Inspection of Youth Offending Work
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From:	Julie Fox, Assistant Chief Inspector
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Report of Short Quality Screening (SQS) of youth offending work in Sandwell

This report outlines the findings of the recent SQS inspection, conducted from 16th-18th December 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 this inspection was to assess the quality and effectiveness of recent casework with children and young people who had offended. In order to do this, we examined 20 cases supervised by Sandwell Youth Offending Service (YOS). 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 dedicated staff team working extremely hard with children and young people who had complex needs, in a challenging environment at both an operational and management level. Noticeable progress had been made against some of the recommendations since the last inspection in March 2011. Staff involved and engaged the child or young person and their families in the development of assessments and plans. Planning to reduce the likelihood of reoffending was particularly good. However, additional attention is needed to produce more robust assessments and reviews where the child or young person poses a risk of harm to others or is vulnerable. While progress in management oversight was evident since the last inspection, middle managers now need to address deficiencies in assessments and reviews. Pleasingly, every case manager we interviewed reported that they were fully supported in their work by their manager.

Commentary on the inspection in Sandwell:

1. Reducing the likelihood of reoffending

1.1. In the inspection we look at whether the assessment for a child or young person who has offended is good enough. In 16 out of the 20 cases, we considered it was. In the majority of instances, case managers used an inquisitive approach to assess the causes of the child or young person's offending behaviour. We were encouraged to see a good level of engagement with the child or young person and their parents/carers in almost all of the cases.

1.2. Just over half of the pre-sentence reports (PSRs) we inspected were of a good quality. However, a number lacked sufficient analysis and the assessments of risk of harm and vulnerability were limited. We could see clearly that procedures were in place to check the quality of the reports before they were submitted to the courts, but this system needed to be more vigorous, as the deficits outlined above had not been picked up appropriately.

1.3. All reports presented to the referral order panel were well written and good attention had been given to victim work, reparation and the level of interventions required to reduce the likelihood of offending.

1.4. As children and young people's lives can change frequently, reviews are necessary to ascertain if the same issues still require attention. In almost every community case we examined, we concluded that sufficient reviews had been carried out to reassess the issues involved in the likelihood of that child or young person reoffending. Similarly, in every community and custodial case we found that there was an appropriate level of planning aimed at reducing reoffending.

2. Protecting the public

2.1. This is an area of work that requires further attention. In 13 out of the 20 cases we found that the assessment of the risk of harm to others presented by the child or young person was done well. However, in seven cases it was neither clear nor thorough. In these instances, we were of the opinion that the screening had not been carried out appropriately and some relevant experiences, previous offences or behaviours of the child or young person had not been taken into account. We were not entirely satisfied that all staff fully understood the components of risk of harm to others work.

2.2. In just under one-third of cases inspected we could not see evidence of adequate reviews having been undertaken to assess the risk of harm. Reviews were completed, but often lifted from previous assessments and did not provide enough indication of the changes that had taken place. As outlined previously, children and young people's personal circumstances can fluctuate very quickly and it is essential that these changes are used to inform assessments.

2.3. We were pleased to see that, as far as the commencement of the community sentence was concerned, 13 out of the 15 cases included suitable planning for interventions to manage the risk of harm to others. However, this was not the case with custodial sentences, since two out of six cases did not contain enough planning for work to impact on the risk of harm to others. While custody clearly removes the child or young person from the community for a period of time, inadequate planning is likely to have an adverse impact on reducing the risk of harm they may present to others, particularly once back in the community.

2.4. In six out of ten cases we found that reviews of plans to deal with and reduce risk of harm throughout the sentence were done well. Where this was not done well was

primarily down to plans not being carried out, not being modified as required or the quality being deficient.

2.5. Where there was an identifiable or potential victim, the risk of harm they faced was effectively managed in 10 out of the 12 cases. This is an encouraging finding.

2.6. Managers provided effective oversight to make sure that risk of harm work was being undertaken in 10 out of the 14 cases where this was necessary. In order for this to be fully consistent, the key gaps in assessment outlined earlier need to be addressed and followed though.

2.7. Almost every case manager interviewed reported that they understood local procedures for the management of risk of harm. However, in our view the application of this knowledge was not always evident.

