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 Haringey

The inspection was conducted from 08–10 June 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 34 cases of children and young people who had offended recently and were supervised by Haringey 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 Haringey was 40.9%. This was significantly better the previous year of 47.2% but worse than the England & Wales average of 36.1%.

Overall, we found a dedicated staff team where the YOS workers had built constructive relationships both with the children and young people who had offended, and their families. The case managers were committed to identifying what aspects of a child or young person's life contributed to their offending behaviour. Compliance was supported through flexibility and breach was instigated where necessary. Although staff spoke positively about the support offered by their managers, we found that the oversight of work, in particular to safeguard children and young people, was not effective enough.

Commentary on the inspection in Haringey YOS:

1. Reducing reoffending

1.1. Pre-sentence reports (PSRs) were provided to the court in 22 of the cases sampled. The majority were of a good quality and there was evidence that the reports had been quality assured before they were submitted to the courts. There was sufficient assessment of the

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

reasons given for offending and clear recommendations of alternatives to custody were given. In one particular good example, an inspector noted: "*There was a very thorough and comprehensive PSR with good assessment of the child or young person and individual diversity issues fully taken into account. The initial assessment levels for the child or young person for risk and vulnerability were appropriate.*"

1.2. The initial assessment of the child or young person was found to be sufficient in over two-thirds of the cases sampled. However, where there were gaps, this was because the case manager had failed to identify factors linked to offending behaviour, and diversity factors were not identified sufficiently.

1.3. Although planning was good in most cases, there were instances in which the language was not accessible and the plans were not signed by the child or young person. We saw a strong emphasis on getting children and young people into education, training or employment. In some cases, the timing of this was at odds with other difficulties in the child or young person's life. This meant that the individual was not able or ready to cope. There were often too many objectives in plans, with no clear priority attached.

1.4. Reviews were sufficient in only half of the sample inspected. This was mainly due to the reviews not being undertaken following a change in circumstances, for example, where vulnerability had increased.

1.5. Nine of the children and young people in the sample were sentenced to custody. There was insufficient planning for the custodial part of the sentence in five out of the nine cases sampled. The insufficient plans were focused only on the custodial element and contained objectives based on the available provision of that establishment, rather than considering the longer term needs of the child or young person. Plans lacked any resettlement focus.

2. Protecting the public

2.1. We expect to see a detailed assessment of the risk of harm a child or young person poses to others. This should cover all relevant information, including past offending and behaviour as well as the impact on victims. We found that this happened in three-quarters of cases. Gaps were identified in instances where the risk of harm screening was not undertaken, or insufficient account was taken of potential victims.

2.2. Having assessed the risks that the child or young person poses, the youth offending service should put plans in place to manage these risks. Haringey YOS used an integrated intervention plan for this purpose. Plans were put in place to a satisfactory standard in over half of the relevant cases sampled. In some instances, the victim issues had not been addressed specifically and the potential changes to risk of harm had not been anticipated.

2.3. Reviews are completed at six-monthly intervals unless there has been a significant change in circumstances. It is of concern that satisfactory reviews were only completed in less than half of the applicable sample. This was due in some instances to the case managers not undertaking a review following a significant change in circumstances. Some updates were only completed in relevant sections of the assessment, and it was not always clear which sections were updated without looking through the whole document.

2.4. In ensuring the quality of risk of harm work, management oversight was effective in just over half of applicable cases. In too many cases, managers had signed off assessments and plans of insufficient quality as opposed to helping staff to develop their practice.

3. Protecting the child or young person

3.1. Often, children and young people who offend are themselves vulnerable and we expect to see that their safeguarding needs have been thoroughly assessed and planned for. While the majority of PSRs were of good standard, we found that seven reports contained insufficient information about how the child or young person's vulnerability linked to their offending.

3.2. Overall, the initial assessment of the child or young person's safeguarding needs reflected the fact that case managers had taken time to understand the vulnerabilities that were presented. This included consideration of their substance misuse, education, training and employment needs. Where the assessment was insufficient, we found that greater attention should have been paid to the child or young person's care arrangements and their emotional and mental health.

