Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
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To:	Kathy Bundred, Chair of Havering YOS Management Board and Head of Children and Young People's Service
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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 Havering

The inspection was conducted from 13-15 July 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 20 cases of children and young people who had recently offended and were supervised by Havering Youth Offending Service (YOS). In all cases, this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

The published reoffending rate[1] for Havering was 41.9%. This was worse than the previous year and worse than the England and Wales average of 36.6%. As the service has a small cohort, small changes can have a significant effect. The management team has already started to use the YJB live tracker tool to ensure that they fully understand reoffending patterns and trends.

Overall, we found good assessments of offending behaviour and public protection arrangements; these had improved since our last inspection. Case managers knew the children and young people well, and had engaged with them and their parents/carers to understand what was contributing to their offending. We found good support for children and young people to access education, training or employment and for tackling substance misuse issues. Parents/carers were seen as being central to the child or young person and were supported to help their child to stop offending. Planning was not always clear, this was recognised by YOS management and a new system was being introduced. Oversight of work by managers had focused on processes, and it was positive to find that both the managers and staff had recognised this and wanted to find a way of incorporating the quality of work and practice into supervision sessions.

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

Commentary on the inspection in Havering:

1. Reducing reoffending

1.1. When assessing the reasons for offending, case managers had been diligent in obtaining and considering a wide range of relevant information about the child or young person. It was clear that they had tried to understand individual circumstances and had listened to the views of the child or young person. In particular, attention had been paid to how education, training and employment, attitudes to offending and the impact of a child or young person's neighbourhood had contributed to their offending, or how it might help prevent further offending.

1.2. Understanding of the reasons for offending was supported further by partner agencies. Of note was the work of the parenting worker, the mentoring scheme for those involved in or on the periphery of gangs (Spark2Life) and the efforts made to maintain placements in school and college. We were impressed with the case managers' knowledge of the children and young people they were working with; they had ambition for the children and young people and were persistent in trying to engage them and in working with others.

1.3. Pre-sentence reports were good of good quality, providing a sense of what had contributed to the offence and any risk of harm to others posed by the child or young person. Alternatives to custody were well presented and it was positive to see that parents/carers had been involved in the production of reports. The management oversight of pre-sentence reports was effective.

1.4. The YOS was introducing a new system of planning; case managers had recently received training in the use of an integrated action plan. The move to the integrated action plan gives an opportunity for plans to be focused, specific to individuals and to better reflect the work that was happening. Existing plans often failed to do this.

1.5. Planning for those children and young people in custody was not always effective, and it appeared that there were difficulties in obtaining information from some custodial establishments. This needs to be resolved as it has the potential of undermining some good practice by Havering YOS in resettlement.

1.6. Planning for children and young people who were on a referral order was underdeveloped, and tended to consist of a list of activities added to the end of the referral order panel report.

2. Protecting the public

2.1. There was a good understanding of the risk of harm posed to others in 17 of the 20 cases we assessed, these being effectively reviewed as time went on. The understanding that case managers had of risk of harm issues was often gained through our discussions with them, and the detail of risk of harm was not always evident on the electronic case recording systems.

2.2. Planning to manage identified risk of harm to others was mixed. There was a range of issues that had affected the overall quality. This included three cases where there should have been a risk management plan but one had not been produced; planned responses being unclear; plans not following on from assessments and victim safety not being fully addressed.

2.3. In four cases the completion of a full assessment of Risk of Serious Harm (RoSH) would have helped the case manager better plan for all areas of risk including the potential for future harmful behaviour and specifying how victims could be best protected from this.

2.4. The caseload of Havering YOS included a number of children and young people who have come to live in the area because of their involvement in serious youth violence in other London boroughs. This brings some challenges in managing risk of harm to others and in keeping these individuals safe. We saw a number of examples of effective practice to manage these risks, including sharing information between the YOS staff so that rival gang members do not meet up at the YOS, and the provision of the Spark2Life programme which provides mentors to help children and young people move away from gang associations.

2.5. All of the staff we spoke to had a good understanding of the local policies and procedures in relation to risk of harm.

3. Protecting the child or young person

3.1. In our view, 17 of the 20 children and young people in the cases we looked at were classified as being of at least medium vulnerability, and in all but 2 cases we agreed with the YOS's classification.

3.2. In 25% of the cases we assessed the children or young people had been found in possession of or to have used weapons. While the risk of harm this posed to others was considered, the implications for the individual's vulnerability were not always recognised.

