panel appeared to be effective.
- Even though there was a necessary focus on risk of harm, where it was appropriate, vulnerability issues were also successfully managed.
- Children and young people were actively involved in their assessments and the plans that were developed to help them.

- Staff set clear boundaries for compliance, and the enforcement of court orders was well managed.

Areas requiring improvement

- Staff and managers should ensure that all assessments and plans are reviewed when there are significant developments in the circumstances of the children and young people under supervision.
- Managers should ensure that all staff are able to use the computerised recording system employed by the YOT to a sufficient standard.

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 Mark Boother. He can be contacted at mark.boother@hmiprobation.gsi.gov.uk or on 07771527326.

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