Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
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To:	Helen Lincoln, Chair of Essex YOS Management Board
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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 Essex.

The inspection was conducted from 27th – 29th October 2014. It is part of our programme of inspection of youth offending work. This report is 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

The aim of the youth justice system is to prevent offending by children and young people. As good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes, we examined 47 cases of children and young people who had offended and were being supervised by Essex Youth Offending Service (YOS). Wherever possible this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

The published reoffending rate[1] for Essex was 26.8%. This was better than the previous year and the England and Wales average of 35.4%. We found some work of good quality in the YOS. Staff were well engaged with the children and young people under their supervision, and responsive to their needs and situations. They were using a wide range of methods and interventions to reduce reoffending, and working constructively with other agencies involved with the cases. There was scope for improvement, particularly to ensure that the work is appropriately reviewed to take account of changes in the child or young person's circumstances.

Commentary on the inspection in Essex:

1. Reducing reoffending

1.1. Pre-sentence reports (PSRs) were provided to the court in 27 of the cases we inspected, and in all but 2 these were of a good standard. We consider that information about the child or young person should always be provided to the court prior to sentencing (unless the court intends to make a referral order) and this should be clearly recorded on the file. However, in one-quarter of cases more information could have usefully been given to the court, and in ten cases there was no record of any information having been provided. Records of actions by court duty staff were normally missing from case records.

[1] Published July 2014 based on binary reoffending rates after 12 months for the October 2011 to September 2012 cohort. Source: Youth Justice Board

1.2. We were pleased to see that children and young people, and their parents/carers, were involved in the preparation of the report in all but one case. Reports paid sufficient attention to diversity factors and potential barriers to engagement. Local quality assurance arrangements were effective in identifying areas for improvement in report writing. A good quality report was provided to the youth offender panel in seven of the eight referral orders we inspected. Generally, these reports were concise and well written.

1.3. Assessments of why the child or young person had offended were good enough in almost four-fifths the sample. In five cases the initial assessment had not been completed, or had been completed too late to be useful. Where quality was insufficient, assessments often required greater attention to living arrangements, lifestyle, substance misuse, family and personal relationships, or Employment Training or Education. In a few cases more attention could have been paid to information or assessments held by others.

1.4. Planning to prevent reoffending was sufficient in most cases. In appropriate cases the YOS had recently moved to integrating vulnerability management, risk of harm management and sentence planning within a single sentence planning framework. In many cases this resulted in more objectives and actions than most children and young people could be expected to meaningfully engage with being in a single document. Many objectives for vulnerability and risk management detailed actions that applied only to the case manager, but sharing these with the child or young person within the jointly agreed plan was a good way of involving them in all aspects of their order. Further work was in progress to improve the mechanics of this new approach.

1.5. The YOS had a system of 'Case Planning and Review Meetings' which were chaired by the team manager and attended by the case manager, child or young person, parents/carers and other staff involved with the case. These appeared to be an effective way of engaging children and young people and their parents/carers in the work of the YOS.

1.6. There was a sufficient review of the assessment and the sentence plan in more than three-quarters of cases. In other cases a review had either not been undertaken, or the initial assessment not been sufficiently updated following a significant change in the circumstances of the child or young person. There was often valuable information in case diary entries that could have usefully been included within sentence plans or reviews.

1.7. We were pleased to find that some referral order panels were held quickly following sentence. However, in some cases contact with the child or young person and engagement in their referral or youth rehabilitation order should have started more promptly following sentence.

1.8. We were encouraged by the wide range of approaches and interventions used with the children and young people. Particularly impressive was the effective use of the Targeted Youth Advisor posts in the YOS which were used in many cases to support the children and young people to access education or training, working alongside the case manager to provide additional specialist support. The case managers we met demonstrated considerable knowledge of, and commitment to, those under their supervision.

