Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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

This report outlines the findings of the recent SQS inspection, conducted during 8th-10th April 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 Staffordshire 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 Staffordshire Youth Offending Service (YOS) was performing well. A good service was being provided to children and young people and the wider community. YOS staff were highly motivated and spoke positively about the organisation; they benefited from the support and oversight of managers and effective links with other agencies. We did find some areas for improvement, particularly in relation to the quality of plans found on case files. Given the commitment of staff and managers at Staffordshire YOS we anticipate that the high quality demonstrated in some cases could be replicated across all the work.

Commentary on the inspection in Staffordshire:

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 almost all cases. Checks made with other agencies such as schools and Children's Services had helped to provide a full picture of the child or young person's circumstances.

1.2. Pre-sentence reports (PSRs) were provided to the court in 13 cases. Ten were assessed to be of good quality and all 13 had given sufficient attention to diversity factors and potential barriers to engagement.

1.3. 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. An example of good practice included plans that had been written jointly between the case manager and the child or young person.

1.4. In almost all cases, the assessment and plan 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. This should cover all relevant information including past offending and behaviour, as well as the impact upon victims. We found that this had happened in three-quarters of cases. However, in four cases we disagreed with the YOS's assessment of the level of harm posed to others, finding that it had been underestimated. Consequently, in three cases the PSR had contained an insufficient assessment of the risk of harm posed by the child or young person.

2.2. Having assessed the risks, the YOS should put plans in place to manage them. Overall, this had been done well for community cases, but not so for three out of the six custodial cases in the sample. It was felt that two should have had risk management plans in place covering the custodial period of their sentence.

2.3. The risk of harm posed to others can change over time and therefore needs to be kept under review. We were pleased to note that the assessment of risk of harm had been reviewed sufficiently well in almost all relevant cases. However, the same attention had not always been paid to updating plans.

2.4. Where there was an identifiable victim or potential victim, the risk of harm they faced had been effectively managed in well over three-quarters of cases.

3. Protecting the child or young person

3.1. In many cases, children and young people who have offended are also themselves vulnerable. Overall, work to protect children and young people had a high profile at Staffordshire YOS and case managers demonstrated an investigative approach. In one case, detailed enquiries had been made with children's social care services not only in Staffordshire but also out of the county. Social workers were then able to make contact with a vulnerable young woman with whom the young person was hoping to reside upon release from custody.

3.2. We found that the great majority of cases had a sufficient assessment of safeguarding and vulnerability needs, especially those for whom a PSR had been prepared.

3.3. Planning to address vulnerability and safeguarding issues was good enough in all six custody cases but not always so for community cases. Where there were gaps (in 5 out of 19 relevant cases) this often related to there being an insufficient planned response should the level of vulnerability increase.

3.4. 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, the plan was updated when the young person's older brother returned to the family home. The case manager was concerned about the negative influence of this individual and added a specific objective to monitor the young person's home environment.

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. Half of the cases within the sample had complied fully with their order. For those who had not we found that the YOS had responded appropriately. This was a credit to the efforts made by case managers including visiting the home and working with parents/carers to seek compliance. For a young person with educational needs and poor memory, the case manager had scheduled all appointments for the same day and time each week. This was particularly important as the young person had not kept to court orders in the past. He responded well to the regular appointment slot and was, for the first time, starting to open up to YOS staff, allowing them in turn to help reduce the likelihood of reoffending.

4.3. 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 the great majority of cases. Although due regard had also been paid to diversity at the planning stage, it had not always been explicitly recorded (in five relevant cases).

4.4. There was a good level of engagement with the child or young person and their parents/carers in order to complete assessments, but a little less so in undertaking plans.

Operational management

The structure of Staffordshire YOS supported effective operational management. Case managers had access to advice from senior practitioners (who themselves supervised children and young people) and team managers. YOS work was underpinned by a detailed quality assurance strategy and expectation that case files were regularly sampled by managers. In one example the case file included a completed quality assurance form which demonstrated an active level of oversight and included appropriate feedback to the case manager.

We interviewed 13 case managers and they spoke positively of the operational management arrangements at Staffordshire 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. The great majority felt that their training and skills needs were fully met, with the remainder feeling that they had been partially met. A number spoke positively of the opportunities to access training through the county council, irrespective of whether they were council employees. One gap identified by staff was training in the speech, language and communication needs of children and young people.

We look for evidence that, where relevant, management oversight had been effective in ensuring the quality of work to address risk of harm to others, vulnerability and safeguarding. Overall, we found that staff supervision or other quality assurance arrangements had made a difference in at least three-quarters of cases and slightly more so where there were safeguarding needs. 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 Staffordshire included:

- The investigative approach often adopted when undertaking assessments, ensuring that information was checked and acted upon. An example of this included the case of a young person who was both a high risk of harm to others and vulnerable himself. The case manager had drawn up a map of the young person's associates. This included adults who had offended and potential victims both within the county and cross-border. The map identified those at potential risk of harm from him, as well as those who posed a danger to him. This was then used to inform the work undertaken, not only by the YOS but also by other agencies such as police, probation and Children's Services.
- YOS staff worked hard to help children and young people comply with their court orders. They were particularly good at building relationships with the child or young person and undertaking home visits to help understand issues thoroughly.

Areas requiring improvement

The most significant area for improvement is:

i. Planning, specifically
    - planning for work to address safeguarding and vulnerability in the community,
    - planning for risk of harm work during the custodial period of the sentence,
    - review of plans to manage and reduce risk of harm to others, and
    - involving parents/carers in plans produced in respect of their child or young person.

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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