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To:	Gwen Kennedy, Chair of Southwark 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 Southwark

The inspection was conducted from 03-05 October 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 27 cases of children and young people who had recently offended and were supervised by Southwark Youth Offending Service (YOS). Wherever possible, this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff. The published reoffending rate[1] was 41.0% for Southwark, compared to 37.8% for all England and Wales.

Summary

Overall, we found excellent work being undertaken to understand and address the particularly complex situations of children and young people, some of whom used serious violence against their peers and the public. While presenting this risk of harm to others, these children and young people were also very vulnerable and, for some, violence and neglect were a common feature of their lives. They were often traumatised and this had had a significant impact on their behaviour and showed itself through disproportionate responses to everyday occurrences. For many years Southwark YOS has had to respond to serious youth violence, which is highly challenging work and reducing reoffending in this context is very difficult. We found that the YOS, and partner agencies, had fundamentally changed their approach to addressing these challenges, and that this new approach was showing some real benefits in tackling offending behaviour, risk of harm to others and the vulnerability of children and young people. The approach was delivered consistently by energised, skilled and capable staff. We believe that there is learning for other Youth Offending Teams about this approach. As a result of our very positive assessment, we have taken the

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

unusual step of providing further information about Southwark's approach in Appendix 1 of this report.

Commentary on the inspection in Southwark:

1. Reducing reoffending

1.1. The quality of pre-sentence and referral order panel reports was of a consistently high standard, providing a balanced and carefully assessed view of offending, risk of harm to others and vulnerability. We saw effective management oversight of reports, which made sure that both the courts and the referral order panels received accurate information. Importantly we found that credible alternatives to custody were provided to the courts.

1.2. The intake team made careful and holistic assessments in order to identify why offences had occurred, always including the perspective of the child or young person. In all cases we found good use of a wide range of screenings to highlight issues including drug and alcohol use, emotional and mental health. Assessments of communications needs were routinely undertaken and used to tailor the way in which staff worked with the child or young person. This led to accurate and insightful assessments that then enabled other workers and children and young people to identify all of the key issues. Notably, the experiences of the child or young person were effectively analysed, enabling workers to understand offending behaviour and decision-making through the 'eyes' of the child or young person. As a consequence of this, staff were more equipped to anticipate triggers and patterns to future offending.

1.3. Too often, information from the Crown Prosecution Service was not available at the start of the order; this limited the opportunity for staff to provide immediate challenge to a child or young person's account of the offending. This was particularly important for staff in fully understanding the child or young person's perspective and for those who denied the offence or might have been fearful of talking to YOS staff.

1.4. The high quality of the initial and ongoing assessments had assisted partner agencies to adjust their perception of children and young people and, in some cases, they received better support as a result.

1.5. Planning was effective, dynamic, focused and well sequenced. Children and young people had been meaningfully involved, as had parents and carers. Planning was flexible and responsive to situations as they developed and the case management model being used supported this. We saw numerous examples of staff making adaptations to interventions to increase their likely impact.

1.6. Work to address offending behaviour was started promptly, sometimes before the child or young person went to court. The YOS's own analysis showed that reoffending occurred quickly and so the timely start of interventions was helpful. Planning was well coordinated with the work of other agencies and thought had been given to exit planning, including good transition planning.

1.7. The focus on preventing reoffending included the following rapid response to a major incident. During the summer, two groups of children and young people were involved in 13 separate stabbings against each other. In order to try and prevent further incidents, the YOS and police undertook joint home visits to their parents/carers to make sure they knew what was happening, and offering support for them to best manage their child or young person. Work was also undertaken with the children and young people on a group and individual basis, to try and de-escalate issues.

1.8. Cases were continually reviewed by managers and specialists, providing ongoing and supportive guidance and advice to case managers. This approach enabled workers to

focus their time on establishing trusting and effective relationships with children and young people and their parents/carers.

1.9. Staff across the YOS demonstrated a good understanding of the principles of effective practice and factors contributing to reducing reoffending, and we saw that children and young people were making progress. Most children and young people showed that they were becoming more stable and, as a result, less likely to reoffend.

