Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

HM Inspectorate of Probation
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Neil Pocklington
Chair of Management Board
South Tees Youth Offending Service

20th February 2013

Dear Neil Pocklington,

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

This report outlines the findings of the recent SQS inspection, conducted during 28th-30th January 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 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 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

South Tees Youth Offending Service covered the Middlesbrough and Redcar & Cleveland local authorities. It managed a caseload that was often complex. Case managers were passionate about their work and had been kept well involved during a recent YOS restructuring. Differences in staff understanding of vulnerability led to inconsistency in this aspect of work. The opportunity to bring relevant factors together to form robust assessments was often missed. This reduced the quality of work to protect the public and to address vulnerability of children and young people. Engagement with children and young people and response to non-compliance were both strong.

Commentary on the inspection in South Tees:

1. Reducing the likelihood of reoffending

1.1. Many initial assessments demonstrated a strong investigative approach from case managers, with evidence of information from one source being checked against others. An example was the use of YOS police staff to confirm information. However, only half the assessments were good enough. In some cases the assessments were not timely to meet the needs of the case. Offending related vulnerability, including substance misuse and emotional or mental health, had not been identified in a significant proportion of cases.

1.2. Two-thirds of pre-sentence reports (PSR) met the required standard, providing the court with good advice to inform sentencing. All PSRs provided sufficient analysis of the likelihood of reoffending, and an appropriate proposal. Where the PSR was not good enough it was because the assessment of risk of harm to others and/or vulnerability was not sufficiently clear. In one good example the vulnerability assessment led to an appropriate proposal for a Parenting Order which, when combined with the support provided by the YOS, led to significantly improved outcomes for the child or young person. Comments from sentencers and other information about the engagement of the child or young person, or their parent/carers, at court were often absent from the case record.

1.3. When reviews of assessments were undertaken they met the needs of the case. However, case managers often did not recognise when significant changes to circumstances should have triggered a review. An example of this was where a change of living arrangements was a significant factor in the likelihood of reoffending. In particular there was insufficient review following the start of the sentence, where the initial assessment was undertaken to inform a PSR, and following custodial planning meetings.

1.4. These assessment shortcomings inevitably meant that only half the initial plans were sufficient, often because there was insufficient planning to address substance misuse, emotional or mental health and other vulnerability factors that were linked to the likelihood of reoffending. In custodial cases the most significant area for improvement was the need for plans to reflect the whole sentence and not just the custodial period.

1.5. We considered that case managers who we met had a sufficient understanding of the principles of effective practice with children and young people who have offended, and adopted a positive case management approach to their work. These provide a solid basis on which to further develop work to reduce the likelihood of reoffending.

2. Protecting the public

2.1. Overall work to protect the public was inconsistent and required improvement, particularly in Middlesbrough. Assessment of risk of harm to others was sufficient in only one-third of cases. The main cause was in the screening, where insufficient use was made of the opportunity to bring together all of the harm related behaviour and previous offences to inform a robust and defensible assessment. As a consequence, a full assessment was not always undertaken in cases where this was required.

2.2. These shortcomings carried through into reviews of risk of harm to others and were compounded by case managers sometimes not recognising when changes in circumstances should have led to a review.

2.3. Largely as a consequence of these problems, planning to manage risk of harm to others was sufficient in only half the cases where it was required. In addition contingency plans needed improvement and planning to manage risk of harm to others following release

from custody needed to begin earlier in the sentence. Plans should be reviewed more often, in line with the planned review period and following changes in circumstances.

2.4. There was insufficient evidence that the risk of harm to identifiable actual or potential victims had been managed well. There needed to be clearer planning to protect identified victims and sometimes the risk of harm to them was not clearly recognised in assessments.

2.5. We were pleased to find evidence of frequent management oversight of cases. However, this was not effective in ensuring the quality of work in almost half the cases where it was required. Even though assessments and plans were countersigned, important deficiencies in them had sometimes not been addressed. Case managers indicated that managers returned assessments and plans for amendments to be made before they would be countersigned. Therefore there must be some question about the precise approach that some managers adopted when doing this. For example, in one case where the sentence was for offences including robbery, we found reference in the assessments post sentence that the child or young person was pleading not guilty and therefore these offences could not be assessed yet – and this had not been addressed before the assessments were accepted as sufficient, and countersigned.

3. Protecting the child or young person

3.1. Work to reduce vulnerability of children and young people was the weakest area of work in South Tees YOS. The YOS had developed helpful guidance on indicators of vulnerability that took a holistic approach and recognised a range of vulnerability factors. Many staff did not follow this and instead adopted a narrow approach that focussed primarily on child protection and did not reflect broader expectations about reducing vulnerability. This confusion was further illustrated by a case in which a manager providing oversight also misunderstood the circumstances in which vulnerability required an explicit plan for its management. In our view a broad approach should be taken to this work that focuses on the needs of the child or young person however these may arise.

