Inspection of Youth Offending Work
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From:	Helen Mercer, Assistant Chief Inspector (Youth Justice)
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Report of Short Quality Screening (SQS) of youth offending work in East Sussex

The inspection was conducted from 28-30 September 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 20 cases of children and young people who had recently offended and were supervised by the East Sussex Youth Offending Team. 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 East Sussex was 36.3%. This was 2.6% higher than the previous year and lower than the England and Wales average of 37.4%. We found work of good quality in the Youth Offending Team (YOT). Staff were well engaged with the children and young people under their supervision, and were responsive to their needs and situations. They used appropriate methods to maximise engagement to reduce reoffending, and were working constructively with other agencies involved with their cases. There was scope for improvement, particularly in planning to manage the safeguarding and vulnerability of the children and young people.

Commentary on the inspection in East Sussex:

1. Reducing reoffending

1.1. A newly prepared pre-sentence report (PSR) was provided to the court in seven of the cases we inspected, and these were all of a good standard. In a further eight cases, the child or young person was already subject to supervision, and in these cases it was YOT practice to provide information to sentencers in the form of a breach report, while in two more cases a report prepared for a previous occasion was used. The court was able to

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

follow the YOT's recommendation for sentence in all the cases, although we considered more information could have been usefully provided to sentencers in one-quarter of them.

1.2. We were pleased to see that children and young people, and their parents/carers, were involved in the preparation of their PSR in all but one case. Reports paid sufficient attention to diversity factors and potential barriers to engagement. Local quality assurance arrangements were effective in identifying areas for improvement in report writing. A good quality report was provided to the youth offender panel in all four of the referral orders we inspected.

1.3. The assessment of why the child or young person had offended was good enough in three-quarters of the sample. In three cases, an initial assessment had not been prepared and in two it was not of sufficient quality. In general, the largest scope for improvement was in the assessment of lifestyle, emotional and mental health, and the child or young person's motivation to change. Some assessments lacked clarity as a result of having a single ASSET document to cover successive court orders, and not reviewing and editing it adequately following the making of a new order.

1.4. Planning for work in the community to prevent reoffending was insufficient in more than one-third of cases, either because it was not timely, not done at all, or because poor attendance by the child or young person delayed, or prevented, its completion. However, in most cases the intervention plan objectives related clearly to the child or young person's offending and their sentence. There was a sufficient review of the assessment and the sentence plan in more than three-quarters of the cases where this was required.

1.5. Six cases in our sample were subject to custodial sentences, and planning during the custodial phase of the sentence for work to reduce reoffending was insufficient in half of them. In one case, a planning meeting had been held but the completed plan had not been forwarded to the YOT. Two required more focus on the personal needs and resettlement of the child or young person.

1.6. We were impressed by the approaches and interventions used with the children and young people, including a YOT psychologist, a youth employment scheme, substance misuse work, and a junior attendance centre. We saw creative responses to the learning styles and any communication needs of the children and young people. The case managers we met demonstrated considerable knowledge of, commitment to, and enthusiasm for working with those under their supervision.

2. Protecting the public

2.1. The work to understand and explain the risk of harm to others posed by the child or young person was of sufficient quality in all but three of the cases we inspected. Where required, planning to manage assessed risks was sufficient in all cases, except three where no plan had been completed, due to poor attendance (as noted above). For those serving custodial sentences, planning for work to address risk of harm to others while in custody was sufficient in only three of five relevant cases.

2.2. The YOT had integrated the planning of vulnerability and risk of harm management, and sentence planning, within a single sentence planning framework. While it was helpful to address all objectives for the work with the child or young person in a single document, how the proposed work would *specifically* address the management of the risk of harm or the child or young person's vulnerability could have been clearer in some cases.

2.3. Where there was an identifiable victim or potential victim, there was sufficient evidence that the risk of harm they faced had been effectively managed in all but one case. The ongoing review of risk of harm to others was sufficient in all but three of the cases where

this applied. In some cases it was not reviewed following a significant change in circumstances. Risk management was formally reviewed in a similar number of cases and not reviewed in two cases where we considered this to be required.

2.4. We assessed that management oversight had been effective in ensuring the quality of work to address risk of harm to others in two-thirds of relevant cases. In the other cases, deficiencies in assessment and planning had not been rectified.

3. Protecting the child or young person

3.1. A considerable proportion of the children and young people in our sample were considered to be vulnerable, and four of them had been a Looked After Child (via a care order or remand to local authority accommodation) during the period of supervision being inspected.

