Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

HM Inspectorate of Probation
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Dali Sidebottom
Chair of North Somerset Youth Offending & Prevention Service Management Board

19th December 2012

Dear Dali Sidebottom,

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

This report outlines the findings of the recent SQS inspection, conducted during 26th-28th November. 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 20 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, case managers were undertaking positive work, and were committed to their work with children and young people, and the local community. Services provided to the court were of a very high standard. Staff were good at involving children and young people and, where appropriate, parents/carers throughout the order. There were positive outcomes for children and young people as the result of multi-agency working. The quality of many initial assessments and some planning could be improved.

Commentary on the inspection in North Somerset:

1. Reducing the likelihood of reoffending

1.1. The initial assessment of the child or young person's likelihood of reoffending was found to be sufficient in only half of the cases sampled. Where we found gaps, the case manager had often provided unclear or insufficient evidence, either because they had failed to use information available from other workers, or because the assessment was

largely based on the contents of a previous assessment. Improvements were noted in the quality of assessments when they were later reviewed.

1.2. Pre-sentence reports (PSRs) were provided to the court in ten cases; all were of a good quality and in all cases there was evidence in the case file that reports had been quality assured before they were submitted to the court. All reports gave sufficient attention to appropriate alternatives to custody which were well argued. In one case, when the magistrates were considering sentencing a young person to a detention and training order (DTO), the case manager was able to argue in court for a more appropriate order that better met the needs of the case, as the young person was no longer associating with antisocial friends and was making good progress at school and home.

1.3. Plans to reduce the likelihood of reoffending were sufficient in the majority of cases, including those of children and young people sentenced to custody. A good example of planning for release from custody involved children's social care services, the school, the family, the young person and the YOS. A holistic release plan, with contingencies in case the planned return home failed, was put in place.

1.4. The vast majority of plans to reduce the likelihood of reoffending had been reviewed sufficiently well.

2. Protecting the public

2.1. In eight cases the assessment of risk of harm to others posed by the child or young person was insufficient. This was because the screening was of insufficient quality, relevant previous offences had been ignored or the assessment was unclear about the different risks that applied during the child or young person's time in custody and on release back into the community. For example, the assessment of a young person starting a long month DTO failed to take account of the fact that he was now in custody and would remain so for almost a year, and assessed accommodation as the main risk factor. The Risk of Serious Harm (RoSH) screening also incorrectly stated that the most recent offence was for the theft of a car, whereas it was a domestic burglary.

2.2. All ten PSRs contained clear and thorough assessment of the risk of harm to others.

2.3. The risk of harm to others posed by a child or young person often changes; it can be reduced as well as heightened. There are certain significant changes that are associated with an increase in risk of harm, for example increased substance misuse or reoffending. Reviews of risk of harm were often insufficient because they were simply a copy of previous assessments, and therefore contained information that was no longer relevant to the young person's current risk of harm to others.

2.4. There was sufficient planning to address issues of the risk of harm to others in 14 of the 19 relevant cases. We saw positive examples of joint working in complex cases where children and young people had mental health, education and substance misuse needs. However, in two of the five custody cases, there was insufficient planning to address the risk of harm in the custodial period. A risk management plan had not been completed in either case.

2.5. The vast majority of plans to address the risk of harm to others had been reviewed sufficiently well. In one particular case we found that the intervention plan was clearly linked to the risk management plan. As a result the interventions delivered had the desired outcome of reducing likelihood of reoffending and risk of harm, and reviews clearly recorded progress made.

2.6. Where there was an identifiable victim or potential victim, the risk of harm they faced had been effectively managed in almost all cases. Efforts had been made to contact victims and to seek their views in the majority of cases sampled. In many cases we found that

the victim or potential victim was related to the child or young person. The YOS had noticed a significant rise in domestic abuse where the parents/carers were the victim, and was in the process of introducing a programme to work with children and young people involved in this type of offending. We also saw good use of local Multi-Agency Risk Assessment Conference.

2.7. Management oversight of risk of harm work was ineffective in 8 out of 18 relevant cases; assessments and plans that the inspection team judged insufficient had been countersigned by the manager without addressing clear quality issues.

3. Protecting the child or young person

3.1. In the vast majority of cases there was a sufficient assessment of vulnerability and safeguarding that was reflected in PSRs. In five cases the initial assessment of safeguarding and vulnerability was insufficient, due either to the quality of the screening or the assessment not taking place. In two custody cases the assessments were unclear about the risks that applied separately during the custodial and community parts of the sentence. Reviews of safeguarding and vulnerability throughout the sentence were of a similar standard. In three cases this was due to the review simply being a copy of the initial assessment and not taking account of changes in the child or young person's current circumstances. Other reviews were insufficient as they had not taken place as required, when there was a significant change in the child or young person's circumstances; such as a further conviction or release from custody.

