Inspection of Youth Offending Work
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To:	Tony Zaman, Chair of Hillingdon YOS Management Board & Director of Children and Young People's Services
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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 Hillingdon

The inspection was conducted from 3rd-5th November 2014 as 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. Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. We examined 20 recent cases of children and young people who had offended and were supervised by Hillingdon Youth Offending Service (YOS). Where possible this was done in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

The published reoffending rate[1] for Hillingdon was 34.0%. This was better than the previous year and better than the England and Wales average of 35.4%.

We were pleased to find that Hillingdon YOS had responded positively to the disappointing findings in our previous inspection in 2011. As a result it had achieved some substantial improvements in practice, but further work is still required to ensure that practice is consistently of good quality.

Commentary on the inspection in Hillingdon:

1. Reducing reoffending

1.1. Work in custodial cases was positive. We were particularly pleased to find that the sentence plan produced at the start of the custodial phase was sufficient in all inspected cases. One inspector commented "*the custodial sentence plan in this case was one of the best I have seen for a long time. The case manager chaired the meeting and ensured that all of the reasons for offending identified in the assessment were reflected in the plan. The young person should soon transfer to Probation and to an adult institution. The quality of the plan should help maintain the focus of work through the transfer*".

1.2. Pre-sentence reports (PSRs) are the main means by which the sentencing court is advised about the reasons for offending and the work required to address them. Their quality was

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

variable. Some were too long, repeating facts already known to the court, when what was required was a clear and concise assessment. Others should have been carefully checked; for example one included dates when events had occurred that were incorrect and in the future. Many had not included a clear assessment of the child or young person's vulnerability. These shortcomings should have been addressed during quality assurance. We were pleased to see some good parenting assessments attached to PSRs.

1.3. Almost two-thirds of initial assessments were sufficient. Many were comprehensive, appropriately concise and analytical, and provided a sound basis on which to plan. We were encouraged that case managers recognised the characteristics of a good assessment and understood areas for improvement that we discussed. Where assessments were not good enough this was usually because the evidence was insufficient or unclear. In some there was so much evidence, which was often historical, that it was difficult to form a clear current picture of the issues in the case without discussing it with the case manager. Assessments should be complete and understandable without the need to refer to other staff, and hence act as an effective means of communication to all who need to use them.

1.4. The YOS had a process called CRISP (Combined Risk Intervention and Safeguarding Planning) which was a positive approach to consistent and comprehensive planning. However, we judged that preparation for the CRISP meeting (including a separate briefing template), and discussion of the case there, sometimes became a substitute for the case manager taking responsibility to produce their own good quality assessment and plan to inform those discussions. We also felt that CRISP was sometimes treated as a substitute for effective supervision, case discussion, and oversight by immediate line managers.

1.5. An integrated intervention plan (IIP) template was used that included work to reduce reoffending, work to manage risk of harm and work to reduce vulnerability. The template encouraged setting of outcome focused objectives, and linking together of the different elements of planning. Where it was used well it led to good plans that included a broad range of appropriate and clear interventions; where everyone involved could clearly understand what was required, what outcomes were sought and what actions were required to achieve these. However, sometimes the precise focus of work to reduce reoffending, and the intended interventions, were unclear. In referral order cases the contracts that had been negotiated with the community panel were not written in language that helped the child or young person make an informed decision to sign them. The relative roles of the IIP, child or young person's plan and the contract agreed with the panel were unclear, since the plan that counts is the signed contract.

2. Protecting the public

2.1. We were very pleased to find that all except one of the inspected PSRs included a clear assessment and summary of the risk of harm to others that applied in the case.

2.2. The proportion of assessments of risk of harm that were good enough was substantially higher than in the previous inspection, but there was need for further improvement. The initial screening was sometimes inadequate or not completed. Sometimes there was insufficient exploration of victim issues, including the child or young person's current attitude towards their victim. In some cases it appeared that the assessment was written after the CRISP meeting, and primarily recorded the outcome from that meeting rather than forming a robust assessment. In our view the assessment should be complete and used to inform the CRISP meeting, not the other way round. Almost half the assessments were not reviewed as required. Sometimes the case manager had not recognised the need for a review following a significant change or receipt of information. For example, in a custodial case there was evidence of a threat made to a victim by a relative of the child

or young person. We were pleased that the appropriate actions had been taken in custody, but there was no recognition of the situation in the YOS assessment or planning.

2.3. Planning for work to manage risk of harm had also improved substantially. However, it was still not good enough in almost half the cases where it was required. The most common reasons were required actions had not been identified and included in the plan, lack of sufficient precise actions to address risk of harm to victims and contingency planning was not good enough. For example, sometimes the contingency plan was "*referral to CRISP*", rather than the immediate and precise actions that case managers often identified when we discussed this. However, in one positive example we were pleased to find early consideration of an exclusion zone in a custodial case. We were also pleased to find that the IIP included a section on risks to staff safety. This was used well.

