Inspection of Youth Offending Work
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To:	Ann Goldsmith, Chair of Sunderland Youth Offending Team Management Board
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From:	Alan MacDonald, Assistant Chief Inspector (Youth Justice)
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Report of Short Quality Screening (SQS) of youth offending work in Sunderland

The inspection was conducted from 08-10 February 2016 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. 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 Sunderland was 37.0%. This was slightly worse than the previous year but better than the England and Wales average of 38.0%.

Overall, we found that Sunderland Youth Offending Team (YOT) was supported by an experienced, committed and motivated team who knew their cases and their families well. There was a commitment to the ‘Strengthening Families’ initiative, which supported a holistic approach to deliver improved outcomes beyond the child or young person under supervision. The YOT benefited from mature embedded relationships with key services, for example, community policing, children’s services, education and the Youth Drug and Alcohol Project. There were impressive links with health services, which facilitated fast-track health assessments and access to specialist services. Assessment and planning was generally good, although less so in high risk of harm work. There was scope to strengthen management oversight of high risk cases and improve practitioners’ understanding and confidence of Multi-Agency Public Protection Arrangements (MAPPA) and risk management practice. We found staff reflective and ready to improve their practice, they were ambitious for those they worked with.

[1] Published January 2016 based on binary reoffending rates after 12 months for the April 2013 – March 2014 cohort. Source: Ministry of Justice

Commentary on the inspection in Sunderland:

1. Reducing reoffending

1.1. A high proportion of pre-sentence reports were of good quality. Court reports were reliably supported by an assessment of the reasons for offending with the majority of assessments providing sufficient planning for work in the community to reduce reoffending.

1.2. Work to review progress and assessment of risk of harm and vulnerability was less consistent. Reviews were not prepared in a timely way, or revisited following a significant event/decision where we would have expected this in one-third of relevant cases, for example, following sentence or a decision to deregister a child or young person from MAPPA.

1.3. There were a number of positive examples where the case manager had worked hard to keep parents/carers engaged who had been exhausted by their child's behaviour. An inspector was impressed by the guidance and encouragement provided by a case manager to a father who became reconciled with his son and provided the young person with settled accommodation and full-time employment. "*The young person had moved through many different addresses in the past two years and this change in his circumstances provided the catalyst for a significant improvement in his behaviour. The case manager provided guidance to the father to monitor any return to drug misuse and the importance of praise to support his son's good progress.*"

1.4. Case managers recognised the importance of supporting children and young people to access education, training and employment. Good relationships existed with the staff from the Pupil Referral Unit, who made interview space available for case managers and contributed to the coordination of interventions. One outstanding piece of work cited by an inspector was: "*The case manager recognised Mark's reluctance to attend training was because of negative experiences in education and subsequent lack of confidence in his own abilities. The case manager discussed this with the training provider and 'staged' Mark's introduction into the training environment at an appropriate pace, this included arranging initial attendance when there were no other young people there.*"

2. Protecting the public

2.1. Case managers communicated both with the team member leading for Restorative Justice and, where relevant, the Victim Liaison Officer. In all but one case it was clear that the risk of harm to known victims was effectively managed. Case managers were confident in addressing victim empathy work and ensured this formed part of the planned interventions.

2.2. Good attention was given to sequencing tasks within a sentence plan and case managers were able to provide examples where they had made changes to prioritise management of risk of harm, address vulnerability and reduce barriers to engagement.

2.3. One-quarter of the cases inspected were assessed as presenting a high risk of serious harm, with seven presenting as a low risk. Given the small number of high risk cases, we would have anticipated greater evidence of management oversight/scrutiny. In one example, we were concerned that no review of assessment or risk management planning had been taken following sentence, where it was clear family circumstances had changed which were significant to the young person's potential for risk of harm. While it applied to a very small number of cases, the case managers' understanding and experience of MAPPA was limited and required development.

2.4. Risk management planning for cases identified as presenting a high risk of serious harm was not always clear. The YOT had committed to producing 'one plan' in 2012, which on

the whole worked well and made it easier for the child or young person to understand, however, there was less explicit attention given to risk management and we considered this was an area for improvement.

3. Protecting the child or young person

3.1. Assessment and planning to address children and young people's vulnerability was thorough and, in particular, it was pleasing to see case managers demonstrate tenacity, determination and perseverance to find ways to address resistance and develop strategies to support compliance. One inspector commented: "*Julie was at risk of breaching her order, her lifestyle was chaotic and she had high vulnerability and welfare needs. The case manager rescheduled the times of her appointments and took a more flexible approach, which enabled her to continue to engage and complete the work.*"

3.2. The YOT received daily reports from the police informing them of any children or young people who had been arrested so they were in a position to respond quickly, providing information where appropriate to court and checking on the child or young person's well-being. We found many examples of excellent local knowledge of relevant issues, for example, patterns of changing drug use (legal highs), policing strategies, peer and family networks that contributed to case management.