3.2. In five cases insufficient planning had taken place to enable safeguarding and vulnerability issues to be addressed effectively either because vulnerability management plans had not been completed, or because barriers to engagement had not been considered sufficiently. However, plans were often improved following review. In some cases where there was multi-agency involvement it was difficult to see which plan the case manager was working to. One case had a YOS vulnerability management plan, an action plan from the YOS risk management planning meeting, and the Children's Services' safeguarding plan. This will have been confusing for the young person concerned.

3.3. Management oversight of this area of work was not effective in one-third of cases because deficiencies in assessment and planning had not been addressed.

4. Ensuring that the sentence is served

4.1. Attention had been paid to assessing the child or young person's diverse needs and any barriers to engagement in the vast majority of cases. This included attention to the child or young person's health and well-being. An example of this work was the case of Tina (not her real name), who had both learning and communication difficulties. The case manager had undertaken a learning style questionnaire with Tina, and another worker had looked at her communication skills. This had enabled workers to plan their work to meet Tina's assessed needs, in particular interventions were delivered; for example, Tina communicated mainly through social networks, so the case manager helped her to say how she was feeling by playing tunes on her iPod.

4.2. There was evidence of excellent involvement of the child or young person and their parents/carers in the assessment and planning of interventions. For example, one case manager arranged telephone reminders to the young person and text reminders to his mother two hours before each appointment. This resulted in an improvement in compliance and greater involvement of the parent in motivating her son.

4.3. In three-quarters of the cases we reviewed, sufficient attention had been given to the health and well-being of the child or young person. We saw a number of cases where the child or young person was believed by the case manager to have a learning difficulty, but

workers had difficulties gaining professional assessments or help from the Child and Adolescent Mental Health Service (CAMHS). The YOS management team believed the main problem was children and young peoples' reluctance to engage with CAMHS, as a result of their chaotic lifestyle: not keeping appointments, not arriving on time, not arriving for appointments or arriving under the influence of alcohol/drugs; or refusal to accept that they needed help and support. A specialist mental health worker was available within the YOS but we found little evidence of her involvement in the cases inspected.

4.4. Two-thirds of the children and young people complied with the requirements of their sentence and where they did not fully comply, the response of the YOS was sufficient in all cases.

4.5. In North Somerset YOS we found continuity of case management and good use of multi-agency working within the YOS and the wider children and young people's service. Effective practice emphasises the importance of the quality of the relationship between the case manager and the child or young person. Developing this working relationship takes time but the benefit is that positive change is more likely. There was clear evidence of positive outcomes for children and young people as the result of multi-agency working and the use of effective practice by professionally qualified workers across the YOS.

Operational management

The YOS Management Board had worked hard to ensure that the YOS remained a multi-agency service, within the Youth Offending & Prevention Service structure. Employing qualified staff from all partners had contributed to the quality of service and successful outcomes we saw during this inspection.

The majority of the staff we interviewed had a sufficient understanding of effective practice, and local policies and procedures for the management of risk, safeguarding and responding to non-compliance. Most understood the priorities of the organisation. Not all staff felt they received support or effective and appropriate supervision. Countersigning/management oversight was not viewed as an effective process.

The last inspection, in 2010, identified management oversight as a concern. We found evidence of management oversight in almost every case. The quantity of management oversight had increased but there was room for considerable improvement in the quality or effectiveness of that oversight.

Outstanding strengths

The following were particular strengths:

- services provided to the courts and in particular PSRs were of a very high standard,
- assessments of diversity factors and barriers to engagement. This had been aided by the introduction of learning style questionnaires and more recently communication skills screening tools,
- good levels of compliance and where needed effective enforcement of court orders,
- the engagement of children and young people and parents/carers in carrying out initial assessments and planning,
- positive outcomes for children and young people as the result of multi-agency working.

Areas requiring improvement

The most significant areas for improvement were:

i. the assessment of the likelihood of re-offending (which in many cases lacked clear or sufficient information),

ii. the assessment of risk of harm to others (which was due to insufficient quality of screening and failure to take account of relevant offences),

iii. the quality of management oversight of risk of harm to others and vulnerability.

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 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 Les Smith. He can be contacted on 07798 607 828 or by email at les.smith@hmiprobation.gsi.gov.uk.

Yours sincerely,

Julie Fox
HM Assistant Chief Inspector of Probation

Copy to:
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Graham Turner, Chief Executive Officer, North Somerset Council
Sheila Smith, Director of Children & Young People's Services, North Somerset Council
Councillor Jeremy Blatchford, Executive member for Children's Services
Councillor Felicity Baker, Executive member for Community and Corporate portfolio
Pauline Kinton, Business Area Manager YJB
YJB link staff with HMI Probation
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