Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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Publication date:	24th July 2013

Report of Short Quality Screening (SQS) of youth offending work in Blaenau Gwent and Caerphilly

This report outlines the findings of the recent SQS inspection, conducted during 17th-19th June 2013. We carried this out as part of our programme of inspection of youth offending work. This report will be 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

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.

Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. The purpose of the SQS inspection is to assess the quality and effectiveness of casework with children and young people who have offended, at the start of a sample of 20 recent cases supervised by the Blaenau Gwent and Caerphilly Youth Offending Service. Wherever possible this is undertaken in conjunction with the allocated case manager, thereby increasing the effectiveness as a learning opportunity for staff.

We gather evidence against the SQS criteria, which are available on the HMI Probation website - http://www.justice.gov.uk/about/hmi-probation.

Summary

Overall, we found that Blaenau Gwent and Caerphilly Youth Offending Service (YOS) was performing well. YOS staff were highly motivated and spoke positively about the organisation and their contribution to the work. Considerable improvements had been made since our last inspection in 2010, in particular to the work to safeguard children and protect the public. Efforts should now be focused on ensuring that all assessments and plans are of good quality. Given the commitment of staff and managers we anticipate that the standards observed in the majority of cases can be replicated across all the work.

Commentary on the inspection in Blaenau Gwent and Caerphilly:

1. Reducing the likelihood of reoffending

1.1. We look to see if the assessment of why the child or young person has offended is good enough and found that it was in all cases. Checks made with other agencies such as schools and social services had helped to provide a full picture of the child or young person's circumstances.

1.2. Full pre-sentence reports were provided to the court in seven cases. Overall, they were considered to be of good quality. All seven had given sufficient attention to diversity factors and potential barriers to engagement. In one case, better attention should have been paid to the assessment of the child or young person's vulnerability and risk of harm to others.

1.3. In some cases sentencing had been informed by a verbal update of progress as opposed to a written report. In the majority of instances this was appropriate, but care needed to be taken to ensure that there was always a written record of this in the case file.

1.4. Following on from the assessment we expect to see a plan of work to help reduce the likelihood of reoffending. This was in place and of sufficient quality in the great majority of cases.

1.5. In almost all cases, the assessment and planning to reduce the likelihood of reoffending had been appropriately reviewed, taking into account changes in the child or young person's circumstances.

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. We found that this had happened in three-quarters of cases which was a considerable improvement since our last inspection. Of the remainder, better attention needed to be paid to covering all relevant information, including past offending and behaviour, as well as the impact upon victims. In two cases we disagreed with the assessment of the level of harm posed to others, finding that it had been underestimated.

2.2. Having assessed the risks, the YOS should put plans in place to manage them. This had been done well in 15 out of 19 relevant cases. Of the remainder, intervention plans had failed to pick up on some harmful aspects of behaviour. Further, the planned response should the risk of harm to others increase was not always clearly articulated.

2.3. The one case eligible for Multi-Agency Public Protection Arrangements (MAPPA) had been appropriately notified to the relevant authority. We did, however, note some confusion on another case where staff had assumed that it qualified for MAPPA where, in fact, it did not.

2.4. The risk of harm posed to others can change over time and therefore needs to be kept under review. We found that the assessment of risk of harm had been reviewed sufficiently well in three-quarters of relevant cases.

2.5. Where there was an identifiable victim or potential victim, the risk of harm they faced had been effectively managed in over three-quarters of relevant cases. Better reference in assessment and planning to the safety of victims was required in the remainder.

2.6. Management oversight had been effective in ensuring the quality of work to address risk of harm to others in five out of ten relevant cases. In some instances greater scrutiny was required before countersigning assessments and plans.

3. Protecting the child or young person

3.1. In many cases, children and young people who have offended are also themselves vulnerable and we expect to see that this has been taken into account. We found that just over three-quarters of cases had a sufficient assessment of safeguarding and vulnerability needs. In two cases we felt that the level of vulnerability had been underestimated.

3.2. Planning to address vulnerability and safeguarding issues was good enough in all five custody cases, but not always so for community cases. Where there were gaps (in 5 out of 15 relevant cases) the reasons for this included the need to better tailor intervention plans to assessed needs and an insufficient planned response should the level of vulnerability increase.

3.3. Children and young people's safeguarding needs change over time and must, therefore, be kept under review. We found that assessments and plans had been reviewed to an acceptable standard in well over three-quarters of the cases sampled. In one case, demonstrating an active and investigative approach, home visits raised concerns about a young woman's well-being leading to joint visits with other professionals and a referral for specialist services to prevent sexual exploitation.

3.4. Oversight by management was slightly more effective in ensuring the quality of work to help safeguard children and young people. While improvement is still required, this also shows significant progress since the last inspection.

4. Ensuring that the sentence is served

4.1. We expect to see that the YOS is doing what it can to help children and young people complete their sentences successfully. This includes engaging them and their parents/carers in the assessment and planning processes, identifying and addressing barriers to engagement, and putting measures in place to ensure they comply with the requirements of their sentence.

4.2. Diversity issues and other potential barriers to engagement, including the child or young person's health and well-being needs, had been assessed sufficiently well in all cases. For the vast majority, identified needs were then addressed in the plan of work.

4.3. Engagement with the child or young person and their parents/carers in order to complete assessments and plans was a strong aspect of practice in the YOS.

4.4. 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. This had not been explored sufficiently well in four cases. Very often the first point of contact with YOS staff is at court and an additional prompt on the court monitoring form would help to capture this information.

4.5. The majority of the children and young people within our sample had complied with their order. For those who had not we found that the YOS had responded appropriately in all but one case. This was a credit to the efforts made by case managers including visiting the home and working with parents/carers to seek compliance. Where there were particular difficulties the YOS held 'compliance panels' and included the family or relevant others. Often, this would help to get children and young people back on track.

Operational management

We interviewed six case managers and they spoke positively about the operational management arrangements at Blaenau Gwent and Caerphilly YOS. All felt supported in their work and commented that their managers were appropriately skilled and knowledgeable. We found that all case managers understood the principles of effective practice and were familiar with local policies and procedures for managing risk of harm, safeguarding, engagement and compliance. All felt that

their training and skills needs were fully met in relation to their current post and the majority felt that their future development needs had also been responded to. One gap identified by staff was training in the speech, language and communication needs of children and young people.

Management oversight had been a focus of improvement work since the last inspection and although improvements had been noted there was further work to do. In some instances greater scrutiny was required before countersigning risk and vulnerability management plans, ensuring that specific contingency arrangements had been identified should the child or young person's circumstances change.

Key strengths

The best aspects of work that we found in Blaenau Gwent and Caerphilly included:

- the substantial improvement in practice since the previous inspection. Although driven by the management team, this had been embraced by a staff group committed to their work and the community they serve
- engagement of children and young people and their parents/carers which then provided a firm foundation from which to work to reduce the likelihood of reoffending.

Area requiring improvement

The most significant area for improvement is:

i. Consistent management oversight to ensure the quality of assessments of risk of harm to others and the quality of plans to address vulnerability.

We strongly recommend that you focus your post-inspection improvement work on these particular aspects of practice.

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 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 Helen Davies. She can be contacted on 07919 490420 or by email at helen.davies@hmiprobation.gsi.gov.uk.

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