Inspection of
Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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To:	John Gregg, Interim Chair of Suffolk Youth Offending Service 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 Suffolk

This report outlines the findings of the recent SQS inspection, conducted from 10th–12th March 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 33 cases supervised by Suffolk 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 - http://www.justice.gov.uk/about/hmi-probation.

Summary

Overall, we found a committed staff group working imaginatively and enthusiastically with children and young people in Suffolk so as to promote their engagement with court orders. Staff carefully researched the backgrounds of children and young people to help inform their assessments. In turn, they made good use of this information to develop effective initial plans to manage risk of harm to others and vulnerability. However, intervention plans designed to reduce the likelihood of reoffending were less effective. Planned work was not always reviewed thoroughly, particularly in response to significant changes in the child or young person's circumstances; this deficiency was not consistently picked up by managers. Where children and young people failed to comply with their orders, the response from the YOS was exemplary.

Commentary on the inspection in Suffolk:

1. Reducing the likelihood of reoffending

1.1. The initial assessment of the child or young person's likelihood of reoffending was sufficient in all but four of the cases sampled. The vast majority of these assessments were thoroughly researched, well analysed and covered the child or young person's perspective about reasons for their offending. This area of work had improved compared with our previous inspection in 2012.

1.2. New pre-sentence reports (PSRs) were provided to the court in 15 cases, all but two of which were of a good standard, demonstrating effective local management arrangements for ensuring the quality of these reports. The six referral order reports we examined were less consistent, with two lacking clarity about the risk of harm the child or young person posed to others and one being insufficiently concise or analytical.

1.3. The YOS made good use of a 'Court Update Form'; an addendum to a PSR where the original information was still accurate. The update, presented verbally by the case manager where possible, included details of progress, concerns, any requests from victims and a recommendation. Through this efficient means, comprehensive and consistent information was provided to sentencers.

1.4. Plans to reduce the likelihood of reoffending were unsatisfactory in 10 out of the 33 cases. Objectives were not always clear or sufficiently focused on the desired outcome. This potentially made it difficult for the child or young person to understand what was required of them and for the case manager to accurately measure progress against the objectives. Planning throughout the custodial phase was insufficient in two out of the six relevant cases; in one case the custodial plan was not done and in the other it did not fully reflect the case manager's assessment.

1.5. Less than half of all plans to reduce the likelihood of reoffending had been reviewed sufficiently well; in some cases reviews were required but not conducted, while in others the plan was either reviewed late or with insufficient modification.

2. Protecting the public

2.1. In all but two relevant cases the assessment of risk of harm to others posed by the child or young person was sufficient. This finding showed a marked improvement on the last inspection. Good use was made of police colleagues to access intelligence to help inform assessments of risk of harm, with case managers being alert to the need to take other behaviour into account, as well as formal convictions.

2.2. There was sufficient initial planning to address the risk of harm to others in 26 out of the 29 cases where this was an issue. Again, this was a significant improvement compared with the last inspection. We saw many positive examples of joint working in complex cases where children and young people had accommodation, educational, mental health or substance misuse needs. In all but one of the five custodial cases where this was relevant, planning to address the risk of harm to others was satisfactory.

2.3. Reviewing assessments of, and plans to manage, risk of harm to others was less of a strength. Fewer than half of all risk management plans had been sufficiently reviewed; some were not done when required and others were late or made insufficient adjustment to planned work. Similarly, assessments of risk of harm were not always reviewed effectively when required, particularly in response to changing circumstances. This had been identified as an area for improvement during the last inspection.

2.4. Where there was an identifiable victim or potential victim, the risk of harm they faced had been effectively managed in three-quarters of all relevant cases.

2.5. Management oversight of risk of harm work was evident in the vast majority of cases; however, we considered that this was effective in just half of the 28 relevant cases. Although the monthly multi-agency risk forum provided clear guidance on a number of cases, on others, assessments and plans that we considered insufficient had been countersigned by the manager without addressing weaknesses. We understood that the YOS had plans to review the forum, with a view to providing a clearer strategic focus for individual cases together with consistency across the YOS, which was welcome news.

2.6. All 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. In most relevant cases, the initial assessment of safeguarding and vulnerability was sufficient. Similarly, in all but two relevant cases details of the child or young person's vulnerability were reflected in the PSR. However, in seven cases the initial vulnerability assessment was insufficient for a range of reasons, including the quality or timeliness of the screening, the accuracy of the vulnerability classification, or the assessment not taking place. In one case there had not been enough liaison with Children's Services, which was surprising, given the ready access that case managers had to the local authority's social care database.

