Inspection of Youth Offending Work
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To:	Jennie Stephens, Chair of Devon YOS Management Board
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From:	Helen Mercer, Assistant Chief Inspector (Youth Justice)
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Report of Short Quality Screening (SQS) of youth offending work in Devon

The inspection was conducted from 29 June – 01 July 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 20 cases of children and young people who had recently offended and were supervised by Devon Youth Offending Service (YOS). 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 Devon was 32.8%. This was better than both the previous year (32.9%) and the England and Wales average of 36.6%.

Overall, we found a very mixed picture. We saw some individual examples of excellent, committed and creative work. In other cases, assessments and plans were inadequate, and work with children and young people lacked focus. Managers were not ensuring that key tasks were completed when they were needed, and were not making a positive impact on the quality of work that was being delivered. Little progress had been made towards the recommendations we made in our last inspection report, published in 2010.

Commentary on the inspection in Devon:

Reducing reoffending

1.1. It is important to identify all the factors in the lives of children and young people so as to know what work is needed to reduce reoffending. Just over half of the assessments at the start of sentences were good enough. Many assessments contained large amounts of out

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

of date information, and few explained the link between problems in the lives of children and young people and their offending.

1.2. We saw 13 cases where pre-sentence reports (PSRs) had been prepared to assist sentencing. Seven of these reports were of a good quality, while others lacked analysis of the reasons the offences had been committed. Not all reports made strong proposals for appropriate sentences. We did not see active management oversight of PSRs.

1.3. Plans of the work needed in the community to reduce reoffending were good enough in 13 of the 18 relevant cases. Plans could be improved by using language that is appropriate to the individual, and by addressing all the factors linked to reoffending. The views of children and young people and their parents/carers had been taken into account in most plans, but few had received written copies.

1.4. Most of the practitioners we spoke to were alert to a range of diversity issues experienced by children and young people. They were skilled at adapting their ways of working to take these factors into account, but the need to do this was not explained in written plans.

1.5. We saw examples of imaginative and personalised work with children and young people, but in some cases there was little focused work. Reparation was used creatively. For example: "*Robert's mother had to pay compensation for one of the offences. The YOT arranged for him to make picture frames that were sold with the proceeds going back to his mum*". In another case, a young person had committed offences at a local hospital. He baked cakes to take up to the hospital to apologise for what he had done.

1.6. There was good access to speech and language therapists in all of the teams. Staff recognised that this helped them to understand the best ways to work and improved their understanding of offending behaviour. One practitioner told us: "*because of his difficulties with communication, sitting down face-to-face would not work with Andrew. He learned by seeing and doing things, so I arranged for him to visit the hospital to find out how serious stab injuries could be*".

1.7. We saw good links to a range of other agencies, including substance misuse and mental health services. This meant that children and young people were able to access a range of resources to meet their individual needs.

1.8. In six cases, the children and young people had been charged with new offences during the period of supervision, and three had been convicted. YOS staff did not always respond actively to further offending or consider whether any new actions needed to be taken.

2. Protecting the public

2.1. We expect to see a detailed assessment of the risk of serious harm a child or young person poses to others at the start of sentences. In two-thirds of cases this had been done well enough. Assessments did not always take account of previous convictions, or of other known behaviour that could indicate a risk of serious harm. We were not assured that middle managers had sufficient understanding of risk of harm issues to be able to guide staff appropriately. In most cases where there were changes in circumstances linked to risk of harm, assessments were reviewed as needed.

2.2. Too few PSRs gave a clear explanation to the courts of the risks of serious harm that children and young people could present in the future.

2.3. Following an assessment of risk of harm, we expect the YOS to put in place plans to manage any behaviour likely to lead to harm being caused, including direct work needing to be done with the children and young people linked to risk of serious harm. We looked at 17 cases which needed risk management plans; 9 were done well enough, 3 were inadequate and 5 were not completed at all.

2.4. Risk management plans should be reviewed regularly to ensure they are up to date, but this was done in less than half of the cases where it was needed.

2.5. 'Risk panels' were used in some cases where risk of serious harm was medium or high, to provide oversight by managers. Risks to identified or potential victims had been well managed in almost all cases. However, notes of the panels were not always on file or did not set out clear actions or review periods.

2.6. Overall, understanding of Multi-Agency Public Protection Arrangements (MAPPA) was inconsistent. Some cases were wrongly identified on case records as being managed at MAPPA level 1. There was no evidence of management oversight of the cases which were correctly identified as MAPPA level 1. In the two MAPPA level 2 cases we saw, YOS staff engaged well with the MAPPA processes.

