Inspection of Youth Offending Work
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From:	Helen Mercer, Assistant Chief Inspector (Youth Justice)
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Report of Short Quality Screening (SQS) of youth offending work in Pembrokeshire

The inspection was conducted from 27-29 April 2015 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 14 cases of children and young people who had recently offended and were supervised by Pembrokeshire Youth Offending Service. 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 Pembrokeshire was 25.4%. This was substantially better than both the previous year (31.1%) and the England and Wales average (36.1%).

Overall, we found that the work of the YOS to ensure that children and young people complied with the requirements of their sentence was good. However, since our last inspection in 2010, and despite achieving improved reoffending rates, there has been deterioration in the quality of work to reduce reoffending, protect the public and protect children and young people. Management oversight needed to be more consistent and robust. The YOS has recently been through a period of turbulence due to a number of staff changes, which may have impacted upon the quality of the work we assessed. The YOS has recognised these issues and has taken action to address them accordingly.

Commentary on the inspection in Pembrokeshire:

1. Reducing reoffending

1.1. Pre-sentence reports (PSRs) and panel reports are the principal means by which the sentencing courts and panels, that oversee referral orders, are advised about the causes of offending and the work required to address it. All of the PSRs in the sample were of a

[1] Published January 2015 based on binary reoffending rates after 12 months for the April 2012 – March 2013 cohort. Source: Ministry of Justice

good quality overall, and the child or young person and their parents/carers were engaged in the development of all PSRs. Panel reports were also of a good quality.

1.2. The initial assessment of the child or young person's likelihood of reoffending was done well in the great majority of the cases in the sample. Most were thorough and provided a full picture of the child or young person's circumstances, such as how living arrangements, family and personal circumstances, and substance misuse might impact on reoffending.

1.3. Children and young people's lives can change very quickly and, as a result, assessments need to be reviewed throughout the sentence. We found that reviews of initial assessments were sufficient in just over half of the cases sampled. Where there were gaps, it was because reviews had not been undertaken as required, were not timely, or were copies of a previous assessment, with insufficient update.

1.4. Plans to reduce the likelihood of reoffending required improvement and were insufficient in 6 of the 14 cases in the sample. In three cases plans had not been produced at all, while in others the objectives were not clear and did not give structure to the work to be undertaken. In referral order cases, the YOS policy is that the contract itself forms the plan. The objectives were written in very generic terms and needed to be more specific, explaining the actions to be taken, or changes that the child or young person needs to make, to reduce their likelihood of reoffending.

1.5. There was also room for improvement in reviewing plans to reduce the likelihood of reoffending. Reviews of plans were completed well enough in only half of the cases.

2. Protecting the public

2.1. We expect to see a thorough assessment of the risk of harm a child or young person poses to others. This should cover all relevant information, including past offending behaviour, and impact on victims. We found that this had been done well in three-quarters of cases in the sample. Where it was not, this was mostly because an assessment of risk of harm had not been undertaken, or insufficient account had been taken of victims.

2.2. Having assessed the risks, plans should be put in place to manage them. This had been done sufficiently well in 7 of the 11 relevant cases. In four cases the plan was not completed. There was some confusion about the requirement for risk management plans in medium risk of harm cases.

2.3. The assessment of risk of harm to others had been reviewed well enough in just over half of relevant cases. Where they were not, this was because reviews were either not undertaken as required, or reviews were not timely. More attention also needed to be given to reviewing plans to manage risk of harm.

2.4. More attention sometimes needed to be given to the risk of harm to identifiable victims, ensuring that both assessment and planning sufficiently reflect victim issues.

2.5. Management oversight to ensure the quality of risk of harm work needed improvement. It was effective in less than half of relevant cases, mostly because important deficiencies in assessment and planning had not been addressed.

3. Protecting the child or young person

3.1. Children and young people can be at risk of being harmed by others or as a result of their own behaviour. This may be by placing themselves in dangerous or potentially harmful situations. It is the YOS's role to work with others to help protect them. Initial assessment

of safeguarding and vulnerability had been done well enough in the large majority of cases. It was pleasing to see that case managers had a good understanding of safeguarding and vulnerability issues. In one good example an inspector noted: "*The case manager had concerns regarding child sexual exploitation and undertook an assessment, which triggered a referral to the Child Care Assessment Team. A strategy meeting was called and a comprehensive action and safety plan prepared.*"

3.2. The safeguarding needs of children and young people change over time and need to be kept under review. Satisfactory reviews of safeguarding and vulnerability assessments had been completed in more than two-thirds of the cases in the sample. Of the remainder, this was mostly because reviews were a copy of the previous assessment, with insufficient update.

