Inspection of Youth Offending Work
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To:	Val Hall, Chair of Gateshead 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 Gateshead

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 Gateshead Youth Offending Team (YOT). 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 Gateshead was 32.6%. This was better than the previous year and better than the England and Wales average of 37.8%.

Overall, we found that work to reduce reoffending, to protect the public, protect children and young people, and to make sure sentences were served, was of very high quality. It was encouraging to see that the work of the Youth Offending Team had improved substantially in all areas since our previous inspection in 2010. Staff were committed and enthusiastic, and they had a detailed knowledge of the children and young people they were working with.

Commentary on the inspection in Gateshead:

1. Reducing reoffending

1.1. Pre-sentence reports (PSRs) are the principal means by which the courts, and the panels that oversee referral orders, are advised about the causes of offending, and the work required to address it. The six PSRs in the sample were of good quality overall; they provided a clear explanation of offending behaviour, and in all cases children and young people and their parents/carers were involved in the preparation of the reports. We found, however, that two PSRs did not give sufficient consideration to appropriate alternatives to custody. All reports to referral order panels were of good quality.

[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

1.2. Case managers had effectively assessed the reasons for offending in all 14 cases in the sample, and had engaged with the children and young people and their parents/carers. Assessments were thorough and provided a full picture of the child or young person's circumstances, such as their lifestyle, substance misuse, and emotional or mental health, and how these might impact on their reoffending. Case managers took account of diversity and barriers to engagement in all cases; learning styles and speech, language and communication needs were carefully considered. An inspector commented: "*A comprehensive assessment which identified the most relevant risk factors linking to accommodation, education, training and employment, thinking skills, lifestyle and associates. It also identified protective factors in relation to visiting her mum*".

1.3. Children and young people's lives can change very quickly, and so assessments need to be kept under review. We found that reviews of the reasons for offending had been undertaken in a timely manner in all cases where appropriate, for example where there had been a change in a child or young person's living arrangements.

1.4. Following on from the assessment, we expect to see a plan to address the offending behaviour. Overall, planning was done well, both in custody and in the community; we found that objectives were clear and focused on meeting the needs that had been identified in the assessments. Plans took account of barriers to engagement, and in all but two cases, children and young people and their parents/carers were involved in the development of the plan. An inspector noted: "*The plan had appropriate objectives to address the assessed need. It was child-friendly and agreed by the young person and his mum*".

1.5. There was good evidence of YOT engagement with partner agencies in support of children and young people. In particular, children's mental health, children's social care, the police, education, training and employment services, and substance misuse services.

2. Protecting the public

2.1. We expect to see a thorough assessment of the risk of harm a child or young person poses to others. This should contain all relevant information, including past offending behaviour and impact on victims. We found that Risk of Serious Harm assessments had been done sufficiently well in all but three cases in the sample; in these three cases we felt the risk classification was too high. An example of this was a high risk classification when there was a lack of serious harm having been caused, and a lack of evidenced intent to cause serious harm. Assessments drew on information from relevant sources, for example, police intelligence. All but one of the PSRs we examined had a clear and thorough explanation of the risk of harm to others.

2.2. Having assessed the risks, appropriate plans should be put in place to manage them. We found planning to manage the risk of harm to others was of good quality in all cases; this included planning in relation to the three custody cases in the sample.

2.3. We were pleased to find that the YOT had a well-established case review meeting, known as the pod meeting, which was held weekly. This was a forum for all agencies involved with the child or young person to share information and agree plans to manage the risk of harm and vulnerability. The pod meetings gave case managers an opportunity for peer support, and exploration of risk of harm and vulnerability, leading to considered and appropriate plans. The risk of harm to known or potential victims was also managed well.

2.4. The assessment of risk of harm to others had been reviewed sufficiently in all of the 11 relevant cases in the sample, and risk management plans reviewed appropriately in all but 1 case.

2.5. Effective management oversight is an important part of accurate risk assessment and appropriate risk management planning. We found management oversight of the risk of harm work to be effective in almost all cases.

3. Protecting the child or young person

3.1. Children and young people can be at risk of being harmed by others, or at risk as a result of their own behaviour, by placing themselves in dangerous or potentially harmful situations. It is the YOT's role to work with others to help protect them. All PSRs contained a clear and thorough explanation of the safeguarding and vulnerability needs that applied in the case, and all initial assessments were of good quality. The safeguarding needs of children and young people change over time and need to be kept under review. Reviews of safeguarding and vulnerability assessments had been undertaken as required in all but one case in the sample.

