Inspection of Youth Offending Work
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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 Buckinghamshire

The inspection was conducted from 15-17 June 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 14 cases of children and young people who had recently offended and were supervised by Buckinghamshire 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 Buckinghamshire was 34.8%. This was slightly better than both the previous year figure of 36.2% and the England & Wales average of 36.1%.

Overall, we found that Buckinghamshire YOS was delivering excellent work to reduce reoffending, protect children and young people, and ensure that sentences were served. Work to protect the public was mostly good. In all of the work we saw, Buckinghamshire had maintained or improved the position we found in our last inspection in 2011, and there had been encouraging progress to improve public protection outcomes.

Commentary on the inspection in Buckinghamshire:

1. Reducing reoffending

1.1. In all of the cases we saw, case managers had built up detailed knowledge of the children and young people, their families and care arrangements. This meant that the assessments we saw were comprehensive, and all the factors related to reoffending had been identified. We noted that even in the referral order cases, the lives of children and young people were complex and many factors were influencing their offending.

1.2. We saw seven cases where pre-sentence reports (PSRs) had been prepared to assist sentencing. All of these reports were of a good quality, and gave clear explanations of the

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

factors in the lives of children and young people that were related to reoffending. It was evident that active management oversight was improving the quality of these reports.

1.3. In all but three cases the intervention plans setting out the work needed to reduce reoffending were good. One plan was not completed until two months into an order, which was too slow. One plan did not cover all the assessed needs, and another should have been more focused on reoffending.

1.4. We thought the style of intervention plans was commendable. The words of the child or young person were used to explain clearly what work needed to be done. For example, a young woman wrote, "*I want to find out why I get angry so quickly and want to find out ways to calm down so I don't hit my mum again*". This showed a very high level of involvement from the children and young people in agreeing the work that they would undertake.

1.5. Restorative justice work was clearly embedded in practice. In every case where there had been an identifiable victim, their needs and wishes were considered, and detailed work was done with children and young people to increase awareness of the impact of their offences. Depending on the consent of the victims and the children and young people, letters of apology were written and face-to-face meetings were considered when appropriate.

1.6. Practitioners had very good links to a range of other agencies, including Connexions, substance misuse and mental health services. This meant that children and young people were able to access a wide range of resources to meet their individual needs.

2. Protecting the public

2.1. We expect to see a detailed assessment of the risk of harm a child or young person poses to others. In almost all cases, we found that this had been done well enough at the start of sentences. In one case we thought that the risk of serious harm classification was too high, and in one case too low. Assessments could be improved by considering all the information that was available to the case manager from internal records and other agencies.

2.2. The risk of harm to others can change over time and therefore needs to be kept under review. There were 11 cases where a review of risk of harm was needed, and this had been completed in nine. In one case, a high level of violent behaviour in a care home should have triggered a review and did not. In another, a review had been carried out eventually following the arrest of the young person for a serious offence, but it should have been completed more quickly.

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, and try to prevent it taking place. Nine of the cases we looked at needed risk management plans; six were done well enough while two were not completed at all. In other cases, the plans were not clear about how people potentially at risk, including family members, were to be protected, and contingency planning could have been stronger.

2.4. Risk management plans should be reviewed regularly to ensure they are up to date. While all except one case was reviewed when needed, revised plans were not always sufficient. For example, "*Niall had not previously shown any violent behaviour. His mother told the YOS worker that he had picked up a knife during a family argument at home. His risk level was reassessed, but the plan that was written did not explain how any risks to family members would be managed.*"

2.5. Buckinghamshire YOS have set up a Risk Management and Vulnerability Panel (RMVP) where cases considered to present a high risk of serious harm or high vulnerability are discussed and plans are agreed on a multi-agency basis. This provided an additional level of oversight of the most serious cases. We saw evidence of this being used effectively, but in one case the panel was delayed, which meant that it took too long for the vulnerability management plan to be completed.

