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<i>From:</i>	Julie Fox, HM Assistant Chief Inspector
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Report of Short Quality Screening (SQS) of youth offending work in Cornwall & the Isles of Scilly

This report outlines the findings of the recent SQS inspection, conducted from 14th - 16th July 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 20 cases supervised by Cornwall & the Isles of Scilly 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.justiceinspectorates.gov.uk/hmiprobation/>

Summary

Over the past 12 months Cornwall & the Isles of Scilly's youth justice work had been restructured. Despite this, the YOS had achieved a very good compliance record through its reducing reoffending work. Staff engaged well with children, young people and their parents/carers to develop the initial plans to help stop reoffending. Whilst no child or young person was left at risk of harm, work to manage the risk of harm that children and young people posed to others, vulnerability and safeguarding needed greater focus. Management oversight needed to be more effective and robust to improve both the quality and the consistency of the work of the YOS.

The published reoffending rate¹ for Cornwall & the Isles of Scilly is 31.8% which, although an increase on the previous quarter, is still less than the average for England and Wales 35.4%.

¹ Published April 2014 based on binary reoffending rates after 12 months for the July 2011 to March 2012 cohort.

Commentary on the inspection in Cornwall & the Isles of Scilly:

1. Reducing the likelihood of reoffending

- 1.1. The initial assessment of the child or young person's likelihood of reoffending was carried out well in the majority of the cases in the sample. Case managers had appropriately and consistently paid attention to a wide range of factors that may have contributed to the offending behaviour. In particular we were pleased to find that there was a focus on encouraging the child or young person to reflect on why they had offended.
- 1.2. Self assessments to inform the initial assessment were systematically used in the vast majority of cases. This enabled greater ownership and placed the child or young person at the heart of the sentence of the court.
- 1.3. Reviews of assessments did not always follow a change in the child or young person's circumstances. A number failed to integrate all the relevant factors that needed to be taken into account to support the reduction of reoffending.
- 1.4. Planning for work to reduce the likelihood of reoffending was variable. Some plans contained outcome focused objectives which were meaningful to the child or young person whilst others were not appropriately informed by the needs of the case. The areas that required development were emotional or mental health issues, offending related substance misuse and living arrangements. However, the YOS had identified this as an area for development and now referred all those subject to court orders to the specialist YOS health workers and was currently delivering an action plan to address offending behaviour related to substance misuse.
- 1.5. Less than half of all plans to reduce the likelihood of reoffending had been reviewed well. In a considerable number of cases plans had not been reviewed when this was required.
- 1.6. Overall we found that case managers had a good level of 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. In one example the planned presence of the same case manager at the assessment, planning and delivery of the intervention stages proved to be particularly effective. One inspector commented: *"the case manager was responsible for the assessment, planning and interventions on the Referral Order. This meant that they also supervised the reparation placement at a Donkey Sanctuary, which involved meaningful skills based work. This enabled the case manager to engage with the child or young person more meaningfully and to integrate the skills developed by this placement into other work with them about their life"*.

2. Protecting the public

- 2.1. All case managers reported that they had a good understanding of YOS expectations for the management of the risk of harm to others. However, this needed to be significantly better applied to ensure that assessment and planning for this work was appropriate.
- 2.2. Specifically, assessments needed to take into account other relevant behaviours or offences, screening needed to be more specific about the risks a child or young person may pose, and greater consideration given to actual and potential victims. Risk of harm to others was sometimes assessed as too low because all the information available to the case manager had not been integrated to form a holistic, logical assessment. In one example Wayne had established a lengthy list of convictions, had previously been cautioned for an offence of arson, felt rejected by family members and had recently been arrested for a sexual offence. However, Wayne's risk of harm to others was assessed as being low. As a result of these assessments not integrating all the information available to

the case manager, plans to minimise and manage the risk of harm to others were not comprehensive as they did not include all the relevant factors. Similar approaches were found in a number of cases demonstrating that whilst features of vulnerability were recognised, they were not being routinely pulled together to inform the assessment and needed closer attention by both case managers and line managers.

- 2.3. Review of assessments and planning of work to manage the risk of harm to others was not always good enough. In too many cases reviews did not recognise the relevance of new events or the receipt of significant information. Once received, information was not always integrated into the assessments, and plans were not amended to incorporate them. This reinforced the need to consider *all* information and adjust both the assessment and the planning as a result.
- 2.4. The risk of harm to victims who had been identified was managed well in just over half the inspected cases. Case managers had often not prioritised their assessments and plans to include victim work. When this was done well, it was done extremely well. In one case we found a considered and reflective letter that had been prepared by the child or young person to give to the victim. The insight that had been shown was exceptional and this had been used well by the case manager to inform other work to reduce reoffending. In another case we found some promising practice: *"one of the burglary victims identified in this case attended the initial panel meeting. The victim then specified a community project for the young person to undertake some reparation work. The case manager also undertook some good victim awareness work and adapted her methods of delivery to the needs of the young person"*.
- 2.5. Effective management oversight of risk of harm work needed to be improved as a priority. Evidence of supervision by managers was more frequent than we often find. However, whilst their entries in case management records provided a helpful summary of the current position, it also needed to address the deficits in assessments and plans. Managers sometimes needed to be bolder in challenging the views and judgements of case managers.