3.2. Reviews of safeguarding and vulnerability assessments throughout the sentence were sufficient in 14 out of 24 relevant cases. The most frequent cause of such reviews being deficient was their not having taken place as required, including when a significant change in the child or young person's circumstances occurred such as a move of accommodation or a further conviction.

3.3. Satisfactory initial plans were in place to manage vulnerability in most relevant cases. Where gaps arose (in six cases), these were primarily because a plan had not been put in place or because the planned response was insufficient. Those managing girls and young women were particularly alert to the possibility of sexual exploitation. An inspector noted: "*Tracey's case manager suspected that her unkempt and introverted presentation might be rooted in sexual abuse; as a result, she was working very closely with colleagues from both children's services and the police to build a clearer picture of the risks to both Tracey and her sister, in support of plans to manage these vulnerabilities*".

3.4. Effective planning was in place to manage vulnerability within the custodial setting in all six cases, which was pleasing to note.

3.5. However, more attention needed to be given to the reviewing of vulnerability plans; just under half of these (13 out of 27) were sufficiently reviewed. Too many were either not reviewed, or planned actions were not revised in line with the needs of the child or young person.

3.6. As with planning to manage risk of harm to others, management oversight of vulnerability and safeguarding work, although generally evident, needed to improve. It was effective in 15 out of 25 relevant cases. This was primarily because deficiencies in either plans or, to a lesser extent, assessments of vulnerability were not addressed. The YOS had suffered a higher than normal level of long-term sick absence among managers during 2013, which undoubtedly impacted on the quality of oversight given to case managers during the period from which the case sample was drawn.

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 majority of cases, although such assessments were not always overtly taken into account within plans. Attention was paid to the child or young person's health and well-being in all but four cases. Case managers made good use of the self-assessment questionnaire (*What do YOU think?*) and were skilled at tailoring their approaches to suit the needs of the individual. In one case, the inspector commented: "*The case manager had been struggling to motivate Ben to engage. He therefore decided to run the initial planning meeting as a baking session. Ben was relaxed and fully engaged in the activity, speaking openly with the case manager while enjoying the practical task. This creative approach not only helped the case manager glean sufficient information to complete the intervention plan, but significantly contributed to establishing an open and purposeful working relationship between the two. Ben's self-esteem was also raised through being able to take the cakes home to his family*".

4.2. The child or young person and their parents/carers had been involved with the development of the PSR in all but two cases, and with the assessment and plan in all but four cases. Staff approached the challenge of engaging the child or young person with enthusiasm.

4.3. More than half of children and young people cooperated with the requirements of their sentence, some after initial difficulties. Where they did not fully comply, the response from the YOS was satisfactory in every case. All staff interviewed were felt to have a thorough understanding of local policies and procedures for engaging children and young people and for responding to non-compliance where it occurred. It was evident that case managers managed to strike the delicate balance between welfare and enforcement with skill and sensitivity.

Operational management

We found that staff appreciated the recent creation of a regular forum, in which they could meet directly with the YOS Manager to hear about forthcoming changes and air their views. Staff were very positive about the quality of their supervision by managers, with only two interviewees suggesting this was less than fully effective. Similarly, most felt that their training and skills development needs were met to do their current job, for their future development and to enable them to deliver interventions. We made judgements about whether staff supervision was making a positive difference to the quality of work; we felt it did in less than two-thirds of relevant cases, which left room for improvement.

Key strengths

- Partnership working was effective as illustrated in the following case: "*After a number of unsuccessful placements, Paul was placed in supported accommodation by Children's Services. Although having learning difficulties and Oppositional Defiant Disorder, Paul flourished in his new surroundings with the support of his case manager and the care provider's key worker. Convicted of sexual offences, Paul had recently been accused of sending offensive messages by text. Working with the police, the case manager suggested that Paul could be given the opportunity of a community resolution. She broached the subject of the offensive messages through the key worker in the first instance then followed it up with a direct challenge to Paul. Whereas historically, he might have reacted aggressively to such a challenge, Paul responded reflectively and appeared to learn from this. This outcome was reported back to the police who were happy with the resolution*".
- Although the focus of this inspection was on initial assessment and planning, we found many instances of creative interventions being initiated promptly at the start of the order. These

included one innovative approach where the case manager used teenage fiction as a vehicle for increasing empathy with other people's points of view, through exploring the perspective of the characters in the novel. This approach also had the 'by-product' of improving literacy.

Areas requiring improvement

- Plans to address the likelihood of reoffending should focus on desired outcomes and include objectives that are easy for the child to understand and against which the case manager can readily measure progress.
- Management oversight should be improved in order to ensure that assessments and plans are reviewed when required, particularly in response to significant change.

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 Helen Rinaldi. She can be contacted at helen.rinaldi@hmiprobation.gsi.gov.uk or on 07717 361639.

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