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:	Tony Theodoulou, Chair of Enfield 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)
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Report of Short Quality Screening (SQS) of youth offending work in Enfield

The inspection was conducted from 26-28 September 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 31 cases of children and young people who had recently offended and were supervised by Enfield Youth Offending Service (YOS). 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 40.1% for Enfield, compared to 37.8% for all England and Wales.

Summary

Overall, we found dedicated staff who had built constructive relationships both with the children and young people who had offended, and their families. Well-written reports provided the court with relevant information to assist sentencing. Joint working with other agencies was effective and helped workers assess and plan their work. Some intervention plans designed to reduce reoffending, risk of harm and vulnerability were not always reviewed on time. Staff spoke positively about the support and supervision offered by their managers although we found some evidence that oversight of casework required further improvement.

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

Commentary on the inspection in Enfield

1. Reducing reoffending

1.1. We expect to see a timely and sufficient assessment of the factors that were associated with why the child or young person committed the offence. This should cover all relevant information, including past offending behaviour, as well as the impact on victims; we found that this happened in almost three-quarters of cases. The children and young people supervised by Enfield included complex and entrenched offenders. Case managers had obtained a wide range of information to build a picture of the individual's life and circumstances. In some instances, however, we found that there was insufficient structured analysis or rationale for scores in each section of the assessment.

1.2. Pre-sentence or panel reports were produced in 12 of the cases sampled, all but one gave a satisfactory assessment of the reasons for reoffending, the risk of harm posed to others and clear recommendations for alternatives to custody.

1.3. Following on from the assessment, we expect to see a plan of work to help reduce the likelihood of reoffending. Planning was sufficient in over two-thirds of cases, although there were instances where the formal language used was not accessible to the child or young person. A small proportion of plans included too many targets with no sequencing or priority attached to them.

1.4. We were pleased to find that effective work to address offending behaviour had been carried out in most of the cases. The YOS benefited from having access to a wide range of agencies and resources to help them assess and plan their work, including their partners in the Youth and Family Support Service, Drug and Alcohol Service, Child and Adolescent Mental Health Service, and a Serious Youth Violence Prevention Coordinator. The YOS demonstrated effective joint working and collaboration to support children and young people. There was, however, some evidence the child or young person did not always respond well to multiple agencies being involved in their case. Additionally, some recording of interventions and significant events was not always captured on the contact log, so did not fully reflect the quality work that had been completed.

1.5. Where reviews of the initial assessment were necessary more than two-thirds met the requirements of the case. Attention was sometimes needed to make sure that the importance of completing a review was recognised following a significant change. Some reviews were not completed or were simply a copy of the previous assessment.

2. Protecting the public

2.1. We found assessments of the risk of harm posed by the child or young person was good in 23 of the 31 cases. Staff made effective use of intelligence or other relevant information to prepare their assessments. In some cases we judged that the assessment did not have sufficient evidence to support the high risk of harm level.

2.2. Having assessed the risk of harm a child or young person poses to others, a plan should be put in place to manage these risks. This had been done well in a large majority of cases.

2.3. Risk management plans should be reviewed regularly to make sure that they are up to date. This was achieved in two-thirds of cases. Again, failures to respond sufficiently to changes and to make sure that reviews were timely were the primary reasons why we assessed that some reviews were insufficient. At the time of the inspection the YOS were in the process of transitioning to AssetPlus. This transition had a severe impact on the time taken to complete assessments and plans.

2.4. Case managers showed a good understanding of the potential of Multi-Agency Public Protection Arrangements to contribute to the management of cases and the protection of the public. Where needed, victim issues had been effectively managed.

2.5. Management oversight of this area of work was effective in just over half of applicable cases; deficiencies in assessments and plans were not sufficiently addressed by managers.

3. Protecting the child or young person

3.1. We were pleased to find that in the majority of cases there was sufficient assessment of safeguarding and vulnerability. Enfield YOS had a substantial number of children and young people who had offended and were also at times at risk of harm from others. There were locations identified as long established gang territories and the borough have had many high profile incidents over recent years. The YOS had a Serious Youth Violence Prevention Coordinator who screened children and young people who disclosed or were known to be involved in conflict with others. This included gang association, personal conflict, or those who felt unable to attend the main office. Children and young people were required to provide sufficient evidence for them to be seen at another location. When safety and well-being concerns were indentified, children and young people would be either put on the 'Keep Apart List' and/or seen off-site.

