Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
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To:	Colin Stewart, Chair of Sutton YOT 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 Sutton

This report outlines the findings of the recent SQS inspection, conducted from 16th – 18th June 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 14 cases supervised by Sutton Youth Offending Team (YOT). 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.justiceinspectorates.gov.uk/hmiprobation/

Summary

In Sutton we found a team of experienced and skilled case managers supported by partners both within the Children Young People & Learning Directorate (CYPLD) and wider community partners. Overall, we found a very high standard of service being delivered by case managers and other YOT workers. They had detailed knowledge of the children and young people they were working with, and offered support and challenged behaviour where appropriate.

Commentary on the inspection in Sutton:

1. Reducing the likelihood of reoffending

1.1. In all but one case we found timely and sufficient assessment of the factors associated with the child or young person's offending. All staff interviewed had sufficient understanding of local policies and procedures for managing this work.

1.2. In all seven cases where a new pre-sentence report (PSR) had been requested, a high quality report was provided for the court. Management oversight of the quality of reports was effective. In cases where a report had not been requested, there was evidence of the YOT providing information in the form of breach reports or verbal updates. One inspector commented: *"The pre-sentence report on Matt was thorough and clear about what factors led to the offending, as well as how the recommended sentence could address these factors. It also presented a clear analysis of risk of harm, reoffending and vulnerability."*

1.3. Following on from assessments we expect to see a plan of work to help reduce the likelihood of reoffending. These were in place and of good quality in all cases inspected. The YOT had made changes to the service user self-assessment form *What do YOU think?* The redesigned form was easier to comprehend and helped the child or young person better understand the changes they needed to make. This was an excellent initiative to get children and young people to recognise and take ownership of the work they needed to do to stop reoffending.

1.4. In most relevant cases the assessment and plans to reduce the likelihood of reoffending had been appropriately reviewed, taking into account changes in the child or young person's circumstances. Nevertheless reviews could have been improved by containing more detail on the progress the child or young person had made, and what work still needed to be done.

1.5. Overall, we found that case managers had a good understanding of what was likely to be effective in working with children and young people to help them stop offending and improve the quality of their lives.

2. Protecting the public

2.1. There was a sufficient assessment of the risk of harm to others posed by the child or young person in all but one of the cases we inspected. Comments from inspectors included: "*There was good communication with specialist staff and other agencies in making assessments and planning work to reduce the young person's risk of harm to others"* and "*The risk panel meeting was attended by all agencies working with Josh, including a voluntary organisation who were looking to provide a mentor to help with his safe resettlement"*.

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

2.3. There was sufficient initial planning to address the risk of harm to others in all cases inspected where this was an issue. This was an improvement even on the good standard of assessments we found during the last inspection. We saw a number of positive examples of joint working in difficult cases where children and young people had accommodation, educational and emotional needs. One inspector found that *"In one of the two custodial cases, despite the Young Offenders' Institute (YOI) not arranging general planning meetings the case manager ensured that the young person was referred into the Multi-Agency Public Protection Arrangements (MAPPA) and relevant planning to address the risk of harm to others was in place prior to release".*

2.4. In all but one case, assessments and plans to address the risk of harm to others had been reviewed sufficiently well. Intervention plans were, in the vast majority of cases, clearly linked to the risk management plan. As a result, the interventions delivered had the desired outcome of reducing risk of harm, and reviews also clearly recorded progress made.

2.5. We found that plans were reviewed thoroughly and there were some positive examples of case managers responding effectively to changes. This was a clear improvement on the previous inspection when the report included a recommendation aimed at improving this aspect of YOT work. One inspector commented: *"The risk management plan was bespoke and considered the specific issues relating to the offence - access to computers. All plans included input from family and other agencies".*

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. The YOT had made good use of their victim liaison officer who provided case managers with details of the impact of the offence on the victim. Although we saw many examples of reparation we saw no examples of direct restorative justice reparation being used, even when this would have been appropriate.

2.7. There was effective management oversight in all cases inspected. The YOT had a robust quality assurance process which was understood and valued by case managers. Again this was an area for improvement highlighted in the previous inspection. It was clear that management oversight was now well embedded throughout the work of the YOT and we saw evidence in every case of case managers discussing their work with children and young people with their line managers. All staff understood local policies and procedures for the management of risk of harm and how this would be undertaken in partnership where necessary.

2.8. Despite the high quality of assessment, planning and interventions delivered we found that in 7 out of 11 relevant cases there was little or no evidence that the risk of harm to others posed by the individual child or young person had been reduced. Whilst this may be in part due to the established lifestyles, attitudes and behaviour of some of the children and young people the YOT was working with, it could also be an indication that the YOT would benefit from reviewing, with partners, how it works with these group of difficult children and young people who continue to pose a risk of harm to the public.