3.2. Assessment of vulnerability and safeguarding was not sufficient in over half the cases, reviews needed to be improved in almost half the cases and planning was sufficient in only a quarter of cases, usually because a clear plan had not been developed when one was needed. The initial screening was often not used as an opportunity to pull all of the relevant indicators together to inform a robust defensible assessment.

3.3. We were encouraged that, in those cases where the initial assessment was sufficient and vulnerability or safeguarding needs had been identified, the work was generally stronger. We found examples of good multi-agency working, which was reflected in the planning, to manage identified needs. Nevertheless, staff sometimes needed to be more alert to the need for a review following significant changes, and to ensure that plans were reviewed regularly. Contingency plans needed to be more robust and potential changes needed to be anticipated wherever possible. A good example where potential changes were foreseen was when a case manager anticipated that a young person would have particular difficulty coping over Christmas, and put in place a specific management plan and support strategy to cover this period. More attention was needed to ensure that vulnerability needs that would apply in the community were not lost sight of in the planning for custodial sentences.

3.4. Identical comments apply to the effectiveness of management oversight of safeguarding and vulnerability needs, as applied to oversight of work to manage risk of harm to others. While there was much evidence of oversight in the case record it often did not ensure that important deficiencies were addressed. In addition there was no oversight in some cases where positive use of other information or information systems, such as the

involvement of children's social care services or indicators having been recognised in a screening, may have identified the need for a manager to become involved.

3.5. Purposeful use was made of home visits to inform assessments and, where concerns had been identified, to monitor the situation. In one example increased home visits were used effectively to improve engagement of the young person and their family with the YOS.

4. Ensuring that the sentence is served

4.1. Work to ensure that the sentence was served as the court intended it, and to ensure that children and young and their parents/carers were well engaged, was strong.

4.2. Assessment of diversity factors and barriers to engagement was sufficient in over three-quarters of cases, although in a few the needs of girls or young women were missed.

4.3. The child or young person and their parent/carer were sufficiently engaged in initial assessments and in the development of PSRs. We were encouraged that almost all assessments included an interview with the child or young person that was carried out without a parent or carer being present, providing them the opportunity to say what they felt without concern for how their parent/carer might respond.

4.4. Almost all PSRs, and two-thirds of plans, gave sufficient attention to diversity factors and barriers to engagement. While the inspected case sample did not include children or young people from a black or minority ethnic background, the YOS provided evidence from other cases of how they had responded appropriately to their needs.

4.5. The language used in many plans was not accessible to children or young people – i.e. making it clear to them what they needed to do differently. More children and young people needed to be actively involved in development of their plan.

4.6. In the great majority of cases staff gave sufficient attention to health and well-being, where they may act as a barrier to successful outcomes from the sentence; for example through providing support to access a general practitioner or other medical help.

4.7. Children and young people had complied with their sentence in almost half the cases. When they did not comply then appropriate action was taken in most cases, sometimes leading to improved engagement or to enforcement proceedings.

Operational management

Case managers spoke positively about their understanding of YOS priorities, and in particular about the way managers had sought to engage with them through recent restructuring. Staff valued the open-plan aspect of some accommodation, which led to improved case discussions with colleagues. Some staff, who were regarded as 'unqualified' were concerned about barriers to their progress. Staff spoke positively about the YOS approach to ensuring that ongoing training and skills development needs were met. But less than half considered that they had received sufficient training to enable them to recognise and respond to speech, language and communication needs; and some who had training did not consider that they had access to appropriate screening tools.

Outstanding strengths

The following were outstanding strengths:

- The investigative approach often adopted when undertaking assessments, ensuring that information was checked or followed up.
- PSRs provided the courts with good information about the child or young person and their likelihood of reoffending, to inform sentencing decisions.

- Positive engagement with children and young people and their parents/carers helped to ensure that children and young people understood why they were working with the YOS, and were motivated to work with YOS staff to address their offending behaviour.
- Non-compliance with the requirements of sentence was dealt with well, sometimes leading to improvements in compliance and in appropriate cases leading to enforcement proceedings.

Areas requiring improvement

The most significant areas for improvement were:

i. to ensure a consistent understanding amongst both case workers and managers of vulnerability, leading to improvements in its management and adherence to YOS guidance;

ii. assessment of risk of harm to others and vulnerability both need to be improved, with specific attention given to the initial screening, taking account of all relevant indicators and behaviours; with good quality full assessments undertaken and robust management plans developed in appropriate cases;

iii. oversight provided by managers needs to be effective in ensuring the quality of work to reduce vulnerability and manage risk of harm to others, including ensuring that significant deficits are addressed before work is accepted as sufficient;

iv. reviews of assessments and plans need to be undertaken more often following significant changes in circumstances.

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 Ian Menary. He can be contacted on 07917 183197 or by email at ian.menary@hmiprobation.gsi.gov.uk.

Yours sincerely,

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HM Assistant Chief Inspector of Probation

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