Inspection of Youth Offending Work
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From:	Helen Mercer, Director (Youth Justice)
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Report of Short Quality Screening (SQS) of youth offending work in Stockport

The inspection was conducted from 2-4 March 2015 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 14 cases of children and young people who had recently offended and were supervised by Stockport Youth Offending Service (YOS). Where possible this was undertaken with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

The published reoffending rate[1] for Stockport was 30.8%. This was substantially better than both the previous year (34.6%) and the England and Wales average (36.1%).

Improvement had taken place in many aspects of work since our previous inspection in 2009. Staff were knowledgeable, keen to improve, committed to their work with children and young people who had offended, and understood them well. However, the work was not always driven by good use of the required planning tools. Middle management resources in the YOS were overstretched.

Commentary on the inspection in Stockport:

1. Reducing reoffending

1.1. Almost all assessments of the reasons for offending were of good quality, providing a strong basis to plan and then deliver the right work. They often provided strong evidence of the analytical skills of case managers. The views of children and young people and their parents/carers were clearly identifiable, along with analysis of their impact.

1.2. There was some very good practice involving Looked After Children. Stockport YOS undertook assessment and planning for those placed from elsewhere, where this was not received from their home YOT or was not good enough; thereby ensuring that delivery of the required work was not delayed. Positive relationships had been developed with care homes so that they understood how the YOS could support them. Care homes and the

[1] Published January 2015 based on binary reoffending rates after 12 months for the April 2012 – March 2013 cohort. Source: Ministry of Justice

YOS worked well together. For example, there were instances where case managers had concerns about a child or young person's relationships. They contacted homes, asked them to look out for particular visitors, and the homes provided feedback to the YOS.

1.3. Pre-sentence reports (PSRs) for courts generally reflected the quality of analysis found in assessments. Whilst we saw some good attention given to the use of custody and its impact, there were a few PSRs where assessment of this was insufficient. Further work was also required to ensure that the summary section brought together consistently all the vulnerability factors that applied in the case into a robust conclusion.

1.4. Planning in custodial cases required improvement. Some plans covered only the custodial phase. A detention and training order is a single sentence that is served partly in custody and partly in the community. The plan agreed with the child or young person at the start of the sentence should give shape to the whole sentence, and recognise which aspects of work will be delivered in custody and in the community. We also found an example of positive practice. Sean was serving a custodial sentence and had completed a bike project in custody. Plans were made to continue this on release. He had also improved his literacy and numeracy, so appointments were made for him to look at gaining qualifications on release. This showed a coordinated approach to delivery of resettlement, and consistency between the two elements of the sentence.

1.5. Planning for work in the community was mixed. Objectives were usually clear and were appropriate to the assessed needs, but this was not consistently the case. In a few cases there was insufficient planning linked to family relationships. In one example of good practice, Lucy was concerned at the possible impact of the sentence on her choice of university course and career. The case manager spent considerable time checking individual universities' approach to this, so as to encourage Lucy to continue her studies. As a result, Lucy had been accepted to undertake the course that she wanted.

1.6. In referral order cases, the objectives in the contracts agreed with the community panel were written in very generic terms. These should explain the changes or actions that the child or young person needs to make, thereby helping them to make an informed decision to sign the contract with a full understanding of what is required of them.

1.7. The breadth and quality of multi-agency work was good. A wide range of partners was often involved in cases, and we heard evidence of good engagement with them. However, the positive information sharing was often not apparent from the case record.

2. Protecting the public

2.1. The understanding of risk of harm to others described by case managers was normally appropriate and comprehensive. However, this was not always reflected in the written assessments, meaning that it was not apparent to anyone else who may need to know. There was some confusion about whether a full assessment and risk management plan was required in medium risk of serious harm cases.

2.2. Planning at the start of the sentence for work to manage risk of harm to others had improved substantially since the last inspection. However, further attention needed to be given to planning during the custodial phase of the sentence, and high risk of serious harm cases would benefit from more frequent review than was usually planned.

2.3. More attention sometimes needed to be given to the risk of harm to identifiable victims, by ensuring that both assessment and planning reflect victim issues sufficiently.

2.4. The YOS used a case planning forum (CPF) to provide oversight to cases with the highest risks. We saw examples of how this helped ensure the quality of work. However, their approach to oversight was too reliant on case managers referring cases to managers or to

the CPF. There were no effective systems in place to ensure that managers became aware of cases that required their attention, and there were some medium risk cases where important deficits in the planning had not been recognised and addressed. Middle managers were too stretched to give this work the consistent attention that it needed.

