Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

HM Inspectorate of Probation
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Debbie Ward
Chair of YOT Management Board
Dorset Youth Offending Team

13th March 2013

Dear Debbie Ward,

Report of Short Quality Screening (SQS) of youth offending work in Dorset

This report outlines the findings of the recent SQS inspection, conducted during 18th-20th February 2013. We carried this out as part of our programme of inspection of youth offending work. This report will be published on the HMI Probation website. A copy will be provided to Ofsted to inform their inspections, and to the Youth Justice Board (YJB).

Context

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.

Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. The purpose of the SQS inspection is to assess the quality and effectiveness of casework with children and young people who have offended, at the start of a sample of 20 recent cases supervised by the Youth Offending Team. Wherever possible this is undertaken in conjunction with the allocated case manager, thereby increasing the effectiveness as a learning opportunity for staff.

We gather evidence against the SQS criteria, which are available on the HMI Probation website - http://www.justice.gov.uk/about/hmi-probation.

Summary

In Dorset Youth Offending Team (YOT) we found a committed and motivated staff group who were delivering work of high quality. Overall, most children and young people were benefiting from work that rested upon good quality assessments and plans, and ready access to an appropriate range of services. We did find some specific examples of work that was not of a sufficient standard, particularly in relation to assessment and planning of work to protect children and young people. The challenge for the YOT is to ensure that the high standards of work normally demonstrated by the team are consistently applied in all cases.

Commentary on the inspection in Dorset

1. Reducing the likelihood of reoffending

1.1. There was a timely and sufficient initial assessment of the likelihood of reoffending in 19 out of the 20 cases. Ten of these cases required a review, of which nine were of a sufficient quality.

1.2. Pre-sentence reports were requested and provided to the court in nine cases. The vast majority were of good quality and had been underpinned by effective management oversight. Information in other forms, such as verbal updates provided by case managers, offered sufficient information for the purposes of sentencing.

1.3. Planning to reduce the likelihood of reoffending was sufficient in almost all of the cases. Plans were reviewed as required in all of the cases.

1.4. In one case we noted "*The planning documents were robust and clearly identified the key issues in the case, as well as the work being done to address them. There was a high level of contact with the young person and strong evidence of multi-agency work. Diversity issues were considered and responded to throughout the work. The case manager had drawn on theory and models of practice, e.g. Motivational Interviewing and Solution Focused Therapy, to inform her practice. Some good initial outcomes were seen in this case. The young person had moved to a stable foster placement and had complied with the requirements of supervision. There had been no further offending".*

2. Protecting the public

2.1. There was a clear and thorough assessment of the risk of harm to others in all but 2 out of the 20 cases. In two cases the risk of serious harm classification was too low.

2.2. In 11 out of 13 cases there was sufficient planning to address the risk of harm posed to others.

2.3. Reviews of the risk of harm had been done to an acceptable standard in all relevant cases. This is important as the risk of harm to others posed by a child or young person can change as circumstances change; it can reduce as well as increase.

2.4. Where there was an identifiable victim, or potential victim, the risk of harm they faced had been effectively managed in the majority of cases. Efforts had been made to contact victims and seek their views in the majority of cases sampled. In one case we noted, *"This case saw some very good victim liaison work being undertaken. Both on a face to face basis between the case manager and the young person and also with the involvement of the victim liaison worker. The victim had been involved in the process and further work was planned. This included enabling the victim to attend the review panel meeting and for face-to-face restorative justice work, involving the young person and the victim, in the future*".

2.5. There was a clear and positive contribution being made by managers to the quality of the work done to protect the public. Management oversight of the relevant assessments and plans was effective. We found evidence of managers routinely making entries in case records of case discussions with practitioners and agreeing plans and actions.

2.6. In our view, most case managers had sufficient experience, knowledge and support to enable them to effectively tackle the risk of harm children and young people posed to others. In addition, case managers had confidence in the ability of their managers to offer effective oversight of this work. Our findings lend support to these views.

3. Protecting the child or young person

3.1. All but one of the pre-sentence reports had adequately assessed vulnerability issues. Initial assessments in the whole sample saw over three-quarters having a sufficient assessment of the safeguarding and vulnerability needs of the children and young people. These assessments had been reviewed appropriately in just under three-quarters of cases. For example, in one case we found that "*This was a very complex case, with multiple indicators of vulnerability and several indicators of risk of harm. Vulnerability had been correctly assessed as high and a vulnerability management plan had been produced. The risk of harm was correctly assessed as medium and this had a risk management plan, again produced with oversight from the line manager. The likelihood of reoffending was correctly assessed as medium and a comprehensive core assessment had been completed. Evident in this assessment was an investigative approach, in which the case manager had obtained information from a variety of sources and professionals, thus facilitating effective planning. There had been very good compliance by the young person and good progress had been made. There had been no fresh offences. Work was ongoing with the victim worker and parenting officer and offending behaviour work had been completed and presented to review panel. In addition, the young person had improved her school attendance*".

