Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
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To:	Dr Wendy Thomson, Managing Director Norfolk County Council, and Chair of Norfolk Youth Justice 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 Norfolk

The inspection was conducted from 23-25 May 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 32 cases of children and young people who had recently offended and were supervised by Norfolk Youth Offending Team (YOT). This was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

The published reoffending rate[1] for Norfolk was 36.2%. This was worse than the previous year and better than the England and Wales average of 37.8%.

Overall, we found that staff had a high level of insight about the children and young people they worked with, were confident in dealing with diversity, and creative in their work. Reports and initial assessments were generally good; although reviews and planning required improvement. Management oversight was sometimes not apparent from the case record. It did not always make sure that work was of the required quality. The period during which the inspected cases were operational coincided with implementation of the AssetPlus assessment and planning framework. Difficulties that were experienced as this settled in were recognised by the inspection team.

Commentary on the inspection in Norfolk:

1. Reducing reoffending

1.1. Sufficient efforts had been made in most cases to understand why the child or young person offended and what might have helped to reduce their offending. There were,

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

however, a few cases where a timely initial assessment had not been completed and others where the quality of evidence needed to be improved.

1.2. Pre-sentence reports (PSRs) were, with one exception, of good quality. They provided comprehensive and valuable information to assist the court with sentencing. In a few cases a PSR would have been valuable but had not been requested by the sentencing court, and it was unclear whether this had been proposed to them. Reports to youth offender panels, in referral order cases, were good.

1.3. Greater attention needed to be given to undertaking reviews of assessments and plans, in particular immediately following sentence and when a significant change in circumstances had been identified or new information received.

1.4. Planning with the secure estate at the start of custodial sentences was usually good. It was encouraging to see offending related needs clearly reflected in sentence planning in these cases. There were, however, a few community cases where there was no recorded plan on file. In some other cases more attention needed to be given to the sequencing of work according to both risk of harm to others and the likelihood of reoffending. More detail was often needed about how objectives would be delivered. Shortcomings in planning were particularly frustrating, as case managers often articulated clear and appropriate plans, but since this thinking had not been recorded it was not available to anyone else who may have needed to know it.

2. Protecting the public

2.1. Three-quarters of assessments of the risk of harm to others met the needs of the case. Sometimes, however, the nature or level of risk of harm to others was unclear and the classification of risk of serious harm too low. Enough account had not always been taken of actual or potential victims, or other relevant behaviour. For example, in one case the child or young person was on bail awaiting sentence for other serious offences, but these were not reflected in the assessment. Reviews were not always undertaken as required, in particular following receipt of important new information or a significant change, including immediately post-sentence in relevant cases.

2.2. Plans to manage risk of harm to others were not completed as often as required. Information sharing arrangements were sometimes unclear, more attention needed to be given to the sequencing of work and, in a few cases, also to known victims. While this was not always apparent from plans, a number of examples were provided to us of good day-to-day engagement with the police to help manage risk of harm to others. With some children and young people who received a custodial sentence, or where this was a possibility, there was insufficient clarity about the nature and level of risk of harm to others or vulnerability that would apply separately in custody and in the community. This applied to both assessments and plans.

2.3. We found five cases that were eligible for formal inclusion in Multi-Agency Public Protection Arrangements (MAPPA). In general there was good engagement with the MAPPA coordinator to consider how cases should be managed; although in one case, currently in custody, the need for referral had not been recognised in the planning.

2.4. Management oversight of risk of harm work needed further improvement. There was evidence of oversight in most cases where this was required. Sometimes, however, it focused on countersigning the completion of assessments and plans, rather than on making sure they were of good enough quality before they were accepted. In some cases there was evidence of instructions being given to make improvements, and countersignatures provided, even though the improvements were not made.

3. Protecting the child or young person

3.1. Relevant factors related to the safety and well-being of the child or young person were clearly explained in all except one PSR that was provided. This gave the court important context to inform its sentencing decision.

