Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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Nick Wilson
Chair of YSS Management Board
Surrey Youth Support Service

23rd January 2013

Dear Nick Wilson,

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

This report outlines the findings of the recent SQS inspection, conducted during 17th-19th December 2012. 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, 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 34 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 that most staff in the Surrey Youth Support Service (YSS) were delivering work of high quality. In contrast, we also found examples of work that was not of a sufficient standard, particularly in relation to assessment and planning of work to address the risk of harm to others and protect children and young people. These deficits were not being recognised and addressed by some line managers. The challenge for the YSS Management Team is to ensure all staff and managers understand the practice requirements of these aspects of work with children and young people and that more cases meet the high standards which some staff demonstrated were possible.

Commentary on the inspection in Surrey

1. Reducing the likelihood of reoffending

1.1. There was a timely and sufficient initial assessment of the likelihood of reoffending in 28 out of 34 cases. Where the assessment was insufficient, this usually related to the assessment not being sufficiently thorough.

1.2. Pre-sentence reports were requested and provided to the court in 18 out of the 34 cases inspected. In general, these were of good quality. Information in other forms, such as verbal updates provided by case managers, offered sufficient information for the purposes of sentencing. An inspector noted in one case that *"This young person was known to YSS staff, who responded to the Bench's request for a Specific Sentence Report. The report was thorough. It offered a good understanding of the criminogenic risk factors as well as a full assessment of vulnerability. The conclusion offered a balanced and logical summary of the issues".*

1.3. Planning to reduce the likelihood of reoffending was sufficient in just over three-quarters of cases. Where plans were deemed to be insufficient it was because they did not address the identified needs in the case, or were unclear. In three of the cases a plan had not been completed. There were six detention and training orders in the sample and planning for the custodial element was sufficient in five of these.

1.4. In almost all of the relevant cases adequate reviews of the assessment of likelihood of reoffending had been undertaken. Reviews of plans to address reoffending issues were good enough in over three-quarters of cases.

2. Protecting the public

2.1. There was a clear and thorough assessment of the risk of harm to others in all but 1 of the 18 cases where there had been a pre sentence report. For example, in one case we noted *"This case had an excellent risk of harm plan to manage risk and vulnerability. The plan was detailed, comprehensive and fully reflected the assessed issues. The intervention plan was robust and incorporated a good mix of restrictive and rehabilitative interventions, which were necessary given the serious nature of this case".* On the other hand, the assessment of risk of harm was insufficient in just under one-quarter of the cases in the sample. The most often noted reasons for the assessment being insufficient were that they had either not been done, they had not addressed victims' issues, or that relevant behaviour had been overlooked.

2.2. In almost one-third of cases there was insufficient planning to address issues of the risk of harm to others, although in all five relevant custody cases the planning was of good quality. Compare our view that *"This case was complex and had a number of issues relating to both vulnerability and risk of harm. Planning was of very good quality, there was a detailed and robust plan that addressed harm and vulnerability issues. The intervention plan flowed from the assessment, was child-friendly and clearly identified the work to be undertaken on the problem areas assessed",* with *"In this case there was an underestimation of risk of harm and vulnerability. Even after new information became available at the review stage, the review was not timely and did not sufficiently map out the current and anticipated issues in this case".* The issues that detracted from the quality of plans were that planned responses were not clear, victims' issues were not addressed and anticipation of changes in levels of risk of harm (where circumstances had changed) had not taken place.

2.3. In one-quarter of the relevant cases, reviews of the risk of harm had not been done to an acceptable standard. The risk of harm to others posed by a child or young person can change as circumstances change; it can reduce as well as increase. Reviews of risk of harm were often insufficient as they were simply copies of previous assessments and

contained information that was no longer relevant to the child or young person's current situation.

2.4. YSS probation officers held both YSS and probation cases before and after their transition. This helped to ensure consistency and continuity in the work. In one case we saw that the case manager had completed both the court report and the core assessment. They supervised the young person on his youth rehabilitation order. Upon turning 18, the young person remained with that worker who completed the adult transfer assessment and review and continued with supervision at the probation office.

2.5. Where there was an identifiable victim, or potential victim, the risk of harm they faced had been effectively managed in the majority of cases. Efforts had been made to contact victims and to seek their views in the majority of cases sampled.

