Inspection of Youth Offending Work
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To:	Robert McCulloch-Graham, Chair of Tower Hamlets and City of London YOT Management Board
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From:	Julie Fox, HM Assistant Chief Inspector
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Report of Short Quality Screening (SQS) of youth offending work in Tower Hamlets and City of London

The inspection was conducted from 8th – 10th September 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 34 cases of children and young people who had offended and were being supervised by Tower Hamlets and City of London Youth Offending Team (YOT). Wherever possible this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff. The case sample related to children and young people from Tower Hamlets, there being no cases to select for inspection from City of London.

Summary

The published reoffending rate[1] for Tower Hamlets and City of London was 41.5%, an increase on the previous year and worse than the England and Wales average of 35.4%. However, overall, we found that considerable improvements had been made since our last inspection in 2011, in particular to the work to safeguard children and young people, and protecting the public. The YOT were working with a number of vulnerable children and young people with complex needs, who were also displaying behaviour that indicated that they posed a risk of harm to others. Improved links were in place with other agencies and YOT workers had built constructive relationships with the children and young people who had offended and their families. There remains, however, scope for further improvement, in particular to ensure that the work is appropriately reviewed taking account of changes in the child or young person's circumstances.

[1] Published April 2014 based on binary reoffending rates after 12 months for the July 2011 to June 2012 cohort. Source: Youth Justice Board

Commentary on the inspection in Tower Hamlets and City of London:

1. Reducing reoffending

1.1. The assessment of the child or young person's likelihood of reoffending was sufficient in almost three-quarters of the sample. In five cases, either the initial assessment had not been completed or had been completed too late to be meaningful. In others, better attention should have been paid to the link between the child or young person's thinking and behaviour and their possible reoffending.

1.2. Pre-sentence reports (PSRs) were provided to the court in 22 cases and with one exception, were found to be of a good standard. We were pleased to see that children and young people, and their parents/carers, were involved in the preparation of the reports. Local management arrangements were effective in identifying areas for improvement for report writers.

1.3. There was sufficient planning undertaken to minimise reoffending in most cases. Of the six cases where this had not been good enough, two did not have an initial plan and one was completed late. Further, it was not always clear how the objectives set would help to reduce reoffending.

1.4. Children and young people's lives can change very quickly and, as a result, assessments and plans to reduce reoffending need to be reviewed. Two-thirds of relevant cases had been. Some cases had not been reviewed as required and others were a copy of the initial assessment with insufficient update to reflect the change in the child or young person's circumstances. In an example of good practice, an inspector commented that: "*The planning in this case stood out in terms of its appropriateness and quality. It was evident that the assessment was linked into the plan which was clear about what would happen and who was responsible for each part of the intervention*".

2. Protecting the public

2.1. There was a sufficient assessment of the child or young person's risk of harm to others in just over three-quarters of the sample. This represented a considerable improvement since our last inspection. However, we still found cases where there had either been no analysis or an insufficient analysis of the risk of harm posed to others.

2.2. Having assessed the risks, plans should be put in place to manage them. This had been done well in 23 out of 32 relevant cases. Of the remainder, seven initial plans had either not been completed as required or had been completed too late to be meaningful.

2.3. One case in the sample met the criteria for management by more than one agency under the local Multi-Agency Public Protection Arrangements (MAPPA). We found that there had been appropriate engagement with MAPPA in the assessment and planning for this case.

2.4. The assessment of risk of harm posed to others had been reviewed as required in just over two-thirds of relevant cases. We saw a number of examples where the same, or almost identical documents, had been pulled through from the initial assessment without relevant updates reflecting the child or young person's current circumstances.

2.5. Where there was an identifiable victim or potential victim, we were pleased to see that the risk of harm they faced had been effectively managed in most cases.

2.6. In line with the above findings, we assessed that management oversight had been effective in ensuring the quality of work to address risk of harm to others in 23 out of 30

relevant cases. Although significantly better than the last inspection, some practitioners had needed closer oversight in order to ensure that they had put into place the improvements required of them by their managers. This was not helped by the absence of a formal YOT risk management policy and, in some instances, delays in cases reaching the internal risk management panel.

3. Protecting the child or young person

3.1. Almost all of the children and young people who had offended were also vulnerable themselves. In line with the above findings, some three-quarters of the sample had a sufficient initial assessment of safeguarding and vulnerability needs. In some cases, the impact of key aspects of the child or young person's vulnerability, such as their emotional and mental health, had been underestimated.

