Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
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From:	Helen Mercer, Assistant Chief Inspector
Publication date:	13 May 2015

Report of Short Quality Screening (SQS) of youth offending work in West Mercia

The inspection was conducted from 16-18 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 46 cases of children and young people who had recently offended and were supervised by West Mercia Youth Offending Service. 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 West Mercia was 31.3%. This was better than the previous year and better than the England & Wales average of 36.1%.

West Mercia YOS was formed in October 2012 following the merger of Worcestershire & Herefordshire YOS and Shropshire, Telford & Wrekin YOS. Given that the past two and a half years has been a period of change, including restructuring, it is not surprising that overall there has been a slight deterioration in the quality of work since the previous inspections of the two separate services. We were, however, impressed overall by the commitment of both management and staff to improve the lives of the children and young people they work with and their eagerness to improve their practice.

Commentary on the inspection in West Mercia:

1. Reducing reoffending

1.1. The initial assessment of the child or young person's likelihood of reoffending was found to be sufficient in the majority of cases sampled. Where we found gaps, the case manager had failed to identify factors linked to offending, often providing unclear or insufficient evidence. In general, this was due to a failure to use information available

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

from other workers. Unfortunately, there was little evidence that assessments were improved when they were later reviewed.

1.2. PSRs were provided to the court in 19 cases; the vast majority were of a good quality and, in most cases, there was evidence in the case file that reports had been quality assured before they were submitted to the court. However, we did see one report that had not been quality assured. It was only much later that a neighbouring YOS, managing the case on behalf of West Mercia, identified that the initial risk of harm and vulnerability assessments in the PSR were incorrect. Although this was only one case, it is vital that a process is in place to ensure that all reports are quality assured.

1.3. Plans to reduce the likelihood of reoffending were insufficient in one-third of cases, including those of children and young people sentenced to custody. One example of good planning included actions to address the child or young person's offending behaviour whilst serving the custodial element of his sentence, and actions to support his transition back into the community. A range of agencies were involved and, as a result, accommodation and a training placement were arranged prior to his release, enabling him to transition back successfully into the community.

1.4. The vast majority of plans to reduce reoffending were improved when they were reviewed.

2. Protecting the public

2.1. All but four PSRs included a clear assessment and summary of the relevant risk of harm to others.

2.2. In the majority of initial assessments, an effort had been made to understand and explain the risk of harm posed to the public by the child or young person. However, in a substantial minority of cases, the case manager had not recognised risks posed to identified victims or had failed to take account of potential victims.

2.3. Planning to manage risk of harm was sufficient in the majority of cases inspected. However, it was not good enough in over one-quarter of the cases where it was required. The most common reasons for this were a failure to identify the actions needed, generally and specifically the actions to address risk of harm posed to identified victims; and poor contingency planning. Case managers told us that although there was a forum to discuss cases with risk of harm concerns with managers, the actions agreed were not recorded and, as a result, they were not always followed up.

2.4. Oversight by managers was effective in only half the serious risk of harm cases, mainly because deficits in assessments and plans were not addressed when they should have been.

3. Protecting the child or young person

3.1. In the vast majority of cases, PSRs and initial assessments reflected a sufficient understanding of vulnerability and safeguarding. In eight cases the initial assessment of safeguarding and vulnerability was insufficient, due either to the quality of the screening or the assessment not drawing in information from other agencies.

3.2. Unfortunately, reviews of assessments and plans were not always as good as the initial assessments and plans. In eight cases this was due to the lack of a vulnerability management plan when a child or young person's circumstances had changed significantly. In others, planned responses to changes in the level of vulnerability were unclear or insufficient.

3.3. Assessments and planning to protect children and young people in custody were generally of a high standard. We saw some good examples of caseworkers attending planning meetings and maintaining contact with the child or young person and their parent/carer throughout their time in custody. There were, however, gaps in this work when it came to the child or young person moving back into their community. Reviews often failed to reflect changed circumstances, and in particular issues around the need for safe accommodation and support.

3.4. Management oversight of this area of work was not effective in one-third of cases because deficiencies in assessment and planning were not addressed, and internal forums were not effective in improving the quality of work to protect children and young people.

