Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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Publication date:	13th August 2014

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

This report outlines the findings of the recent SQS inspection, conducted from 7th-9th 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 34 cases supervised by County Durham 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 18 months County Durham has achieved a continuing and substantial reduction in proven reoffending by children and young people. The published reoffending rate[1] at the time of the inspection was 37.5%. This was approaching the average for England & Wales (35.5%).

We found some positive staff and high quality work, but this did not apply to all cases. Senior managers in County Durham YOS had appropriately high expectations for the quality of work that they expected staff to deliver. Many of the cases we inspected coincided with a restructure of the YOS and other difficulties. We trust that this inspection can be a catalyst to ensure that all work is delivered consistently to the required standards.

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

Commentary on the inspection in County Durham:

1. Reducing reoffending

1.1. Pre-sentence reports (PSRs) are the main means by which the sentencing court is advised about the causes of offending and the work required to address that. Almost all PSRs were of good quality. Positively, and unusually, some PSRs informed the court that they had been discussed with the child or young person and they understood the contents.

1.2. We found some good assessments of offending behaviour. However, there were too many cases where there was not a good enough assessment. Sometimes the assessment was largely a copy of a previous one, without sufficient update, that could be factually incorrect or out of date. The areas where assessments could most commonly be improved related to emotional or mental health, perception of self and others, and substance misuse. A nurse completed a physical health screening, which was used by case managers to inform their assessment. This was good practice.

1.3. There was insufficient review of assessments. Often this was due to lack of recognition of the need to review all or part of the assessment following a change in circumstances or another significant event, rather than wait for when it was due under national standards. In one example a young person in custody received a further sentence for an assault, which was the first time he had caused physical harm and had clearly planned an offence. Neither were reflected in a reviewed assessment to inform planning for that sentence.

1.4. The use of self assessments to inform the initial assessment was variable. In some cases there was clear evidence of the assessment having been informed by the child or young person's views. However, in others completion of a self assessment was not considered until after the plan was in place, which meant that the opportunity had been missed to ensure that it reflected their views.

1.5. We found some promising practice. As part of its suite of offending behaviour programmes, the YOS developed an interactive induction module, running on case managers' laptops. The child or young person was asked to explain their understanding of what was expected, what might help and what might hinder their work with the YOS. This was a creative way of understanding barriers to compliance and supporting engagement with the sentence.

1.6. We were pleased to find a good level of contact with children and young people during the custodial phase of sentences, in formal planning meetings and outside of these. However, more attention sometimes needed to be given to ensure that the plan in these cases always reflected the whole sentence and the YOS assessment.

1.7. Planning for work to reduce reoffending was variable. We saw some good examples where case managers had tried to make plans meaningful to the child or young person. The most common areas for improvement were to ensure that emotional or mental health and offending related substance misuse were clearly reflected. Referral order contracts in particular were not presented in language that enabled the child or young person to make a truly informed decision about what they were agreeing to.

1.8. An inspector commented that they found a positive example of sensitive practice: *"Tom had received many sentences for a variety of offence types. Until recently he had never completed a sentence successfully. The case manager recognised that Tom's offences were primarily a response to long-term difficulties with being in care and resenting separation from his parents. [Her] plan therefore included one key objective which was about understanding how to build healthy relationships. Other offending behaviour work*

was wrapped up under this over-arching objective. This helped give Tom a clear direction and avoided the risk of damaging his motivation through too many objectives".

2. Protecting the public

2.1. Most case managers had a good understanding of YOS expectations for management of the risk of harm to others. However, this needed to be applied better to ensure that assessment and planning for this work was good enough.

2.2. In particular, assessments often needed to take more account of other relevant offences or behaviours and give more consideration to actual or potential victims. Risk of harm to others was sometimes assessed too low because all relevant information had not been brought together to form a coherent assessment, including in a number of cases of offending against family members. In one example, Mark had a long history of violent offending against members of his family, and his siblings had been removed from home because of the risk that he posed to them. However, Mark's risk of harm to others was assessed as being low. As a result of inadequate assessments, plans to manage the risk to others were often not produced where required. Plans did not give sufficient consideration to victims.

2.3. An inspector commented that they had seen some promising practice with Lee, who posed a risk of harm at home: *"In one incident he brandished a knife after a disagreement with his father. Both Lee and his father rang the case manager in the evening to ask for help. The case manager appropriately informed the police who dealt with the incident. Following this the case manager helped Lee recognise his need to change. Lee asked for help to manage his anger, which was positive"*.

2.4. We inspected one case that needed, due to the serious nature of the offence, to be subject to Multi-Agency Public Protection Arrangements (MAPPA). We were very pleased to find that engagement with MAPPA in that case was good.

2.5. Review of assessments and plans was not always good enough. Generally this was because there was too much focus on meeting local standards, with not enough emphasis on recognising the significance of new events or the receipt of relevant information.

2.6. Oversight of risk of harm work was variable. Evidence of supervision by managers was, encouragingly, much more frequent than we often find. However, this often focused on following processes rather than ensuring that work was of good quality. Managers sometimes needed to be more willing to test and challenge the views of the case manager. Attention needed to be given to developing approaches that enabled managers to identify where oversight may be required, because of the offence types or other previous characteristics, irrespective of the initial assessment.

3. Protecting the child or young person

3.1. We were pleased that case managers always recognised the impact of custodial sentences on the vulnerability of children and young people. However, sometimes the focus on the possibility of a custodial sentence meant that insufficient recognition and attention was given to risks that may apply in the community.

