Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
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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 Cumbria

This report outlines the findings of the recent SQS inspection, conducted from 2nd - 4th June 2014. 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 34 cases supervised by Cumbria Youth Offending Service (YOS). Wherever possible this was 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 - www.justiceinspectorates.gov.uk/hmiprobation

Summary

Overall, YOS staff engaged well with children and young people both at the start of, and during their orders. This enabled case managers to build up a clear picture of the child or young person's life and to recognise the difficulties they faced that had contributed to their offending and well-being. Staff worked hard to try and keep children and young people safe, however too often this work was not undertaken with Children and Families[1] staff from Children's Services. In our view, much of the case managers' time was spent responding to welfare issues, at the cost of work to reduce reoffending and the management of risk of harm to others. The relationship and response between the YOS and Children and Families had improved over recent time; this now needed to be strengthened with written agreements, a clear framework and a consistent approach to joint work. Plans needed to improve to ensure that work to reduce reoffending was effectively

[1] Throughout the report we refer to Children and Families, which is part of Cumbria Children's Services department.

delivered; that risk could be managed and that keeping children and young people safe was coordinated with partner agencies. Management oversight was variable resulting in confusion for case managers and inconsistent delivery of work. The Senior Management Team had a good understanding of performance priorities and had a clear plan in place to enable improvements to be made.

Commentary on the inspection in Cumbria:

1. Reducing the likelihood of reoffending

1.1. The initial assessment of the likelihood of reoffending was sufficient in just under half of the cases sampled. Case managers had gathered a good range of source information, but had not always explored how these factors had contributed to offending. There was a lack of analysis, particularly around how family and personal relationships impacted on emotional health, and how this could lead to difficult behaviour and offending. The most common factor that had contributed to offending, was family and personal relationships, noted in three-quarters of the cases in the sample.

1.2. A good quality pre-sentence report (PSR) had been provided to courts in 12 of the 18 relevant cases, often reflecting the child or young person's views and any diversity issues.

1.3. Case managers were often able to describe what was currently happening in the lives of children and young people, including changes in their living arrangements and relationships, however this knowledge was not always used to update assessments and change plans. A review of the likelihood of reoffending had been undertaken in half of the cases where needed.

1.4. Planning for children and young people in custody needed to be improved; just two of the nine cases we sampled had a suitable plan in place. It was worrying to find that there was no plan at all for six children and young people. In some cases we could see that case managers were undertaking work to prepare children and young people for release, but this had not been supported by effective, recorded and shared planning.

1.5. Effective plans to help children and young people reduce their offending were in place in only 10 of the 34 cases we sampled. There was no plan in 12 cases. In others we noted a lack of clear objectives and no planned interventions for key offending factors most notably emotional health, family and personal relationships and substance misuse.

1.6. Attention was given to the education, training and employment of children and young people, with good support being provided by a number of education providers.

1.7. Reviews of work to address reoffending had been completed in only a quarter of cases.

1.8. We found that staff generally understood the principles of effective practice. A number of staff were new to the service and brought good knowledge and skills, but these needed to be supported with clearer processes and feedback on the quality of their work.

2. Protecting the public

2.1. Assessments, of the risk of harm children and young people posed to others, were accurate in just over half of the cases. In seven cases there had been no assessment; in others the assessments missed previous behaviours or offences; and in a few we thought that the severity of the risk was under estimated.

2.2. There was a suitable plan to manage risk in 12 of the 30 cases where one was required. There was no plan in 11 relevant cases, and a lack of attention to how victims would be protected. Some plans had been produced, but were not linked with other plans, usually

those held by Children and Families, as the YOS had difficulties on occasions getting these staff to respond to their referrals.

2.3. We saw one case that had been correctly referred to the Multi Agency Public Protection Arrangements (MAPPA). Effective plans were in place and appropriate interventions were being delivered by a specialist agency. The young person was responding well.

2.4. Reviewing the assessments and plans to manage risk of harm to others was often a missed opportunity for case managers to fully consider if existing arrangements were effective. In five cases a review had not been undertaken and in six further cases, new information and changes had not been incorporated into plans. This was despite some good work being undertaken by case managers to respond to changes.

2.5. Victim safety was not fully considered in plans. Often, victims were known to the child or young person and we were concerned that in a few cases previous violence against parents/carers was not managed via a planning process.

2.6. Management oversight was evident in all cases, just prior to the inspection, however this had not ensured that action had been taken as needed. Oversight had been effective in one in five cases, with deficiencies in assessment and planning not identified. In nine cases it was clear that other agencies (such as Children and Families and mental health) needed to be working with the YOS but management arrangements had not provided sufficient challenge to ensure that these services were in place.

2.7. We were pleased to note that the YOS had recently developed a new quality assurance system designed to aid managers' consistency of oversight but this was yet to be fully established.

2.8. Three-quarters of staff interviewed had sufficient understanding of local policies and procedures for managing risk of harm to others.

3. Protecting the child or young person

3.1. Case managers interviewed knew about children and young people's lives and the difficulties they faced. They were able to identify when children were not safe. There were some examples of very effective joint work between the YOS and Children and Families but these were based on individual relationships rather then consistently applied arrangements. The ability of the YOS to plan and act to keep children and young people safe was being made difficult due to a lack of information and cooperation from Children and Families.

