Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
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To:	Kevin Crompton, Chair of Bedfordshire YOT Management Board and Director of Children's Services
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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 Bedfordshire

The inspection was conducted from 17th-19th November 2014 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 offended and were supervised by Bedfordshire Youth Offending Team. 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 Bedfordshire was 34.2%. This was worse than the previous year and better than the England and Wales average of 35.4%.

Overall, we saw a high standard of work in the cases we inspected. Staff engaged well with children, young people and their parents/carers to develop the initial assessments and plans, and used this information effectively to inform decisions in court. Work to ensure management oversight needs to be more consistent, in particular to ensure that the work is appropriately reviewed to take account of changes in the child or young person's circumstances. It is clear that Bedfordshire YOT have continued to work hard and successfully in their work with children and young people since our last inspection in 2012.

Commentary on the inspection in Bedfordshire:

1. Reducing reoffending

1.1. All of the Pre-Sentence Reports (PSRs) submitted by the YOT to the Courts to inform sentencing were of a good quality overall, and all gave sufficient attention to appropriate alternatives to custody. All of the reports submitted to the panels that oversee Referral Orders were also of high quality.

[1] Published on 31st July 2014 based on binary reoffending rates after 12 months for the October 2011 – September 2012 cohort. Source: Youth Justice Board

1.2. The initial assessment of the child or young person's likelihood of re-offending was done well in the great majority of cases. Most were thorough and provided a full picture of the child or young person's circumstances, such as how their family and personal relationships and their education might impact on reoffending. An inspector commented: "*Assessment was thorough, based on up to date information as well as information from the previous Referral Order. This drew on school reports, information from the family intervention service, interviews with the young person and his parents, and information from the Crown Prosecution Service."*

1.3. Children and young people's lives can change very quickly and, as a result, assessments of the likelihood of reoffending need to be reviewed. There had been a good enough review of the assessments in almost two-thirds of cases. Where there were gaps this was mostly because reviews had not been undertaken following significant change.

1.4. There was sufficient planning to minimise reoffending in the great majority of cases. In all cases, the child or young person and their parents/carers were involved in the initial planning. One inspector noted: "*Planning was comprehensive and included both the specific requirements of the Order and actions and roles for other agencies. Plans recognised the need for specialist assessments and how these were going to be progressed."*

1.5. Reviews of plans were also completed well enough in most cases. In the two plans which were not reviewed sufficiently well, one was not reviewed in a timely way, and one not reviewed as required.

1.6. We were pleased to see the level of engagement YOT workers had with children and young people and their parents/carers, in the course of their work to reduce the likelihood of reoffending.

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, whether in custody or in the community. This should cover all relevant information, including past offending behaviour, and impact on victims. We found that this had been done well in all but one of the cases in the sample.

2.2. Having assessed the risks, plans should be put in place to manage them. This had been done sufficiently well in 12 out of 14 relevant cases. Of the remainder, the plan was either not completed, or did not follow from the assessment. An inspector commented: "*There was evidence of discussion and ongoing risk management as due to his ex-girl friend's forthcoming birthday, the young person was worried that he may be thinking about her more, and may be tempted into relapse with alcohol and drugs. It was agreed that he would go away to work with his dad for a two-week period. This experience allowed him to spend some time with his dad, and when he came back he was keen to go to college to gain qualifications in a trade*."

2.3. The assessment of risk of harm to others had been reviewed well enough in over two-thirds of relevant cases. Plans to manage risk of harm had been reviewed sufficiently in five out of eight relevant cases. Where they had not been reviewed well, this was either because reviews were not undertaken, or plans had not been revised as required.

2.4. The risk of harm to victims who had been identified was effectively managed in 75% of cases.

2.5. Management oversight in ensuring the quality of risk of harm work was effective in just over half of relevant cases. Where it was not, important deficiencies in assessment and planning had not been addressed, or management oversight was not timely.

