Inspection of Youth Offending Work
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To:	Jim Saunders, Chair of Luton Youth Offending Service
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From:	Julie Fox, HM Assistant Chief Inspector
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Report of Short Quality Screening (SQS) of youth offending work in Luton

This report outlines the findings of the recent SQS inspection, conducted from 16th-18th 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 the Luton 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.justiceinspectorates.gov.uk/hmiprobation/.

Summary

We were pleased to find that the YOS had not only maintained its good overall performance since our last inspection in February 2012 but had also made significant improvements in addressing offending behaviour work. Staff engaged effectively with children and young people and their parents/carers. Whilst written reports for court contained clear and thorough assessments, work to protect the public and the child or young person did not consistently contain a clear explanation of the nature of risk and how this was to be managed. Unfortunately, this was not systematically remedied by managers either. We felt that objectives in intervention plans could be improved, but enforcement action was proportionate and timely in every case where it was required, and case manager's skill in balancing welfare and enforcement was impressive.

Commentary on the inspection in Luton:

1. Reducing the likelihood of reoffending

1.1. The initial assessment of the child or young person's likelihood of reoffending was done well in all but three of the cases inspected. The vast majority of these assessments were properly informed by research and contained good analysis. In most cases, the case manager had appropriately assessed the impact of the child or young person's lifestyle on their offending. Physical health issues and family and personal circumstances were assessed well, but attitudes to offending needed greater and closer attention. Additionally, offending related vulnerability was sometimes missed and information held by others was not always accessed in a timely manner.

1.2. New pre-sentence reports (PSRs) were provided in ten cases, of which, eight were judged to have been of a good standard, containing clear proposals. Arguments to support community sentences were well made and we saw evidence of effective local management arrangements for ensuring the quality of these reports. In both PSRs where the quality was insufficient, this was due to them not being concise and containing some unnecessary information.

1.3. We were pleased to find that planning for work to reduce the likelihood of reoffending was done well in all but one case inspected. The completion of intervention plans was a clear strength in the YOS, but we found that the objectives were not consistently clear, written in child friendly language or sufficiently targeted on outcomes. This made it confusing for the child or young person to understand everything that was required of them and for the case manager to accurately measure progress against the objectives.

1.4. The personal circumstances of children and young people can change very quickly as they face different situations and experiences. As a consequence, assessments need to be reviewed as changes take place. We were delighted to find, as this rarely happens, that there were timely reviews in every case where this was required. One inspector commented "*The assessment in this case was reviewed in a timely manner and reflected the changes in the young person's circumstances, views, attitudes and the impact of his offending behaviour".*

2. Protecting the public

2.1. Where a child or young person presents a risk of harm to others we expect to see this identified clearly, and a plan implemented to manage that risk. In 8 out of 19 relevant cases this assessment was not done well. Often the nature of the risk was not clear, full account of actual and potential victims had not been taken into account, and case managers had not consistently drawn on information held by other agencies.

2.2. Reviews of the assessment of risk of harm during the course of the sentence were done well in seven out of nine cases where this was required.

2.3. Planning how to protect the public at the beginning of the sentence in the community was sufficient in just under two-thirds of cases. In some cases, the response to the individual's risks of harm to others was unclear, victim issues had not been addressed sufficiently and information sharing arrangements were vague. However, plans were completed on time and they appropriately followed on from the assessment. Planning for risk of harm work during the custodial period of the sentence was significantly better.

2.4. We also examined how well the risk of harm to identifiable victims was being managed. We found that this was not done well in almost half the cases. In these instances, the assessment often lacked clarity and forward thinking was limited. In contrast, where

victim awareness work was required it was done very well. We saw evidence of victim empathy work, letters of apology being prepared by the child or young person and restorative justice interventions taking place. In one case the restorative work that had been started in the community continued after the imposition of a custodial sentence. One inspector wrote, "*As a result of a breach of his youth rehabilitation order and further offending, Bruce was sent into custody for 12 months. Whilst in the community the case manager had been undertaking restorative justice work with Bruce and his parents (victims) from whom he had had stolen. Despite the sentence, the case manager continued the restorative work in custody".*

2.5. Effective management oversight to ensure the quality of risk of harm work was evidenced in 10 out of the 17 cases where this was required. Inconsistencies arose because critical deficiencies in assessments and plans were not systematically addressed and followed through.

2.6. All staff interviewed demonstrated an understanding of local policies and procedures for managing risk of harm to others.

3. Protecting the child or young person

3.1. In the vast majority of relevant cases, the initial assessment of safeguarding and vulnerability was carried out well. Similarly, in all the relevant cases, details of the child or young person's vulnerability were appropriately reflected in the PSR. However, in five cases the initial vulnerability assessment was insufficient for a number of reasons, including the nature or level of the vulnerability not being clear and the assessment not being properly informed by information from other agencies.