2. Protecting the public

2.1. There was an accurate assessment of the risk of harm posed by children and young people in all but three cases. Case managers were very focused on risk of harm and there was good management oversight in this area of work. Most of the children and young people in the cases we saw posed some risk of harm to others; sometimes this was significant. Risk of harm to specific victims was assessed well and responded to in almost all relevant cases.

2.2. Planning to manage the risk of harm to others should be based upon the timely and accurate assessment of risk of harm posed by the child or young person. Staff we interviewed had an in-depth understanding of the risks posed by individuals, and had developed effective plans to manage and reduce these. This included joint work with another YOT for a child placed out of area, the development of meaningful plans for those due to be released from custody and those who were being transferred to adult probation services.

2.3. The circumstances of children and young people can change very quickly and purposeful reviews need to take place in order to make sure that the risk of harm to others is recognised and then responded to effectively. We found appropriate and very quick responses to changes, including breach action. Critical information, however, was not always being received quickly from the police. The process relied on staff requesting intelligence; this was often too late and could only happen when case managers heard about incidents from other sources. Given the particular gang issues and prevalence of the use of knives, real-time information would support more effective work.

2.4. All of the case managers we spoke to had a good understanding of the policies and procedures in place to manage risk of harm to others. The management of risk of harm issues was a jointly owned responsibility, with other agencies contributing to work to protect families as well as the individual child or young person. This was evident with work with the college, who worked well with the YOS, to put measures in place that allowed young people to attend education, while they jointly managed difficult behaviours.

2.5. Management oversight of work to reduce the risk of harm had led to improvements in the quality of practice in almost all of the cases. In the few cases where management oversight had not been as effective, this was because managers tended to confirm the case managers view when a more critical approach was needed.

3. Protecting the child or young person

3.1. Southwark YOS effectively assessed and planned for the factors that made a child or young person vulnerable. All staff understood that most of the children and young people faced issues that put them in vulnerable situations, including the mental health of some parents/carers and gang issues. We saw excellent use of home visits which helped staff to fully appreciate situations, some effective joint work with children's social care and, notably, direct work with parents/carers to improve relationships and home circumstances.

3.2. Detailed and specialist assessments had been undertaken very quickly and used to good effect, including the use of the clinical practitioners. Specific interventions were available, including those to help children and young people who might be involved in an incident where a knife had been used. Unfortunately, being the victim of or witnessing stabbings, was common in the cases we assessed and we saw staff visit individuals in hospital to support them and their parents/carers in order to try and manage potential retaliation.

3.3. Vulnerability planning was effective in almost all cases; the use of written statements making it clear to individuals why adults were worried about them, and what actions would reduce that risk. Referrals had been made to other agencies if the work could not be undertaken by the YOS.

3.4. Children and young people who gave us their views said that things had got better for them, including attendance at school or college. One young person said: "*I did not even attend college until my last order [my worker] from [the] YOT got me into it and I have enjoyed it ever since.*"

3.5. This attention to the importance of education included those children and young people in custody. An inspector found that in one case: "*education had been identified as a key priority. It was encouraging to note the efforts of the case manager to facilitate access to GCSE work. A clear objective to achieve five grades at A-C had been agreed with the young person. Additionally, the case manager had worked closely with the parent and school to gather the coursework that was outstanding for the young person to complete their studies.*"

3.6. As we found in other areas of work, safeguarding and vulnerability issues were constantly reviewed, and action had been taken when needed. Staff had a good understanding of the principles of effective safeguarding work and had established strong relationships with partner agencies to make sure that they took relevant action. Management oversight was highly effective, as were the escalation procedures, on the few occasions where these were needed. As a result, a number of children and young people had been well protected.

4. Making sure the sentence is served

4.1. In order for children and young people to complete their sentences, we expect that they are given appropriate support. Factors that might hamper this were consistently assessed at the start of the order and reviewed as time went on. The involvement of parents/carers was maintained throughout orders and the YOS supported effective parenting.

4.2. Case managers and other staff in the YOS were very flexible in their approach to working with children and young people, striking a balance between setting boundaries and adjusting these when needed. One young person said: "*My YOT worker help me gain [sic] confidence to take part in group activities.*" Work was often aimed at helping children and young people establish and maintain effective relationships with appropriate adults, providing a foundation for future work and in securing compliance with orders.

