Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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From:	Julie Fox, HM Assistant Chief Inspector
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Report of Short Quality Screening (SQS) of youth offending work in Torbay

This report outlines the findings of the recent SQS inspection, conducted from 31st March-2nd April 2014. 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 partner inspectorates 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 this inspection was to assess the quality and effectiveness of recent casework with children and young people who had offended. In order to do this, we examined 14 cases supervised by Torbay Youth Offending Team (YOT). This was 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

The trend in reoffending rates in Torbay was one of consistent improvement. Staff understood well the children and young people with whom they worked, and showed a high degree of commitment to achieving positive outcomes for them. They engaged children and young people and their parents/carers well in assessments. However, plans for work to reduce reoffending were unclear. Similarly, there was a lack of understanding of how to use the required tools to plan effectively to manage risk of harm to others and vulnerability. Attention was given to the protection of known victims from risk of harm. The YOT did what was needed to ensure that sentences were served.

Commentary on the inspection in Torbay:

1. Reducing the likelihood of reoffending

1.1. Monitoring of reoffending outcomes was primarily undertaken using national data. We were pleased that there were plans to develop and include current local data in the near future.

1.2. More than three-quarters of assessments met the needs of the case, and so provided a sound basis on which to plan the delivery of interventions. However, more attention needed to be given to ensure that all assessments, pre-sentence reports (PSRs), and reports for community panels in referral order cases are analytical, so that their conclusions are more defensible and the links with reoffending clearer. Almost three-quarters of PSRs were good enough.

1.3. One inspector noted the following positive example in a PSR: "*an AIM2[1] assessment was undertaken of this young person who had committed a sexual offence. The case manager reported its conclusions in the PSR.* [He] *recognised that, as these particular details were rarely required in court reports, the sentencing judge may not be familiar with them.* [He] *included two paragraphs of explanation of the terminology in the PSR, to help the judge understand its meaning*".

1.4. Initial planning in both inspected custodial cases was good. The young people, who had turned 18 years of age, were placed in an adult institution which was not familiar with the requirements of youth sentences. The case managers, therefore, engaged directly with the young people in custody to agree plans with them for the whole of their sentence, and with the keyworker in custody so that intervention work could be started.

1.5. Planning for work to reduce reoffending was sufficient in less than one-third of the inspected cases. Objectives were often unclear and, in particular, they were not meaningful to children and young people and did not identify the specific changes they needed to make. Nor did they lend themselves to effective monitoring of progress. A good plan should also explain how the objectives will be achieved and the role of the child or young person, YOT staff and others in achieving them.

1.6. The template used for referral order contracts and the presentation of the agreed objectives were poor. Contracts did not clearly explain the desired outcomes and the role of the child or young person, case managers and others in achieving them.

1.7. We were therefore encouraged to find this example of how the YOT was seeking to improve its practice: "*The YOT wanted to improve the way that it supported children and young people to take responsibility for complying with the requirements of their sentence and to take ownership of their progress. They had begun to develop and implement an activity book that is similar to a record of achievement. It will include details about the sentence, young people's views and objectives, agreed plans and reviews of progress, amongst other aspects. It is most suitable for younger children and young people and in particular those who respond to a visual learning style. Whilst implementation of this was at the pilot stage, it was a very positive development*".

2. Protecting the child or young person

2.1. Initial assessments of vulnerability were sufficient in only just over half of the cases. The breadth of potential vulnerability factors that existed in the case were not always recognised and brought together to form a robust assessment, which would then inform

[1] AIM2 – a specialist assessment and planning tool used with those who have committed sexual offences

planning. Examples of factors that had been missed in one or more cases included having committed sexual offences, having a particularly low reading age and the impact of not attending school on the lifestyle of the child or young person.

2.2. Case managers did not have a clear understanding of the objectives of vulnerability management plans. These include supporting the development of a robust and defensible plan to manage vulnerability, supporting effective joint working between agencies and leveraging the provision of services from others, ensuring that all those who may become involved in a case understand precisely what is required of them, and ensuring that there is a robust contingency plan in place. Neither did case managers understand how to use the required planning tools effectively. Therefore, in three-quarters of cases where this was required, a clear and sufficient plan had not been developed to address safeguarding needs and reduce the vulnerability of the child or young person. Where there is current children's social care or relevant other agency involvement with the child or young person then the YOT plans should include the linkage with their plans.