2.4. Oversight by managers had been effective in only a third of risk of harm cases and in only half the vulnerability cases, mainly because assessments and plans had been countersigned when they were not yet good enough.

3. Protecting the child or young person

3.1. Work to assess and plan for actions to reduce the vulnerability of children and young people is the area where most attention needs to be given.

3.2. Case managers often articulated the vulnerability factors in their cases. However these were not always clear from the case record, and so would not be immediately apparent to anyone else who needed to become involved. We found some screenings that were empty or close to, even where there were significant factors; for example where the child or young person had a gang affiliation or their level of cognition was substantially below their biological age. In our judgement case managers were often too reliant on discussions at CRISP and did not ensure that they completed and recorded a robust vulnerability assessment as part of the initial assessment. IIPs often did not reflect the precise actions that case managers described to us, and did not include sufficient focused actions to respond to changes, apart from "*return to CRISP*". For example, one case manager told us they saw the child or young person away from the YOS, to manage their vulnerability by avoiding contact with rival children or young people; but this was not apparent from the plans and so not available to anyone else who might need to know.

3.3. Too few PSRs included a clear assessment of vulnerability factors. Instead they sometimes restricted their assessment of these factors to the possibility of self-harm. In one poor example the writer recognised in the body of the PSR that the child or young person's vulnerability was substantially increased but then, critically, in the conclusion said that they were low vulnerability. A concise but complete assessment of vulnerability factors in the case is necessary to assist the court to decide the most appropriate disposal.

3.4. When assessing the risk of harm or vulnerability of children and young people in custody case managers sometimes lost sight of the risks that would apply when they are released. HMI Probation expect that, for both risk of harm and vulnerability work, the assessment and plan clearly reflect the risks that apply both during the custodial phase and those that would apply if they were to be released. For risk of harm and vulnerability work it is helpful to treat the custodial period as helping manage or control rather than reduce the underlying risks – until there are clear behavioural changes to indicate a reduction.

4. Ensuring that the sentence is served

4.1. Engagement with children and young people and significant others when carrying out the assessments was good enough in two-thirds of the cases. In one particularly good

example the mother and sisters were involved in the assessment, along with the father, who lived in another area. This helped provide a clear insight into the issues that applied in the case. However, self assessments were not always undertaken before the initial assessment had been completed and CRISP meeting held – without a good reason for this. It was therefore difficult to see how the assessment and development of the IIP could always take account of the child or young person's views on the strengths that they wanted to maintain or develop, and the changes that needed to be made in their lives.

4.2. We were pleased to find that the IIP template included a specific section related to diversity and barriers to engagement. This was used well to record the assessment of these factors. However it was not always followed by the setting of clear and precise actions designed to address the impact. Case managers articulated the actions they intended to take but because they weren't recorded these plans weren't available to others who may need to know it.

4.3. The YOS used a Young Person's Plan template, and had recently revised this to provide options for different maturity levels. This was a good idea to help ensure they understood and owned the changes that needed to be made, and the strengths they could build from. However often we found little relationship between the IIP and the Young Person's Plan, so that the changes the YOS had assessed as being required were not always made clear. We noted that it was signed by the child or young person and their parent/carer but not the case manager. In other YOTs where this approach works well the child or young person's plan is usually signed by and is an agreement between them, their parent/carer and the case manager on how they will work together to facilitate the required changes.

4.4. Compliance with the work of the YOS was generally good. Where the young person did not comply then the response of the case manager was appropriate in four out of five cases. In one of these a speedy return to court, and in another a robust referral order compliance panel, had led to good compliance thereafter as the young person now realised how seriously they needed to take their order.

Operational management

We were pleased to find substantial evidence of management involvement in cases. However it was sometimes unclear what that achieved, as it did not always identify the deficits in assessment and planning. Some staff told us they would value more direct comment from their manager on the quality of these, together with ideas for improvement. Otherwise, almost all case managers spoke positively about their training and development opportunities and about the YOS.

Key strengths

- The YOS had made substantial progress since the last inspection.
- Work during the custodial phase of sentences was consistently good.
- Assessment of diversity factors and barriers to engagement was strong.
- Compliance was generally good and appropriate actions were taken following non-compliance.
- Case managers were clearly committed to achieving positive outcomes.

Main areas requiring improvement

- Assessment of and planning to address vulnerability required substantial improvement.
- More attention needed to be given to victim safety and identifying actions to manage this.
- Actions to manage risk of harm, including contingency plans, should be clear and precise.
- CRISP should be informed by good quality assessments that are substantially complete.

- Plans that are agreed with children and young people should clearly identify the changes that the case manager has assessed need to be made in their lives.
- Managers should provide greater support to staff to improve the quality of their assessments and plans, and ensure that their oversight of risk of harm and safeguarding work is effective.

We are grateful for the support that we received from staff in the YOS and their engagement 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 Ian Menary. He can be contacted at ian.menary@hmiprobation.gsi.gov.uk or 07917 183197.

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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.