Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
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To:	Rob Tinlin, Chair of Southend Youth Offending Service Management Board and Local Authority Chief Executive
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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 Southend

The inspection was conducted from 16-18 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 20 cases of children and young people who had recently offended and were supervised by Southend 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 Southend was 42.2%. This was better than the previous year but worse than the England and Wales average of 37.8%.

Overall, we found that the YOS was performing well with enthusiastic and experienced staff. The YOS had found a good balance between protecting the public and assuring the safety and well-being of the children and young people they worked with. Case managers linked well with other agencies and were flexible in their approach in order to achieve positive outcomes. There were no areas of substantial weakness although some improvements were needed to aspects of case reviews, planning and management oversight.

Commentary on the inspection in Southend:

1. Reducing reoffending

1.1. The initial assessment of the child or young person was found to be sufficient in the majority of the cases sampled. Case managers had obtained a wide range of information from various sources to build a picture of the individual's life and circumstances. One inspector commented: "*the case manager made very positive attempts at communicating*

[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

with the police and family in order to gather information about the child's likelihood of reoffending". We did, however, find three examples where the case manager had failed to identify factors linked to offending behaviour.

1.2. Pre-sentence or panel reports were provided in ten of the cases sampled. All but one gave a sufficient assessment of the reasons for reoffending, the risk of harm posed to others and clear recommendations for alternatives to custody.

1.3. Following on from the assessment, we expect to see a plan of work to help reduce the likelihood of reoffending. We saw examples where case managers had worked hard to engage the child or young person to produce an individual plan. Planning was good in most cases, although there were instances where the formal language used was not accessible to the child or young person and some plans lacked detail and clarity.

1.4. Reviews were sufficient in almost all of the cases we looked at. Work to address offending behaviour had been carried out in most of the cases. The YOS benefited from an integrated service from the following agencies; Young People's Drug and Alcohol Team, Targeted Youth Support, Connexions, Troubled Families (which provided family support), Early Help and Teenage Pregnancy who were all managed by the Head of Southend YOS. Where appropriate, staff incorporated these activities in the plan in order to reduce reoffending. We saw evidence of these agencies' active and effective involvement in complex cases, and good examples of case managers directing the delivery of the sentence plan. Recording of interventions and significant events by different members of the YOS was not always captured on the contact log, so did not always reflect the quality work that had been completed.

2. Protecting the public

2.1. We expect to see a detailed assessment of the risk of harm a child or young person poses to others. This should cover past offending and all relevant behaviour. We found that this happened in nearly all cases. Good use was made of home visits which enabled case managers to understand the family dynamics, their relevance to offending and the risk of harm to others.

2.2. Having assessed the risk of harm that the child or young person poses, the YOS should put plans in place to manage these risks. Plans to address risk of harm were sufficient in 17 of the 18 relevant cases sampled.

2.3. Risk management plans should be reviewed regularly to make sure that they are up to date. This was achieved in nearly three-quarters of the relevant cases. Deficiencies identified related to plans that were not reviewed following a significant change in circumstances.

2.4. The YOS understood their role in relation to Multi-Agency Public Protection Arrangements and contributed effectively. Where there was an identifiable victim or potential victim, the risk of harm they faced had been managed effectively in all but one case.

3. Protecting the child or young person

3.1. Often, children and young people who offend are themselves vulnerable and we expect to see that their safeguarding needs have been thoroughly assessed and planned for. We were pleased to find that all pre-sentence reports contained sufficient information about how the child or young person's vulnerability linked to their offending. On some occasions, however, we found that case managers were not explicit enough in their explanation to the court of the negative impact that custody would have on a child or young person.

3.2. In 18 of the 20 cases sampled, the initial assessment reflected the fact that case managers had taken time to understand the vulnerabilities of the child or young person. This included consideration of their substance misuse, and education training and employment needs. Where the assessment was insufficient, we found that case mangers had not used all the information available to them to gain an accurate picture of the emotional and mental health needs. As a result, they had underestimated the level of vulnerability of the child or young person. The YOS was alert to the possibility of child sexual exploitation. Case managers routinely assessed this risk with all the children and young people they supervised.