2.6. Management oversight of risk of harm work was effective in fewer than half of the cases. In some cases oversight had not been provided at all. In others we saw that assessments and plans that were clearly inadequate had been countersigned by managers without addressing quality concerns. We were pleased to note, that on several occasions, some senior practitioners had sought out assistance from an experienced youth justice manager to help them to countersign work on risk of harm and vulnerability. In our view there were staff members who did not have sufficient experience and knowledge to tackle risk of harm to others issues in their work with children and young people. In addition, several staff members did not have confidence in the ability of their managers to offer effective oversight of this work. Our findings would lend some support to these views and it was clear that some managers were not acting as a 'line of last defence', in respect of risk of harm practice issues.

3. Protecting the child or young person

3.1. Whilst almost all pre-sentence reports had adequately assessed vulnerability issues, for the sample overall over one-third had not sufficiently assessed the safeguarding and vulnerability needs of the children and young people. Planning to address vulnerability and safeguarding issues was sufficient in just over half of the 30 relevant cases. For example, in one case we saw a situation where three children and young people (including the young person who was being supervised) were subject to care plans, but we could not find evidence of effective liaison and joint planning with Children's Services staff. Reviews of safeguarding and vulnerability planning were required in 23 cases; this had happened to an acceptable standard in only 13.

3.2. The deficiencies in this work were similar to those identified for risk of harm reviews, as were the deficiencies in management oversight of this practice. Management oversight of safeguarding and vulnerability assessments and plans was effective in less than half of the cases. In some instances the oversight had not been provided. In others we saw assessments and plans, that were clearly inadequate, had been countersigned by managers.

4. Ensuring that the sentence is served

4.1. At the pre-sentence stage and at the commencement of supervision, attention was routinely being paid to assessing the child or young person's diverse needs and identifying barriers to engagement. There was also evidence of good levels of involvement of the children and young people, and their parents/carers, in the assessment and planning of interventions. We found in one case *"Positive evidence of good engagement with the young person and their carer around intervention planning. There was a paper copy of*

the plan and it was evident this had been completed with the young person and was written in a way they could understand".

4.2. In over three-quarters of the cases we reviewed, sufficient attention had been given to the health and well-being of the child or young person.

4.3. Two-thirds of the children and young people had complied with the requirements of their sentence. This was to the credit of practitioners as many of the children and young people required regular input by practitioners to secure their engagement in the work. For those children and young people who had not complied with the requirements of supervision, even after steps had been taken to address non engagement, the response of the YSS was sufficient in all cases.

Operational management

Surrey YSS had undergone considerable change in the period leading up to this inspection. The scope of the responsibilities of the organisation had increased as they moved from being a Youth Justice Service to a broader Youth Support Service. As part of this the organisation had attracted new staff and new responsibilities, for example taking on ownership of child in need work for young people aged 15-17. Generally, we found good morale and positive comments about staff support and development. However, staff had mixed views on the effectiveness of management oversight and, in particular, the adequacy of the developmental support for staff in order to undertake the full range of duties, for example youth justice work alongside work on child in need issues; homelessness; and education, training and employment.

Staff welcomed the development of countywide process and practice guidelines, but a number said they felt they needed more training and support to implement those practices. In particular, we found that several staff were unclear about the practice requirements associated with risk of harm and vulnerability.

There was evidence of good multi-agency liaison and shared working, particularly in undertaking offending behaviour and victim work. Joint work with the police was strong.

Outstanding strengths

The following were particular strengths:

- reports provided to the courts, in particular pre-sentence reports, were of a high standard,
- there was routine engagement with children and young people and their parents/carers in carrying out initial assessments and planning,
- the assessments of diversity and barriers to engagement were good,
- there were good levels of compliance and, where needed, effective enforcement of court orders,
- the YSS had developed the role of seconded probation officers to improve the quality of work done with 17 and 18 year-olds and to ease the transition to probation (adult) supervision.

Areas requiring improvement

The most significant areas for improvement were:

i. the quality of assessments and planning for work to address the risk of harm posed to others,

ii. assessments and planning to tackle vulnerability and safeguarding needs,

iii. reviews of assessments at regular intervals and following significant changes in circumstances,

iv. management oversight of vulnerability and risk of harm assessments, plans and reviews,

v. implementation of countywide policies and practice guidelines on child safeguarding and public protection.

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 YSS 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 Joseph Simpson. He can be contacted on 07917 084764 or by email at joe.simpson@hmiprobation.gsi.gov.uk.

Yours sincerely,

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HM Assistant Chief Inspector of Probation

Copy to:
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YJB link staff with HMI Probation
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