Inspection of Youth Offending Work
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To:	Stuart Gallimore, Chair of West Sussex YOS 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 West Sussex

This report outlines the findings of the recent SQS inspection, conducted from 31st March – 2nd April 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 34 cases supervised by West Sussex 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

We were pleased to see encouraging improvements in the work of the YOS in West Sussex since our last inspection in 2011. Staff were well trained, experienced and confident in their roles, and told us they felt supported by their managers. We saw positive working relationships with children and young people and their parents/carers, and good liaison with a range of partner agencies. Compliance with orders was very good. We found that thresholds for assessing risk of harm and vulnerability were sometimes too low and there was scope for further improvement in the written assessments and planning to manage risk of harm and vulnerability. Case managers did recognise a variety of issues that made children and young people vulnerable and ensured that they were given appropriate protection.

Commentary on the inspection in West Sussex:

1. Reducing the likelihood of reoffending

1.1. Pre-sentence reports were requested and provided to the court in ten of the cases we looked at, and all except one were of good quality.

1.2. In just over two-thirds of relevant cases we found a sufficient and timely initial assessment of factors which influence offending. Most staff had recently received training in how to structure the evidence they recorded on their assessments. Where this technique had been used we found that assessments were clear and analytical. Where assessments were not good enough, this was because key information had not been considered in seven cases, previous assessments had not been updated in two, and in one case no assessment had been done.

1.3. In one case an inspector wrote: *"The report and assessment in this case thoroughly assessed the complex needs of this young person. Risk of harm to others and vulnerability were assessed and planned for and the report provided the court with a detailed understanding of how best to deal with this young person. A comprehensive package was put in place to protect and rehabilitate him"*.

1.4. Assessments need to be reviewed so that they remain relevant to the quickly changing circumstances of children and young people. In over half of the assessments that should have been reviewed, this had been done well enough. There were four cases where routine reviews had not been completed, and five where significant changes in the circumstances of the child or young person had not triggered a review.

1.5. Following on from the assessment, we expect to see a plan of work to order and coordinate the delivery of interventions, thus maximising the likelihood of reducing reoffending. This was in place, and of sufficient quality, in all except five of the cases where it was needed. Plans could be improved by giving greater attention to victims, and by focusing more clearly on factors directly linked to offending. We saw some plans that were comprehensive and written creatively, but others where objectives were not set out in ways that would have been clear and meaningful to the child or young person.

1.6. We found that case managers were skilled and confident in recognising a range of diversity issues. In one case we found: "*The intervention plan clearly identified that Richard had Attention Deficit Hyperactivity Disorder (ADHD) and therefore his engagement and concentration during sessions could be limited. The case manager identified that in order to manage this the sessions needed to be interactive and broken down into small achievable steps. There was also a recommendation that Richard be permitted frequent breaks as necessary in order to try and maximise engagement*".

2. Protecting the public

2.1. We look for a detailed assessment of the risk of harm a child or young person poses to others. In 14 cases, we found that this had not been done well enough, and in seven cases we considered that the risk of serious harm classification was too low. Greater analysis of all violent offences and other behaviour would help to explain how risk of harm classifications are determined, and to recognise the potential for serious harm in cases where there has already been a pattern of lower level violence. In one case we found: *"Anya had committed a number of assaults including on care home staff and residents, her mother, brother and friends. There was no analysis of the risk of harm she presented, which was needed to explain and justify the low risk classification. The case manager stated that this was not needed because Anya had not caused any serious harm in the past*".

2.2. Following an assessment of risk of harm, we would expect the YOS to put in place plans to manage any behaviour likely to lead to harm being caused, and try to prevent it taking place. In just over half of the cases, we found that the plans to manage risk of harm were clear. Ten cases had no plan at all, and in three cases we found that risks to previous and potential future victims, including family members, were not being managed well enough.

2.3. The risk of harm to others can change over time and, therefore, needs to be kept under review. The assessment of risk of harm had been reviewed in almost half of the cases where it was needed. There were seven cases where reviews had not been completed following changes in circumstances, such as new charges for offences of violence. In four cases routine reviews had not been completed.

