Inspection of Youth Offending Work
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To:	Gerald Meehan, Chair of Cheshire West, Halton and Warrington Youth Offending Service Management Board
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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 Cheshire West, Halton and Warrington

The inspection was conducted from 9 November 2015 – 11 November 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 34 cases of children and young people who had recently offended and were supervised by Cheshire West, Halton and Warrington Youth Offending Service (YOS). 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 Cheshire West, Halton and Warrington was 35.6%. This was worse than the previous year but better than the England and Wales average of 37.9%.

The quality of work to protect the public, assess and manage the vulnerability of children and young people was high and had improved since our last inspections in 2009 prior to the amalgamation of Cheshire West and Chester, Halton and Warrington services. Cheshire West, Halton and Warrington YOS was delivering good quality reports to the court, staff were skilled at engaging with children and young people and building trusting relationships. We were impressed by the high quality work we saw from assessment pre-court, to the delivery of interventions.

Commentary on the inspection in Cheshire West, Halton and Warrington:

1. Reducing reoffending

1.1. We looked at 18 cases where a new pre-sentence report (PSR) was requested by the court. We were pleased to find that all the reports contained a thorough analysis of the reasons why the child or young person had offended, their likelihood of reducing

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

reoffending and the risk of harm they posed. In every case, safeguarding and vulnerability issues had been addressed sufficiently. Sentencing proposals were appropriate in all cases. We saw evidence of management oversight in all the reports and judged it to be effective in ensuring a good quality report was produced in all of the relevant cases.

1.2. We found that case managers had effectively assessed the reasons for children and young people's offending in almost all of the cases we inspected. In only two instances, did we think the reasons for offending were not sufficiently analysed. Engagement with parents/carers and people who played a significant role in the lives of children and young people was good in all cases, and reflected in assessments and plans to reduce reoffending.

1.3. Reviews of assessments were completed to the required standard in almost all relevant cases. We found in one case that the assessment was not reviewed when required and in another that it did not contain a sufficient update.

1.4. Plans to reduce reoffending were of a good standard in almost all community cases. Case managers explored, analysed and included the views of the child or young person and their parents/carers. Plans were relevant to the situation of the child or young person and identified interventions to reduce reoffending. Reviews of plans were completed to a sufficient standard in all but one case.

1.5. In all five of the custodial cases we inspected, we saw evidence of effective assessment and planning through custody into the community and good liaison between case managers and staff in the custodial setting.

2. Protecting the public

2.1. All the PSRs we saw had a thorough assessment of Risk of Serious Harm (RoSH). All of the cases had a sufficient assessment of RoSH posed by the child or young person. Assessments drew on information from relevant sources and took into account previous relevant offences. In one case we saw "*..... a very detailed RoSH, providing the reader with a clear picture of actual concerns, potential harm, the concerns of others working with the child or young person and a clear assessment of what needed to happen.*"

2.2. We were pleased to find that the YOS had a well-established risk review meeting as a forum for all the agencies involved with the child or young person, to share information and agree plans to manage the risk of serious harm and vulnerability. We saw evidence of a good exploration of risk of harm and vulnerability issues at these meetings, which led to considered and appropriate risk management and vulnerability plans.

2.3. The risk of serious harm classification can change in response to changes in a child or young person's life. It is important that the situation is monitored and, if significant changes occur, that assessments are then reviewed. We saw effective reviews of RoSH assessments in almost all of relevant cases. Only one case where a review was done was it judged to be insufficient, and this was due to the timeliness of the review, not the quality of the assessment in it.

2.4. We found good quality risk management plans in all but one case. We thought that plans could be made even better by developing robust and specific contingency plans. Almost all cases addressed the risk of harm to potential victims and had clear and detailed plans in place to manage the identified risks. In our view, two cases would have benefited from a more specific plan to manage the potential risk of harm.

2.5. Effective management oversight is an important part of accurate risk assessment and appropriate risk management planning. We judged the management oversight as effective in almost all the cases we examined. In two cases, deficiencies in assessment

had not been identified by managers, and deficiencies in planning had not been addressed.

3. Protecting the child or young person

3.1. All of the PSRs we looked at had a thorough assessment of vulnerability. Following sentence, vulnerability assessments were sufficient in all but two cases. Where they were not, we felt case managers could improve their vulnerability assessments by ensuring they obtained all relevant information from all the agencies involved with the child or young person. In another case, the nature or level of vulnerability was not clear in the assessment. Case managers were good at including the child or young person, their parents/carers and others important to the child or young person in the assessments; we saw evidence of this in all cases.

3.2. Reviews of vulnerability assessments were of a high standard in almost all relevant cases. In only one case did we judge the review to be insufficient; this was due to it being done late, rather than as a result of a quality issue.

3.3. Planning to address vulnerability issues and reduce the risk of serious harm to children and young people is a key task for case managers and we found it was done well in almost all cases. Plans were thorough and identified both the issues and what needed to be done to address them. We judged that some plans could have been even better if the contingency plans had been more detailed. Two cases had insufficient planning for emotional and mental health issues.

