Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

HM Inspectorate of Probation
1st Floor, Manchester Civil Justice Centre, 1 Bridge Street West, Manchester M3 3FX
0161 240 5336 - www.justiceinspectorates.gov.uk/hmiprobation

To:	Helen Jenner, Chair of the London Borough of Barking & Dagenham Youth Offending Service Management Board, and Director of Children's Services
Copy to:	See copy list at end
From:	Alan MacDonald, Assistant Chief Inspector (Youth Justice)
Publication date:	18 May 2016

Report of Short Quality Screening (SQS) of youth offending work in the London Borough of Barking & Dagenham

The inspection was conducted from 25-27 April 2016 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 the London Borough of Barking & Dagenham 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 the London Borough of Barking & Dagenham was 37.4%. This was considerably better than the previous year and better than the England and Wales average of 38.0%.

The YOS was under Youth Justice Board improvement measures and so aware that there was work to be done to improve service delivery. Overall, we found a YOS committed to achieving positive outcomes and evidence of sound, solution-focused thinking at senior management level. Practitioners were interested in developing their practice and helping children and young people to achieve their goals. Gaps in their knowledge and skill, however, limited their ability to manage risk of harm and vulnerability effectively and this needed urgent attention.

Commentary on the inspection in the London Borough of Barking & Dagenham:

1. Reducing reoffending

1.1. Both the court and referral order panels sought advice from youth offending teams to help inform their decisions. Pre-sentence reports were provided by the YOS in ten of the cases we looked at. Some were long but outlined in a helpful way the context within

[1] The reoffending rate that was available during the fieldwork was published January 2016, and was based on binary reoffending rates after 12 months for the April 2013 – March 2014 cohort. Source: Ministry of Justice

which children and young people offended, and provided sensible proposals for sentence. While the large majority of pre-sentence reports were fit for purpose, some reports would have benefited from a clearer explanation of risk of harm, and safeguarding and vulnerability issues. Of the three reports written for referral order panels, there was more to be done in two of these to ensure panel members had enough information on which to base their decisions.

1.2. Case managers were not always able to say why individual children and young people had offended. We were pleased to see that an assessment had been drafted in all but one case and each of these had been prepared in a timely way. Many, however, contained gaps in analysis, for example how lifestyle, and emotional and mental health influenced a child or young person's offending behaviour. There was also a need in a proportion of cases for case managers to explore more carefully how changes in a child or young person's family or other relationships could impact on the likelihood that they would reoffend.

1.3. There was also a review assessment in every case but one. These had been completed at the right time and in the right way in more than half. In a small number of cases, assessments had not been reviewed after a significant change in circumstance, or were copies of previous assessments that had not been updated sufficiently.

1.4. Planning to reduce the likelihood that a child or young person would reoffend varied in quality. Several plans did not meet the needs of the case or only included high level objectives with no supporting detail. In some cases, where children or young people had reoffended, the plans from their previous orders were being used, and there was too little evidence of effective review.

2. Protecting the public

2.1. Work at the start of the order to understand and explain the risk of harm the child or young person posed to others was not good enough. Some case managers did not have sufficient skill to assess risk of harm in their complex cases. Many were not drawing widely enough on the information available to reach their conclusions, and the true nature of the risk the child or young person posed to others was not always made clear. There was a tendency to consider that custody lowered risk of harm, rather than appreciating that this acted as a protective and prohibitive factor that did not necessarily reduce a child or young person's propensity to cause harm to others. The level of risk of harm had been underestimated in five cases. This had no doubt contributed to the fact that while there was a need in 11 cases for a full assessment of risk of harm, this had been completed in only 5.

2.2. Having assessed risk of harm, we would expect to see a written plan to reduce and manage this. This should set out clearly how and when victims and potential victims will be protected, and how agencies will work together to achieve this. The plan should be shared with others involved in a case and easily accessible in the YOS. The YOS will no doubt share our concern that none of the cases we looked at met this standard.

2.3. In most instances, case managers had good links with workers in partner agencies in order to gather new information throughout the course of the case about the risk of harm a child or young person posed to others. This, however, led to a review of assessments and plans in only a small proportion of cases.

2.4. We were pleased to see that the YOS was following Multi-Agency Public Protection Arrangement (MAPPA) referral procedures. We saw two cases, however, involving children and young people who had displayed dangerous behaviour and would be appropriate for MAPPA consideration, but which were being managed by the YOS alone.

In one, we considered that rather than waiting for further convictions the YOS could have considered an appropriate referral to Category 3. In the other, the YOS did not have the necessary guidance at hand to challenge successfully the rejection of its appropriate MAPPA referral.

3. Protecting the child or young person

3.1. It is important to consider not only how and why a child or young person is vulnerable, but also how this could influence their behaviour. Case managers had given enough thought to this in half of the cases we looked at. Referrals were made for specialist assessments where necessary but case managers did not always consider the wider picture to draw their conclusions about the nature of vulnerability. In some cases this led to an inaccurate vulnerability classification and an inevitable impact on the quality of planning.