3.2. The YOS had worked to develop a broad understanding of vulnerability; however it was clear that further work was required to reinforce this. Assessment did not always recognise the range of factors that may apply. Case managers did not always recognise the impact that offending behaviour may have on vulnerability. Examples that we found where this link had been missed included having a drug debt, aggravated vehicle taking, domestic violence against parents, possession of a weapon and the impact of being a

child or young person who had committed sexual offences. In some cases, being looked after, or subject to leaving care services, was not recognised as a factor that may increase vulnerability. As a result plans were not always developed or good enough to manage and reduce vulnerability.

3.3. One of our inspectors found an excellent response to intelligence that had been received: *"Jane had problems with her self-esteem that were directly linked to her offending. The case manager identified that Jane may have become subject to bullying at school. As a result the case manager immediately reviewed the assessment, produced a plan to manage this vulnerability, and undertook the actions that she had planned*".

3.4. The YOS had recently developed its work on child sexual exploitation, including providing training to staff. However, more needed to be done to ensure that case managers consistently recognised potential child sexual exploitation, thoroughly assessed this and put robust plans in place, including with partner agencies, to ensure the safety of children and young people who may be at risk. Given the complex nature of this work it is particularly important that these cases benefit from effective management oversight.

3.5. *"John had recently formed a relationship with a younger girl. The case manager assessed that this may be sexual in nature and was concerned about this due to the girl's age. She immediately referred the girl to children's services and worked with John to develop his understanding of acceptable behaviour, including how the concerns would remain once he was 16 years of age, because his girlfriend was much younger than him*." This was speedy and appropriate action by the case manager that demonstrated concern for the vulnerability of both John and the young girl with whom he was having a relationship.

3.6. The effectiveness of management oversight varied considerably. Some managers provided robust oversight. One case manager commented "*my manager adopts a very collaborative approach. [She] discusses and debates the issues in the case with me, and we then discuss and agree any changes that are required. This helps ensure that my practice also improves in other cases".* However, sometimes plans were accepted that had significant deficits which a brief review should have identified. Sometimes a manager would assume that the case manager knew the case best, therefore did not consider it appropriate to challenge them. Often the manager had instructed that a management plan be written, because it was missing, but did not ensure that it was preceded by a review of the assessment, which would make it more likely that the plan was appropriate.

4. Ensuring that the sentence is served

4.1. There was good engagement between case managers, children and young people, and their parents/carers. In particular it was very encouraging to find that they were clearly involved in the development of assessments and PSRs.

4.2. One inspector found the following positive example of work to break down communication barriers with a young person: *"Frank was a Muslim. His offending was violent in nature, against both peers and staff. He would not engage with his case manager or other professionals, however he would engage with his Imam. The case manager worked jointly with the Imam to break down barriers and setup communication routes. Whilst it was early days, there were signs that Frank was beginning to respond to his case manager*".

4.3. We were particularly 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 appropriate in all the inspected cases. Case managers had a good understanding of the expectations of the YOS when dealing with non-compliance. Where multiple instances developed the YOS had a positive two-stage process to address this. The first stage involved an internal review. Where non-compliance continued, a re-engagement panel

was held, that included the child or young person. This explored the reasons for non-compliance and, where appropriate, agreed a plan with the child or young person and their parent/carer to support improved behaviour.

4.4. Good attention was generally given to diversity factors in reports, assessments and plans. However case managers needed to ensure that agreed plans to address diversity factors, barriers to engagement or non-compliance were clearly communicated to others.

4.5. A high proportion of contacts with children and young people involved home visits. Whilst this was understandable given the geography of County Durham, it should be balanced with opportunities for the child or young person to take more responsibility for compliance with the sentence; for example through meeting at local community facilities that they can make their own way to. This can be a positive part of supervision that can help develop a sense of responsibility for the child or young person's own behaviour.

Operational management

There were a number of cases where case managers had been off sick, but line managers had not taken sufficient steps to ensure that work was covered in a timely and effective manner. It was positive that, bearing in mind the recent substantial changes in the YOS, all case managers we spoke to considered that they were kept well involved in development plans.

Case managers spoke very positively about their managers, although some very experienced case managers indicated that they would value more challenge.

The YOS had recently provided training in speech, language and communication needs. This was very well received and we found a lot of evidence of case managers applying this learning to their work, in particular to the way they planned to engage with children and young people.

Key strengths

- PSRs were of a good standard.
- The YOS was creative in developing interactive tools for work with children and young people.
- Case managers knew children and young people well and could accurately and concisely describe why they offended and what needed to be done to reduce reoffending.
- There was an effective and appropriate response to non-compliance.
- Good attention was given to responding to diversity factors and barriers to engagement.
- There was a positive developing focus on speech, language and communication needs.

Areas requiring improvement

- Assessment of risk of harm to others should reflect all relevant behaviours. This should lead to more robust assessments, and better plans to manage and reduce these risks.
- Case managers should be more responsive to changing circumstances, so that reviews of assessments and plans are undertaken when required and these remain current.
- More attention needs to be given to managing the risk of harm to victims, through good assessment of their needs and subsequent planning.
- Case managers need to be more aware of the possibility of child sexual exploitation, and to ensure that this is adequately considered in assessment and planning.
- There should be better recognition and assessment of the breadth of vulnerability factors that may apply in individual cases, leading to better planning to address this.

- Line managers should have a consistent understanding, and approach to oversight, of risk of harm work and vulnerability management work, to ensure that this is of good quality.

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 Ian Menary. He can be contacted at ian.menary@hmiprobation.gsi.gov.uk or on 07917 183197.

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