3.2. Suitable plans to manage safeguarding and vulnerability issues were put in place at the start of orders in three-quarters of cases. Where there were gaps, the reasons for this included missing or late vulnerability management plans and a failure to plan for the key aspects related to the child or young person's vulnerability, for example, their emotional and mental health needs or alcohol use. In an example of good practice an inspector reported: "*Good joint work with the local authority social worker and young person to discuss how they would plan to manage his risk and vulnerability. It was agreed the best way forward on release from custody would be for him to be placed in an out of area foster placement, with a positive male role model of the same heritage. He has since settled in his placement, not reoffended and engaged full time in education*".

3.3. The safeguarding needs of the children and young people within the sample changed over time and needed to be kept under review. We found that assessments and plans had been reviewed as required in just over two-thirds of cases. In line with our earlier finding above, some reviews had not been undertaken in response to changes in circumstances and others had been pulled through from the initial assessment with insufficient updates.

3.4. Oversight by management was effective in ensuring the quality of work to help safeguard children and young people in 26 out of 32 relevant cases.

4. Ensuring that the sentence is served

4.1. We expect to see that the YOT 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 that they comply with the requirements of their sentence.

4.2. Diversity issues and other potential barriers to engagement had been assessed well in almost three-quarters of the sample, which left some room for improvement. In an effort to broaden the case managers' initial assessment, a contribution was sought from the YOT parenting worker. Some of the cases in the sample predated this practice but others had benefited from a helpful and thorough parenting assessment. These assessments were based on an interview, often at the home address, and drawing on information from other agencies. The parenting worker role was clearly valued by staff and helped them to reflect on their own practice. As noted by one inspector: "*There is good evidence of the case manager reflecting critically on their own initial assessment. The case manager has identified that, in this case, there may be more information than is immediately apparent, and feels that the initial assessment was insufficient as it did not fully engage his mother*". Case managers also drew upon interpreters and, in one case within the sample, used online communication to ensure that the parents were involved. An inspector commented:

"*Really good use of an interpreter, for example, for the PSR interview and assessment interviews the case manager has contacted his parents in Iran via Skype*".

4.3. The majority of the children and young people within our sample had complied with their court order and this often reflected case managers' efforts to develop positive working relationships with them and their parents/carers, including through home visiting. For those who had not complied with their court order, we found that the YOT had responded appropriately, for example; holding compliance meetings, issuing formal warnings or breach proceedings in 11 out of 14 applicable cases.

Operational management

We interviewed ten case managers and they spoke positively about the operational management arrangements at the YOT. All felt supported in their work and commented that their managers were appropriately skilled and knowledgeable. Staff had a good understanding of local policies and procedures and the principles of effective practice with children and young people. All but one felt that their training and development needs had been met in relation to their current post and the majority felt that their future development needs had also been responded to. The vast majority felt that they had the necessary skills to recognise and respond to the diverse needs of the local community. One gap identified by staff was training in the speech, language and communication needs of children and young people and this was reflected in our findings on identifying potential barriers to engagement.

Management oversight had been the focus of improvement since the last inspection where it was largely judged to have been ineffective. Clear improvement had been made and provided a firm foundation from which to build upon.

Key strengths

- The 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.
- The contribution made by the parenting worker to the initial assessment and plans, helping staff to broaden their understanding of the circumstances in which children and young people live.

Areas requiring improvement

- Staff and managers should ensure that all assessments and plans to reduce reoffending, protect the public, and to safeguard children and young people, are of sufficient quality and reviewed as required.
- Clear risk management procedures, understood by all staff, should be put in place addressing all aspects of work relating to protecting the public, including the remit of the internal risk management panel.

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

Copy to:

YOT Manager	*Stuart Johnson*
Head of Service	*Steve Liddicott*
Elected Mayor, Tower Hamlets	*Lutfur Rahman*
Local Authority Chief Executive, Tower Hamlets	*Steve Halsey*
The Town Clerk and Chief Executive of City of London	*John Barradell*
Director of Children's Services, Tower Hamlets	*Robert McCulloch-Graham*
Director of Communities and Children's Services City of London	*Ade Adetosoye*
Services Manager, Community and Children's Services City of London	*Pat Dixon*
Lead Elected Member for Children's Services	*Gulam Robbani*
Lead Elected Member for Crime	*Ohid Ahmed*
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Ofsted – Further Education and Learning	*Sheila Willis*
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Care Quality Commission	*Fergus Currie*
HM Inspectorate of Constabulary	*Paul Eveleigh*

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 Publications at publications@hmiprobation.gsi.gov.uk or on 0161 240 5336.