3.2. There was a need for planning to address safeguarding and vulnerability issues in 12 of the 14 cases we looked at. We were disappointed to find sufficient planning at the start of sentence in only one of these. Plans were hard to find and were missing in more than half of the cases that needed one. In custody cases, case managers were unclear how their placement information forms were used and how establishments intended to keep the children and young people safe.

3.3. In the small number of cases that involved child sexual exploitation, the YOS had recognised relevant issues and in most instances, taken appropriate action.

3.4. Case managers often assimilated information that emerged during the sentence into their thinking but this did not necessarily lead to effective review. We were unable to find any updated plans to manage vulnerability.

4. Making sure the sentence is served

4.1. Strong relationships are often key to helping children and young people comply with their sentences. The YOS engaged well with children and young people, their parents/carers and significant others in order to understand the circumstances of a case. In most instances, planning was also completed in an inclusive way, with case managers making sure they took account of the child or young person's goals.

4.2. Case managers planned to have appropriate levels of contact with children and young people in the community. They had little contact with children and young people in custody, however, and in most cases only saw them when they were able to attend the three-monthly sentence planning meetings. A positive exception saw a case manager making an extra visit to a young person who had been involved in an incident in his establishment.

4.3. Of the ten children and young people being managed in the community, six struggled to comply with the requirements of their sentences. The YOS was too slow to take action to address this in two cases but responded effectively in the remaining four by returning the orders to court.

Operational management

Two-thirds of the case managers we interviewed had a sufficient understanding of the principles of effective practice, and understood the YOS's policies for safeguarding and the management of risk of harm. Almost all felt their managers supported them in their work but a small number identified the need for more effective supervision and management oversight of their practice. Many felt

they would benefit from more training, especially to help them identify and respond to the individual needs of children and young people.

In the cases we looked at, quality assurance processes had made an overall positive difference in only a small number. Management oversight of risk of harm and safeguarding and vulnerability work had made little or no positive impact. Work was not always countersigned, the fact that plans were missing went unchecked, and management suggestions for improvement, for instance that a risk of serious harm assessment be drafted or reviewed, were rarely implemented.

The YOS was taking positive, strategic action in order to improve practice and impact. It was working with other agencies in order to develop the profile, assessment and planning for children and young people who were being criminally exploited. It had also introduced a programme of YOS good practice sessions in areas such as the management of risk of harm, vulnerability and child sexual exploitation. There is scope, now, to put systems in place to measure the impact of these learning events and ensure policies provide the right guidance to support effective practice.

Key strengths

- YOS workers were interested in the children and young people with whom they worked, wanted the best outcomes for them and were keen to develop their skills to achieve this.
- Case managers had good links with other workers and used these to stay up to date with changes in the child or young person's life.
- The YOS submitted to custodial establishments the required Youth Justice Board pre and post court placement forms, providing succinct but helpful information about safeguarding and vulnerability, and risk of harm.

Areas requiring improvement

- Assessment and planning relating to the risk of harm a child or young person poses to others, safeguarding and vulnerability need to be thorough, accurate and meet the needs of the case.
- Case managers should make sure they review progress in their cases, change plans where necessary and document this work.
- YOS workers should have the skills and knowledge to understand and fulfil their roles effectively and be provided with good quality policies to support their practice.
- Oversight processes should make sure that learning is translated into practice, and that assessment and planning relating to risk of harm, and safeguarding and vulnerability are effective and recorded appropriately.

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 make sure 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 Vivienne Clarke. She can be contacted at Vivienne.Clarke@hmiprobation.gsi.gov.uk or 07972 273026.

Copy to:

Head of Service	*Karen Proudfoot*
Interim Youth Offending Service Manager	*Angie Fuller*
Local Authority Chief Executive	*Chris Naylor*
Lead Elected Member for Children's Services	*Bill Turner*
Lead Elected Member for Crime	*Laila Butt*
Deputy Mayor for Policing and Crime	*Stephen Greenhalgh*
Chair of Local Safeguarding Children Board	*Sarah Baker*
Chair of Youth Court Bench	*Sue Johnson*
YJB Business Area Manager	*Adam Mooney, Paula Williams*
Ofsted – Further Education and Skills	*Paul Joyce*
Ofsted – Social Care	*Mary Candlin, Carolyn Adcock*
Ofsted – Links	*Lynn Radley, Caroline Prandas*
Care Quality Commission	*Jan Fooks-Bale*
YJB link staff	*Lisa Harvey-Messina, Paula Williams, Linda Paris, Rowena Finnegan*
YJB Communications	*Ali Lewis, Rachel Brown, Summer Nisar, Adrian Stretch*

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.