Inspection of Youth Offending Work
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To:	Jill McGregor, Chair of South Tyneside YJS Management Board
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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 South Tyneside

The inspection was conducted from 8th - 10th December 2014 as part of our programme of inspection of youth offending work. This report is 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

The aim of the youth justice system is to prevent offending by children and young people. Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. We examined 14 cases of children and young people who had offended and were supervised by South Tyneside Youth Justice Service (YJS). Wherever possible this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

The published reoffending rate[1] for South Tyneside was 43.2%. This was worse than the previous year and worse than the England and Wales average of 35.7%.

Overall, we found that case managers understood the underlying reasons behind why children and young people they were supervising had offended. Assessments were predominantly thorough and engagement with children and young people, parents/carers and significant others was good. Management oversight was not consistently effective and plans did not seamlessly follow the information obtained through assessments.

Commentary on the inspection in South Tyneside:

1. Reducing reoffending

1.1. Work to reduce reoffending in custody was good. Case managers demonstrated an investigative approach in trying to best understand why the child or young person had offended. We were especially pleased to find that the sentence plan produced at the beginning of the sentence met the needs of the child or young person in all inspected cases.

[1] Published October 2014 based on binary reoffending rates after 12 months for the January 2012 – December 2012 cohort. Source: Ministry of Justice

1.2. Pre-sentence reports (PSRs) are the primary instruments by which the sentencing court is advised about the reasons for the offending behaviour, and what interventions are required to bring about lasting change and achieve positive outcomes. The quality of all the reports we assessed was considered to be good. This meant that the core issues of offence analysis, risk of reoffending, safeguarding and vulnerability were addressed appropriately. Quality assurance systems were in place and these effectively picked out deficits before reports were submitted to the sentencing court.

1.3. Initial assessments were carried out well in almost all the inspected cases. Case managers had consistently made enquiries into the range of factors that could have contributed to the offending behaviour. This had enabled them to accumulate a great deal of knowledge about the child or young person.

1.4. It was disappointing to find that information obtained at the assessment stage had not been pulled through into some plans. We found that in some of the cases, plans were either not completed, objectives were not sequenced according to risk of harm, emotional or mental health issues were overlooked and there was an absence of focus on education, training and employment needs in some of the plans.

1.5. Reviews were not always carried out as required and this hindered an appropriate response to managing a change in circumstances. In one case there had been an escalation in the young person's use of violence but this did not trigger a review and the young person was later remanded in custody for a serious assault.

1.6. We were pleased to find a range of current intervention programmes to support the reduction of reoffending. The vast majority of these were delivered on a one-to-one basis and we saw evidence of their use in the case files.

2. Protecting the public

2.1. Overall, we were pleased to find that the majority of PSRs had a clear assessment of the risk of harm to others that were relevant to the case.

2.2. Assessments that provided explanations about the risk of harm posed by the child or young person were evidenced well in almost all the inspected cases. The accounts appropriately cited historical information and explained how these experiences and circumstances had impacted on current offending behaviours. In one case, the risk of harm classification was too low and insufficient account had been given to actual victims.

2.3. Planning to manage the risk of harm in custody and in the community posed by the child or young person was not done well in a third of the inspected cases. This was disappointing since case managers had been able to obtain considerable information from a variety of sources, but an absence of a forensic approach meant that key issues were often overlooked. We found that some plans had not been completed, a number of plans did not flow from the assessment, there were insufficient contingencies in place and work with victim issues was often not central. In one Multi-Agency Public Protection Arrangements (MAPPA) case, whilst a referral had been made, the recorded actions to manage the risk of harm were vague and did not cover all the needs of the case.

2.4. Oversight by managers was not effective in a third of the cases. Whilst there was evidence to demonstrate that managers had reviewed the work, deficiencies in assessments were not adequately addressed, clear oversight was not provided and actions taken were often not recorded.

2.5. Every case manager interviewed reported that they understood local policies and procedures for the management of risk of harm. However, we were not convinced that this was so for all case managers, especially those with MAPPA eligible cases.

3. Protecting the child or young person

3.1. Assessments relating to safeguarding and vulnerability were consistently carried out well in all the inspected cases. Factors in respect of emotional and mental health, alcohol misuse and living circumstances were assessed particularly well. This was a pleasing finding which demonstrated that there was a clear understanding of the centrality of safeguarding and vulnerability needs. It was equally satisfying to find these results reflected in the quality of vulnerability assessments provided in PSRs.