2.3. While managers countersigned all formal vulnerability management plans, they had not ensured that they were always of good enough quality before they did so.

3. Protecting the public

3.1. Over three-quarters of assessments of the risk of harm to others posed by the child or young person were sufficient, and almost all were reviewed as required. This formed a good basis for the development of risk management plans.

3.2. However the development of plans to manage risk of harm to others, along with their oversight by managers, suffered from the same problems as planning to address vulnerability. Only just under half were good enough. A good plan should clearly explain the outcomes sought, the plans for achieving these and how positive or other factors may be used to achieve the desired outcomes, the role of others in the delivery of the plans and how this is to be achieved, and include robust contingency arrangements.

3.3. We were pleased to find that, where there was a clearly identifiable victim, sufficient specific attention had been given to managing the risk of harm to them in the great majority of cases. In one positive example we found that "*the mother was the victim of offending by her daughter. The case manager undertook home visits to see the mother in conjunction with the police. They encouraged the mother to report incidents rather than put up with them and agreed with her a safety plan. As a result the mother was setting more appropriate boundaries with her daughter, had become less colluding with her behaviour, and the risk to her had reduced*".

4. Ensuring that the sentence is served

4.1. Case managers had a broad understanding of diversity factors and potential barriers to engagement, assessed these well and reflected them appropriately in PSRs.

4.2. It is important that children and young people and their parents/carers or significant others are fully involved in the development of assessments, in order to improve the likelihood of their effective engagement in future work. This was carried out well, and we were pleased to find that their input was clearly reflected. Children and young people were seen alone during the initial assessment more frequently than we sometimes find, which is critical to ensuring that their views are understood.

4.3. The YOT expected PSRs to be shared with and explained to children and young people and their parents/carers in advance of their sentencing date. We were pleased to find evidence in most relevant cases that this had happened.

4.4. Case managers gave sufficient attention to health and well-being outcomes, in particular where they may act as a barrier to a successful outcome from the sentence. For example, "*Tim received a sentence that included two months in prison. He was doing very well on his college course. However the college were concerned at the risk that Tim may pose to other students and so were unwilling to keep the place open for his release. The case manager recognised the importance of the college course to Tim's situation. She, along with the YOT education worker, worked with staff at the college to help them understand the risks that would be posed. As a result Tim was able to return to college following his release and is currently doing well*".

4.5. Just over half of the children and young people complied with the requirements of the sentence. YOT staff enforced sentences where this was required, but also gave sufficient attention to ensuring that barriers to non-compliance were considered and action taken to address them where this was appropriate.

Operational management

Staff had a good understanding of local policies and procedures and of the principles of effective practice with children and young people who have offended. They spoke positively about the support and supervision that they received, but there was some indication that managers could be more active in helping them improve their work. They also recognised a culture of learning and development in the YOT, and that the YOT engaged its staff well in its development priorities.

Key strengths

- Reoffending rates in Torbay showed a steady and long-term improvement trend.
- The YOT did what was required to ensure that children and young people served their sentences as they were intended, and held them to account when they did not do so.
- Work done to protect specific identified victims met the needs of the case.
- Children and young people and their parents/carers were involved well in assessment and in the development of PSRs.
- Work during the custodial phase of sentences was good.
- Assessment of diversity factors recognised the potential breadth of possible factors and was of good quality.
- Sufficient attention was given to health and well-being outcomes, where these may act as a barrier to a successful outcome from the sentence.

Areas requiring improvement

- Plans for work to reduce the likelihood of reoffending should be of good quality.
- Referral order contracts should be meaningful to children and young people and their parents/carers, so that they are able to make an informed decision about what they are signing and have a clear record of the objectives that have been agreed.
- Risk of harm and vulnerability management plans should be of good quality, and be used to ensure that required services are delivered.
- Oversight by managers should ensure that plans, including those for work to manage risk of harm to others or vulnerability, are of good quality before they are accepted.
- Assessment of safeguarding and vulnerability should take sufficient account of the breadth of vulnerability factors that may apply in each case.

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 Ian Menary. He can be contacted at ian.menary@hmiprobation.gsi.gov.uk or on 07917 183197.

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