Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
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To:	Margaret Asquith, Chair of Bolton YOT Management Board and Director of Children's Services, Bolton Council
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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 Bolton

The inspection was conducted from 15th – 17th December 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 recently offended and were supervised by Bolton Youth Offending Team (YOT). 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 Bolton was 36.0%. This was better than the previous year and slightly worse than the England and Wales average of 35.7%.

Overall, we found that there had been recent improvements to the quality of assessment and planning. This followed a review to identify factors leading to increased reoffending rates. The management team had developed a focused and targeted improvement plan, and then given staff effective and consistent management oversight. Children and young people were assisted by a range of specialist agencies including the input of a speech and language therapist, an emotional health worker and the Child and Adolescent Mental Health Service (CAMHS). The quality of work had improved since the last inspection and the staff team were positive about the support they had been given.

Commentary on the inspection in Bolton:

1. Reducing reoffending

1.1. In order to understand the reasons that children and young people offend, an assessment of relevant factors had been undertaken in all cases and these were usually completed in

[1] Published October 2014 based on binary reoffending rates after 12 months for the January 2012-December 2012 cohort. Source: Ministry of Justice

good time. Case managers had obtained a wide range of information to build a picture of the individual's life and circumstances. This included efforts to get the views of parents/carers and the child or young person. When needed, specialist assessments, including mental health and sexually harmful behaviour, were also used to increase a case manager's knowledge and understanding of the child or young person's behaviour.

1.2. The case managers we interviewed had a very good understanding of the child or young person, and we were pleased to see that records showed that much more of this knowledge was being included on the recording systems.

1.3. Attention was paid to the identification of diversity factors that might prevent the child or young person from engaging with the YOT. This proved to be important, as almost half of the children and young people in our sample had a learning disability.

1.4. Pre-sentence reports (PSRs) to advise the sentencing court and reports to the youth offender panel about the causes of offending and the work needed to address this, were well written, providing a clear outline of offending behaviour, the risk of harm to others a child or young person posed and any vulnerabilities. We felt that, on occasion, it was not always clear what the YOT was suggesting as the outcome most likely to be effective - sometimes the reports seemed to give a range of options without a clear proposal.

1.5. In all but one case, there had been an effective review of the case. These occurred not only at set time periods but also in response to changes in a child or young person's life. Reviews were also undertaken as part of formal risk management panels (Multi-Agency Risk Meeting) and also through regular supervision, where a discussion about all the case manager's cases took place with the line manager. Case managers were provided with detailed actions to complete and these actions were then followed up.

1.6. In both custody and community cases, we found that there was planning in place that outlined what type of offending behaviour work needed to be completed, and actions to protect the child or young person and to protect actual and potential victims. Plans did not always include the views or priorities of the child or young person. We saw a strong emphasis on getting children and young people into education, training or employment; although the timing of this was sometimes at odds with other difficulties in the child or young person's life meaning that sometimes the individual was not able or ready to cope.

2. Protecting the public

2.1. In a number of custody cases, the child or young person was subject to Multi-Agency Public Protection Arrangements (MAPPA). The YOT understood their role and effectively contributed at this level. In one very complex and challenging case, the YOT had enabled other members of MAPPA to understand the actual and potential risk of harm posed by the individual and, as a result, a range of options were being pursued to prepare for their release from custody. The YOT had also provided direct support to reduce his risk to other children and young people in the secure setting placement. The work to manage this young person's significant risks to others and personal vulnerabilities was exceptional.

2.2. In all inspected cases, there was an assessment of the risk of harm that a child or young person posed to other people. Most of the cases we looked at included elements of violence or sexual offending. Assessments on the violence cases in particular were very thorough and based on a wide range of information, were well evidenced and covered the key areas of that needed to be managed.

2.3. We found that in six cases there was insufficient identification of the exact nature of the violence. The analysis had not drawn out if this was due to a loss of control (expressive violence – for example due to frustration, the inability to effectively communicate or the

use of alcohol) or if it had been used in a controlled and planned way so that the child or young person could get what they wanted (instrumental violence). We did not see offending behaviour and risk management plans which accounted for these differences.

2.4. We saw a similar pattern in the analyses of sexual offending. Case managers tended to focus their work based on the offence code rather than the incident details. For example, two young people were convicted of sexual assault. In one case this seemed to be an attempt to make contact (albeit inappropriately) with a woman, whilst the other had features of an attempted rape. In our view a more detailed analysis would have helped to focus the risk management plans and the subsequent offending behaviour work.

2.5. Planning was effective in managing risks to others, and we saw attention paid to protecting victims. Again the thorough review process allowed for changes to planning in response to emerging issues. In most cases, we felt that the assessed level of risk was correct. In the remaining three, we felt that the risk was under estimated.