3. Protecting the child or young person

- 3.1. The YOS had worked to develop a broad understanding of vulnerability and safeguarding; but it was evident that additional work was needed given that over half the cases inspected did not have a good enough assessment. Case managers did not always recognise the range of factors that may apply including substance misuse, emotional or mental health needs and living arrangements. They did not always understand the impact that offending behaviour may have on vulnerability. Examples that we found where this link had been missed included domestic violence, possession of a weapon, the young person missing from home and the impact of being a child or young person who had been arrested for a sexual offence. As a consequence, plans were not always developed to provide a clear direction to manage and reduce vulnerability.
- 3.2. Reviews of assessments relating to safeguarding and vulnerability were not carried out well in the majority of cases. Children and young people's lives can change very rapidly. New and relevant information did not trigger an update. Whilst reviews were consistently prepared they lacked analysis and it was not clear how they had noticeably changed from the initial assessment.
- 3.3. Planning for work to address safeguarding and vulnerability was marginally better but again a significant number of cases lacked plans to achieve clear and meaningful outcomes. Greater focus was needed to address drug misuse, care arrangements and the refining of objectives in plans.

- 3.4. Similarly, the reviews of plans relating to safeguarding and vulnerability showed that the majority were not done well. Often plans were not completed when necessary, and the response from the case manager did not meet the assessed needs of the child or young person, with interventions to address safeguarding and vulnerability not included in the plans.
- 3.5. The effectiveness of management oversight should be far more robust in the majority of cases. Some managers did provide good oversight. One case manager commented that their manager scrutinised their work thoroughly by challenging their decisions and providing clear direction as to how the deficits could be addressed. However, this was not evidenced in a number of cases. Whilst every case manager interviewed commented that they understood local arrangements for the management of safeguarding, we did not see this demonstrated in their work. This imbalance needs attention.

4. Ensuring that the sentence is served

- 4.1. We found a very good level of engagement in almost every case between case managers, children and young people and their parents/carers. It was particularly pleasing to note that they were appropriately involved in the development of assessments and reports. This was a clear strength in the YOS. One inspector noted real efforts being made to engage the young person: *"the case manager tried to visit Ashley even while out of the area, she regularly wrote to him as well and also sent post cards"*.
- 4.2. Case managers gave appropriate attention to barriers to engagement and other diversity or potential discriminatory factors at the start of sentences in the vast majority of cases. We found evidence of case managers taking time to speak with children, young people and their parents/carers about how best their diversity issues could be managed. Equally pleasing were the real actions that had been taken to maximise engagement. In one case a decision had been taken to sequence an intervention in a way that was more meaningful to the young person. This bespoke approach had the benefit of achieving some positive outcomes. Similarly we found some promising practice with Tariq: *"Tariq had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). The case manager adjusted her intervention style by having shorter but more frequent meetings. These had then been followed up with conversations with Tariq's mother to check whether there had been any changes in his behaviours, thinking and attitudes"*.
- 4.3. Case managers gave sufficient attention to health and well-being outcomes, specifically where they may act as a barrier to a successful outcome from the sentence, in almost all cases. In addition the Rapid English programme designed to support young people experiencing severe literacy barriers was being used well.
- 4.4. In almost every case the child or young person had complied with the requirements of their sentence, some after initial difficulties. This was an impressive finding for it showed the dedication of case managers and their commitment to holding children and young people to account.
- 4.5. We were pleased to find that where the child or young person had not complied with the requirements of the sentence, the response of the case manager was not only appropriate but robust in almost every non-compliance incident. Case managers had a good understanding of the expectations of the YOS when dealing with this. Compliance panels were convened in a timely fashion in order to achieve engagement. It was encouraging to note that parents/carers were also actively involved in this process.

Operational management

Staff reported that they had a good understanding of local policies and procedures and the principles of effective practice with children and young people who have offended. They spoke positively about their manager's knowledge to assess their work, support them in their work and guide them in improving the quality of their work. Interestingly, a number commented that they wished there was greater challenge of their decisions. Case managers described the countersigning and management oversight as largely effective but we found evidence to suggest that this was not the case in issues relating to risk of harm to others, vulnerability and safeguarding.

It was encouraging to find that all nine case manager interviewed reported that they were clear about how the organisation's priorities affected their role in reducing reoffending. They were unanimous in their view that there was a positive and supportive learning and development culture in the organisation which bodes well for improving the identified areas of development within the YOS. Some identified the need for more current training in diversity.

Key strengths

- Children and young people and their parents/carers were actively involved in initial assessments.
- High levels of compliance were achieved and enforcement action, when required, was appropriately taken demonstrating that staff delivered the sentence of the court.
- The Rapid English communication programme was an innovative development in the YOS.
- Positive outcomes in reducing reoffending were being achieved.

Areas requiring improvement

- Assessment of risk of harm to others should reflect all relevant behaviours. This should lead to more meaningful assessments and improved plans to manage and reduce these risks.
- Case managers should be more receptive to changes in circumstances so that reviews and plans are undertaken when required.
- Managers should consistently ensure that work to assess and address safeguarding and vulnerability is of sufficient quality.

We are grateful for the support that we received from staff in the Cornwall & the Isles of Scilly 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 Avtar Singh. He can be contacted at avtar.singh@hmiprobation.gsi.gov.uk or on 077969 48325.

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