3.2. Initial checks using the Children and Families Integrated Childcare System (ICS) , had been completed, notes from Child In Need meetings were not sent to the YOS routinely and the outcome of meetings was not routinely checked on the system by the YOS.

3.3. YOS managers described the relationship between Children and Families and themselves as improving, and this is positive to note. However, we saw children and young people who were not being fully protected.

3.4. YOS staff had focused on meeting the welfare needs of children and young people, and as a result work to address reoffending and to manage the risk of harm to others was not given the focus and attention needed.

3.5. There was a sufficient initial assessment of safeguarding and vulnerability in only 13 of the 34 cases. For the 21 that were insufficient, some had no assessment at all, some had an incorrect classification, and some needed to be referred to Children and Families.

3.6. Sufficient reviews of safeguarding and vulnerability had been undertaken in 13 of the 21 relevant cases, this was often in response to case managers becoming aware of new

information including children and young people harming themselves or a breakdown in relationships with parents/carers.

3.7. In our view, 32 of the 34 children and young people in the case sample were vulnerable; the YOS assessments sometimes under estimated the impact of poor emotional health, living arrangements and parenting issues. Similarly, planning to keep children and young people safe missed some key issues including substance misuse and its effect on physical health.

3.8. There were 15 cases where a vulnerability management plan had not been produced where one was required. This included cases in the community and in custody. In custody it was clear that staff in the secure establishments had taken actions to respond to incidents, but the YOS had not planned to manage identified vulnerabilities, including emotional distress that had led to self-harm. YOS staff had always forwarded information about vulnerability to the secure establishment using the personal information form, however these had not been supported by effective plans to manage issues or joint work with Children and Families. Management oversight had not identified or rectified these problems.

3.9. More attention was needed to review vulnerability plans; just under half of these (11 out of 23) were not done well enough. Too many were not reviewed, or were a copy of the previous plan with insufficient update to reflect new information.

3.10. Three-quarters of case managers interviewed had a good understanding of the local policies and procedures to manage safeguarding.

4. Ensuring that the sentence is served

4.1. Engagement with children and young people and their parents/carers was very good. Case managers took care and time to get to know the individual circumstances of each child or young person and to find out what was important to them. This was often done through discussion, and sometimes using the *What do YOU Think?* self assessment questionnaire.

4.2. In all but one case, the child or young person was involved with the development of the PSR. Attention was paid to identifying diversity factors that might inhibit the child or young person from cooperating with the order. It was a shame that these factors were then not included in plans, however we found that case managers worked in such a way that barriers to engagement could be overcome.

4.3. An inspector noted: *"Rex, aged 14, was struggling to understand what he was supposed to do to stop his offending. The case manager encouraged and supported him to draw his own intervention plan where he decided what work he needed to do. The case manager explained to him how they would work together to do the work. As a result, he clearly understood what he needed to do and he knew what to expect from the case manager. He made progress and complied with the order".*

4.4. Overall there was sufficient attention paid to health and well-being in just over half of the cases. Despite activity to improve the welfare of the child or young person, a lack of joint coordination impacted on the work. In seven cases, the required interventions were not delivered, including those from mental health services and from Children and Families.

4.5. In our view there was a reduction in factors linked to safeguarding in a quarter of relevant cases.

4.6. Where children and young people had not complied with their order, there was a good response to try and re-engage them, or to return the order to court. In the vast majority of cases children and young people engaged and cooperated with their court order.

Operational management

The last inspection was undertaken five years ago, and since that time, there has been a period of significant change including relocation of the YOS offices, changes to the management structure and a number of new staff joining the teams. The YOS senior management team were aware of their areas of strength and improvement; these matched the findings from this inspection. The senior managers recognised the need to standardize practice, to reduce inconsistencies and to improve joint working with some partner agencies. Plans were in place to address these issues.

Key strengths

- There was good engagement between YOS staff and the children and young people. Case managers were knowledgeable and understanding about the lives of children and young people. Staff responded to crises when they occurred, often taking practical steps to help individuals.
- Good quality PSR's including barriers to engagement, and the views of children and young people, were prepared for court.

Areas requiring improvement

- Plans to address reoffending, risk of harm to others and vulnerability are produced and the required actions are clear, timely and enable the recognition of progress.
- Case managers ensure that children and young people have their safeguarding needs assessed through referrals to Children and Families, who respond appropriately.
- Management oversight should ensure that assessments and plans are accurate and reviewed when required.
- Managers should ensure that case managers know the outcome of referrals made to partner agencies in a timely manner and that cases are escalated for resolution when needed.

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 Yvonne McGuckian. She can be contacted at Yvonne.McGuckian@hmiprobation.gsi.gov.uk or on 07973 29547

Copy to:

YOS Manager/Head of Service	*Deborah Royston*
Local Authority Chief Executive	*Diane Wood*
Director of Children's Services (acting)	*John Macilwraith*
Lead Elected Member for Children's Services	*Anne Burns*
Cabinet Member for Fire and Fleet (covering crime)	*Barry Doughty*
Police and Crime Commissioner for Cumbria	*Richard Rhodes*
Chair of Local Safeguarding Children Board	*Gill Rigg*
Chair of Youth Court Bench (in behalf of others too)	*Will Lawrenson*
YJB Business Area Manager	*Liza Durkin*
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