3.2. Planning to address vulnerability issues is a key task for case managers, and we found it to have been done to a high standard in almost all cases. Plans were thorough and identified both the issues, and what needed to be done to address them. Reviews of plans to manage safeguarding and vulnerability were done well in all but one case; this was because a review had not yet been undertaken as required.

3.3. We found the management oversight of work to address safeguarding and vulnerability to be effective in all cases, and case managers had sufficient understanding of local safeguarding policies and procedures.

3.4. The risk of child sexual exploitation was considered routinely by case managers in the course of their work. We saw evidence to show that case managers had undertaken child sexual exploitation assessments, and that children and young people who went missing from home or care were referred for consideration at the missing, sexually exploited and trafficked (MSET) meetings. An inspector noted: "*The young person had been considered at risk of child sexual exploitation in the past, and recent absconding behaviour and associations raised concerns and led to her being referred to the MSET meeting, with police, social care and YOT actions*".

3.5. Children's social care teams were co-located with the YOT in Gateshead, and this had strengthened communication and working relationships.

4. Making sure the sentence is served

4.1. We expect to see that the YOT is doing what it can to help children and young people complete their sentences successfully. This includes engaging them and their parents/carers in the assessment and planning processes, identifying and addressing barriers to engagement, and putting measures in place to make sure they comply with the requirements of their sentence.

4.2. We found that case managers engaged well with children and young people, and their parents/carers in all cases when developing PSRs and initial assessments, and in most cases when developing plans. As a result, case managers had sound knowledge of the children and young people they were working with.

4.3. In all of the cases we examined, case managers gave careful consideration to diversity factors and barriers to engagement, and also to health and well-being outcomes for children and young people. The YOT had good access to partnership resources to help and support children and young people. A mental health worker was based within the team, and we saw evidence of case managers participating in care planning meetings for Looked After Children.

4.4. The YOT had a robust approach in making sure that children and young people complied with the requirements of their sentence, giving clear boundaries and warnings. We saw evidence of the use of compliance panels and, where necessary, returning children and young people to court. The YOT response to children and young people who did not comply was sufficient in all cases. An inspector commented: "*The case manager made determined and creative efforts to engage with the young person, who had a history of persistent breach and failure to engage*".

Operational management

We found that all of the case managers we interviewed had a sound understanding of the principles of effective practice, and they understood policies and procedures for the management of risk of harm, safeguarding and compliance. They all felt well supported in their work by their managers, and that their training and skills development requirements were met. Their training included speech, language and communication needs, and child sexual exploitation; as a result we saw evidence of staff considering and responding to these factors within the cases we examined. The YOT had designated case managers as leads in certain areas, for example, Looked After Children, working with girls, sexual offending and transition to adult probation. We saw clear evidence of active management oversight recorded within case records, and gate-keeping processes, for example in relation to the quality of PSRs. We judged that quality assurance arrangements had a positive impact in most of the cases we inspected.

Key strengths

- High quality initial assessments of children and young people provided a firm foundation for work to reduce future offending.
- Vulnerability assessments were of good quality, informing the work that needs to be undertaken to protect children and young people.
- Planning for work to reduce offending, manage the risk of harm posed to others, and address safeguarding and vulnerability was very good.
- Case managers engaged very well with children and young people and their parents/carers, taking diversity factors and barriers to engagement into account.
- Management oversight was effective in ensuring the quality of the work.

Areas requiring improvement

- In a small number of cases pre-sentence reports failed to give sufficient attention to considering suitable alternatives to custody.

We are grateful for the support that we received from staff in Gateshead YOT 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 Sue McGrath. She can be contacted at susan.mcgrath@hmiprobation.gsi.gov.uk or on 07557 848458.

Copy to:

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Lead Elected Member for Crime	*Linda Green*
Police and Crime Commissioner for Northumbria	*Vera Baird*
Chair of Local Safeguarding Children Board	*Gary Hetherington*
Chair of Youth Court Bench	*Gerald Tierney*
YJB Business Area Manager	*Gary Oscroft*
Ofsted – Further Education and Skills	*Paul Joyce, Stephen Miller*
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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.