

<i>To:</i>	Chris Spencer, Chair of Harrow YOT Management Board
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<i>From:</i>	Julie Fox, HM Assistant Chief Inspector
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Report of Short Quality Screening (SQS) of youth offending work in Harrow

The inspection was conducted between Monday 20th and Wednesday 22nd October 2014. It is 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. As 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 offended and were being supervised by Harrow Youth Offending Team (YOT). Wherever possible this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

The published reoffending rate¹ for Harrow was 35.4%. This showed a substantial decrease on the outturn the previous year (44%) but was exactly the same as the England and Wales average. Between July 2013 and March 2014, there has been a steady decline in the local custody rate.

Overall, we found mixed picture with evidence of some good work to reduce reoffending, but also a number of important areas for improvement. An especial priority is work to protect the child or young person. More generally, inconsistency in the quality of assessment, adequacy of planning and review arrangements, and inefficacy of management oversight should form key areas of improvement activity. However, some aspects of assessment were done extremely well and the quality of reports was also largely good. Just prior to the inspection there had been a substantial turnover of staff, so it was pleasing to find that practitioners were committed, knew their cases well and keen to improve practice.

Commentary on the inspection in Harrow:

1. Reducing reoffending

- 1.1. In order to help stop reoffending, each child or young person is assessed to establish the factors which led to their offending, and as noted, the reoffending rate for Harrow was

¹ Published July 2013 based on binary reoffending rates after 12 months for the October 2011 – September 2012 cohort. Source: Youth Justice Board

the same as the national average. That said, in only half of the cases was this assessment found to be good enough. The main reasons for them being inadequate were; failures to identify positive factors; offence related vulnerability; and key drivers to a young person's offending. Nonetheless, we did find some good examples of practice. One practitioner sourced a range of information, including police intelligence, to build a picture of a young person's offending behaviour, including peer associations, and used it: "*...to challenge Graham about his assertion that he is disassociating himself from negative peers*". They said this open and candid approach: "*...actually appears to have led to a respectful relationship*".

- 1.2. Because children's lives change very quickly, reviews are required to take into consideration new information. Just over half of the reviews were of sufficient quality. Three had not been reviewed at all, whilst four had not been reviewed following a significant change in circumstances.
- 1.3. Nearly all the pre-sentence reports (PSRs) we examined were of sufficient quality. In the one instance that did not meet this level, vulnerability had not been adequately assessed. The consideration of alternatives to custody was an area of particular strength, and was met in all the reports considered.
- 1.4. Plans of work to reduce reoffending were not robust. Less than one-quarter were good enough. The main issues in planning were two-fold. In half, factors relating to offending as identified in the assessment were not always reflected in plans. As one inspector found: "*...the intervention plan was poor and did not address the key areas of concern that had been identified in the assessment*". In a further six cases, the plans did not contain clear, measurable goals or objectives, or were written in very generalised terms. A number of actions were simply statements of supervision requirements, for example: "*...attend appointments with my case worker*". Such actions gave little indication of the focus for work; the type or appropriateness of interventions; or the goals and objectives which the worker hoped to achieve with the child or young person.
- 1.5. Only one-third of plan reviews (from a total of 12 cases) were adequate. In eight insufficient cases, we found that reviews had not take place in two, were not timely in three, and had not been revised as required in four.
- 1.6. In two of the four cases in which children or young people had received a custodial sentence was the planning for the custodial phase sufficient. A custodial sentence plan was missing in one case although the worker had raised this as a concern with the YOI in an effort to rectify this situation. In another, there was a lack of clarity about which aspects of intervention were to be delivered in custody and which in the community.

2. Protecting the public

- 2.1. The initial assessment of risk of harm posed by the child or young person was more consistent, with all bar one of the 14 cases inspected being sufficient. There was clearly a strong understanding and appreciation of relevant risk factors, and analysis took account of the broader context of behaviour, in the family home, for example, or at school. As one inspector wrote: "*...there was a very clear analysis of family influences, the fact that Melanie was the youngest of six siblings, her feeling that she had not received the parental attention she craved, the impact of this on her self esteem and ultimately, offending was extremely well drawn*".
- 2.2. Pleasingly, all the court reports contained a clear and thorough account of risk of harm, illustrating that there are elements of strong assessment practice in place.

- 2.3. Such solid foundations were, regrettably, undermined by a failure to review adequately in half of the relevant cases. The reasons for this included not being undertaken at all; not being timely; and not taking place following a significant change in the child or young person's circumstances.
- 2.4. Planning to manage the risk of harm was also inconsistent. Just over half were good enough, with plans missing altogether in four cases. Contingency plans to address identified risk were not robust in three cases.
- 2.5. Two cases met Multi-Agency Public Protection Arrangements (MAPPA) criteria. We judged that neither case was sufficiently engaged with the MAPPA process. No referral had been made on one and in the other, the referral had not been timely. Interviews with case managers also indicated that there may be a more general lack of understanding about MAPPA.
- 2.6. Risk of harm to identifiable victims was effectively managed in just 5 of the 12 relevant cases. The inadequacy of plans was a factor in all of the remaining insufficient cases. The recent appointment of a victim worker has the potential to improve this area of work.
- 2.7. As many of these matters had not been identified or rectified, management oversight of the quality of risk of harm work was found to be good enough in only 5 of the 13 relevant cases inspected. We saw a lack of rigorous follow-up in some instances and inconsistency in the application of management oversight exemplified in delays in requests for countersigning and differing levels of risk between the PSR and assessment.
- 2.8. For children and young people in custody, risk of harm work had been completed well enough in only one of the four cases where this was required. MAPPA issues had not been fully addressed in two cases, whilst planning or contingency planning was a deficiency in two cases.

