

Tom Cray and Jason Harwin
Joint Chairs of Rotherham YOS Management board
Rotherham Youth Offending Service

05th December 2012

Dear Tom Cray and Jason Harwin

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

This report outlines the findings of the recent SQS inspection, conducted during 12th-14th November. 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 Ofsted 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, to promote continuous improvement by the organisations that we inspect and contribute 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 Youth Offending Team. 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 a mixed picture in Rotherham. Case managers were committed to providing a good service to children and young people and to the wider community. While we saw some work of the highest standard, in other cases assessments and plans were insufficient. A number of the children and young people who offended were vulnerable and this had not always been fully recognised. With a few exceptions, management oversight arrangements had not been effective in assuring the quality of work undertaken.

Commentary on the inspection in Rotherham:

1. Reducing the likelihood of reoffending

- 1.1. The initial assessment of the child or young person's likelihood of reoffending was found to be sufficient in a little over half of the cases sampled. For those where we found gaps

the case manager had often provided unclear or insufficient evidence, in seven cases this related to the child or young person's living arrangements. Improvements were noted in the quality of reviews.

- 1.2. Pre-sentence reports (PSR) were provided to the court in 15 cases. While a number were of the highest standard, five contained insufficient consideration of how the child or young person's vulnerability linked to their offending.
- 1.3. In one-quarter of all cases the plan to reduce the likelihood of reoffending was either late or had not been completed at all. As a result it was not clear who was responsible for delivering the work needed to stop offending. Where plans were in place most were sufficient, including those drafted in custodial cases. Overall, we saw positive examples of joint working to address substance misuse and education, training and employment. However, the child or young person's emotional and mental health needs had not always been included in the plan despite being linked with offending.
- 1.4. More than two-thirds of the plans to reduce the likelihood of reoffending had been reviewed sufficiently well.

2. Protecting the public

- 2.1. The initial assessment of the child or young person's risk of harm to others was found to be sufficient in just over half of the cases sampled. Where the assessment was insufficient, this was usually because relevant previous offences or behaviour had been overlooked. In almost half of all applicable cases, the assessment had not been reviewed at regular intervals or following a significant event. However, we did agree with the YOS's assessment of the level of harm posed by the child or young person in all but one case.
- 2.2. Almost three-quarters of PSRs contained a thorough assessment of the risk of harm to others.
- 2.3. There was sufficient planning to address the child or young person's risk of harm to others in 10 of the 14 cases where this was an issue. We saw positive examples of joint working in complex cases where children and young people had accommodation, education and substance misuse needs. However, in three of the five custody cases, there was insufficient planning to address the risk of harm in the custodial period.
- 2.4. More than two-thirds of the plans to address the risk of harm to others had been reviewed sufficiently well.
- 2.5. Where there was an identifiable victim or potential victim, the risk of harm they faced had been effectively managed in almost three-quarters of cases. We found that efforts had been made to contact victims and to seek their views in the majority of cases sampled.

3. Protecting the child or young person

- 3.1. The initial assessment of the child or young person's vulnerability and safeguarding needs was found to be sufficient in only seven of the cases sampled. Where the assessment was insufficient, this was usually because the vulnerability screening had overlooked relevant information. This included the child or young person's emotional and behavioural difficulties, care arrangements and associates. In three cases the assessment had not adequately reflected information held by other agencies. There had been insufficient liaison with children's social care services in two cases.
- 3.2. Assessments of the child or young person's vulnerability and safeguarding needs were seldom reviewed sufficiently well.

- 3.3. Planning to address vulnerability and safeguarding issues was sufficient in only six cases in the whole sample. Of the five cases of children looked after by the local authority, the social worker or carer had been involved in the planning to address vulnerability and safeguarding in three cases. Of the six cases that received custodial sentences, only three had a sufficient plan in place to manage safeguarding and vulnerability during the custodial phase. Overall, plans had seldom been sufficiently reviewed and in eight applicable cases had not been reviewed at all.

4. Ensuring that the sentence is served

- 4.1. Attention had been paid to assessing the child or young person's diverse needs and any barriers to engagement in three-quarters of cases. This included attention to the child or young person's health and well-being.
- 4.2. The child or young person and their parents/carers had been involved in the assessment and planning of interventions in some three-quarters of cases.
- 4.3. The great majority of children and young people had complied with their order and this was a credit to the efforts made by case managers including visiting the home and working with parents/carers.

Operational management

There had been gaps in operational management oversight over the past few months and following a service restructure the team had reduced from three to two operational managers.

Overall, we found that staff supervision or other quality assurance arrangements had made a positive difference in just over a third of the sample. In some instances there had been no management oversight at all despite concerns surrounding the child or young person's vulnerability or risk of harm to others. We found other examples where rather than providing advice on how to improve, practice managers had signed off insufficient assessments and plans.

We interviewed seven case managers and they spoke positively about the new management arrangements, stating that their managers had the necessary skills and knowledge to undertake the role. All felt that their training and skills development needs were at least partly met if not fully met. They spoke positively about training received in meeting diverse needs, in particular speech, language and communication and this was reflected in the findings. Case managers demonstrated a good understanding of local policy and procedures to protect the public. This wasn't always the case for YOS procedures for the management of safeguarding (which link to the wider procedures within Rotherham Metropolitan Borough Council), and this was reflected in the findings.

Outstanding strengths

The following were particular strengths:

- Attention was paid to the changing demographic in Rotherham and earlier this year specialist training had been delivered by a local Czech Roma community worker. We saw evidence of this being put into effect in one particular case in the sample. An interpreter was used and letters translated both for the young person and his mother. Another member of staff was learning key greetings and phrases and including these on appointment cards.
- A number of children and young people had completed reparation hours at a local hospice, benefiting the community and developing their own insights into the needs of others.
- A voluntary drop-in service was offered to children and young people at the end of their court order where they could seek advice from a YOS worker. By providing this opportunity they felt better supported at the end of their contact with the YOS and would have someone to speak to if they felt tempted to reoffend.

Areas requiring improvement

The most significant areas for improvement were:

- i. assessment and planning to address the child or young person's vulnerability and safeguarding needs,
- ii. assessments of the risk of harm to others - with attention being paid to relevant offences and behaviour,
- iii. review of assessments at regular intervals and following significant changes in circumstances,
- iv. management oversight, including supervision and quality assurance arrangements.

We strongly recommend that you focus your post inspection improvement work on those 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.

Yours sincerely,

Julie Fox

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Copy to:

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YJB link staff with HMI Probation

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