Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
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To:	Keith Rutherford, Chair of Monmouthshire and Torfaen YOS Management Board
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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 Monmouthshire and Torfaen

The inspection was conducted from 22-24 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 14 cases of children and young people who had recently offended and were supervised by Monmouthshire and Torfaen 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 Monmouthshire and Torfaen was 42.9%. This was worse than the previous year of 36.3% and worse than the England and Wales average of 36.6%.

Overall, we found that the performance of the Monmouthshire and Torfaen YOS was consistent with our findings from our previous inspection in 2010. Staff were well supported in their work and they engaged positively with children and young people and partner organisations. There is scope for improving the quality of practice by ensuring that all assessments and plans are underpinned by an analysis of relevant case issues and integrate diversity matters when required. Achieving consistency between staff in this respect would help to improve the quality of the services offered by the YOS as a whole.

Commentary on the inspection in Monmouthshire and Torfaen

1. Reducing reoffending

1.1. We found that sufficient advice had been given to courts to assist with sentencing in all cases.

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

1.2. Assessments and plans form the bedrock of service delivery. In 3 of the 14 cases reviewed the assessments of what was likely to make a child or young person offend were not of good enough quality. This was largely because these assessments were insufficiently analytical. This was reflected in the case plans for those children and young people and it meant that the scope of the work envisaged with them limited the possibilities of positive outcomes being achieved. Assessment and planning was an aspect of practice that was strong for many staff members and there was scope for improving the position of the team overall by ensuring consistency between staff in the quality of assessments and plans produced.

1.3. The family and personal circumstances of children and young people can change quickly and can show the need for a change of direction in supervision. As a result, assessments and plans to address offending issues need to be reviewed in order that they keep pace with case developments. Three of the nine assessments that were reviewed had not been done well enough. This was mirrored in the reviews of the associated plans.

1.4. Plans of work to address potential reoffending were strengthened by the voluntary resettlement support facility. This supported children and young people who were coming to the end of supervision but needed ongoing support, were coming out of custody, or were in the process of transferring to adult probation supervision. The scheme offered a range of services, including initial transport support for children and young people as they made contact with their probation officers and began supervision in that setting.

2. Protecting the public

2.1. A good quality assessment of risk of harm to others was seen in 12 of the 14 cases we reviewed. Where a child or young person may pose a risk of harm to others, we expect to see a plan to minimise the likelihood of this happening. In seven of the nine relevant cases, this was evident and we could see how the risk of harm would be managed. Such planning was satisfactory for two out of the three relevant custodial cases. In the custody case that did not have an adequate plan to address risk of harm issues, the plan for release and to deal with barriers to engagement was insufficient.

2.2. In the case of Helen[2], the YOS case manager was instrumental in mobilising a range of partnership services to address her vulnerabilities and the risk of harm she posed. Helen was vulnerable, at risk of sexual exploitation and her angry outbursts put others at risk of harm. The YOS case manager was at the centre of a process to work with others to create and implement a comprehensive plan which saw Helen living in a supported environment, reflecting on her behaviour and on her future prospects, and accessing education and other developmental services.

2.3. Reviews of risk management plans are important as they ensure the work continues to minimise the risk of harm posed to others. In only five of the eight relevant cases, plans to address the risk of harm to others had been reviewed satisfactorily. For one case, the review had not been done. The other two were of insufficient quality because they did not reflect either the changes in the circumstances, or the diversity issues, of the children or young people.

2.4. Where there was an identifiable or potential victim, we noted that the risk of harm they faced had been effectively managed in five of the eight relevant cases.

2.5. We heard from staff that management oversight of risk of harm work had been provided in almost all of the relevant cases, but this was evident in the case record in under half. Deficiencies in the quality of some assessments and plans had not been addressed.

[2] The names in this report have been changed to protect the identity of the child or young person

3. Protecting the child or young person

3.1. In 12 of the 14 cases, safeguarding and vulnerability needs had been sufficiently assessed at the initial stage, but only half of the eight relevant cases could show that the assessments had been reviewed in the light of changing circumstances.