3.2. The quality of planning for work to reduce the vulnerability of children and young people was good in well over three-quarters of cases. Where gaps were noted these included planned responses being insufficient or unclear.

3.3. It was evident that staff supported and promoted the well-being of the child or young person throughout the sentence. 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. One inspector noted: "*Potential Child Protection issues relating to the unborn child were identified. The risk factors were fully understood and a referral was made to children's social care. A 'Team Around the Family' was the initial approach from the children's services to these concerns and the YOS maintained their commitment and contributed to the processes*."

3.4. We found that assessments and plans had been reviewed to a sufficient standard in 13 of the 18 applicable cases; again timeliness of reviews was a factor here.

3.5. Of the eight children and young people sentenced to custody all but one had a good enough plan to address safeguarding and vulnerability.

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 to develop trusting relationships. 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 found, however, that such involvement was less evident with the development of initial plans; in particular the child or young person's views about what should be a priority were not always reflected.

4.2. There were positive examples where case managers had worked hard to keep parents/carers involved who had become exasperated by their child or young person's behaviour: "*Engagement with Sandro[2] improved considerably once the case manager made a particular effort to engage with the parent/carer and worked closely with them*

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

both. This resulted in Sandro identifying the impact that his behaviour had had on his mother. As her supervision and support of Sandro improved so did his engagement." Good use was made of home visits. In the majority of cases, sufficient attention had been given to the health and well-being of children and young people.

4.3. Not all case managers made enough effort to understand the factors that could enhance, or negatively affect, engagement and compliance; there was also insufficient planning in some cases to address these factors. In over half of the cases we looked at, children and young people had struggled to comply with the requirements of the sentence. In cases where they did not fully comply, the response by the YOS, in all but one case, was sufficient. Compliance panels were held and breach processes used effectively. Case managers, however, did not always explore the reasons behind the non-compliance well enough, and in some instances could have sought more creative solutions.

Operational management

We look for evidence that the management oversight has been effective to make sure that the quality of the work to address public protection 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. There were recent vacancies in the team; the YOS found it a challenge to recruit quality staff to fill them and agency staff were used as an interim solution.

We found evidence of management oversight in cases which included comments about the quality of work and improvements that were required. This practice, however, was not consistent. While managers would rightly not countersign work until they judged it was good enough, sufficient attention was not always given to make sure that required actions (for example to complete an intervention plan) were undertaken in a timely manner.

Overall, staff felt that their managers had the skills to support them and help them to improve the quality of their work; they felt that their managers were approachable and supportive. Staff were familiar with local policies and procedures for managing risk of harm, safeguarding, engagement and compliance. They stated the culture in the YOS was positive and encouraging with regards to learning and development.

Key strengths

- Services provided to the court and referral order panels, particularly pre-sentence and panel reports were of a high standard.
- It was evident that there was a commitment to children and young people and their parents/carers.
- Risk of harm to identifiable victims had been effectively managed.

Areas requiring improvement

- Plans for the delivery of interventions need to have greater clarity, precision and be sequenced in order of priority.
- Plans should be owned by children and young people and written in a language that is meaningful to them.
- Management oversight should be more effective across all aspects of work; specifically managers need to make sure that required actions are addressed in a timely manner.

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 Yvette Howson. She can be contacted at Yvette.howson@hmiprobation.gsi.gov.uk or on 07825 453092.

Copy to:

YOS Head of Service	*Samantha Boyce*
Local Authority Chief Executive	*Rob Leak*
Director of Children's Services	*Tony Theodoulou*
Lead Elected Member for Children's Services	*Councillor Ayfer Orhan*
Lead Elected Member for Crime	*Councillor Krystle Fonyonga*
Deputy Mayor for Policing and Crime	*Sophie Linden*
Chair of Local Safeguarding Children Board	*Geraldine Gavin*
Chair of Youth Court Bench	*Linda Logan*
YJB Business Area Manager	*Adam Mooney*
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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.