3.2. Planning and the reviewing of work to address safeguarding and vulnerability concerns were done less well. Again, information obtained during the assessment stage of the process was not always adequately utilised to inform plans. In a small number of cases, interventions and objectives to support the management of emotional and mental health issues were lacking. The Risk Review Meetings were a good addition to the process but the actions identified in these meetings were not consistently integrated into other plans. Often, reviews were not triggered by a change in circumstances which led to plans remaining the same.

3.3. Management oversight to ensure that safeguarding and vulnerability work was carried out was done, but was not effective in almost half of the cases. Deficiencies in assessment and planning were often not identified and it was not clear that the advice given by managers had been followed through.

3.4. We found several examples of good joint working with case managers and police staff based at the YJS. This ranged from joint home visits where safeguarding and vulnerability concerns had escalated, to the sharing of intelligence where a child or young person had gone missing.

4. Ensuring that the sentence is served

4.1. This is an area of strength in the YJS. Engagement with children and young people and significant others when preparing assessments and plans was good in almost every inspected case. In one particular example of a good assessment, the case manager had involved both parents who had separated and were living apart. This enabled the case manager to obtain a fuller picture of the range of issues which applied in the case. In addition, we saw a parenting screening tool being used in this case, which provided valuable information about how one of the parents felt about the child's offending behaviour and the impact that this had had on her. Critically, this was then used to inform the assessment and plan. Self-assessments by children and young people were largely carried out at the initial assessment and provided opportunities to explore what would work best to reduce reoffending and achieve positive outcomes.

4.2. Diversity factors and barriers to effective engagement were assessed well. We saw several examples where case managers had modified offending behaviour materials to suit the needs of the children and young people. One inspector commented, "*The case manager had carried out a thorough learning styles questionnaire - this identified that the young person was a visual learner. In her work to reduce reoffending she then used pictures as a tool to engage with him*".

4.3. It was disappointing to note that despite diversity factors having been identified at assessment, these did not appear in some plans. Again, these deficits were not always addressed by line managers.

4.4. Overall, the YJS gave appropriate attention to the health and well-being outcomes of almost all the children and young people in our sample, in so far as these presented as potential barriers to successful outcomes from the sentence.

4.5. Case managers had an informed understanding of local policies and procedures relating to enforcement and supporting effective engagement. This was evidenced in case managers taking appropriate compliance action in almost all the inspected cases where this was necessary.

Operational management

We interviewed seven case managers and all spoke positively about the quality of support and supervision they received from their operational managers, whom they considered to be suitably skilled and knowledgeable. However, we found that management oversight was effective in half of the cases. One case manager reported that in their opinion the organisation did not positively promote a culture of learning and development. Two case managers were dissatisfied with the lack of opportunities for their own future career development. All of the case managers interviewed had a good understanding of local policies and procedures and an informed knowledge of the principles of effective practice. Overall, staff were able to appropriately articulate the priorities of the organisation to us and thought they had received sufficient training to carry out their duties.

Key strengths

- Case managers had good knowledge about the children and young people whom they were supervising.
- Children and young people and their parents/carers were meaningfully engaged in the assessment and planning process.
- Initial assessments relating to safeguarding and vulnerability were done well.
- The quality of all the inspected Pre-sentence reports was good.

Areas requiring improvement

- Staff and operational managers should ensure that planning for work to reduce reoffending, protect the public and to safeguard children and young people is of sufficient quality and clear to children and young people and their parents/carers.
- Managers should provide greater support to staff to improve the quality of their plans and reviews, and ensure that their oversight of risk of harm and safeguarding work is consistently effective.

We are grateful for the support that we received from staff in the South Tyneside Youth Justice Service 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 at avtar.singh@hmiprobation.gsi.gov.uk or on 077969 48325.

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Note 1: 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.

Note 2: We gather evidence against the SQS criteria, which are available on the HMI Probation website - http://www.justiceinspectorates.gov.uk/hmiprobation.

Note 3: To request a paper copy of this report, please contact HMI Probation Communications at communications@hmiprobation.gsi.gov.uk or on 0161 240 5336.