3.3. We found that plans to address vulnerability had been completed to a good standard in most applicable cases. Greater attention was required to address the child or young person's emotional and mental health needs, and substance misuse. We found one example where the vulnerability management plan had recognised that the young person was using cannabis and alcohol, but there was no specific action in the plan to address this.

3.4. Children and young people's safeguarding needs change over time and must, therefore, be kept under review. We found that assessments had been reviewed sufficiently in almost two-thirds of cases. Where gaps were identified, this most often related to a failure to review the assessment following a significant change in circumstances, for example, when the vulnerability of the child or young person had increased.

3.5. Of the five children and young people sentenced to custody, only two had a good enough plan to address safeguarding and vulnerability. With one case there was no vulnerability management plan produced, despite the young person being assessed as high risk of vulnerability. There was also a failure to address the emotional and mental health needs that were highlighted in the assessment.

4. Making sure the sentence is served

4.1. Case managers took time to get to know the children and young people they were working with. One inspector noted: "*There was evidence that the case manager worked hard to establish a relationship with the young person and would amend the content of the meeting with him in response to his mood and levels of motivation which was good to see*." Diversity issues and other potential barriers to engagement, such as learning styles, had been assessed in all cases during the report writing stage and planned for sufficiently in well over three-quarters of the cases sampled.

4.2. There was effective engagement with children and young people and their parents/carers in most of the sample inspected. Contact logs contained evidence that parents/carers were present during the report writing stage and their involvement in the planning of interventions. On some occasions, insufficient engagement with parents/carers resulted in assessments and plans that did not always reflect their views. It was, however, evident the case managers viewed parents/carers just as important to the successful completion of an order. There were a number of positive examples where case managers had worked hard to keep parents/carers involved who had become exasperated by their child or young person's behaviour, one inspector noted: "*significant effort and attention had been placed on trying to engage with parents/carers*."

4.3. Case managers made a consistent and substantial effort to support children and young people to comply with their sentence, which included sending text messages to individuals to remind them of their appointments. Promptly following up reasons for non-attendance or compliance was a key strength of the YOS. If the child or young person failed to attend, compliance meetings were held without delay to support their engagement rather

than immediately resorting to breach action. In all cases we considered the response by the YOS to non-compliance was appropriate.

Operational management

We look for evidence that the management oversight has been effective to make sure the quality of the work to address the risk of harm to others and safeguarding. The YOS conducted monthly quality audits of a specified number of cases which added a further level of scrutiny beyond regular line management meetings. There was clear recording by managers in case records, particularly in relation to high risk of harm classifications and risk management plans, in which they identified the sufficiency and deficits in practice. We found that the process had been largely effective where we expected it to have made a difference. We did, however, note instances where managers had asked for work to be done, but had evidently not monitored its completion. Overall, staff felt that their managers had the skills to support them and help them improve the quality of their work; they also felt that their managers were approachable.

We were pleased to find that staff were familiar with local polices and procedures for managing risk of harm, safeguarding, engagement and compliance. Staff felt that the culture in the YOS was positive and encouraging with regards to learning and development.

Key strengths

- It was apparent that there was excellent staff commitment to children and young people and their parents/carers resulting in more effective interactions.
- Good quality reports provided the courts with relevant information to assist sentencing.
- There was a good level of support to promote compliance and, when necessary, enforcement of court orders.

Areas requiring improvement

- Plans should be kept under review and updated in response to any significant change of circumstances.
- Recording on the contact log should be consistent and include key decision-making and activity of all YOS staff contributing to the sentence plan.
- Management oversight should make sure that the quality of assessments and plans to manage risk of harm, reoffending and vulnerability are sufficient.

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 Yvette Howson. She can be contacted at Yvette.howson@hmiprobation.gsi.gov.uk or on 07825 453092.

Copy to:

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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.