3. Protecting the child or young person

3.1. The initial assessment of safeguarding and vulnerability had been completed well enough in the large majority of cases. An inspector noted "*Assessment was of a good quality and timely. It drew on a range of sources and was able to identify the positive as well as risk factors. Vulnerability was screened, and the young woman's relationship was appropriately assessed as being protective.*"

3.2. The safeguarding needs of the children and young people within the sample changed over time and needed to be kept under review. Satisfactory reviews of safeguarding and vulnerability assessments had been completed in almost two-thirds of the cases where required. The most frequent deficit was the absence of a review following a significant change in the child or young person's circumstances, for example; moving home, or going missing from home.

3.3. Suitable plans to manage safeguarding and vulnerability issues were put in place at the start of the sentence in the great majority of cases.

3.4. Plans were sufficiently well reviewed in seven out of the ten relevant cases. Where there were gaps this was because reviews had not been undertaken, or did not ensure plans were revised as required, such as in response to changes in circumstances.

3.5. Management oversight in ensuring the quality of safeguarding and vulnerability work needed to be more robust. We found it to be effective in less than half of relevant cases. This was because deficiencies in assessment or planning had not been addressed, or because oversight was not timely.

4. Ensuring that the sentence is served

4.1. We expect to see that the YOT is doing what it can to help children and young people to 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 ensure that they comply with the requirements of their sentence.

4.2. We were pleased to find a high level of engagement in all but one case between case managers, children and young people and their parents/carers in carrying out the initial assessment, and in all cases in the planning process. This was a clear strength of the YOT.

4.3. Diversity issues and other potential barriers to engagement had been assessed sufficiently in well over three-quarters of cases. These issues had been incorporated into plans where relevant in the large majority of cases. Case managers also gave attention to health and well-being outcomes in almost all relevant cases.

4.4. The YOT responded appropriately to young people who did not comply with the requirements of their sentence in 8 out of 11 relevant cases, for example; issuing formal warnings or breach proceedings.

Operational management

We found that most of the case managers we interviewed had a good understanding of local policies and procedures and all had a sound knowledge of the principles of effective practice. All spoke positively about the operational management arrangements at the YOT. They felt supported in their work, and commented that their managers were sufficiently skilled and knowledgeable. All of the case managers interviewed said their training and skills development needs were met for their current role and for their future development. They all felt they had sufficient skills to recognise and respond to the diverse needs of the local community. A gap identified by staff was

training in recognising and responding to speech, language and communication needs, and this was reflected in our findings in identifying potential barriers to engagement. All but one of the case managers interviewed were positive about the countersigning and management oversight of risk of harm and safeguarding work. However, as outlined above, we found evidence to suggest it was not always effective. It was pleasing that all staff reported they understood the priorities of the organisation.

Key strengths

- Pre-Sentence Reports (PSRs) and reports to the panels that oversee Referral Orders were of a very high standard.
- Children and young people, along with their parents/carers were actively involved in their assessments and plans.
- Initial assessments and plans were generally good, and indicated that practitioners possessed relevant skills and ability.

Areas requiring improvement

- Case managers should be more attentive to changes in circumstances so that reviews of assessments and plans are reviewed when required.
- Management oversight should ensure the timeliness and quality of reviews.

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

Copy to:

Acting YOT Manager	*Brian Weatherall*
Local Authority Chief Executive	*Philip Simpkins*
Director of Children's Services	*Kevin Crompton*
Lead Elected Member for Children's Services	*Councillor Sue Oliver*
Chair of Bedford Police and Crime Panel	*Councillor Fiona Chapman*
Police and Crime Commissioner for Bedfordshire Police	*Olly Martins*
Chair of Local Safeguarding Children Board	*Jenny Myers, Alan Caton*
Chair of Youth Court Bench	*Karen Beagent*
YJB Business Area Manager	*Gary Oscroft*
YJB link staff	*Malcolm Potter, Paula Williams, Linda Paris*
Ofsted – Further Education and Learning	*Sheila Willis*
Ofsted – Social Care	*Simon Rushall, Carolyn Adcock*
Care Quality Commission	*Fergus Currie*
HM Inspectorate of Constabulary	*Paul Eveleigh*

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.