3.3. Planning to manage vulnerability was good enough in just over half of the relevant cases. While it was very positive to find that planning had a strong focus on how substance misuse services, education and family could assist in keeping children and young people safe, the same attention was not always given to how physical or emotional and mental health needs would be met.

3.4. We identified three cases where a plan to manage vulnerability should have been produced but was not. However, it was clear from discussions with the case managers that action was being taken to manage vulnerabilities and we saw examples where work was reducing vulnerability. In one case we saw the following example: "*Rex was in custody and had become friends with another young person. When his friend took his own life, Rex was distraught. His case manager and custodial staff talked soon after the event and put a number of measures in place to help him and keep him safe. These included keeping a watch on him, giving him extra contact with his mum and talking to him. He was also supported to talk to his friend's parents. As a result, Rex has been able to grieve for his friend, has not harmed himself and although his friend's death has affected him, he is learning how to deal with his feelings in an appropriate way*".

3.5. Management oversight of work to keep children and young people safe was mixed but we found some good work to help case managers see issues clearly. However, we also saw cases where help with this was not forthcoming despite case managers needing and requesting it.

4. Ensuring that the sentence is served

4.1. This was the strongest area of work for the YOS. Case managers had a detailed understanding of the children and young people and were good at identifying any barriers to engagement. The use of home visits had helped to develop relationships with families and timely and tailored support for parents/carers made them integral to the support network being developed around the child or young person.

4.2. When a child or young person did not comply with their order, careful consideration was given to how to resolve this, and we saw appropriate action being taken to either encourage the individual to engage with the order or to take enforcement action.

4.3. Case managers worked well with partner agencies to make sure that any potential barriers were known and could be responded to such as holding joint meetings so that individual needs could be explained and understood.

4.4. We consult with children and young people through an electronic survey called Viewpoint. Twenty one children and young people from Havering YOS have completed this, and were generally very positive about the service they have received. They said that things were explained to them so that they understood what the court expected of them. They had been asked directly what makes them offend and what would help them to stop. They felt that their views had been taken seriously and all reported that when they had needed help they had got it and that in most cases things had got better for them. One young person told us: "*I learned how to think before doing things and I don't let myself get angry anymore. My relationship with my mum has got better. I go to school and can concentrate more in school. I stopped smoking cannabis and drank less alcohol. My relationship with my sister and my friends had got better*".

Operational management

It is important to note that there have been recent significant changes in the formation and management of the YOS. Until November 2014, it was managed by the London Borough of Barking & Dagenham. Havering Borough Council decided to bring the YOS back in-house and the current manager was appointed in December 2014. Our inspection found that a significant amount of work had been undertaken to establish clear and effective processes and procedures, and to develop work that was centred on the needs of individual the children and young people.

The YOS manager had a very clear and accurate understanding of the performance of the YOS, our findings confirming his assessment.

Key strengths

- Effective assessments of offending behaviour and risk of harm to others.
- Parents/carers are fully involved in assessment and planning, and are seen as being a central support to the child or young person.
- Case managers' detailed knowledge of barriers to working with the YOS and individual preferences of children and young people had led to effective compliance and engagement.
- Children and young people have access to a range of specialist services including substance misuse, emotional and mental health and mentoring.

Areas requiring improvement

- Management oversight should make sure that planning provides clear directions for all involved in the case and that all staff receive regular and appropriate supervision.
- Assessments of the risk of serious harm to others should include the potential for future harmful behaviour.
- Assessments of vulnerability must consider if and how offending behaviour contributes to a child or young person's vulnerability.

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 Yvonne McGuckian. She can be contacted at Yvonne.McGuckian@hmiprobation.gsi.gov.uk or on 07973 295475.

Copy to:

YOS Manager	*Jonathan Taylor*
Local Authority Chief Executive	*Cheryl Coppell*
Director of Children's Services	*Isobel Cattermole*
Lead Elected Member for Children's Services	*Councillor Meg Davis*
Lead Elected Member for Crime	*Councillor Osman Dervish*
Elected Mayor of Havering	*Councillor Brian Eagling*
Deputy Mayor for Policing and Crime	*Stephen Greenhalgh*
Chair of Local Safeguarding Children Board	*Alice Peatling*
Chair of Youth Court Bench	*Martin Camilleri*
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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.