3.2. Reviews of assessments relating to safeguarding and vulnerability were not sufficient in three-fifths of cases where these were required. The gaps in these four cases primarily occurred because some assessment information was simply lifted from previous reviews and key pieces of new information such as association with older offenders, not having a fixed address and arrests for new offences were overlooked. One inspector noted "*A significant incident arose in which the young person was caught by a group of approximately five males, some carrying knives. This should have triggered a review of his assessment, in particular, vulnerability. However, the review was completed two months later".*

3.3. Satisfactory initial plans to manage safeguarding and vulnerability issues were in place for 12 out of 18 relevant cases. Whilst the plans were consistently completed on time and paid good attention to barriers to engagement, it was not clear how the identified issues would be managed and what resources were necessary. Additionally, in some cases insufficient attention had been given to how issues relating to emotional or mental heath would be addressed.

3.4. As reported earlier, these omissions were not consistently identified through management oversight procedures. Of the relevant 15 cases, we found that 7 did not receive the level of input from managers that was required to ensure the quality of work to address safeguarding and vulnerability.

3.5. Case managers clearly understood local policies and procedures for the management of safeguarding, but we did not find consistent evidence of this being demonstrated.

3.6. We were pleased to find that in five out of six custodial cases there was an appropriate level of planning in place for work to address safeguarding and vulnerability. This showed that case managers had liaised with the custodial institution and sufficiently contributed to plans to meet safeguarding and vulnerability needs.

4. Ensuring that the sentence is served

4.1. It is critical that children and young people and their parents/carers or significant others are meaningfully involved in the development of assessments in order maximise engagement in future work. This was done well in all but one case, and is a clear strength in the YOS. Children and young people were interviewed alone during the course of the initial assessment and their parents/carers were also invited to actively contribute. Encouragingly, we found evidence in the development of nearly every PSR that the report writer had actively engaged the child or young person and their parent/carer. One inspector noted *"The level of engagement with the young person's mother by the case manager was exceptional".*

4.2. The YOS has clear expectations on report writers to share and explain the contents of reports with children and young people and their parents/carers prior to their sentencing date, as well as for them to be provided with a copy of the PSR. We were pleased to find evidence of this having taken place.

4.3. Report writers assessed diversity factors and barriers to engagement in their PSRs but this was not always followed through or developed in later assessments and plans. However when this was done, it was done so extremely well. For example, one case manager had used pictures to facilitate conversation, and another had appropriately drawn on their own cultural background which was similar to that of the young person.

4.4. We were delighted to find that case managers gave appropriate attention to health and well being outcomes, specifically where they may act as a barrier to a successful outcome from the sentence in every case we inspected.

4.5. Almost half of children and young people complied with the requirements of their sentence, some after initial difficulties. Where they did not cooperate, appropriate enforcement action was taken in every case. This was proportionate and timely, and clearly reflected how well case managers understood local policies and procedures for enabling effective engagement and responding to non-compliance. Their skill and sensitivity in balancing welfare and enforcement was very impressive.

Operational management

Staff had a good understanding of local policies and procedures and of the principles of effective practice with children and young people who have offended. The vast majority had completed their Professional Certificate in Effective Practice. They consistently praised their manager's knowledge to assess, support and guide them in improving the quality of their work. However, we found that in 8 out of 19 cases supervisory input had not made a positive difference. This was in part due to case managers not consistently following through directions that they had been given. We acknowledge that the YOS had not had a full compliment of managers for some time and this will have placed additional pressures on existing managers. Case managers described the countersigning and management oversight as largely effective but there was some evidence to suggest that management instructions were often not followed up. This meant that actions to rectify deficiencies were not monitored effectively. It was encouraging to find that eight out of nine case managers interviewed were clear about how the organisation's priorities affected their role. They were unanimous in their view that there was a positive culture to support learning and development in the organisation. Two identified the need for more up to date training in diversity, and others suggested that training should be better scheduled throughout the year.

Key strengths

- Pre-sentence reports contained a clear and thorough assessment of risk of harm and vulnerability to inform plans.
- Children and young people and their parents/carers were actively involved in carrying out initial assessments.
- Enforcement action, when required, was taken appropriately in every case.

Areas requiring improvement

- Objectives in intervention plans should be outcome focused, tailored to the child or young person and written in language that is meaningful to them.
- Assessments and planning for work to manage the risk of harm, safeguarding and vulnerability should include a clear explanation of the nature of risk (including to actual or potential victims) and how this is to be managed.
- Managers should consistently ensure that work to address public protection and safeguarding is of a sufficient standard.

We are grateful for the support that we received from staff in the Luton Youth Offending Service 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 Avtar Singh. He can be contacted at avtar.singh@hmiprobation.gsi.gov.uk or on 077969 48325.

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