2.4. We looked at six cases where the child or young person received a custodial sentence. In three of these we found that there were sufficient plans in place to manage the risks they presented to others while in custody. Two of these cases were not reviewed well enough on release.

3. Protecting the child or young person

3.1. In many cases, children and young people who have offended are also vulnerable themselves, and we expect to see that this has been taken into account. We found that the initial assessment of vulnerability and safeguarding issues was not done well enough in 13 cases. Case managers did not always record the increased vulnerability of children and young people who were looked after, living in unstable circumstances, or with mental health issues, for example.

3.2. Where there were written plans to address vulnerability and safeguarding issues these were good enough in all except two cases. In a further 13 cases plans had not been completed and should have been. However, we did find that all case managers were actively managing vulnerability and safeguarding issues well; they were minimising the impact of these factors on children and young people and were making appropriate referrals to a range of agencies to provide specialist services.

3.3. We expect to see a regular review of vulnerability issues, because children and young people's lives can change very quickly. In 12 relevant cases, we found that this was done when needed. In nine cases, a review had not been completed following a significant change in the child or young person's circumstances, such as breakdown of a foster care placement, or deterioration in mental health.

3.4. In our sample there were ten cases where the child or young person was in the care of the local authority. We saw excellent joint working between YOS case managers and social workers, to coordinate the services provided. In a number of cases where the child or young person had been recognised as being at risk of sexual exploitation, very good work was done in liaison with other services in order to minimise this risk.

4. Ensuring that the sentence is served

4.1. Performance in this area was robust. In almost all cases the child or young person complied with the requirements of their order. There were two cases where we felt the response of the YOS to failed appointments was inadequate and just one where we thought breach action should have been taken and it had not been.

4.2. In most cases we saw good work to engage with children and young people and their parents/carers, including foster carers and staff in residential settings. There were just seven cases where we felt this could have been done better.

4.3. Attention had been paid to assessing the child or young person's diverse needs and any barriers to engagement in the majority of cases. When we spoke to case managers we found they clearly understood how to tailor their approach to fit the individual needs and circumstances of the child or young person, but this was not often explained in written assessments and plans. In one case the inspector wrote: *"This case worker has shown an excellent commitment in attempting to engage Danny and his family who are from a travelling background. Home visits and a consistently accountable and transparent approach had broken down scepticism towards professionals. Danny's mother had been supportive and involved throughout and she attended many of the supervision sessions providing a calming influence to reinforce the work done"*.

4.4. We were disappointed that the assessment of learning styles was not routinely undertaken, although we were told that tools to do this were available locally. Case managers also explained that it was hard to access specialist services for children and young people who were thought to have speech and language problems. This meant that they could not always be confident that they were using the most effective methods to engage children and young people.

Operational management

We interviewed 13 case managers and found that they all felt supported and said that their line managers had the skills and knowledge to help them to improve the quality of their work. Six identified a need for further training in working with speech and language needs, and three would like more training on responding to other diversity issues. We found that almost all of the case managers were aware of local polices and procedures that related to compliance, vulnerability and risk of harm and how the principles of effective practice applied in their work with children and young people.

We found a mixed picture of management oversight of the work of the YOS. An internal panel of managers provided oversight of cases where risk of harm and/or vulnerability were assessed as high. This could be strengthened by arranging for case managers to attend in person. We did not see a high level of routine management oversight of cases. Oversight by managers had made a positive difference in 14 cases, but in 15 cases none was evident. This was a lost opportunity to improve the quality of assessments and plans.

Key strengths

- Assessments of children and young people were clear about the factors that could lead to further offending.
- Attention was paid to a wide range of issues linked to vulnerability.
- There was good partnership working particularly with social workers and education staff.
- Case managers built strong working relationships with children and young people and their parents/carers and this resulted in a high level of compliance with their orders.

Areas requiring improvement

- Plans to address the likelihood of reoffending should include objectives that are easy for the child or young person to understand.
- Management oversight should ensure that risk of harm and vulnerability are not underestimated and that clear plans are made to manage these issues when needed.
- Assessments and plans should be reviewed when required, particularly in response to significant changes in circumstances.

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 Liz Smith. She can be contacted at liz.smith@hmiprobation.gsi.gov.uk or on 07827 663397.

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