2.7. An example of good practice was noted in the case of a young man convicted of sexual offences: "*There has been excellent joint working with children's services, the speech and language therapist and NSPCC to ensure that a specialist assessment was completed. MAPPA has been used appropriately. Aaron has been kept safe and the public protected.*"

3. Protecting the child or young person

3.1. In many cases, children and young people who have offended are also vulnerable themselves, and we expect to see that this has been taken into account in the work done with them. Of the cases we inspected, 15 should have been assessed as medium vulnerability at some point during their supervision, and 5 as high. Assessments could be improved by a better understanding of the level of vulnerability that arises from the impact of trauma, bereavement, and family breakdown.

3.2. In three cases, there was a possibility that the children and young people were, or had previously been, vulnerable to child sexual exploitation. None of these concerns had been fully recorded in assessments of their vulnerability.

3.3. PSRs often failed to explain the vulnerability of children and young people, which could result in the courts failing to understand the context in which offences were committed.

3.4. All of the cases we looked at needed plans at some point to manage and reduce vulnerability. Four cases had no plans at all, and in seven cases, the plans did not clearly set out all the actions that needed to be taken to keep the children and young people safe. One inspector wrote that plans: "*contained more of a narrative about the young person than actions that needed to be followed*".

3.5. The lives of children and young people can change quickly, and we would expect that assessments and plans in connection with vulnerability are updated to take these changes into account. Assessments were reviewed in two-thirds of cases where it was needed but plans were only updated in one-third of the relevant cases. Plans were not always updated following the breakdown of care placements or release from custody.

3.6. We saw examples of well coordinated work with social workers in cases involving Looked After Children. One young woman was subject a child protection plan, but her vulnerability management plan did not mention this at all.

3.7. We inspected one case where a young person had recently moved to live at an address where it was known he would be at risk of serious harm, and we required the YOS to take immediate action with other agencies to protect him.

4. Ensuring that the sentence is served

4.1. In many cases, there were good working relationships with children and young people and their parents/carers. Practitioners were sensitive to a range of diversity issues and potential barriers to compliance, although this was not always fully recorded.

4.2. Given the large rural area covered by the service, achieving a good level of compliance is a challenge and Devon YOS meets this well. Over three-quarters of the children and young people had fulfilled the requirements of their sentences. This was assisted by considerable efforts made to undertake home visits, and by assistance given to children and young people who came into the office for their contact. Two cases were breached appropriately, and another should have been breached but action was not taken. We saw some good examples of use of compliance panels to understand why children and young people were not attending appointments and improve this, but this was not consistent.

4.3. Decisions made about when, or if, young people approaching the age of 18 should transfer to adult services, did not always consider maturity or circumstances of the case.

4.4. In a case which had been transferred to another YOS, the inspector noted: "*the case manager had worked for several years with the same young man, and argued to make a small number of visits to him after he had transferred out of the area. He recognised the importance of balance between continuity and over-dependence*". This would maximise the chances of him complying in the new area.

4.5. We were concerned that two of the young people serving custodial sentences had been sentenced by video link. While this was not within the control of the YOS, we were very concerned that this appeared to increase the vulnerability of these two young men.

Operational management

Most staff in Devon are well trained and enthusiastic about their work. They told us they valued the knowledge and experience of their managers, and described a culture of continuous learning and development. We did not see effective management oversight of work. Some managers did not have a clear understanding of the quality of work that they should be aiming for.

Key strengths

- Diversity issues and other barriers to engagement were understood and taken into account.
- The level of compliance with sentences was good.
- Reparation was used creatively and tailored to the needs of the case.
- Good access to a speech and language specialist meant that staff could be clear about the most effective ways of communicating with children and young people.

Areas requiring improvement

- Assessments should contain up to date information only, and must explain whether or not individual issues are linked to reoffending.
- Plans of work to be undertaken by children and young people should be written in language that is meaningful to them and copies should be given to them and their parents/carers.
- Managers and practitioners should improve their understanding of risk of serious harm and vulnerability, including how plans to manage these should be written.
- Management oversight of PSRs should be improved.
- Managers should ensure that all key assessments and plans are completed.

- Use of compliance panels and risk panels should be consistent and any necessary actions should be recorded and followed up.

We are grateful for the support that we received from staff in the YOS 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 Liz Smith. She can be contacted at liz.smith@hmiprobation.gsi.gov.uk or on 07827 663397.

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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.