2. Protecting the public

2.1. The assessment of the child or young person's risk of harm to others was of sufficient quality in four-fifths of the cases we inspected. Planning to manage assessed risks was sufficient in two-thirds of the cases. For those serving custodial sentences, planning for work to address risk of harm to others while in custody was sufficient in only 5 of 11 relevant cases. In some cases interventions to manage risk of harm were either not included in the sentence plan, or not given sufficient priority within it. A common area for improvement was contingency planning and the anticipation of potential changes in risk.

2.2. Many of the risk management plans produced using the YJB standalone template were of a high standard. In other cases where the YOS had moved to a single integrated sentence planning framework further work to embed this new approach fully might address some of the deficiencies we found.

2.3. Where there was an identifiable victim or potential victim, there was sufficient evidence that the risk of harm they faced had been effectively managed in half of the cases. This was mainly due to deficits in planning.

2.4. The ongoing review of risk of harm to others was sufficient in almost three-quarters of the cases where this applied. In some other cases it was not reviewed following a significant change in circumstances, or while the child or young person was in custody. Risk management plans were formally reviewed in two-thirds of the cases where we considered this was required.

2.5. Linked to the above findings, we assessed that management oversight had been effective in ensuring the quality of work to address risk of harm to others in two-thirds of relevant cases. In other cases deficiencies in the assessment or planning had not been rectified.

3. Protecting the child or young person

3.1. A large proportion of the children and young people in our sample were considered to be vulnerable, and one-third of them had been a Looked After Child (via a care order or remand to local authority accommodation) during the period of supervision being inspected.

3.2. In three-quarters of all the cases we inspected there had been a sufficient assessment of safeguarding and vulnerability needs. However, the impact of key aspects of the child or young person's vulnerability, particularly in relation to their emotional and mental health or substance misuse, had sometimes been underestimated.

3.3. Appropriate plans to manage safeguarding and vulnerability needs were in place in two-thirds of the cases. For those serving custodial sentences, while in custody the planning was sufficient in half of the relevant cases. Areas for improvement were similar to those in relation to plans to manage risk of harm. In some cases planned actions to address vulnerability were unclear, or interventions required to manage vulnerability were not given sufficient priority within the sentence plan. A common area for improvement was contingency planning and the anticipation of potential changes that might affect vulnerability. Arrangements for sharing information were unclear in some cases.

3.4. Many of the vulnerability management plans produced using the YJB standalone template were of a high standard. As with risk management planning, in other cases where the YOS had moved to a single integrated sentence planning framework further work to embed this new approach fully might address some of the deficiencies we found. Planning to address vulnerability could be improved particularly in relation to the child or young person’s emotional and mental health or substance misuse, and also in relation to arrangements for their care.

3.5. The ongoing review of safeguarding and vulnerability needs was sufficient in just over three-quarters of the cases where this was required. But as with reviews of risk of harm to others, in other cases it was not reviewed following a significant change of circumstances, or while the child or young person was in custody. Plans to address safeguarding and vulnerability were formally reviewed in half of the 26 cases where we considered this was required. In nine cases the plan had not been reviewed at all, while in four others the review was insufficient.

3.6. In line with these findings, we assessed that management oversight had been effective in ensuring the quality of work to address safeguarding and vulnerability in less than two-thirds of relevant cases. In other cases deficiencies in the assessment or planning had not been rectified, or managers were unsuccessful in ensuring other agencies delivered the required services.

3.7. Overall, the YOS gave sufficient attention to the health and well-being outcomes of almost all the children and young people in our sample, in so far as these acted as potential barriers to successful outcomes from the sentence. We were pleased to find that in over a third of the cases there had already been a reduction in factors linked to safeguarding within the first three to six months of the sentence. In many instances there was evidence of effective communication and co-working of cases with children's services and other agencies. This appeared to be supported by the 'Case Planning and Review Meetings' described above.

4. Ensuring that the sentence is served

4.1. In most cases the child or young person and their parents/carers were involved in the planning, but in more than a third of cases more attention could have been paid to identified barriers to engagement even where these had been covered in the assessment.