3.3. Suitable plans were put in place at the start of the sentence to manage safeguarding and vulnerability issues in over two-thirds of cases. Where there were gaps, this was because plans were not completed, or they did not link with others' plans, for example, social care. Almost half of the plans were not reviewed sufficiently well in relevant cases. In three cases reviews were not undertaken when required.

3.4. Management oversight in ensuring the quality of safeguarding and vulnerability work needed to be more robust. We found it to be effective in less than half of relevant cases. Where it was not, this was mostly because important deficiencies in assessment and planning had not been addressed. These issues mirror those identified in oversight of risk of harm work.

4. Ensuring that the sentence is served

4.1. This is the strongest area of work we found in Pembrokeshire YOS. We expect to see that the YOS is doing what it can to help children and young people to complete their sentences successfully. This includes engaging them and their parents/carers in the assessment and planning processes, identifying and addressing barriers to engagement, and putting measures in place to ensure that they comply with the requirements of their sentence. In one good example an inspector noted: "*The case manager has thoroughly reviewed all assessments and plans following a recent breach panel, and has effectively updated the referral order panel with all of the recent information, so they can support Martin's compliance*."

4.2. There was a high level of engagement in most cases in the sample between case managers, children and young people and their parents/carers in carrying out the initial assessment, and in all PSRs. However, engagement was less good in relation to the planning process. It is important that the changes that need to be made by children and young people are clear to them, that they own and understand their sentence plan, and are able to have input to its contents.

4.3. In the great majority of cases, attention had been paid to addressing the child or young person's diverse needs and any barriers to engagement in the initial assessment. However, this was less so in relation to initial plans, where only half of plans sufficiently addressed barriers to engagement and diversity factors. This was mostly because barriers which had been identified through the assessment were not addressed in the plan.

4.4. We found that the YOS had paid sufficient attention to health and well-being outcomes for the large majority of children and young people under their supervision.

4.5. It was pleasing to see that the YOS responded appropriately to children and young people who did not comply with the requirements of their sentence in all but one relevant case, for example, by issuing formal warning letters or breach proceedings.

Operational management

We found that staff had sound knowledge of effective practice in working with children and young people, alongside a good understanding of local policies and procedures for managing risk of harm and safeguarding. Staff were positive about the management oversight of risk of harm and safeguarding work and most staff spoke positively about their managers. However, as outlined above, we found evidence to suggest that management oversight was not always effective and some staff indicated that they would welcome more active help to improve the quality of their work.

Case managers reported a mixed picture in relation to their training and skills development needs being met. A minority felt they had been left to 'learn on the job' due to all the staffing changes which had taken place, and would welcome more training. For example, in relation to the electronic case management system. A gap identified by staff was training in recognising and responding to speech, language and communication needs. It was positive to hear that staff were able to recognise the risk factors which may indicate child sexual exploitation, though processes for screening, referral and assessment were not always being completed in a timely manner, or followed up accordingly.

Key strengths

- Pre sentence reports were of a good standard and initial assessments of the likelihood of reoffending were mostly thorough.
- Children and young people and their parents/carers were engaged well in pre-sentence reports and initial assessments.
- There was good access to emotional and mental health support for children and young people.
- Case managers had good working knowledge of safeguarding and vulnerability issues, and an understanding of the risks of child sexual exploitation.
- Staff worked well with children and young people in ensuring they complied with the requirements of their sentence.

Areas requiring improvement

- Management oversight should be more consistent and robust to ensure the quality and timeliness of both risk of harm, and safeguarding and vulnerability work, so that the public and children and young people are protected.
- Sentence plans need to be clearer and more specific to enable the child or young person to understand the changes they need to make, or actions to take to reduce their likelihood of reoffending.
- Assessments and plans need to be reviewed thoroughly and in a more timely way, in order to take account of changes in the lives of children and young people.
- More needs to be done to manage the risk of harm to identified victims.
- Change of case managers should be minimised as far as possible, in order to offer continuity of support to the child or young person.

We are grateful for the support that we received from staff in the 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 Sue McGrath. She can be contacted at susan.mcgrath@hmiprobation.gsi.gov.uk or on 07757 848458.

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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.