Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
HM Inspectorate of Probation
1st Floor, Manchester Civil Justice Centre, 1 Bridge Street West, Manchester M3 3FX
0161 240 5336 - www.justiceinspectorates.gov.uk/hmiprobation

To:	Jon Reilly, Chair of Bristol YOT Management Board
Copy to:	See copy list at end
From:	Julie Fox, Assistant Chief Inspector, HMI Probation
Publication date:	4th March 2015

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

The inspection was conducted from 9th-11th February 2015 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 34 cases of children and young people who had recently offended and were supervised by Bristol 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 Bristol was 35.0%. This was better than the previous year and lower than the England and Wales average of 36.1%.

Bristol YOT had seen some improvement since our last SQS in 2012. However, there remained considerable room for development in work to protect the public and safeguard the child or young person. Case managers gave careful thought to assessing and planning for issues linked to offending and provided the courts with good information. They paid particular attention to addressing individual needs to help children and young people meet their sentence requirements.

Commentary on the inspection in Bristol:

1. Reducing reoffending

1.1. An accurate assessment of why a child or young person has offended can help the court to make appropriate sentencing decisions, and the YOT to plan its work to help reduce further offending. The court had asked for a pre-sentence report in half of the cases we looked at. Most of these provided sound proposals for sentencing, based on a good assessment of the offence and circumstances leading up to it. However, many would have

[1] Published January 2015 based on binary reoffending rates after 12 months for April 2012 – March 2013 cohort. Source: Ministry of Justice

benefited from a more thorough analysis of safeguarding issues and, especially, the risk of harm the child or young person posed to others.

1.2. Overall, more than two-thirds of initial assessments provided an adequate, and often good, picture of the factors linked to the child or young person's offending behaviour. We noted, however, that case managers were not drawing often enough on information held by other agencies or workers. In a number of assessments, there was little exploration of the impact of family and relationship issues.

1.3. Many assessments were not being reviewed to a sufficient standard, and sometimes not at all. The custom of copying the original, then adding short updates, made it difficult to gauge the full and current picture in a case.

1.4. Case managers paid careful attention to planning work in the community to help reduce reoffending. Nonetheless, in a couple of cases the intervention plan was missing. We were pleased to see a marked improvement since our visit in 2012 in the quality of planning reviews. There was still a lot to do, however, to ensure that planning for the custodial phase of a sentence met the needs of the individual child or young person.

2. Protecting the public

2.1. Work to assess and plan to protect the public was not good enough and we were not assured that all YOT practitioners properly understood the concept of risk of harm to others.

2.2. Case managers had made sufficient effort to understand and explain the risk of harm the child or young person posed to others in just over half of the cases we looked at. There was a range of reasons for this: screenings were not being completed well enough; the case manager had underestimated risk of harm to others and not completed a full assessment; the focus of analysis was too narrow; and, in a number of cases, case managers failed to draw on information from other sources or explore the impact of relevant offences and behaviours.

2.3. The quality of planning had improved since our inspection in 2012, yet not as much as we would have liked. There was no specific plan to manage the risk of harm in a small number of cases. Where there was a plan, some lacked clarity about what was to be done to manage and reduce risk of harm, by whom and how. In a number of cases, little attention had been given to contingency planning, or how to manage risk of harm in custody and on release.

2.4. We saw a notable improvement in planning for custodial cases. One inspector found: "*The case manager had responded quickly to an escalation in violence by the young person and submitted an appropriate referral for multi-agency public protection arrangements (MAPPA) – thus enabling a coordinated, inter-agency response*." Another noted: "*The case manager had invited relevant agencies, including probation, to meet with the young person in custody to help plan for his possible transition to adult services on release*."

2.5. Assessment and planning were reviewed well enough in less than half of the cases we looked at. Often, reviews were not undertaken at all.

2.6. Taking account of the needs of victims is crucial in helping to keep them safe. We found that there was enough work undertaken to protect victims in just over half of the cases which merited this. There were noticeable gaps in the quality of the assessment of harm to victims and planning to address and minimise this harm.

2.7. We saw very little evidence that management oversight enhanced the quality of work to manage risk of harm. Internal risk management meetings appeared to add little value

with a lack of focus and no system in place to ensure decisions made at meetings were incorporated into YOT assessments and plans.

3. Protecting the child or young person

3.1. Case managers had made an effort to understand and explain vulnerability and safeguarding needs in just over half of the cases we looked at. In many, there had been insufficient liaison with children's social care, or not enough analysis of factors relating to home circumstances and emotional or mental health. There was no assessment at all in three cases.