3.3. We found evidence of forward planning for the termination or transfer into adult services. In particular, attention was given to exit strategies, allowing where appropriate for the child or young person to continue to access wrap around support, on a voluntary basis.

4. Ensuring that the sentence is served

4.1. In a number of instances we found the court had been informed appropriately through a breach report, which explained the level of engagement and compliance supported by a clear proposal. We also saw examples where the case manager had attended court and provided an immediate oral report based on their current working knowledge of the child or young person, which had enabled the court process to be completed efficiently and supported the early implementation of interventions.

4.2. Compliance panels were held with the child or young person and their parents/carers where there was a likelihood of breach proceedings and efforts were made to check whether all opportunities to support compliance had been explored. When the child or young person did not comply with the sentence action was taken appropriately.

4.3. There was a commitment to ensure the child or young person met the requirements of the order. In one case there had been poor compliance of requirements in a referral order which led to a return to court and imposition of a youth rehabilitation order. The case manager clearly continued to address the unmet requirements and made sure that they were completed. The case manager was careful to explain that despite no further offending in the previous 12 months, the young person was still required to address the consequences of their original offending.

4.4. Recording of the outcome of the compliance panel and decisions taken were not always clearly noted. This finding supported other observations that the recording of events on ChildView contacts was applied inconsistently. It was recognised that the recent move to ChildView2 had presented some recording challenges and was being explored by the YOT.

4.5. Recording of interventions and significant events by different members of the YOT were not always captured on the contact log. Where this was managed well it was possible to observe the case manager 'orchestrating' the delivery of the sentence plan, with contributions from different specialists within the YOT, for example, the case manager and

reparation officer worked closely to support compliance. Sentence plans and contacts should provide an effective means of communication for all who need to use them to support the delivery of the order.

Operational management

We found that the staff interviewed had a good level of confidence in their management, received regular supervision and considered they were supported to access relevant training and develop their skills. Assessments and court reports were gate kept and we saw examples of feedback being taken on board. Recording of management oversight in case records, however, was inconsistent in approach. For example, oversight of significant decision-making events could be improved if outcomes in relation to compliance panels and MAPPA meetings were recorded and review dates followed up.

The YOT also conducted regular thematic quality assurance internal inspections, which added a further level of oversight and scrutiny beyond the monthly supervision by line managers. Evidence was provided that showed that the YOT routinely examined learning from national reports and considered how recommendations could be incorporated locally where appropriate.

Key strengths

- Case managers knew their children and young people and their parents/carers well. They demonstrated tenacity and persistence to engage them and 'stay in there' and work through any resistance.
- Case managers were skilled and confident in making plans and conscientious in sequencing tasks to address vulnerability and encourage engagement and compliance.
- Arrangements within Sunderland YOT were well-organised, mature and supported by a culture of learning and improvement.
- The Sunderland Strengthening Families initiative was impressive; the Family Intervention Practitioners were able to provide additional support enabling parents/carers who were struggling to cope.
- Sunderland YOT benefited from an effective child focused paediatric service that enabled vulnerable children and young people to be fast-tracked for assessment and directed to specialist services.
- There was a good understanding and knowledge of the locality, which was informed by strong effective partnerships, where intelligence was shared and acted upon.

Areas requiring improvement

- Reviews of assessment and planning should be completed, particularly relating to significant events, changes in risk levels and sentence.
- Recording on the contact log should be consistent and include key decision-making and activity of all YOT staff contributing to the sentence plan.
- Management oversight, particularly of high risk of harm cases, should be better targeted to provide assurance that all required action has been taken to minimise risks.
- Practitioners' understanding and familiarity of MAPPA processes was limited and they lacked confidence and required training to improve their management of cases where there was a high risk of harm to others.

We are grateful for the support that we received from staff in Sunderland 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 Tessa Webb OBE. She can be contacted at Tessa.webb@hmiprobation.gsi.gov.uk or on 07920 818943.

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Elected Mayor	*Cllr Barry Curran*
Police and Crime Commissioner for Northumbria	*Vera Baird*
Chair of Local Safeguarding Children Board	*Colin Morris*
Chair of Youth Court Bench	*Geryy Tierney*
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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.