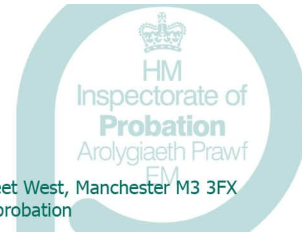
HM Inspectorate of Probation
1st Floor, Manchester Civil Justice Centre, 1 Bridge Street West, Manchester M3 3FX
0161 240 5336 - www.justiceinspectorates.gov.uk/hmiprobation



To:	Colin Everett, Chair of Flintshire Youth Justice Service Management Board
Copy to:	See copy list at end
From:	Alan MacDonald, Assistant Chief Inspector (Youth Justice)
Publication date:	07 September 2016

Report of Short Quality Screening (SQS) of youth offending work in Flintshire

The inspection was conducted from 25-27 July 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 Flintshire Youth Justice Service (YJS). Wherever possible, this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff. The published reoffending rate[1] was 33.3% for Flintshire compared to 37.8% for all England and Wales.

Summary

Overall, we found an enthusiastic and dedicated group of staff who had built constructive relationships with the children and young people who had offended, and their families. Case managers were committed to identifying what aspects of a child or young person's life contributed to their offending behaviour. Good links were in place with other agencies and workers had access to a wide range of resources to help them assess and plan their work, including a parenting worker and the Child and Adolescent Mental Health Service. Compliance was supported and breach was instigated where necessary. Attention was needed to make sure contingency plans to manage risk of harm to others and safety and well-being were effective.

Commentary on the inspection in Flintshire

1. Reducing reoffending

1.1. The initial assessment of the child or young person was comprehensive and well evidenced in all the cases sampled. There was good use of information and liaison with partner agencies to assess and review the likelihood of offending. Disability and diversity needs were always assessed. A self-assessment was completed, and the views of children

---

[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.

and young people and their parents/carers obtained. It was clear that case managers had used the information to better understand children and young people with whom they were working. One inspector noted: "*The assessment captures the main features of the case and is informed by information gleaned from the police, Crown Prosecution Service and social care records which provide a good sense of the family home over the years.*"

1.2. Pre-sentence reports were written in nine of the cases sampled. There was evidence that reports had been quality assured before being submitted to the court. They provided clear recommendations and convincing arguments for alternatives to custody. We found, however, that four reports were not sufficiently succinct or analytical. The three referral order reports we examined were all produced to a good standard. We were pleased to find that the reports refrained from providing specific recommendations on what needed to be in the contract; as a consequence the decision of the panel was not pre-empted. It was good to see that the referral order panel and subsequent reviews were attended by the case manager.

1.3. Following on from the assessment we expect to see a plan of work to help reduce the likelihood of reoffending. We saw examples where case managers had worked hard to engage the child or young person to produce an individual intervention plan. Planning was good in almost all of the cases, although there were instances in which the formal language used was not accessible to a child or young person and some plans lacked detail and clarity.

1.4. Reviews were sufficient in over three-quarters of the cases sampled. Work to address offending behaviour had been carried out in most of the cases. The YJS had access to a variety of internal agencies and partnerships including the Child and Adolescent Mental Health Service, drug and alcohol services, and a parenting worker. We saw evidence of these agencies' active and effective involvement in the cases we inspected. Recording of interventions and significant events by the YJS were well evidenced.

1.5. Staff across the YJS demonstrated a good understanding of the principles of effective practice and factors that contributed to a reduction in offending.

2. Protecting the public

2.1. We expect to see a detailed assessment of the risk of harm a child or young person poses to others. This should cover all relevant information, including past offending and behaviour, as well as the impact on victims. We found that this had happened in well over three-quarters of the cases.

2.2. Having assessed the risk of harm a child or young person poses to others, the YJS should put plans into place to manage these risks. This had been done well in all but three relevant cases. We felt that these plans lacked clear actions and contingencies to address a change in circumstances of the child or young person. Where there was an identifiable victim or potential victim, the risk of harm was managed sufficiently well.

2.3. When a child or young person was assessed as high or very high risk of serious harm to others, Flintshire YJS held risk and safety, and well-being meetings, consisting of a multi-agency panel to formulate a joint risk management plan with YJS and partner agencies. This was a valuable process used to support integrated working between agencies to manage risk of harm and share intelligence.

3. Protecting the child or young person

3.1. Often children and young people who offend are themselves vulnerable and we expect to see that their safety and well-being have been thoroughly assessed, with plans in place to

manage those needs. Overall, we found that case managers had taken time to identify and understand the vulnerabilities that were presented in most of the relevant cases. This included consideration of children and young people's substance misuse, education, training and employment needs and any evidence of child sexual exploitation.

3.2. Once an assessment has been completed, a plan should be put in place to address the child or young person's safeguarding needs. The quality of planning for work to reduce the vulnerability of children and young people was variable. Where gaps were noted these included planned responses being insufficient or unclear. We found some plans that did not set out all the actions needed in relation to the individual risk factors. We felt that the reason for this was, in some instances, a lack of clarity among some staff about how to produce clear and precise plans within the integrated AssetPlus plan. In one example there was no contingency to address the safeguarding needs of a child or young person who frequently absconded from their home.