4.2. In most cases there was sufficient assessment of diversity factors and barriers to engagement, although some planning needed to pay more attention to levels of maturity. However, in most of the cases we inspected there was evidence of the use of methods and tools to engage and interact with the child or young person in way that was responsive to their age and learning style.

4.3. As an example, one inspector found use of what was called the 'Wakey Wakey' approach: *"Jack was a very vulnerable young person with complex needs and concerns about his risk of harm to others. A key element of his sentence plan was to stabilise his education at a local college. Over a two week period the case manager, YOS education worker and the support worker from the college organised a rota system which involved them making home calls in the morning to assist Jack in getting up and out of the house. This intervention succeeded in making a significant improvement to Jack's college attendance."*

4.4. Ensuring that the child or young person was in the right place at the right time was a significant challenge for the YOS where interventions were delivered in centralised locations within the large geographical area covered by the Service, and for those undertaking intensive programmes of multiple activities. One inspector noted that:*"James had a lengthy journey to attend a weekly offending behaviour programme, that involved him making a long train journey from his own town into central London, and then catching a second train out on another long journey to reach the town where the programme was delivered. The case manager had provided James with a timetable for all his YOS meetings, including a detailed railway itinerary for attendance at the programme built into the YOS timetable. This had helped towards his good attendance to date."*

4.5. In another case we saw that: *"Charlene was on a youth rehabilitation order with intensive supervision involving attendance on different programmes and at various locations over four days each week. The simple use of colour coding on a basic grid style timetable helped Charlene to remember what she had to do each day to comply with her order."*

4.6. The engagement of the child or young person with the work of the YOS was maintained and/or improved in almost three-quarters of cases, and nearly two-thirds had complied with the requirements of their sentence. Case managers were able to develop positive working relationships with them and their parents/carers, with good use of home visiting and joint working with other agencies with whom they were involved.

4.7. For those who had not complied with their sentence, we found that the YOS had responded appropriately, for example, in using formal warnings or breach proceedings in 17 out of 19 applicable cases.

Operational management

We interviewed 32 case managers and almost all spoke very positively about the quality of support and supervision they received from their managers, whom they considered to be appropriately skilled and knowledgeable. Staff thought the culture of the organisation promoted learning and development.

All but one case manager felt that their training and development needs had been met in relation to their current post. The majority felt that their future development needs had also been responded to, and that they had received sufficient training to deliver the interventions they used in their work. More than three-quarters of staff thought they had received sufficient training in the speech, language and communication needs of children and young people, and to recognise and respond to other diversity factors or potential discriminatory factors. These views were generally reflected in the quality of the work we saw.

Key strengths

- PSRs and referral order panel reports were of a good standard.
- There was a wide range of approaches and interventions used with the children and young people in their supervision, and effective joint working with other agencies.
- Case managers demonstrated good knowledge of and commitment to those under their supervision.
- Children and young people and their parents/carers were involved in the assessment and planning of work with them.
- Diversity factors and barriers to engagement were assessed, and tools to engage and interact with children and young people in ways responsive to their age and learning style were used.

Areas requiring improvement

- Staff and managers should ensure that all plans to protect the public and to safeguard children and young people are of sufficient quality and clear to children and young people and their parents/carers.
- Staff and managers should ensure that all plans to protect the public and to safeguard children and young people are reviewed and updated promptly in response to changes in circumstances.

We are grateful for the support that we received from staff in the Essex 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 Steve Woodgate. He can be contacted at steve.woodgate@hmiprobation.gsi.gov.uk
or on 0778 994 3088.

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Note 1: 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.

Note 2: We gather evidence against the SQS criteria, which are available on the HMI Probation website - http://www.justiceinspectorates.gov.uk/hmiprobation.

Note 3: to request a paper copy of this report, please contact HMI Probation Communications at communications@hmiprobation.gsi.gov.uk or on 0161 240 5336.