Inspection of Youth Offending Work
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To:	Alison Newcomb, Chair of West London Tri-Borough Youth Offending Service Reducing Reoffending Board
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From:	Alan MacDonald, Assistant Chief Inspector (Youth Justice)
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Report of Short Quality Screening (SQS) of youth offending work in West London Tri-Borough Youth Offending Service (YOS)

The inspection was conducted from 14 -16 December 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 recently offended and were supervised by West London Tri-Borough YOS. Wherever possible, this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

West London Tri-borough YOS came into being in January 2012 with the merger of the youth offending services of Westminster, Hammersmith & Fulham and Kensington & Chelsea. The published reoffending rates[1] for each area were 43.6%, 49.6% and 47.2%, respectively. These figures were worse than the previous year and above the England and Wales average of 37.9%. Reoffending rates can fluctuate and should be understood in the context of the issues facing a local area and the complexity of cases in any sample.

We found that the YOS was performing very well. Staff were enthusiastic, committed and their knowledge of cases was impressive. The quality of work was good enough across all areas of practice in the vast majority of cases. Engagement with children and young people was excellent. There were no areas of significant weakness although some improvements could be made to reviews and some aspects of planning and management oversight.

[1] Published October 2015 based on binary reoffending rates after 12 months for the January 2013 – December 2103 cohort. Source: Ministry of Justice

Commentary on the inspection in West London:

1. Reducing reoffending

1.1. Case managers evidently had a solid understanding of the drivers for the offending behaviour of children and young people, with all 34 assessments found to be sufficient, and in several instances of high quality. Assessment is the foundation for effective planning and delivery, and this was evidenced in the work. As one inspector commented: "*...the case manager had a strong sense of what the priority concerns were and sequenced the delivery of interventions in line with identified needs and risks. Account was taken of the young person's learning style and diversity needs and these were well evidenced in records*". Reviews were undertaken in all but 3 of 22 relevant cases.

1.2. Pre-sentence reports (PSRs) were consistent and well-written. All 17 inspected gave an accurate account of offending behaviour. The quality assurance of PSRs by management was effective in each case.

1.3. Planning work to address offending in the community was sufficient in 32 out of 33 cases. Inspectors found some exemplary practice: "*...the planning in Jeremy's case was excellent...The intervention plan was written in the young person's language, was sequenced and was clear who was doing what. A very good piece of work*". Reviews were completed in 23 out of 25 relevant cases.

1.4. Nine of our sample involved children and young people subject to custodial sentences. In two cases, sentence planning to reduce reoffending was insufficient because of a lack of focus on resettlement issues and reviews.

1.5. The 3 Boroughs which make up the West London Tri-Borough YOS are ethnically diverse, with between 42.0% and 58.5% of the population identified as belonging to black, Asian and minority ethnic communities. Diversity issues were generally identified and addressed well by case managers, and it was pleasing to see that there was a broad understanding of barriers to engagement, participation and achievement.

2. Protecting the public

2.1. The assessment of risk of harm to others was of sufficient quality in all but three of the sample. In most instances, staff looked beyond the current offence and drew on historic and non-criminal behaviours (e.g. aggression in the family home or bullying at school) to inform their assessments. Regular and effective use was also made of police intelligence and information from the Integrated Gangs Unit. Assessments of risk of harm were reviewed appropriately in 20 of 23 cases. Satisfactory engagement with Multi-Agency Public Protection Arrangements was in place for the single eligible case in the sample.

2.2. The explanation of risk of harm provided in PSRs was good enough in 14 out of the 17 examples inspected.

2.3. Sufficient plans to address risk of harm were in place for 28 of 32 relevant cases. In the four which did not meet the criteria, the main weaknesses were deficiencies in planned responses and contingency measures to address identified risk. Reviews had been undertaken in all but 2 of 24 cases. Risk of harm plans were satisfactory in each of the relevant custodial cases.

2.4. Where there had been an identifiable victim, the work to manage the risk posed by the child or young person was sufficient in nearly every case.

2.5. The management oversight of risk of harm was judged to be good enough in 25 of 30 cases. In the five unsatisfactory examples, deficits in plans and reviews had not been redressed.

