Inspection of Youth Offending Work
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To:	Merlin Joseph, Chair of Dudley Youth Offending Service 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 Dudley

The inspection was conducted from 23-25 May 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 14 cases of children and young people who had recently offended and were supervised by Dudley 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 Dudley was 32.6%. This was worse than the previous year but much better than the England and Wales average of 37.8%.

Overall, we found case managers who were committed to achieving positive outcomes and knew the children and young people under their supervision well. Strong communication links supported effective information sharing. Gaps in recording evidence, or staff's own gaps in knowledge and skills, however, limited their ability to understand the wider picture and, therefore, effectively plan to manage the vulnerability of the child or young person. Management oversight did not address ineffective planning or reviews.

Commentary on the inspection in Dudley:

1. Reducing reoffending

1.1. Both courts and referral order panels seek advice from youth offending teams to help inform their decisions. Pre-sentence reports (PSRs) were provided by the YOS in eight of the cases we looked at. All were appropriately concise and outlined in a helpful way the context within which children and young people offended, and provided sensible

[1] The reoffending rate that was available during the fieldwork was published April 2016, and was based on binary reoffending rates after 12 months for the July 2013 – June 2014 cohort. Source: Ministry of Justice.

proposals for sentence. While the large majority of PSRs were fit for purpose, a few reports would have benefited from a clearer analysis of the offending behaviour and explanation of the child or young person's safeguarding and vulnerability issues. More attention could be given to the inclusion of diversity factors and potential barriers to engagement.

1.2. Case managers were generally able to say why individual children and young people had offended. We were pleased to see that an assessment had been completed in all cases and each of these had been prepared in a timely way. In one case an inspector noted clear evidence that a case manager had sought to understand the underlying reasons driving a young person's behaviour. There was less focus purely on offending and more exploration and targeting of his emotional well-being and self-perception/identity. The recognition of the effects of his disrupted upbringing and experiences as a Looked After Child had clearly informed the assessment and plan.

1.3. A few assessments did, however, contain gaps in analysis, for example: the child or young person's safeguarding and vulnerability issues, their emotional or mental health or disability, or how their age or maturity influenced their offending behaviour.

1.4. There was also a review of the assessment in eight cases. In all but two these had been completed at the right time and in the right way. One review had not been completed at all and another was not of sufficient quality to make sure the assessment had been updated sufficiently.

1.5. Planning to reduce the likelihood that a child or young person would reoffend varied in quality. Planning was sufficient in custodial cases, but in the community, several plans did not meet the needs of the case or only included high level objectives with no supporting detail. The voice of the child or young person was not included; plans were created and imposed by the case managers.

2. Protecting the public

2.1. Work at the start of the order to understand and explain the risk of harm the child or young person posed to others was good enough in three-quarters of relevant cases. Case managers assessed the risk of harm in their complex cases, drawing widely on the information available to reach their conclusions, and the nature of the risk the child or young person posed to others.

2.2. Having assessed the risk of harm posed, we would expect to see planning to reduce and manage this. This should set out clearly how and when victims and potential victims would be protected, and how agencies would work together to achieve this. Again, planning in custodial cases to manage the risk of harm posed to others was sufficient. In the community, planning generally did meet the needs of the case but some planning did not address victim issues sufficiently, or include required interventions to manage risk of harm.

2.3. In most instances, case managers had good links with workers in partner agencies in order to gather new information throughout the course of the case about the risk of harm a child or young person posed to others. This, however, did not make sure that all relevant cases included a thorough review of assessments and plans, which we considered to also be a failing in management oversight in those cases.

3. Protecting the child or young person

3.1. It is important to consider not only how and why a child or young person is vulnerable, but also how this could influence their behaviour. Case managers had given enough

thought to this in two-thirds of the cases we looked at. Referrals were made for specialist assessments where necessary and good use was made of the in-house speech and language specialist. Case managers, however, did not always consider the wider picture to draw their conclusions about the nature of vulnerability and this had an inevitable impact on the quality of planning.