3.3. Once an assessment has been completed, a plan should be put in place to address the child or young person's safeguarding needs. We found that plans had been completed to the required standard in just over half of the applicable cases. Again, greater attention needed to be given to the child or young person's emotional and mental health needs, and their care arrangements. Of those cases in the sample where the child or young person was looked after by the local authority, we found the quality of initial plans to be better, but with attention needing to be given to reviews.

3.4. Children and young people's safeguarding needs change over time and must therefore be kept under review. We found that assessments had been reviewed to an acceptable standard in only 9 out the 21 cases. Where gaps were identified, this most often related to a failure to review the assessment following a significant change in circumstances, for example, when vulnerability of the child or young person had increased. We found one instance where there was no review despite the child or young person being a victim of a violent crime. We found a similar picture in relation to reviewing safeguarding plans.

3.5. Nine of the children and young people in our sample had been sentenced to custody. In six of these cases the YOS had not completed a plan for safeguarding and vulnerability work during the custodial period.

3.6. Deficiencies in assessment and plans were not sufficiently addressed by managers.

4. Ensuring that the sentence is served

4.1. Case managers took time to get to know the children and young people that they were working with and to develop trusting relationships. Diversity issues and other potential barriers to engagement had been assessed during the report writing stage and planned for when considering interventions in three-quarters of the cases sampled. Gaps were in relation to plans not being adapted to the identified learning style of the child or young person, race and ethnicity not being considered in the planning, and the parent/carer not being engaged sufficiently in developing the plan. Good attention was given to considering the health and well-being of the child or young person in almost all of the cases.

4.2. Engagement with children and young people and their parents/carers was of a good standard for over three-quarters of the sample inspected and there was evidence that parents/cares were present at the report writing stage, and were involved in the planning of interventions. Good use was made of home visits and it was evident that case managers viewed parents/carers as essential to the successful completion of an order. One inspector noted that: "*The parents were included where possible in all aspects of the*

intervention planning. Home visits were completed and the parents were invited to panel reviews and given feedback from the substance misuse worker."

4.3. Case managers made a consistent effort to support children and young people to comply with their sentence. We saw evidence of case managers sending text messages and emails to the child or young person to remind them of their appointments; if the child or young person failed to attend, breach action was not taken immediately, but compliance meetings were held to support engagement of children and young people.

4.4. When it was necessary to return an order to court, for breach due to non-compliance, enforcement action was taken promptly.

Operational management

We look for evidence that the management oversight has been effective in ensuring the quality of work to address the risk of harm to others and child safeguarding. This can take the form of one-to-one sessions between the worker and their manager, wider meetings with internal colleagues and the implementation of a sound quality assurance process.

Overall, staff felt that their managers had the skills to support them and to help them to improve the quality of their work; they felt that their managers were approachable and supportive. However, while managers were approachable, we found that staff supervision or other quality assurance arrangements have been effective in only 13 out of the 25 cases where we would have expected it to have made a difference. In too many cases this process had not identified shortfalls or helped staff to develop their practice.

We found that the vast majority of staff were familiar with local policies and procedures for managing risk of harm, safeguarding, engagement and compliance. The staff felt that the culture in the YOS was positive and encouraging with regards to learning and development.

Key strengths

- It was evident that there was a commitment to children and young people and their parents/carers. YOS staff were particularly good at building relationships and undertaking home visits.
- Services provided to the courts, in particular PSRs, were of a high standard.
- There was a good level of supported compliance and, where needed, enforcement of court orders.

Areas requiring improvement

- Custodial plans should cover the whole sentence and give clarity about what aspects need to be delivered in custody and what can be delivered in the community.
- The quality of initial plans to address safeguarding and vulnerability needs to be improved. Plans should be kept under review and updated in response to any significant change in circumstances.
- Effective management oversight and quality assurance of assessment and plans should be provided.

We are grateful for the support that we received from staff in the Haringey 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 Yvette Howson. She can be contacted at Yvette.howson@hmiprobation.gsi.gov.uk or on 07825453092.

Copy to:

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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.