3.3. Joint work to promote the safeguarding and well-being of the child or young person was evident. Where required, staff liaised effectively and worked collaboratively with other specialist services. In cases where other agencies held responsibility for specific interventions, case managers were still diligent advocates on behalf of the children and young people being supervised. It was evident that staff supported and promoted the well-being of the child or young person throughout the sentence.

3.4. Of the four children and young people sentenced to custody, only two had a sufficient plan to address safety and well-being. Some custody plans did not provide enough detail about what would be done and by whom. Improvement was required in relation to information sharing arrangements for children and young people who were in custody and were at risk of self-harm. When difficulties with information sharing with the secure estate arose, staff escalated these issues appropriately to managers.

4. Making sure the sentence is served

4.1. Case managers took time to get to know the children and young people that they worked with and developed trusting relationships. Diversity issues and other barriers to engagement had been assessed during the report writing stage and planned for when considering interventions in almost two-thirds of the cases sampled. Efforts were made at the start of the sentence to understand and identify how the individual needs of the child or young person may affect their engagement. This resulted for example, in case managers adapting how they worked to allow for communication difficulties. There were some cases where more consideration should have been given to the learning style of the child or young person.

4.2. Engagement with children and young people and their parents/carers was sufficient in almost all of the sample inspected. It was evident that parents/carers were present at the report writing stage and involved in the planning of interventions. When relevant, a parenting needs assessment was completed pre-sentence, which was a good example of engaging parents/carers and offering support at the earliest opportunity. We saw more than one example of work to support parents/carers with their own needs where these were impacting on children and young people. Good use was made of home visits and it was evident that case managers viewed parents/carers as essential to the successful completion of the order.

4.3. When inspecting in Wales we expect to see evidence of active and timely screening of the Welsh/English language preference of the child or young person. We were pleased to see that all children and young people were asked about their language preference at the first

point of contact with the YJS staff. This included their preferred written and spoken language.

4.4. We found that three-quarters of children and young people within our sample had complied with their order. Case managers made a consistent and substantial effort to support children and young people to comply with their sentence; this was a particular strength for Flintshire. In all cases we considered the response to non-compliance was appropriate.

Operational management

We look for evidence that management oversight has been effective to make sure that the quality of the work to address the risk of harm to others and the well-being of the child or young person is sufficient. This can take the form of one-to-one sessions between the worker and their manager, or a wider meeting with internal colleagues, as well as the implementation of sound quality assurance processes. We were pleased to find evidence of all of the above in Flintshire. There were clear notes by managers in case records, in which they identified the sufficiency and deficits in practice. We found, however, that management oversight had been effective in only half of the relevant cases where we would have expected it to have made a difference. While identifying deficiencies in assessment and planning, managers need to make sure that these have been addressed promptly.

The staff we interviewed felt that their managers had the skills to support and help them improve the quality of their work. Some felt, however, that one-one sessions with managers should provide a greater focus on reflective practice. All felt that their training needs were met in relation to their current post.

Key strengths

- YJS staff worked hard to help children and young people comply with their court orders.
- They were particularly good at building relationships with the child or young person and parents/carers, undertaking home visits to help understand issues thoroughly.
- There was effective liaison and joint work with other agencies.

Areas requiring improvement

- Contingency plans, relating to the risk of harm a child or young person poses to others, and safety and well-being, need to be effective.
- Plans to address the likelihood of reoffending should include objectives which are easy for the child or young person to understand and against which the case manager can readily measure progress.
- Management oversight should make sure that the quality of assessments and plans to manage risk of harm and vulnerability are sufficient.

We are grateful for the support that we received from staff in the YJS 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 Yvette Howson. She can be contacted at Yvette.howson@hmiprobation.gsi.gov.uk or on 07825 453092.

Copy to:

YOT Head of Service	*Ann Roberts*
Local Authority Chief Executive	*Colin Everett*
Director of Children's Services	*Ian Budd*
Lead Elected Member for Children's Services	*Christopher Bithell*
Lead Elected Member for Crime	*Jenny Williams*
Police and Crime Commissioner for North Wales	*Arfon Jones*
Chair of Local Safeguarding Children Board	*Ian Budd*
Chair of Youth Court Bench	*John Donolly*
Head of YJB Cymru	*Dusty Kennedy*
Wales Government	*Sarah Cooper*
YJB link staff	*Lisa Harvey-Messina, Paula Williams, Linda Paris, Rowena Finnegan*
YJB Communications	*Ali Lewis, Rachel Brown, Summer Nisar, Adrian Stretch*
Estyn	*Alun Connick, Jassa Scott*
Care and Social Services Inspectorate Wales	*Nigel Brown, Bobbie Jones*
Healthcare Inspectorate Wales	*Alison Kedward, John Powell*
Welsh Audit Office	*Huw Rees*

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.