3. Protecting the child or young person

3.1. We found a satisfactory assessment of safeguarding and vulnerability needs in 29 of the 34 cases inspected. Reviews of assessments had been completed in the large majority of cases in which we judged they should have taken place. Commenting on information gathering in one case, an inspector found that: "*...prior to being allocated, case administrators search through Framework-I (used by children's social care) and complete a summary of the key information. This aids case workers to have a better understanding of their case and ensure they are apprised of any pertinent historical information*".

3.2. A clear and thorough assessment of safeguarding and vulnerability was found in all except one of the PSRs in the sample.

3.3. Planning was carried out consistently well and we found sufficient plans in place for 28 of 31 cases in which issues were identified, including all 9 custodial sentences. Although YOS responses or contingency plans were insufficient in a very small number of cases, we did find examples of good practice in planning: "*The engagement of Geoff and his grandmother to develop a Personal Safety Plan and work through scenarios where conflict and offending arise was well thought through, coordinated well across the partnership with children services and the Focus Practice Team, and (had) the potential to improve motivation and engagement for release*". Reviews had also been completed in almost all relevant instances.

3.4. Three of the case sample were Looked After Children. There was good evidence of effective communication, liaison and joint working with children's social care and police to protect and safeguard the child or young person. The YOS had taken appropriate action in each of the nine cases where inspectors found potential indicators of child sexual exploitation.

3.5. Management oversight of safeguarding and vulnerability had been sufficient in 23 of 28 cases.

4. Ensuring that the sentence is served

4.1. The identification and understanding of diversity factors and barriers to engagement was sufficient almost all cases. Satisfactory engagement with children and young people and their parents/carers in the assessment process and preparation of PSRs was evidenced across the entire sample.

4.2. There was consistently good evidence of work to identify and address diversity issues and barriers to engagement. One excellent piece of work cited by an inspector found: "*...Hanif had a head injury (which) affected his speech and ability to understand...The case manager made great efforts to assist him to understand and learn. The attention to barriers to learning and complying in this case were extremely good. Hanif helped to create his own behaviour agreement which he 'owned' and was now complying with. This case was well-managed and attention to individual needs and barriers was of a very good standard*".

4.3. The YOS had responded appropriately in all 12 cases in which compliance issues had been identified, including the use of formal warnings and, in some cases, the instigation of breach proceedings.

Operational management

In the course of the inspection we interviewed a total of 16 case managers. Staff were extremely positive about the quality of management support and the vast majority were of the view that their line manager had the relevant skills and knowledge to oversee and help them improve their work. There was also a consensus that training and development opportunities were available and accessible, although almost half felt they would benefit from more training around speech, language and communication needs.

Regular management oversight of work was evidenced in the case record and the YOS had good quality assurance processes in place.

Key strengths

- Case managers had a strong understanding of the needs of, and risks presented by the children and young people they supervised.
- Assessments and plans were completed consistently well.
- PSRs and panel reports were of a good standard.
- Workers effectively engaged with children and young people and their parents/carers.
- The YOS worked well with other agencies and there was good evidence of effective liaison, information sharing and joint working with children's services, police and the Integrated Gangs Unit.
- Diversity issues and barriers to engagement were identified and addressed well.

Areas requiring improvement

- In a small number of cases, assessments and plans should be completed in a more timely fashion and in response to changes in a child or young person's circumstances.
- Some plans did not address identified areas of risk or vulnerability.
- Management oversight should ensure the quality of assessments and plans.

We are grateful for the support that we received from staff in the West London Tri-Borough 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 Colin Barnes. He can be contacted at colin.barnes@hmiprobation.gsi.gov.uk or on 07825 420119.

Copy to:

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Director of Children's Services	*Andrew Christie*
Lead Elected Member for Children's Services: Westminster Hammersmith & Fulham Kensington and Chelsea	 *Cllr. Danny Chalkley* *Cllr. Sue MacMillian, Cllr. Sue Fennimore* *Cllr. Elizabeth Campbell*
Lead Elected Member for Crime: Westminster Hammersmith & Fulham Kensington and Chelsea	 *Cllr. Nickie Aiken* *Cllr. Mike Cartwright* *Cllr. Gardener*
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Ofsted – Links	*Lynn Radley, Caroline Prandas*
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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.