2.6. An innovative practice called 'case formulation' had been introduced recently. This involved a range of staff from other agencies, including a forensic psychologist, meeting to discuss all the factors that might be influencing a child or young person's offending. Staff told us that it helped them form a clearer analysis of the case, and to identify the most effective way of intervening.

2.7. Management oversight had made a positive impact on the quality of risk assessments and plans in some of the cases we looked at. However, sometimes managers had not noticed or addressed the absence of other key documents.

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. We were impressed with the quality of almost all the initial assessments of vulnerability and safeguarding we looked at. We were pleased to see that most case managers recognised the raised vulnerability of children and young people who were looked after by the local authority, and those experiencing poor parenting. In a few cases, the impact of substance misuse or health issues had been underestimated.

3.2. Case managers were alert to factors in the lives of children and young people that could indicate child sexual exploitation, and took an investigative approach in these cases. An aide-memoire screening tool was used, and appropriate referrals were made to 'R-U-Safe', a project which promotes the safety of children and young people who might be at risk of sexual exploitation.

3.3. The quality of work being done to ensure the safety and well-being of children and young people was very good. In a few cases though, this was not reflected fully in written plans.

3.4. The RVMP meetings described above supported robust multi-agency planning for cases judged to be high vulnerability. For cases that were medium vulnerability, case managers prepared plans that were then quality assured by managers, and this oversight was effective in most cases.

3.5. There were four cases in the sample who were Looked After Children, and three who were subject to child protection plans or child in need arrangements. We found that the level of communication and information sharing with social workers in these cases was very good. In one case, frequent changes of placement were a barrier to engagement with the YOS.

4. Ensuring that the sentence is served

4.1. A particular strength in Buckinghamshire was the quality of working relationships with children and young people and their parents/carers. Very good use was made of home visits to get to know parents/carers and families. YOS workers were confident in the support they gave to parents/carers, who were often dealing with very challenging behaviour. We saw one case where a child or young person was living in a private children's home, and despite the best efforts of the case manager, staff at the home did not support the child or young person to keep appointments with the YOS.

4.2. A wide range of potential diversity factors and barriers to engagement was taken into consideration by case managers. Given the large semi-rural area covered by the YOS, careful thought was given to when and where to meet with children and young people, and this resulted in a high level of attendance at appointments.

4.3. Where there were difficulties with compliance, this was dealt with effectively by YOS staff. Three community sentences had been taken back to court. In all of these, the orders continued with improved compliance. One child or young person was appropriately recalled to custody for repeated non-attendance during a licence.

4.4. We saw thoughtful practice in connection with children and young people approaching the age of 18, when decisions had to be made about when or if they should transfer to adult services. The maturity of the child or young person was always taken into account. Where transfer was thought to be appropriate there was a staged approach, which gave the best chance of understanding and cooperating with probation services.

Operational management

Staff in Buckinghamshire were very well trained and highly enthusiastic about their work. Several had gained professional qualifications through working in the YOS. Staff told us that they valued the knowledge and experience of their managers. We saw many examples of effective management oversight, and practitioners recognised that this helped them to improve the quality of reports, assessments and plans. This level of oversight had clearly improved since the last inspection. Staff described a culture of continuous learning and development.

Key strengths

- Staff were well trained, committed and felt supported by their managers.
- High quality reports were prepared for the courts.
- There were strong and caring working relationships between YOS staff and children and young people and their parents/carers.
- Diversity issues and other barriers to engagement were fully considered.
- Plans for work were written in the words of the child or young person and set clear and understandable targets.
- The level of compliance with sentences was excellent.
- Restorative justice was embedded into the work of the YOS.
- YOS workers were skilled at recognising factors linked to vulnerability and at drawing down services to protect and support children and young people.

Areas requiring improvement

- Managers should ensure that their oversight addresses all tasks that are required considering the level and nature of risks and needs of the case.
- All staff should ensure that written plans are updated to describe fully the work that they are actually undertaking.
- Plans to manage risk of serious harm should set out clearly steps that need to be taken to protect individuals who could be identified as potential victims.

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.