3.2. The case of Alun, aged 17 years, illustrated the value of the YOS involvement with the Torfaen Complex Case Forum. This brought together a range of agencies involved in the care of highly vulnerable children and young people. Through this forum the YOS was able to contribute to the multi-agency assessments of risks and needs, and to coordinate their work with social workers and others. Alun had benefited from these arrangements as the agencies had been able to identify appropriate priorities for his care and, in particular, to focus on his accommodation needs.

3.3. In three-quarters of the relevant cases, planning for work to manage and reduce vulnerability was of a good quality. In those that were not, missing relevant diversity factors, insufficient information exchanges with other agencies and not addressing substance misuse had undermined the quality of the work.

3.4. In seven out of the ten relevant cases, we found adequate reviews, throughout the sentence, to address safeguarding and vulnerability needs.

3.5. In 10 of the 13 relevant cases sufficient attention had been given to addressing the health and well-being needs of the child or young person.

3.6. There was evidence of effective management oversight of work to address safeguarding and vulnerability in over half of the cases.

4. Ensuring that the sentence is served

4.1. The majority of assessments of diversity factors and barriers to engagement were sufficient and appropriate attention had been given to these issues in almost all of the pre-sentence reports. This work is important as it helps the child or young person to form an effective working relationship with their YOS case managers.

4.2. The child or young person or their parents/carers were involved in the preparation of all of the pre-sentence reports. We also found that they had good engagement to carry out further assessments and plans. While we found attention was being paid in most plans to diversity factors and to potential barriers to engagement, it was not always adequately considered in respect of age and maturity and family matters. In some cases, missing these issues limited the ability of the YOS to work towards achieving positive change with the child or young person.

4.3. Levels of contact with the children or young people subject to supervision maintained a good balance between promoting compliance, providing interventions to help achieve positive change for the individual and holding them to account. Five of the children or young people fully met the requirements of their sentence. Nine needed work by the case manager to secure their compliance. In all cases where the child or young person had not cooperated as required, the response of the YOS was appropriate. This led to them either re-engaging with the work, or, in two cases, being returned to court for breach proceedings. One inspector noted: "*This case showed creativity and flexibility in seeking to ensure a young person from the travelling community successfully completed his referral order. The young person and his family were reluctant to engage with professionals and put many obstacles in the way of participating in the work. The YOS worker offered flexibility in making appointments. She also used materials that were accessible and engaged the interest of the young person. Simple messages and reminders about appointments, backed by reminders about the consequences of non-compliance,*

helped the young person to meet his obligations to the order. He had not reoffended or come to the notice of the police throughout the period of supervision".

Operational management

We found that the YOS had responded to the previous inspection in 2010 by implementing a range of measures aimed at improving the quality of their work. These included establishing a quality assurance process to improve a number of practice areas and rolling out Assessment, Planning, Interventions and Supervision (APIS) training to help with this. More recently, the YOS established a case planning forum to support work in complex cases. Practitioners welcomed these and other practice developments and had incorporated them into their work. In the period leading up to the inspection the YOS faced a number of challenges, including moving to a new case management system and carrying an operational manager vacancy for some time.

Case managers valued management oversight of their practice. Almost all described countersigning and management oversight of work as an effective process. We judged that staff supervision and quality assurance arrangements had made a positive impact in many of the cases inspected, but it was not regularly evidenced in the case files and had not delivered the required quality in all cases. In general, staff said they received effective supervision and that their line managers had the skills and knowledge to help them to improve the quality of their work.

Most staff reported having received recent training to enable them to do their current job, but several said they had not had enough training in delivering interventions and addressing diversity issues, although they valued the recent training in speech, language and communication needs. We found that most practitioners could demonstrate an awareness of the principles of effective practice and local policies and procedures to address compliance, vulnerability and risk of harm practice issues.

Key strengths

- The quality of advice given to the courts.
- The engagement of children and young people and parents/carers in assessments.
- Priority was being given to addressing compliance and non-engagement issues.

Areas requiring improvement

- All assessments and plans are informed by an analysis of relevant issues.
- Diversity issues need to inform relevant assessments and plans.
- Reviews need to reflect any significant changes in the circumstances of children and young people.
- Evidence of the impact on quality of management oversight of cases needs to be better recorded.

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 Joseph Simpson. He can be contacted at joe.simpson@hmiprobation.gsi.gov.uk (07917 084764).

Copy to:

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Director of Children's Services Torfaen County Council	*Sue Evans*
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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.