4. Ensuring that the sentence is served

4.1. Engagement with children and young people and significant others when carrying out the assessments was good enough in the vast majority of cases. In one particularly good example: *"Carl had breached a number of previous orders. On release from his Detention and Training Order, his worker recognised that Carl was easily overwhelmed by contacts and appointments, and planned work which was simple and easier for him to manage. Carl completed his licence period successfully without reoffending or breach.*"

4.2. Attention had been paid to assessing the child or young person's diverse needs and any barriers to engagement in the majority of cases. This included attention to the child or young person's speech, language and communication skills (SLACS). We were pleased to see examples of the YOS specialist SLACS worker working with case managers to both address the child or young person's needs and improve their motivation. An example of this work was: *"Liam, who suffered with speech impairment. The speech, language and communication worker met Liam and his caseworker to assist with communication and to advise the case manager on how to plan his work with Liam – asking questions that required only short answers and using worksheets that could be completed without much talking.*" We also saw examples of the SLACS worker assisting case managers when interviewing children and young people with learning disabilities.

4.3. There was evidence of good involvement of the child or young person and their parents/carers at the PSR stage, and in understanding diversity factors linked to offending. However, there was less evidence of service user involvement in the planning of interventions or in the reviewing of both assessments and plans.

4.4. To help a child or young person desist from further offending, the case manager needs a clear understanding of barriers to engagement. In almost half of the cases there was little or no evidence that the case manager had such an understanding. This was mainly because the case manager had not considered them at the planning stage.

4.5. We were pleased to find that, overall, the YOS had paid sufficient attention to the health and well-being outcomes for the children and young people under their supervision. A good example was: *"Mia, who was sectioned due to deterioration in her mental health leading to self-harm, and in her physical health due to her harmful behaviour. In her assessment and planning, the case manager recognised the paramount importance of maintaining good regular contact during Mia's stay in a mental hospital, and then a secure care home. As a result, when Mia returned to live with her parents, the case manager was able to build quickly on their relationship as Mia saw her case manager as someone she trusted.*"

4.6. Compliance with the work of the YOS was generally good. When the child or young person did not comply, the response of the case manager was appropriate in almost all cases.

Operational management

As previously reported, the YOS had undergone a period of change and restructure and the management board recognised that this had impacted adversely on service delivery. At the time of the inspection, the YOS was about to launch a practice improvement programme aimed at both improving service delivery and achieving better outcomes for the children and young people they work with and their local community. There is a clear need to improve both practice and management oversight.

The majority of the staff we interviewed had a sufficient understanding of effective practice, and local policies and procedures for the management of risk, safeguarding and responding to non-compliance. Most understood the priorities of the organisation. Countersigning/management oversight was not viewed as operating effectively by almost half of all case managers interviewed.

Key strengths

- Services provided to the courts, and in particular PSRs, were of a high standard.
- Assessments of diversity factors. This had been aided by the introduction of learning style questionnaires and the availability of a speech, language and communication skills worker within the Worcestershire area of the YOS.
- Good levels of compliance and, where needed, effective enforcement of court orders.
- The engagement of children and young people and parents/carers at the PSR stage and in understanding diversity factors.
- Positive health and well-being outcomes for children and young people as the result of multi-agency working.

Areas requiring improvement

- Planning to address vulnerability required substantial improvement.
- Reviews of assessment and planning to address reoffending and vulnerability needed improvement.
- Assessments and interventions of the speech, language and communication skills worker should be available across all areas of the YOS.
- More attention needed to be given to victim safety and identifying actions to manage this.
- Managers should provide greater support to staff to improve the quality of their assessments and plans, and ensure that their oversight of risk of harm and safeguarding work is effective.

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 Les Smith. He can be contacted at les.smith@hmiprobation.gsi.gov.uk or on 07798 607828.

Copy to:

YOS Head of Service	*Keith Barham*
Local Authority Chief Executives	*Herefordshire - Alistair Neill* *Shropshire - Clive Wright* *Worcestershire - Clare Marchant* *Telford and Wrekin - Richard Partington*
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Police and Crime Commissioner for West Mercia	*Bill Longmore*
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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.