Inspection of Youth Offending Work
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| *To:* | Tony Tweedy, Chair of Sheffield Youth Justice 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 Sheffield

The inspection was conducted from 24th–26th November 2014 as part of our programme of inspection of youth offending work. This report is 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

The aim of the youth justice system is to prevent offending by children and young people. Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. We examined 34 cases of children and young people who had recently offended and were being supervised by Sheffield Youth Justice Service (YJS). Wherever possible this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

### Summary

The published reoffending rate[1] for Sheffield was 34.9%. This was better than the previous year and better than the England and Wales average of 35.4%.

Overall, we found that staff engaged well with children, young people and their parents/carers but their work to assess and manage the risk of harm, vulnerability and safeguarding was not always timely or well recorded. An internal restructure, designed to enhance practice, had taken place shortly before we arrived, following a review and the National Standards audit. With a significant investment in staff training across key practice areas, we saw improvements coming through but not enough to significantly influence the results of this inspection. Management oversight needed to be more effective to improve both the quality and the consistency of the work.

### Commentary on the inspection in Sheffield:

### 1. Reducing reoffending

1.1. We found some good quality assessments of offending behaviour, which used standard headings within the evidence boxes, to identify the link for each section to harm, vulnerability, positive factors and individual needs. It was easy to follow and understand

[1] Published July 2014 based on binary reoffending rates after 12 months for the October 2011 – September 2012 cohort. Source: Published as MoJ Proven Reoffending Statistics October 2011 – September 2012

the rating given. However, there were too many cases where the assessment had not been completed properly, or recorded at the right time. This delay affected effective case management throughout many of the cases we inspected.

1.2. Pre-sentence reports (PSRs) and panel reports are the principal means by which the sentencing court or youth offender panel are advised about the causes of offending and the work required to address that. About two-thirds of the PSRs and panel reports were of good quality.

1.3. There was insufficient review of assessments. Often this was due to the initial assessment being late, but there was also a lack of recognition of the need to review all or part of the assessment following a change in circumstances or another significant event, such as a child or young person leaving custody and returning home under supervision.

1.4. Overall, staff engaged well with children and young people. For example, we were pleased to find, for example, a good level of contact with children and young people specifically during the custodial phase of sentences, in formal planning meetings and beyond these. However, more attention needed to be given to ensure that the intervention plan in those cases always reflected the whole sentence and the YJS assessment.

1.5. Following on from the assessment, we look to see if there is a plan of work to help reduce the likelihood of reoffending. Planning was variable, with some cases having no plans at all for several months, or plans being recorded late, or not taking into account the needs of the child or young person. The objectives in referral order contracts were not presented in language that enabled the child or young person to make a fully informed decision about what they were agreeing to, or that allowed the case manager to ensure they were dealing with the most important issues first. However, where used, the local planning forum assisted with good quality planning, for example, identifying the need for a female young person to attend the all-girl 'Saturdays' group run by the YJS.

## 2. Protecting the public

2.1. Most case managers had a good understanding of the YJS's expectations for management of the risk of harm to others. This needed to be applied consistently to ensure that assessment and planning for this work were good enough. We expect to see a detailed assessment of the risk of harm a child or young person poses to others, covering all relevant information, including past offending and behaviour, as well as the impact on victims. YJS assessments that we saw often needed to take more account of other relevant offences or behaviours and give more consideration to actual or potential victims.

2.2. Having assessed the risks, the YJS should put in place plans to manage them, but frequently we found that as a result of untimely assessments, plans to manage the risk of harm to others were often not produced where required, or included in relevant intervention plans. Plans did not give sufficient consideration to the protection of victims. Reviews of assessments and plans were again incomplete or late.

2.3. One inspector noted that a particular case had been handled well: "*Mario was sentenced to an 18-month detention and training order for three offences of Attempted Robbery. He had a concerning antecedent history which demonstrated a pattern of robbery offending. This was a complex case and was correctly assessed as high risk of causing serious harm to others. The case manager ensured all plans and referrals were in place. Prior to release, Mario was discussed at the multi-agency risk panel, where conditions of his supervision were agreed, including intensive supervision, non-contact with victims and the co-accused, and exclusion zones. The implementation of the robust conditions contributed*

*to the victims being safeguarded, but also ensured that Mario received the support which he needed to help him stop offending."*

2.4. Oversight of risk of harm work was variable. Evidence of supervision by managers was, encouragingly, much more frequent than we often find. However, whilst their entries in case management records provided a helpful summary of the current position, it did not ensure that case managers addressed the deficits in assessments and plans. Attention needed to be given to developing approaches that ensure managers and staff completed required activities in a timely manner and then recorded reviews accurately.