3.2. In three-quarters of all the cases we inspected there had been a sufficient assessment of safeguarding and vulnerability needs. However, in a small number of cases, an adequate screening or assessment of vulnerability had not been undertaken. The impact of key aspects of the child or young person's vulnerability, particularly in relation to their emotional and mental health or substance misuse, had sometimes been underestimated.

3.3. There was insufficient planning in place to manage safeguarding and vulnerability needs at the start of the sentence in more than one-third of the cases. In these, contingency planning, planned responses, and attention to barriers to engagement were insufficient. More generally, areas for improvement included planning to address safeguarding related to drug or alcohol misuse, and emotional or mental health. For those serving custodial sentences, the planning while in custody was of sufficient quality in only half of the relevant cases.

3.4. We found there were indicators for child sexual exploitation in 11 of the 20 cases. We were pleased that these had been recognised by the YOT in all of them, and responded to as required in all but one. We found examples of good use of police intelligence to support safeguarding work where the child or young person was at risk from known adults. In some cases, more consideration should have been given to the likelihood of criminal exploitation by older offenders, typically in relation to drug dealing. The ongoing review of safeguarding and vulnerability needs was sufficient in 10 of the 13 cases where this was required.

3.5. In line with these findings, we assessed that management oversight had been ineffective in ensuring the quality of work to address safeguarding and vulnerability in more than half of relevant cases. In these cases, deficiencies in the assessment or planning had not been rectified.

3.6. Overall, the YOT gave sufficient attention to the health and well-being of almost all the children and young people in our sample, in so far as these acted as potential barriers to successful outcomes from the sentence. We were pleased to find that in one-third of the cases, there had already been a reduction in factors linked to safeguarding within the first three to six months of the sentence. In many instances, there was evidence of effective communication and co-working of cases with children's services and other agencies. We were pleased to see the use of multi-agency 'complex case planning meetings'.

4. Ensuring that the sentence is served

4.1. Sufficient effort was made to identify and understand diversity factors and possible barriers to engagement in almost all cases, and in the large majority the children and young people, and their parents/carers, were sufficiently involved in the planning of their

supervision. In the majority of cases we inspected, there was evidence of the use of methods and tools to engage and interact with the child or young person in a way that was responsive to their age, learning style and level of maturity.

4.2. Poor attendance at the initial planning stage (as noted above) meant that insufficient attention was paid to barriers to engagement, and other diversity or discriminatory factors, in one-quarter of the cases, even though generally these factors were sufficiently assessed.

4.3. The engagement of the child or young person with the work of the YOT was maintained and/or improved in three-quarters of cases, and nearly two-thirds had complied with the requirements of their sentence. Case managers were able to develop positive working relationships with them, and their parents/carers, and other key people in their lives. There was good use of home visiting and joint working with other agencies, enlisting the support of other staff with whom the child or young person was involved to help maintain contact.

4.4. We have noted that there were problems with the attendance of some of the children and young people, but we were pleased to find that the YOT had responded appropriately in all cases, for example, in using formal warnings or breach proceedings.

Operational management

We interviewed eight case managers and all spoke very positively about the quality of support and supervision they received from their managers, whom they considered to be appropriately skilled and knowledgeable. Staff thought the culture of the organisation promoted learning and development. All of the case managers thought that their training and development needs had been met in relation to their current post, and all but one that their future development needs had also been responded to.

Case managers considered they had received sufficient training to deliver the interventions they used in their work, and nearly all felt able to recognise and respond to diversity or potential discriminatory factors. All of the YOT practitioners had been on a training course to recognise and respond to the speech, language and communication needs of children and young people. These views were generally reflected in the quality of the work we saw.

Key strengths

- PSRs and referral order panel reports were of a good standard.
- Case managers demonstrated good knowledge of, and commitment to, those under their supervision.
- The potential risk of child sexual exploitation was recognised in all likely cases.
- Good attention was paid to the health and well-being outcomes of children and young people.
- Children and young people, and their parents/carers, were involved in the assessment and planning of work with them.

Areas requiring improvement

- Staff and managers should ensure that, in all cases where required, there is sufficient planning in place to manage the safeguarding and vulnerability of the child or young person.
- Managers should ensure there is effective oversight of the quality of work to address the risk of harm to others, and the safeguarding and vulnerability of children and young people.

We are grateful for the support that we received from staff in the YOT 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 Steve Woodgate. He can be contacted at steve.woodgate@hmiprobation.gsi.gov.uk or on 07789 943088.

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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.