3.2. We were disappointed to find sufficient planning at the start of a sentence, to protect the child or young person, in only one-third of cases. Planning did not address safeguarding related factors such as emotional or mental health, employment, training and education, physical health and substance misuse. Plans did not give sufficient attention to diversity factors or other barriers to engagement.

3.3. In custody cases, case managers did make sure that sufficient planning was in place during the custodial period to address the child or young person's vulnerability in two of the three relevant cases.

3.4. Case managers often assimilated information that emerged during the sentence into their thinking, but this was not recorded often enough in assessments or reviews. Reviews were, therefore, considered insufficient in almost three-quarters of cases and did not drive necessary changes in planning. Again, management oversight did not effectively make sure the quality of work to address safeguarding and vulnerability was sufficient in half of the relevant cases we inspected.

3.5. In cases that involved child sexual exploitation, the YOS almost always recognised relevant issues and in most instances, had taken appropriate action, although case managers needed to improve their recording of planned actions by other agencies and teams.

4. Making sure the sentence is served

4.1. Strong relationships are often key to helping children and young people comply with their sentences. Case managers engaged well with children and young people, their parents/carers and significant others in order to understand the circumstances of a case. All were sufficiently engaged in the development of their PSR.

4.2. This good engagement, however, did not continue into planning, where children and young people and their parents/carers were not sufficiently included in the planning process. Case managers did not fully take account of the child or young person's goals when planning interventions to reduce reoffending, protect the public, the child or young person's own vulnerability or to make sure that the sentence was served.

4.3. Case managers planned to have appropriate levels of contact with children and young people in the community. They had regular contact with children and young people in custody and strong communication links with key officers in the custodial environment to make sure the sharing of information was comprehensive and flowed in both directions. Case managers gave sufficient attention to the health and well-being of the children and young people supervised, giving good attention to health, including sexual health.

4.4. Communication was also good with other agencies. One inspector noted particularly good work where a young person had been challenging and disruptive at school and home. The young person and her family had undertaken Multi-Systemic Therapy, to positive effect. The young person had been accepted back into mainstream schooling, a very successful outcome in light of her offending. She had, however, to appeal against a withdrawn offer of a place at a particular school. The case manager and social worker had worked well together to support the appeal and advocate for the young person, but were also making contingency plans in case the appeal was unsuccessful.

4.5. Where children and young people were not fully compliant with the order of the court, we found that the YOS responded effectively by holding compliance panels and, if necessary, by returning the orders to court, demonstrating staff's clear understanding of the local policies for responding to non-compliance.

Operational management

All of the case managers we interviewed had a sufficient understanding of the principles of effective practice, and about half fully understood the YOS's policies for safeguarding and the management of risk of harm to others. All felt their managers supported them in their work. Many felt they would welcome more training.

In the cases we looked at, quality assurance processes had made an overall positive difference in only a small number. Management oversight of safeguarding and vulnerability work had not made sufficient impact on the quality of work. Planning was not always sufficient and management suggestions for improvement were not always implemented.

The YOS already had clear sensible guidance for staff on the management of risk of harm and vulnerability. Planned training had suffered during the several delays in the migration to AssetPlus. There is scope, now, to reinforce training and the consistent application of local policies to support effective practice.

Key strengths

- YOS workers were interested in the children and young people with whom they worked, wanted the best outcomes for them and were keen to develop their skills to achieve this.
- Case managers had good links with other workers or agencies and used these to stay up to date with changes in the child or young person's life.

Areas requiring improvement

- Assessment and planning needs to be thorough, analytical and meet all the needs of the case.
- Case managers should make sure they review progress in their cases, change plans where necessary and document this work.
- Oversight processes should make sure that learning is translated into practice, and that assessment and planning relating to safeguarding and vulnerability are effective and recorded appropriately.

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 make sure 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 Caroline Nicklin. She can be contacted at caroline.nicklin@hmiprobation.gsi.gov.uk or on 07766 290969.

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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.