**3. Protecting the child or young person**

3.1. Whilst the YJS had worked to develop a broader understanding of vulnerability, assessments and reports did not always recognise the range of factors that may apply, or the impact that offending behaviour may have on vulnerability. Even where needs were identified, some cases had no plan to manage the vulnerability of the child or young person (in one case for seven months after the start of the case), and others did not address all the needs to manage and reduce vulnerability.

3.2. Pleasingly, staff consistently recognised potential child sexual exploitation, thoroughly assessed this and, with the inclusion of partner agencies, put robust plans in place, to protect and ensure the safety of children and young people who may be at risk. For example, an inspector noted that there was: "*a good awareness of child sexual exploitation risks that were associated with the case of Bob and he was assessed as vulnerable due to this and other concerns. Evidence included his return from missing periods with money, drugs and belongings. He was seen getting into a car and the number plate was taken. There was good liaison with the accommodation provider, the Looked After Child social worker and the police child sexual exploitation team to identify and monitor this. As a result, Bob engaged with the appropriate support provision.*"

3.3. The effectiveness of management oversight varied considerably. Some managers provided robust oversight. However, sometimes assessments and plans were accepted that had significant deficits which a brief review should have identified. Plans are likely to be more effective if they are based on an up to date assessment. Such documents are an aid to assisting the work to develop comprehensively, enabling others involved to know what is going on and to aid multi-disciplinary team working. Sometimes, where there was no plan in place, a manager had asked that a plan be written, without specifying that a review of the assessment should precede it.

**4. Ensuring that the sentence is served**

4.1. There was very 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. Children and young people generally complied with court orders. Case managers had a good understanding of the expectations of the YJS when dealing with non-compliance, but in four cases this was not applied effectively.

4.3. Good attention was generally given to diversity factors in reports and assessments. However, case managers did not always ensure that plans included the methods by which diversity factors, barriers to engagement or non-compliance would be addressed. However, inspectors noted some good examples of creative thinking, for example: "*where Connie had learning needs and anxieties about meeting new people, the case manager took pictures of all of the workers involved. Those pictures were given to Connie to help her to recognise who they were.*"

4.4. A high proportion of contacts with children and young people involved home visits, ensuring effective information gathering as well as positive relationship building with children and young people, and their parents/carers. One inspector noted that: "*there was really good evidence of the case manager maintaining contact with both parents whilst Ritchie was in custody; the case manager completed home visits, assisted the parents to attend meetings and ensured they understood every step of the way, from sentence to release*".

### Operational management

We also found that case managers spoke very positively about their managers and described the countersigning and management oversight as largely effective, but we found evidence to suggest that this was not always the case in issues relating to risk of harm to others, vulnerability and safeguarding. Regular multi agency risk panels were now in place to oversee work with children and young people who posed a high risk to the public or who were themselves vulnerable.

### Key strengths

- 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.
- Good attention was given to identifying diversity factors and barriers to engagement.
- Child sexual exploitation was properly considered in assessment and planning.
- Positive outcomes in reducing reoffending were being achieved.

### Areas requiring improvement

- Case managers should complete and record assessments and planning in a timely manner.
- Case managers should be more responsive to changing circumstances, so that reviews of assessments and plans are undertaken when required and address the needs of the case.
- More attention needs to be given to managing the risk of harm to victims, through better assessment of their needs and subsequent planning.
- Management oversight should ensure the quality of assessments and planning.

We are grateful for the support that we received from staff in the YJS 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 Caroline Nicklin. She can be contacted at caroline.nicklin@hmiprobation.gsi.gov.uk or on 07766 290969.

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Note 1: 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.

Note 2: We gather evidence against the SQS criteria, which are available on the HMI Probation website - http://www.justiceinspectorates.gov.uk/hmiprobation.

Note 3: To request a paper copy of this report, please contact HMI Probation Communications at communications@hmiprobation.gsi.gov.uk or on 0161 240 5336.