4.3. There was considered use of professional discretion, with efforts made to re-engage children and young people when needed. Breach was used effectively in cases where there were serious risk of harm issues and this was appropriate.

Operational management

We found that the operational model implemented two years ago had a significantly positive impact on the quality of management oversight and, as a result, the quality of work with children and young people. All managers have detailed knowledge of cases and were frequently actively involved in evaluating and reviewing the effectiveness of case management. Weekly discussion of

individual cases, including direction of the clinical lead, had led to constant active reviews of cases which, in turn, was showing impact. This approach informed everyone who came into contact with the child or young person of the most appropriate method of working. This included consideration of the way the child or young person was dealing with the trauma they had experienced. Caseworkers were very positive about the support they received and described holding joint responsibility for case management.

This approach was making noticeable differences in the cases we assessed, with improved outcomes for some.

Key strengths

- Excellent quality of assessment and planning, leading to focused and individual programmes of work.
- Effective balance of managing offending, risk of harm and vulnerability issues.
- Energised, knowledgeable and skilled staff team, well supported by colleagues and managers.
- Effective and supportive management oversight, appreciated by staff, which made sure of joint responsibility and shared decision-making in complex cases.
- An effective model of case management carefully implemented and resourced.
- Collaborative and joint working with parents/carers.
- Evidence that staff had established meaningful relationships with children and young people.

Areas requiring improvement

- Crown Prosecution Service information should be available to assist with all assessments as soon as possible.
- Police intelligence should be provided quickly to assist with assessment and response to the risk of serious harm to others.

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 Yvonne McGuckian. She can be contacted at Yvonne.McGuckian@hmiprobation.gsi.gov.uk or on 07973 295475.

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Chair of Youth Court Bench	*Terence Geater*
YJB Business Area Manager	*Paula Williams, Adam Mooney*
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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.

Appendix 1

Model of case management developed by Southwark YOS, abridged from information supplied by Jenny Brennan, YOS manager

Southwark Social Care launched Social Work Matters in 2013 in order to transform social care practice within the borough and respond to the changing needs and expectations within social work.

As part of children's social care services, Southwark YOS fully embraced these changes and welcomed a more family-based approach to reducing offending. The YOS began training in systemic practice in 2013 and launched the new practice group structures in May 2014. The focus on the restructuring was to create systemic 'practice groups' that were led by an advanced practitioner with three or four YOS officers, a practice coordinator to provide administration/coordination and a clinical practitioner. The aim was to create a different culture – to work with the whole family, increase direct work, enhance continuity of support and focus on relationships.

The YOS created three 'clusters':

- intake – the first point of contact for families (including out of court work), work with the court and Out of Court Disposals
- community – practice groups that deliver the court order and lead on groupwork/interventions
- community and custody – practice groups that deliver the court order plus specialise in custody.

Each cluster has three practice groups, with one keyworker and one clinical practitioner supporting each cluster. Prevention work is distributed across the practice groups.

Court work comes into 'intake' and, after a full assessment using specialist staff, the case transfers to a practice group to deliver the order. Each practice group then 'holds' that family whatever the court order is or if there is reoffending, in order to focus on building the relationship (this includes future report writing). Each child or young person is allocated a lead worker but others in the practice group or specialist staff will also get to know them and their family, and joint working is expected. There is only a second point of transfer if a child or young person gets a significant custodial sentence. They would then transfer to the custody practice group who have established relationships with the secure estate. Cases are discussed at a weekly practice group discussion which also provides group supervision. The case discussion use systemic tools such as the reflective team and all members of the group participate in hypothesising and agreeing actions/tasks. Other specialist staff or social workers may join the discussion.

Systemic practice focuses on the relationships between children and young people in the criminal justice system, and YOS staff will explore the impact of offending on the family system and its functionality. The planning with the family uses a 'Signs of Safety' approach to work with the family to understand different perspectives and manage risk of harm to others. A culture of openness, transparency and professional discretion is key to delivery of the model.