2.6. Joint work with the Family First project (designed to help families who were experiencing difficulties) enabled the YOT to work with parents/carers and siblings to reduce the chances of violence and other offending occurring within the home. We saw good work to restore and improve these relationships. This was not only important to provide stability, but also because problems with family and personal relationships was the second most common factor identified with offending in assessments.

3. Protecting the child or young person

3.1. A number of the cases we looked at were Children Looked After by the local authority. We expect to see good communication and joint work between the home and host YOT, and Bolton YOT did not disappoint. In each relevant case, we saw joint work that enabled a clear exchange of information, joint work and effective handover of cases. It was positive to see from published data that the offending rate for Looked After Children in Bolton (5.0%) was lower than the English average (5.6%)[2]. The work of the YOT provided good support to social workers who were managing the cases of Looked After Children.

3.2. In the majority of cases, staff took steps to understand the vulnerabilities of the child or young person, including their emotional well-being, substance misuse and education, training and employment. Planning was in place to minimise the risks faced by children and young people both in the community and in custody. In one case, we saw positive attention being given to the emotional health of a young person in custody. An inspector noted: "*On his release from prison, Tim had been referred to the emotional health worker due to concerns about his ability to cope with his experience of custody. He had been placed in an adult prison, where his brother had committed suicide and despite representation from the YOT he was not moved. The work undertaken with him, on release, enabled Tim to manage his emotions (reducing his vulnerability and chances of reoffending) and changed his frame of mind so that he would engage with offending behaviour work*."

3.3. Case managers did not always use the knowledge and information they had to fully consider what the child or young person's life might be like in reality, and how this might increase the chances of them being involved in some very risky behaviour. By doing so, case managers might be able to anticipate heightened risks (before they are exhibited by the child or young person) and take steps to prevent harm to the individual. In one case a young woman was living with a known heroin user, this was the key relationship in her life. Given his dependency on drugs it was highly likely that she would be drawn in to

[2] Published December 2014 by the Department for Education - Offending by Looked After Children

helping him find the money to buy drugs. She had an offence of stealing and this was linked to his drug use. The assessment of the case did not consider how she might be drawn into taking drugs and relied on the girls own reports that she was not using drugs, despite a rapid change in her appearance and increased offending.

4. Ensuring that the sentence is served

4.1. Case managers took time to get to know the children and young people they worked with, and to develop trusting relationships. Discussions with case managers showed that the link with the Family First Project enabled workers to see children and young people in their homes more frequently and to better understand the impact of the family dynamic on offending and risk of harm to others. Case managers exercised good judgements when making the balance between encouraging compliance and enforcing court orders.

4.2. We found numerous examples of how assessments from the speech and language therapist had ensured that children and young people's communication levels were known and responded to. One of our inspectors noted that in one case, the therapist wrote to the court to explain the young person's communication difficulties and how this would impact on his ability to answer questions in the court setting. This was reinforced by the case manager who contacted the court office on the day of sentencing.

4.3. The review process in place enabled case managers to adapt to changes quickly, and the thorough knowledge of individuals needs meant that work was responsive to their situation and needs. This was supported by the use of home visits.

Operational management

Case managers were very positive about the management support they had received; all of those interviewed stated that their managers had the skills needed to assess and improve the quality of their work. All thought that management oversight of risk of harm and safeguarding was effective. When inspectors looked at cases it was very positive to see that managers had made clear recordings of their observations of the case, in both case diaries and supervision records and that the requested actions were followed up. It was also clear that case managers were able to have professional discussions, which had enabled them to reflect on their practice and, where needed, make changes.

Case managers were complimentary about the training and development opportunities available to them and the culture in the organisation that positively promoted learning and development. All staff had received training in communication needs and diversity and were being trained on working with girls.

In our view, effective management oversight had improved the quality of assessment and planning and was supporting case managers in their role.

Key strengths

- The quality of assessment, planning and recording achieved through consistent and robust management oversight and supervision.
- Access to specialist services including the speech and language therapist, the emotional health worker and the Child and Adolescent Mental Health Service, enhanced assessments and case managers' understanding of individual children and young people and their consequent responses. As a result, case managers were better able to anticipate and plan for situations.

Areas requiring improvement

- Assessments of violence by children and young people should identify how this is used and plan to manage this accordingly.
- Proposals in Pre-sentence reports should clearly indicate which is likely to be the most effective.

We are grateful for the support that we received from staff in Bolton 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 Yvonne McGuckian. She can be contacted at Yvonne.McGuckian@hmiprobation.gsi.gov.uk or on 07973 295475.

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.