Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

HM Inspectorate of Probation
6th Floor, Trafford House, Chester Road, Stretford, Manchester M32 0RS
0161 869 1300 www.justice.gov.uk/about/hmi-probation

To:	Julia Hassall, Chair of Wirral YOS Management Board
Copy to:	See copy list at end
From:	Julie Fox, Assistant Chief Inspector
Publication date:	30th October 2013

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

This report outlines the findings of the recent SQS inspection, conducted during 30th September - 2nd October 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 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 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 Wirral 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

Overall, we found a very positive picture in Wirral YOS. The previous inspection had taken place just over four years ago and at that point in time substantial improvement was required in all areas of work. It was pleasing to see that significant progress had been made. Staff were well supported and committed. They produced good quality reports, assessments and plans and had access to a range of services. There was still scope for further improving the quality of work by ensuring risk and vulnerability plans were more specific and linked to decisions made in other meetings.

Commentary on the inspection in Wirral:

1. Reducing the likelihood of reoffending

1.1. In all but two cases we found that good quality pre-sentence reports (PSRs) were provided to the court. In one case the report was commended by the court. One inspector

noted: "*This case contained a very thorough PSR, which provided a good biographical account of the young person, leading to a detailed assessment of the risk of harm posed, as well as the vulnerability issues"*. In another case we noted: "*The PSR was of a good quality and identified and analysed the triggers for offending, the likelihood of reoffending and the risk of harm he posed. The proposal was appropriate and well argued. The case manager was in court to argue the case as was a support worker who delivered Multisystemic Therapy"*. Management oversight of the quality of reports was effective.

1.2. Almost all initial assessments of what was likely to make a child or young person offend were on time and of a good enough quality. We noted: "*The panel report and initial assessment was based on relevant and verified information from sources such as social care, education, health and police. In particular, the case manager had obtained a copy of a psychology assessment which assessed the learning difficulties and IQ of the young person - which was on file"*.

1.3. Experiences of children and young people are dynamic and can change quite quickly. As a result, assessments need to be reviewed, and should include a descriptive and analytical component. The great majority of the reviewed assessments we looked at were completed well enough. However, there were several reviews that were a copy of a previous assessment, with insufficient update or historical information which did not reflect the current circumstances of the child or young person.

1.4. Following on from assessment, we expect to see a plan of work to help reduce the likelihood of reoffending. Almost all plans were of a sufficient standard and more than three-quarters were reviewed well enough. In one case we noted: "*The intervention plan was detailed and contained objectives that were consistent with the issues that were identified in the assessment. Informed also by information obtained from the 'What do YOU think' self assessment completed by the child or young person, the objectives were framed in a manner which was child or young person friendly"*.

1.5. Where the child or young person was serving a custodial sentence, we found sufficient planning during the custodial phase of the sentence to reduce the likelihood of reoffending in all six cases.

2. Protecting the public

2.1. There was a clear and thorough assessment of risk of harm to others in 15 out of 19 cases where there had been a PSR.

2.2. A good quality assessment of risk of harm to others was seen in 25 out of 31 cases. There were three cases where previous violent offences had not been taken into account. Assessments of risk of harm were adequately reviewed in the great majority of cases. Two reviews were copies of earlier assessments that had not been updated to reflect what had recently happened in the child or young person's life.

2.3. Where a child or young person may pose a risk of harm to others, we expect to see a plan to minimise the likelihood of this happening. In 20 out of 25 cases, planning was done well enough to manage risk of harm. This applied to all of the custodial cases. Where plans were insufficient, this was mainly because potential changes in risk of harm were not anticipated and the planned response to any increase in risk of harm was reactive (review risk of harm and/or discuss the case in a meeting). It was also unclear why, how and when information about the child or young person would be shared between other agencies (for example the Anti-Social Behaviour Team or the police) and the case manager to manage risk of harm effectively.

2.4. In most cases, plans to address the risk of harm to others had been reviewed sufficiently well.

2.5. Where there was an identifiable victim or potential victim, the risk of harm they faced had been effectively managed in the great majority of cases. Where it had not been effectively managed it was mainly due to insufficient planning.

2.6. Management oversight of risk of harm work was effective in half of the relevant cases. There were important deficiencies in assessment and planning that had not been addressed.

3. Protecting the child or young person

3.1. In almost three-quarters of cases, vulnerability and safeguarding needs were sufficiently assessed and these components were fully addressed in all but four PSRs. In a number of cases we felt that vulnerability had been underestimated. This was mainly because relevant factors had not been taken into account or a narrow view of vulnerability was applied. One inspector noted: "*A medium vulnerability classification would have been more appropriate than low at the start of the order given that the young person has autism, ADHD, SEN and had only just moved to live with his Dad and was missing his Mum*". In six cases we concluded that the vulnerability classification was inaccurate.

3.2. The great majority of reviews of safeguarding and vulnerability throughout the sentence were an acceptable standard. In two cases we felt that a review should have been completed after a significant change and two reviews had not been sufficiently updated.

3.3. In 20 out of 27 cases planning for work to manage and reduce vulnerability was adequate. We considered a vulnerability management plan should have been produced in five cases in the community and in two cases when the child or young person was in custody. In two cases it was unclear how the plan linked to other plans and actions from relevant meetings.