3. Protecting the child or young person

- 3.1. The quality of assessment in respect of safeguarding and vulnerability was poor, with just four of the full sample being assessed as good enough. The most significant deficits were that either assessments of vulnerability were not undertaken, or where they had been completed, were of poor quality. Factors relating to emotional and mental health; physical health; education; and care arrangements, were those which had been most inadequately assessed. It is perhaps not surprising to find these results reflected in the quality of vulnerability assessments offered in reports.
- 3.2. Satisfactory reviews of assessments were completed in less than half of the cases where one was required. The single most frequent deficit was the failure to undertake a review following a significant change in the child or young person's circumstances. This may be indicative of an unduly process driven approach to review, rather than one informed by a professional judgement of a child or young person's needs.
- 3.3. Of most concern was that planning to address safeguarding and vulnerability was adequate in only 2 of the 14 cases inspected, mainly because plans has not been completed. Often, responses to identified vulnerability factors and contingency planning were not sufficient. Required interventions were not included in plans in four cases.
- 3.4. Adequate reviews were completed in one-quarter of cases where they were judged necessary.
- 3.5. The case records evidenced regular management oversight. However, it was not effective. All 12 cases that needed oversight had failed to either identify or redress deficiencies in assessment or planning. A lack of timeliness in management oversight, for example, in checking or countersigning assessments, was also identified as a factor in five cases. The

observations made earlier regarding a lack of rigour and consistency, also apply to management oversight of safeguarding and vulnerability.

- 3.6. In none of the four cases in which children and young people had received a custodial sentence, was planning for safeguarding and vulnerability sufficient. In one case, the assessment of the young person's vulnerability level, and planning following a serious incident, had not been reviewed sufficiently well, which was of concern.

4. Ensuring that the sentence is served

- 4.1. There was evidence that practitioners were able to build effective purposeful working relationships. In one case this had contributed to: *"Jennifer...[being] the most stable she has been for some time...She was engaging in education and this was followed through into an appropriate course in the community...which is clearly a positive and a credit to the worker."*
- 4.2. Case managers identified diversity factors and barriers to engagement in 8 of the 14 cases. In the remainder, speech, language and communication needs, and learning styles were areas which had been missed. Similar issues applied to court reports where three-quarters identified diversity factors and barriers to engagement well enough. This theme applied across other areas of work, such as planning, where there was also a lack of specific actions to address them. This disconnect between assessment, which is good in some respects, and planning, should be a key area for improvement.
- 4.3. The active engagement and involvement of children and young people, and their parents/carers, was found to be effective in just over one-third of cases.
- 4.4. Sufficient attention to health and well-being matters was seen in 8 of 13 cases where this was relevant.
- 4.5. The YOT's response to non-compliance overall was good with appropriate steps being taken in nine of the ten cases in which a response was required.

Operational management

All staff interviewed felt that their line managers possessed the skills and knowledge to effectively assess their practice, provide support, and improve the quality of their work. The majority felt that they received effective supervision. There had been a significant change in the staffing complement, with four of the seven practitioners interviewed being new to Harrow YOT, and one was relatively new to youth justice. We received some comments indicating the need for more in-depth local induction and grounding in youth justice practice prior to assuming full caseloads.

However, in the light of the findings of this inspection, it was of note to find that only around two-thirds felt that management oversight of risk of harm, and safeguarding and vulnerability, was effective. A lack of timeliness in countersigning work was identified, as was a lack of follow-up to management instructions. Both these observations are consistent with the findings from the case inspection.

It was also revealing that of the seven practitioners interviewed, only three felt that their training and skills development needs to do their current job were met. In particular, six of the seven practitioners identified that they had not had sufficient training to recognise speech, language and communication needs. This corresponds with our case sample findings.

Key strengths

- Assessment of risk of harm was generally good, and indicated that practitioners possessed relevant assessment skills and ability.

- Pre-sentence reports provided sentencers with good information about alternatives to custody and risk of harm.
- The YOT's response to non-compliance was effective.

Areas requiring improvement

- Significant improvement is needed to improve the overall quality of management oversight in order to drive up the quality of assessment, planning and review.
- Measures to improve the quality and consistency of safeguarding and vulnerability work, at both management and practitioner level, needs to be implemented urgently.
- In order to support improvement in staff practice and performance, personalised training and induction plans should be in place, specifically addressing; assessment; planning; MAPPA; and speech, language and communication needs.

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 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 07826 905352.

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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.