3.2. Over three-quarters of assessments of safety and well-being were good enough. More attention sometimes needed to be given to assessment of emotional and mental health, the suitability of care arrangements, and to recognising the breadth of relevant factors. Reviews were not always undertaken as required, for largely the same reasons that applied to reviews of risk of harm to others. Similarly, when plans were not good enough the same issues were found.

3.3. Sufficient attention was given by the YOT to safety and well-being issues throughout the custodial phase of relevant sentences in all except one relevant case. In that case no attention had been given in the planning to the possibility of a custodial sentence, and this was not resolved until some time into the period in custody.

3.4. Oversight by management required the same improvements as applied to risk of harm work.

4. Making sure the sentence is served

4.1. We were impressed by the staff's understanding of the breadth and impact of diversity factors. Assessment of diversity factors and barriers to engagement was particularly strong. There were, however, a few cases where insufficient attention had been given, during assessment and planning, to the potential impact of any contrast with the culture the child or young person had come from.

4.2. In some cases we found review meetings being led by a manager. These were valuable. They provided an independent view of progress that had been made and helped motivate children and young people.

4.3. Engagement with children and young people, parents/carers and significant others while undertaking assessments was good. PSRs usually reflected their views and gave sufficient attention to diversity. More attention, however, was needed to make sure they understood and had the opportunity to comment on the PSR before it was made available to the court. There was little evidence of children and young people having signed their plans to indicate their understanding of and agreement with them.

4.4. Children and young people and their parents/carers had enough involvement in assessment and planning in most cases; although there were a few instances where this was unclear and others where the plan was not meaningful to them.

4.5. There were 13 cases where the child or young person had not fully complied with the requirements of the sentence. The YOT's response to this was sufficient in all except one of those cases. Good use was made of panels to help identify and address the causes of non-compliance. Similarly, where the YOT became aware of instances of further offending behaviour the response to these was appropriate in most cases. In one positive example a Police Community Support Officer attended Lee's[2] initial youth offender panel, for a referral order, to explore the possibility of agreeing a non-association requirement and arrangements for monitoring compliance. This was an effective way of preventing further offending in the short-term, protecting the public and giving Lee and his case manager the opportunity to address his behaviour.

[2] Please note - the name has been changed to protect the individual's identity.

Operational management

Staff in the YOT worked together well. They made good use of partner agencies to support their work.

Local policies and procedures for risk of harm and safeguarding work, and for promoting engagement and dealing with non-compliance, were understood well. There was, however, some confusion among staff about when cases should be referred to the YOT's forum for the oversight of high risk cases. This was left too much to their discretion. Managers needed to be more pro-active in addressing this as part of their oversight of work. Case managers described many more discussions with managers about individual cases than was apparent from the case records.

Case managers greatly valued the group supervision system that provided peer review of cases where advice was needed. They found their managers to be knowledgeable and helpful. Some said that more training was required to help them recognise and respond to speech, language or communication needs, or to deliver specific interventions effectively. The YOT, as part of a Norfolk County Council initiative, was implementing the Signs of Safety model into its work. This was well received by staff and made a positive difference to the quality of work where it was used.

Key strengths

- Staff understood the children and young people with whom they worked.
- Work to understand and respond to diversity factors was very strong.
- There was a creative approach to delivering interventions.
- Work to support compliance with the requirements of the sentence was done well.
- There was good joint work with police officers to support compliance.
- Reports to courts and youth offender panels were of good quality.

Areas requiring improvement

- Managers should make sure that assessments and plans are good enough before they are countersigned.
- Plans to manage risk of harm to others and to address safety and well-being concerns should be precise, and developed in all cases where they are required. They should clearly identify those actions to be taken in custody and those in the community.
- There should be a timely plan of work recorded in each case that is meaningful to the child or young person and is sequenced according to the priorities in the case.
- Assessments and plans should be reviewed following significant changes.

We are grateful for the support that we received from staff in the YOT 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 Ian Menary. He can be contacted at ian.menary@hmiprobation.gsi.gov.uk or on 07917 183197.

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.