3.2. The YOT will need to look carefully at planning for work to address safeguarding and vulnerability. We were satisfied with the quality of this in less than half of the cases we looked at. There was no specific plan to manage vulnerability in ten of the cases that needed one. In six of these, the case manager had underestimated the level of vulnerability and so, understandably, would have seen no need to complete such a plan. Where there was a plan, it was not always clear what action was to be taken, by whom and when. Important issues relating to care and emotional and mental health had not always been taken into account, sometimes because specialist workers had not been involved in the planning process.

3.3. We were pleased to see that the YOT manager was already aware of the need for better management of custodial cases. Planning to safeguard the child or young person during the custodial phase of a sentence will need particular attention. There were areas of vulnerability to be addressed in each of the eight custodial cases we looked at. In three, there was no plan for managing these.

3.4. Reviews of assessments and plans were not always being undertaken, especially in custody. In some cases, the assessment or plan was copied from the original with little or no update.

3.5. Despite the overall picture, we saw examples of good work. One inspector noted: "*A case manager showed tenacity in ensuring partner agencies, such as children's services, were involved in her case, in order to prevent an increase in the child or young person's level of vulnerability*."

3.6. We were also pleased to see developments in work relating to child sexual exploitation but anticipate the YOT will need to take further steps to ensure that all case managers are able to recognise and respond appropriately to relevant indicators.

4. Ensuring that the sentence is served

4.1. We found a high number of cases where case managers were working well to build relationships with children and young people. In the majority of cases, there was sufficient engagement with the child or young person and their parent/carer to assess, and plan to address, issues linked to offending. It is clear that case managers were giving measured thought to how to maximise engagement and we would have liked to have seen more evidence of this consideration incorporated into assessments and plans.

4.2. Case managers took varied routes to encourage engagement and respond to non-compliance. We found examples where they facilitated discussions in a range of settings in order to create an environment that put the child or young person at ease. An inspector commented: "*In one case, a case manager persistently and successfully pursued an assessment for Attention Deficit Hyperactivity Disorder for the young person she was working with in order to help him comply with his sentence*."

Operational management

Most case managers felt their managers were skilled and knowledgeable, and supported them well to improve the quality of their work. They welcomed the regular seminars to help them recognise and respond to diversity issues. However, they identified a need for more training to do their current jobs. Our inspection has highlighted that while some case managers were reflective and highly competent, too few had a sufficient understanding of effective practice. It was good to learn that case managers had recently been offered the opportunity to attend a course on sexually harmful behaviour.

In many cases, there was a gap in partnership working with children's social care, or, especially, the police. We learned of case managers who had unsuccessfully tried to link their work with police initiatives, for instance, gangs projects. Others, however, had not begun to recognise the benefits that liaison with the police could bring to their work to manage risk of harm. There were also a number of cases which would have benefited from links with the Troubled Families scheme. We were encouraged to learn that the YOT is working hard to improve inter-agency communications.

Key strengths

- Pre-sentence reports were relevant and analytical, and provided the courts with good quality information about why a child or young person had offended.
- The YOT had made considerable progress since the last inspection in planning work to manage risk of harm to others, especially during the custodial phase of a sentence.
- Case managers went the extra mile to take account of health and well-being factors that could affect how well a child or young person completed their sentence.

Areas requiring improvement

- Management oversight should ensure work to protect the public and reduce the vulnerability of children and young people is of sufficient quality to contribute to reducing offending.
- Planning for work to protect the public and safeguard the child or young person should be evident in every appropriate case. Plans should be sufficiently detailed and based on an accurate and thorough assessment of relevant behaviours and offences, including information held by other agencies. In particular, planning for work to safeguard the child or young person during the custodial phase of their sentence should be in place, where necessary.
- All case managers and other YOT workers need to have the skills and confidence to recognise and respond appropriately to indicators of child sexual exploitation.
- Assessments and plans for work to protect the public and safeguard the child or young person should be reviewed appropriately in order to help gauge and acknowledge progress, and amend the direction of work, where necessary.
- More account should be taken of the needs of victims in order to ensure that appropriate action can be taken to manage the risk of harm to them.

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 Vivienne Clarke. She can be contacted at Vivienne.Clarke@hmiprobation.gsi.gov.uk or on 07872 485611.

Copy to:

YOT Manager	*Justine Leyland*
YOT Service Manager	*Pete Anderson*
Local Authority Chief Executive	*Nicola Yates*
Director of Children's Services	*John Readman*
Lead Elected Member for Children's Services	*Brenda Massey*
Lead Elected Member for Crime	*Daniella Radici*
Police and Crime Commissioner for Avon and Somerset	*Sue Mountstevens*
Chair of Local Safeguarding Children Board	*Sally Lewis*
Chair of Youth Court Bench	*Lindsay Forbes*
YJB Business Area Manager	*Jamie Clynch*
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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.