3.4. In almost three-quarters of the cases we examined, there were sufficient reviews throughout the sentence to address safeguarding and vulnerability needs.

3.5. In 11 out of 24 cases management oversight was effective in ensuring the quality of work to address safeguarding and vulnerability. There was evidence of management oversight taking place in meetings and in one case it was noted: "*The case manager felt appropriately supported by their line manager to challenge decisions by social care via the risk and vulnerability meetings at the YOS".* More attention was required to ensure that deficiencies in assessment and, in particular planning were addressed.

4. Ensuring that the sentence is served

4.1. The great majority of assessments of diversity factors and barriers to engagement were sufficient. It was noted in one case: *"The young person had previously been assessed by educational psychology and found to have a very low IQ. The case manager made sure that all work undertaken was discussion-based and recognised their preferred learning style. There was good shared and joint working with the foster carer, social care and reparation staff alongside contributions to LAC reviews. Actions from these meetings were reflected within the intervention plan, VMP and the daily work undertaken with the young person. The young person had also been linked in with a specialist careers support worker who was employed by an organisation who specifically worked with individuals with learning difficulties. This work was due to continue well beyond the end of their court order, in conjunction with the support that would be provided by the Leaving Care (Pathways) team until the young person was 21*".

4.2. Sufficient attention had been given to diversity factors and barriers to engagement in all PSRs. We noted: "*Very good assessment of barriers to engagement in the PSR, which detailed the impact of asperger's syndrome and autism of the young person but also linked these to the likelihood of reoffending and risk of serious harm. Well argued proposal in the report which identified a robust plan for intervention*".

4.3. In almost all cases there was sufficient engagement with the child or young person and parents/carers to carry out assessments and plans. One inspector noted: "*There was evidence that the parents and young person were involved with the assessment. The parents and young person had completed a self assessment form and both documents were quoted in every section of the Asset where relevant*". The child or young person or parent/carer were involved in the preparation of every PSR.

4.4. Whilst we found attention was being paid in most plans to diversity factors and potential barriers to engagement, it was not always considered or explored in relation to Looked After Children and girls and young women.

4.5. In almost all cases we reviewed, where relevant, sufficient attention had been given to the health and well-being of the child or young person.

4.6. Twenty-six children or young people had complied with the requirements of their sentence. In all cases where the child or young person had not complied, the response of the YOS was sufficient.

Operational management

Three-quarters of the staff we interviewed described countersigning and management oversight of risk of harm and safeguarding work as an effective process. However, we judged that staff supervision and quality assurance arrangements had made a positive impact in less than half of the cases inspected. The inspection team found that there was more evidence of accountability and effective management oversight through the quality assurance process than in supervision.

The great majority of staff said that they received appropriate and effective supervision and their line manager had the skills and knowledge to help them improve the quality of their work. Fewer staff thought managers were able to assess the quality of their work, but all staff felt supported by them. Staff reported that they received training and skills development to enable them to do their current job and deliver interventions, but fewer felt that their future development needs were met. Several staff said that they would like more training to improve their ability to recognise speech, language and communication needs of children and young people. We found that all staff were aware of local polices and procedures that related to compliance. The majority had knowledge of procedures about vulnerability and risk of harm and how the principles of effective practice applied in their work with children and young people.

Key strengths

The best aspects of work that we found in Wirral included:

- the quality of PSRs prepared for the courts
- the engagement of children and young people and parents/carers in assessments
- the use of a wide range of sources to inform and verify assessments
- the attention paid to encouraging and achieving compliance. Different tactics were employed, and mostly these were successful. Enforcement was used only as a last resort
- the assessment and consideration of diversity factors
- there were several examples of positive initial outcomes for children or young people.

Areas requiring improvement

The most significant areas for improvement were:

i. planning for work to manage risk of harm to others and reduce vulnerability

ii. management oversight of the quality of assessments and plans.

We strongly recommend that you focus your post-inspection improvement work on these 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 Nigel Scarff. He can be contacted on 07766 422290 or by email at nigel.scarff@hmiprobation.gsi.gov.uk.

Copy to:

YOS Manager	*Steve Pimblett*
Local Authority Chief Executive	*Graham Burgess*
Director of Children's Services	*Julia Hassall*
Lead Elected Member for Children's Services	*Tony Smith*
Lead Elected Member for Crime	*George Davies*
Police and Crime Commissioner for Merseyside	*Jane Kennedy*
Chair of Local Safeguarding Board	*Julia Hassall*
Chair of Youth Court Bench	*Ruth Shaw*
YJB Business Area Manager	*Liza Dirkin*
YJB link staff	*Malcolm Potter, Paula Williams, Alaina Tolhurst*
Ofsted – Further Education and Learning	*Sheila Willis*
Ofsted – Social Care	*Debbie Jones, Matthew Brazier, Carolyn Adcock*
Care Quality Commission	*Fergus Currie, Daniel Carrick*
HM Inspectorate of Constabulary	*Paul Eveleigh, Rob Bowles*

Note: to request a print out of this report, please contact HMI Probation Publications publications@hmiprobation.gsi.gov.uk, 0161 869 1300