3. Protecting the child or young person

3.1. There was a satisfactory assessment of vulnerability and safeguarding issues in around three-fifths of the cases. This provided a foundation for work by the YOS to address and reduce the vulnerability of those with whom it was working. However, we found that in 8 out of 20 cases the vulnerability screening was not done well and relevant behaviours were either overlooked or not used to fully inform assessments. One inspector noted this in a case, for example where there was not a satisfactory plan to protect the young person by summarising "*with regards to vulnerability, 'X' has previously self-harmed, attempted suicide and recently been threatened over the internet with being stabbed by another young person*". Despite this knowledge, there was no plan to adequately protect this young person. This was also evidenced in three out of the eight PSRs we examined. In these instances greater attention was needed to bring together all relevant behaviours, rather than to limit the assessment to current issues. We were pleased to see that the YOS held a weekly Risk and Vulnerability forum. However, the decisions and actions from the forum needed to be better integrated into the management of every relevant case.

3.2. Nine out of fifteen reviews of assessments relating to safeguarding and vulnerability throughout the sentence were of an acceptable standard. However, a number were traced from previous assessments, there were insufficient updates and the reviews lacked clarity. Management oversight in this area was not always effective, as deficiencies in assessments were not consistently highlighted and addressed.

3.3. Planning to address vulnerability and safeguarding at the start of the sentence was much better. This had been done well in three-quarters of the cases. One inspector commented "*the plan in this case was of a good standard, pertinent to the identified risks and broken down into what would be done, where, how and by whom*".

3.4. In two out of six custodial cases we found that there had been insufficient planning in place throughout the period that the child or young person was in custody.

4. Ensuring that the sentence is served

4.1. This area of work was a significant strength in the YOS. In around nine-tenths of the cases we found that case managers had worked collaboratively with the child or young person and their parent/carer to, not only complete accurate assessments, but also to develop plans.

4.2. In every PSR we examined, from a service user's perspective, we saw clear evidence that the report writer had engaged meaningfully with the child or young person and their parent/carer to develop a suitable and properly informed document.

4.3. In four-fifths of the cases we could see clear evidence of the case manager working hard to identify, at the start of the sentence, any obstacles that would hinder positive engagement with the child or young person. Completed learning style questionnaires were consistently seen on case files and diversity needs were identified. This demonstrated that the YOS had been able to develop this area of work, which was one that had been highlighted as requiring attention in the last inspection.

4.4. In almost all of the cases, the YOS had given a good level of focus to health and well-being outcomes for the child or young person, as far as these factors may have been a hurdle to achieving favourable outcomes.

4.5. We were satisfied that all of the case managers interviewed had a good knowledge of local policies and procedures to support effective engagement with the child or young person and to properly respond with breach action where appropriate. This was impressive and ensured that the sentence of the court was served. Inspectors noted "*enforcement was swift and appropriate; compliance carried out very well*".

Operational management

We found that there were inconsistencies in the positive impact that staff supervision had had on some cases. In 10 out of the 16 cases, where supervisory oversight was required, we found that an effective contribution had been made. Case managers reported excellent generic support from their managers. However, some commented that they did not always feel confident that all their managers were adequately skilled in assessing the quality, and giving them guidance, to oversee and develop the different areas of their work. This may offer some explanation for the deficiencies we found in the risk of harm and vulnerability work. The vast majority of case managers stated that their training and development of skills to do the work and deliver interventions was well met. However, the majority reported that insufficient attention was paid to their own continuous professional development and longer-term career plans.

Case managers were generally satisfied with their training to recognise diversity factors and to respond to prejudice and discrimination. However, three out of the ten interviewed asked for additional developmental opportunities to respond to speech, language and communication needs of children and young people.

It was pleasing to hear case managers saying that they were clear in what the organisation expected of them and the role they needed to play.

Key strengths

- The engagement of case managers with children and young people and their parents/carers in carrying out assessments and completing plans to address their offending behaviour.
- The consistent planning of work to reduce the likelihood of reoffending.
- The positive attention that was given by case managers to removing barriers that may have been getting in the way of achieving good health and well-being.

Areas requiring improvement

- Assessing and reviewing of the work to manage risk of harm to others and reduce vulnerability.
- Consistent and effective management oversight in highlighting and addressing deficiencies in assessments and reviews of risk of harm to others and vulnerability work.

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 Sandwell 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 Avtar Singh. He can be contacted on 077969 48325 or by email at avtar.singh@hmiprobation.gsi.gov.uk.

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