3.2. Planning to address vulnerability and safeguarding issues was insufficient in 4 out of the 15 relevant cases. This gave rise to some concern and showed the need for continued work to improve the consistency of practice in this important area of work. Reviews of safeguarding and vulnerability planning had taken place to an acceptable standard in all but one out of the nine relevant cases.

3.3. The contribution to the quality of this work provided by management oversight was also observed, although to a lesser degree than in the work done to protect the public. Whilst we found evidence of effective management oversight of safeguarding and vulnerability work in most of the cases, in a small number we found that inadequate assessments and plans had been countersigned by managers.

4. Ensuring that the sentence is served

4.1. At the pre-sentence stage and at the commencement of supervision, attention was routinely being paid to assessing the child or young person's diverse needs and identifying barriers to engagement. There was also evidence of good levels of involvement of the children and young people, and their parents/carers, in the assessment and planning of interventions.

4.2. In all but two of the cases we reviewed, sufficient attention had been given to addressing the health and well-being of the child or young person. We found in one case that "*The work done with the young person in relation to screening their health was particularly good - the process within the YOT is that a health practitioner will meet a young person and screen for a range of health issues (e.g. mental health, substance misuse, sexual health, general health). If further work is needed they will makes referrals as necessary, whilst remaining the key point of contact with the young person. A clear plan for meeting health needs is drawn up and is shared with the young person*".

4.3. All but two of the children and young people had complied with the requirements of their sentence. This was to the credit of practitioners, as many of the children and young people required regular input by practitioners to secure their engagement in the work.

Operational management

Staff were positive about the organisational environment in which they worked. They reported that they felt they were well trained and supported in their work. Systems, processes and practice guidance helped staff to reflect upon their practice and to solve problems as they arose. For example, the YOT had introduced a number of measures to support practitioners in their work. These included the provision of procedural guidance on managing the risk of harm to others, addressing vulnerability issues and dealing with compliance matters. We found that case managers were generally clear about good practice issues in respect of working with children and young people and addressing the risk of harm or vulnerability issues that may be present for individual children and young people. The YOT had also introduced a management oversight of practice framework, and this was supported by quality assurance arrangements. We saw evidence of the application of these arrangements in practice.

The practical challenges faced by the need to offer services across a large geographical area, much of which was rural and had poor transport links, had been addressed. Case managers were undertaking regular home visits to enable service users to engage in the work. An added benefit of this was that we found many cases where good and productive relationships had been formed with the parents/carers of the children and young people. This was an important part of the service offered by the team and also of the approach they took to achieve positive outcomes from the work.

We saw evidence of good multi-agency liaison and joint working with partner agencies, including several examples of joint work in with colleagues from education, health, the police, social care, accommodation and substance misuse services. In one case we noted *"In this complex case there was evidence of effective work undertaken by a variety of professionals. Appropriate referrals had been made to mental health, health, psychologists, education and social care. There was evidence of positive liaison between the professionals involved. In addition, line management oversight was supportive and evident, with decisions clearly explained in terms of rationale and planned future work. A good investigative approach was taken and information had been gathered from previous sources and historical records. These informed the plans to address vulnerability and risk of harm, as well as the daily work undertaken with the offender*".

Outstanding strengths

The following were particular strengths:

- Good quality reports were being provided to the courts, in particular pre-sentence reports.
- There was routine engagement with children and young people and their parents/carers in carrying out initial assessments and planning.
- Assessments and plans to address risk of harm and vulnerability issues were generally of good quality.
- The assessments of diversity and barriers to engagement were good.
- There were high levels of compliance and, where needed, effective enforcement of court orders.

Area requiring improvement

The most significant area for improvement is:

i. assessments and planning to tackle vulnerability and safeguarding needs.

We strongly recommend that you focus your post-inspection improvement work on this particular aspect of practice.

We are grateful for the support that we received from staff in the 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 Joseph Simpson. He can be contacted on 07917 084764 or by email at joe.simpson@hmiprobation.gsi.gov.uk.

Yours sincerely,

Julie Fox
HM Assistant Chief Inspector of Probation

Copy to:
Clive Hawkins, YOT Manager
Debbie Ward, Chief Executive Officer, Dorset County Council
Jackie Last, Director of Children's Services, Dorset County Council
Toni Coombs, Lead Member Children
Malcolm Potter, Business Area Manager, YJB
YJB link staff with HMI Probation
Ofsted

Note: please contact our Publications department on 0161 869 1300 for a hard copy of this report.