3. Protecting the child or young person

3.1. Case managers had an excellent understanding of the safeguarding and vulnerability issues in most cases. However, this understanding was often not apparent from the recorded assessment and so not available to others, and did not drive good planning. The vulnerability screening in ASSET[2] was often not used to bring together all the vulnerability factors that applied in the case to create a comprehensive picture to inform future work.

3.2. Planning for work to reduce vulnerability required particular attention. There were too many cases, in particular those classified as medium risk, where a vulnerability management plan was not produced. In others, the plans were unclear or too generic, or did not anticipate and address potential changes sufficiently. Case managers often provided evidence that the right work was being undertaken, but the clarity of these plans was not apparent to others who may need to know, for example, in the absence of the case manager. More attention sometimes needed to be given to smoking cessation work.

3.3. One inspector commented on this example of positive practice: "*staff meet regularly with Mark and his mum to encourage them to engage in activities to avoid conflict and develop bonds with each other. In one session, they completed a board game together on the effects of drug use. This served both as a bonding session and also provided the mother with insight on how to recognise if Mark was using the drugs.*"

3.4. We were disappointed to find that vulnerability management plans were not always developed where required in custodial cases. In two examples of poor practice, case managers had recognised that a custodial sentence would increase vulnerability substantially and require the development of a new or revised management plan, but had still not undertaken this even after a custodial sentence had been given.

3.5. Further attention needed to be given to oversight of safeguarding and vulnerability work, including ensuring that there are effective systems in place to identify those cases where management oversight is required. Plans often included a helpful summary of the key factors that applied in the case, which was intended to support communication with partners. Sometimes these were out of date and incorrect, but had been signed off. The frequency of planned reviews was not always sufficient for complex cases. These issues mirror those identified in oversight of risk of harm work.

4. Ensuring that the sentence is served

4.1. Assessment of diversity and potential discriminatory factors, together with planning to address the impact of these, was generally good. In most cases of Looked After Children, the case manager had developed a good understanding of the impact of being looked after on the individual. However, one case illustrated the need for continuing care. Lee was on a Child Protection Plan and had a statement of special educational needs. The case manager had not obtained a copy of these nor spoken to the workers involved in them. As a result, the planning took no account of these two key issues in Lee's life.

4.2. There was sufficient engagement with both the child or young person and their parents/carers in the assessment in all except one case. However, more attention needed to be given to ensure that their involvement in the development of PSRs is effective, including ensuring that PSRs are understood fully before they are used in court. This

[2] ASSET – the YJB mandated assessment and planning framework used by YOTs.

engagement can be critical to starting the sentence on a positive note. We saw two cases where ineffective engagement in the PSR coincided with a poor start to the sentence.

4.3. Children and young people were not involved sufficiently in planning. It is imperative that the changes that need to be made by children and young people are clear to them, that they own and understand their sentence plan, and are able to influence its contents. More attention should be given in plans to positive factors that may help prevent offending.

4.4. Case managers described a consistent and appropriate approach in the YOS towards non-compliance with the requirements of the sentence. They used a mixture of home and office visits, thereby ensuring that children and young people took responsibility for their own compliance. Where they did not comply, the response was sufficient in all except one case. One inspector commented: "*Lois was looked after and lived in a neighbouring area. Her compliance and relationship with the case manager caretaking the case were deteriorating. A Stockport case manager who had previously worked with Lois visited them both, meeting them in a coffee shop, to help rebuild the relationship, and continued to visit them monthly. Lois's compliance improved considerably.*"

Operational management

Case managers spoke positively about their managers and the support that they provided. They were well informed about and involved in changes. They recognised the pressure that managers were under. There was less evidence of quality assurance work than we would have expected.

Key strengths

- Multi-agency work in Stockport YOS was good.
- The YOS took a positive approach to work with Looked After Children, irrespective of whether they were originally from Stockport.
- Case managers had a good understanding of the children and young people with whom they worked, and on a day-to-day basis were doing good work with them.
- Good engagement had been maintained with staff throughout a difficult recent restructure.
- Assessment of the reasons for offending was generally strong.
- Risk of harm work had shown substantial improvement since the last inspection.

Areas requiring improvement

- Management oversight should ensure that good quality assessments and plans are completed when required, with sufficient resource and systems in place to support this.
- Planning for work to reduce the vulnerability of children and young people should be consistent, of good quality and informed by comprehensive recorded assessments.
- Planning in custodial cases should reflect the whole sentence.
- Engagement with children and young people in planning should support effective delivery of the sentence and ensure that they understand clearly the changes that need to be made.

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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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.