3. Protecting the child or young person

3.1. In all relevant cases vulnerability and safeguarding needs were sufficiently assessed, and these aspects were wholly covered in all PSRs examined. Following on from the assessment, we were pleased to see that vulnerability and safeguarding factors were fully included in the work planned to make the child or young person safe.

3.2. Reviews of safeguarding and vulnerability assessments throughout the sentence were sufficient in all relevant cases.

3.3. Planning to address vulnerability and safeguarding issues was of a good standard in both custody and community cases. One inspector stated: *"The sentence plan was robust and took into account the young person's needs in order to prioritise work to safeguard her. The vulnerability management plan was comprehensive and included an additional crisis management plan around the specific issue of self harm".*

3.4. Effective arrangements were in place to manage vulnerability within the custodial setting in both cases. In one case the inspector commented: *"Alex, who suffered from autism, was sentenced to a six month detention and training order. The case manager contacted the YOI's learning disability nurse who not only worked with Alex on a daily basis but also provided staff with guidance on how to work with him to meet his needs while he was in custody. This resulted in him remaining safe and returning safely to the community".*

3.5. Reviews of plans to address safeguarding and vulnerability issues had been undertaken to a good standard in all relevant cases. However, more could have been included to

recognise progress and emphasise work still to be done particularly near the end of orders.

3.6. As with public protection we found some real improvements in the quality of management oversight in those cases where the child or young person was recognised as being vulnerable.

4. Ensuring that the sentence is served

4.1. An early assessment of the diversity factors and barriers to engagement is essential in helping children and young people get the most from their sentence and comply with their order. In all but one case we found there was a good quality assessment of these factors. As part of their induction children and young people had a screening session with the YOT's speech and language therapist, who provided a detailed assessment of the individual's communication skills. This not only helped them access any extra services they may need, but provided guidance on what methods of communication would help them to understand what was happening in their supervision.

4.2. We found a strong culture in the YOT of engaging well with the child or young person and their parents/carers to inform the initial assessment. This was evident in all but one of the PSRs.

4.3. There was evidence of excellent involvement of the child or young person and their parents/carers in the assessment and planning of interventions. Case managers often visited the children and young people at home and school, and worked with parents/carers to ensure that they all achieved the most out of their work with the YOT. This resulted in good levels of compliance in the majority of cases inspected.

4.4. Where children or young people did not fully comply, the case manager responded satisfactorily in every case. All staff interviewed had a clear and thorough understanding of local policies and procedures for engaging children and young people, and for responding to non-compliance where it occurred. There was strong evidence that case managers were able to meet the challenge of motivating and encouraging compliance, and take enforcement action when needed.

Operational management

We found that case supervision, case discussions and in particular improvements in quality assurance procedures and management oversight had made a positive contribution in all relevant cases inspected. Case managers themselves were confident in the abilities of their managers to both assess and help to improve the quality of their work. All but one thought that effective and appropriate supervision was provided. Most believed that Sutton YOT had a culture that actively promoted learning and development. They were all clear about organisational priorities, and this was supported by the evidence we saw.

The YOT had recently moved into a multi-agency office with other staff from the CYPLD. This was generally seen as positive by staff interviewed. In our view, employing suitably qualified staff from all partner agencies, including early interventions and prevention staff, had contributed to the high quality of service and successful outcomes we saw during this inspection.

Key strengths

- Partnership working was effective as illustrated in the following case: *"Lucas, who suffered from autism, was due to be released from custody and was likely to be homeless. The case manager, working with adult care services, housing support and other agencies, arranged for an assessment of Lucas' needs, leading to him initially being placed in supported accommodation pending the completion of his assessment. Although the process did not run*

smoothly, it was clearly helped by a multi-agency approach, leading in the end to his safe resettlement into the community".

- The YOT managers ensured that case managers had the right tools to engage with the child or young person and help them successfully complete their sentence. This included the employment of a speech and language therapist, who provided assessment at a post court clinic, and a psychologist who was able to assess young peoples' mental health needs and signpost them to mainstream services. In addition a wide range of partnership agencies was actively involved with the children and young people throughout their order.
- We have already mentioned the improvements in management oversight and quality assurance arrangements since the last inspection. It cannot be overstated how impressive this improvement is as an enabler to the high quality of work seen on this inspection.

Areas requiring improvement

- Although multi-agency work has been highlighted as a key strength, there were one or two cases where we found that the case manager needed to be more assertive with other professionals, or to escalate the issue to ensure that the children and young people they were working with had access to the services they needed. One example related to where disclosed information from a child to the consultant psychiatrist had been described as 'secret'. Whilst we acknowledge the issue we consider ways could be explored in which this information could legitimately be shared for the benefit of the child or young person, and/or the information sharing arrangements could be revisited.

We are grateful for the support that we received from staff in the YOT 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 les.smith@hmiprobation.gsi.gov.uk or on 07798 607828.

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