3.4. Plans to manage vulnerability were reviewed to a good standard in all but one case; again this was due to a timeliness issue. In one case, the review did not address all the relevant issues in the case. In another, the review was not completed when required.

3.5. The risk review meeting was one of the measures in place to ensure effective management oversight of safeguarding and vulnerability. It was clear that staff working with children and young people were also receiving regular supervision and were involved in case discussions with the management team. We found management oversight to be good in almost all cases. Oversight processes did not, however, identify deficiencies in the vulnerability planning in one case, and a late review in another. We were impressed by the level of meaningful management oversight we found.

4. Ensuring that the sentence is served

4.1. Diversity factors and barriers to engagement were identified in almost all of the cases inspected. We saw evidence these issues were incorporated in the majority of assessments, and plans devised to address those barriers were clear and appropriate.

4.2. In almost all cases, we judged that case managers were engaging well with children and young people and building the trust needed to do the work to address their offending and reduce reoffending. The views of parents/carers and other significant people in the child or young person's life were taken into account by case managers and influenced court reports, assessments and plans. We were impressed by the quality of the work in this area. An Inspector saw "*.....really good engagement via the Intensive Supervison and Surveillance and other support worker involved in the case - clearly significant resources were available to support young people. The case manager and others were clearly invested in working with the young person and developed a strong relationship with him.*"

4.3. Plans to address barriers to engagement and other diversity or potentially discriminatory factors were good in most cases. Whilst work in this area was generally good, we did identify five cases where the quality of this work needed to improve. Issues were that not

all barriers to engagement were addressed, for instance, speech language or communication needs in two cases were not given sufficient attention. In another two, the children or young people were Looked After by the local authority and these factors were not identified and planned for sufficiently.

4.4. The health and well-being of children and young people was addressed effectively in all but one case and case managers were quick to identify the relevant medical support needed for children and young people.

4.5. There were 14 cases in which the child or young person did not comply with the requirements of the order. In eight of these cases, the case managers worked with the children and young people and were able to overcome their lack of engagement without returning them to court in breach. Three cases were returned to court.

Operational management

We found that all case managers interviewed had an understanding of the principles of effective practice; understood organisational policies and procedures concerning risk management; and safeguarding and compliance. All staff felt that the management oversight of risk of serious harm and safeguarding was effective. Staff stated they were supported by their line manager and that their line manager had the skills required to assess the quality of their work, and help them to improve the quality of their work. We judged that quality assurance arrangements through supervision had a positive impact in almost all of the cases we inspected. All staff felt that the training provided had been successful in enabling them to do their job, although a need for further training in speech, language and communication needs was identified by some.

Strengths

- High quality reports were produced and provided for the courts and referral order panels.
- Vulnerability and risk management plans were thorough and identified relevant issues and methods for reducing the vulnerability of children and young people.
- Staff were excellent at engaging both children and young people and their parents/carers.
- Management oversight was of a high quality and was effective in ensuring high quality work with children and young people.

Areas requiring improvement

- Risk management plans and vulnerability management plans could be further improved by the inclusion of well-developed contingency plans.
- Case managers must ensure that barriers to engagement and other diversity issues are captured at assessment and inform planning.

We are grateful for the support that we received from staff in Cheshire West, Halton and Warrington 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 Jonathan Nason. He can be contacted at jonathan.nason@hmiprobation.gsi.gov.uk or on 07768 073286.

Copy to:

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Local Authority Chief Executive – Cheshire West and Chester Council	*Steve Robinson*
Local Authority Chief Executive – Halton Borough Council	*David Parr*
Local Authority Chief Executive – Warrington Borough Council	*Professor Stephen Broomhead*
Director of Children's Services – Cheshire West and Chester Council/Halton Borough Council	*Gerald Meehan*
Director of Children's Services – Warrington Borough Council	*Stephen Reddy*
Lead Elected Member for Children's Services - Cheshire West and Chester Council	*Councillor Nicole Meardon*
Lead Elected Member for Children's Services - Halton Borough Council	*Councillor Ged Philbin*
Lead Elected Member for Children's Services - Warrington Borough Council	*Councillor Jean Carter*
Lead Elected Member for Crime - Cheshire West and Chester Council	*Councillor Nicole Meardon*
Lead Elected Member for Crime - Halton Borough Council	*Councillor Dave Cargill*
Lead Elected Member for Crime - Warrington Borough Council	*Councillor Jean Carter*
Police and Crime Commissioner for Cheshire	*John Dwyer*
Chair of Local Safeguarding Children Board - Cheshire West and Chester Council	*Gill Frame*
Chair of Local Safeguarding Children Board – Halton Borough Council/Warrington Borough Council	*Richard Strachan*
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Care Quality Commission	*Fergus Currie*

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.