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 Plymouth

The inspection was conducted from 29 June 2015 – 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 14 cases of children and young people who had recently offended and were supervised by Plymouth 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 Plymouth was 30.6%. This was worse than the previous year but better than the England & Wales average of 36.6%.

Overall, we found that Plymouth YOT was delivering good quality reports to the court and that staff were skilled at engaging with children and young people and building trusting relationships. There had been an improvement in the quality of the work to protect the public and assess and manage the vulnerability of children and young people since our last inspection report in 2010. The YOT was undergoing a complete team restructure that includes a new case work operating model. This change had created some uncertainty for staff and the new quality assurance arrangements were yet to deliver the level of effectiveness required.

Commentary on the inspection in Plymouth:

1. Reducing reoffending

1.1. There were eight cases where a new pre-sentence report (PSR) was requested by the court prior to sentencing. We were pleased to find that all the reports contained a

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

thorough analysis of the reasons why the child or young person had offended, their potential for reoffending and the risk of harm they posed. In every case but one, vulnerability and safeguarding issues had been addressed sufficiently. Sentencing proposals were appropriate in almost all cases. We saw evidence of management oversight in all the reports and judged it to be effective in three-quarters of the reports examined.

1.2. We found that case managers had assessed effectively the reasons for children and young people's offending in almost three-quarters of the cases we inspected. In two instances, the reasons for offending were not clear and in two others, the assessment had not been updated sufficiently from an earlier assessment. Engagement with parents/carers and people who played a significant role in the life of the children and young people was good in all cases and reflected in assessments and plans to reduce reoffending.

1.3. Reviews of assessments were completed to the required standard in two-thirds of cases. We found in three cases that the assessment was not updated sufficiently in all sections and appeared to be a copy of a previous assessment.

1.4. Plans to reduce reoffending were of a good standard in most cases and included the views of the child or young person and their parents/carers. They were relevant to the situation of the child or young person and identified interventions to reduce reoffending. In two cases, the assessment itself had missed relevant factors relating to offending and, therefore, the plans, while they met the assessed need, did not address all the issues in the case. Reviews of plans were completed to a sufficient standard in all but one case.

1.5. In the two custodial cases inspected, we saw evidence of effective assessment and planning through custody into the community and good liaison between case managers and staff in the custodial setting. In one case there was: "*...excellent progress on the objectives set both in custody and in the community. John had managed to complete various offending behaviour exercises, attend the Prince's Trust, abide by a curfew, completed his education and secured an apprenticeship with British Rail*".

2. Protecting the public

2.1. The YOT had recently established a risk review meeting as a forum for all the agencies involved with the child or young person to share information and agree plans to manage the risk of serious harm and vulnerability.

2.2. Over three-quarters of the cases had a sufficient assessment of the risk of serious harm posed by the child or young person. In two cases, the assessment had not taken into account previous relevant offences and in one case there was no assessment. All the PSRs we saw had a thorough assessment of risk of serious harm.

2.3. The risk of serious harm classification can change in response to changes in a child or young person's life. It is important that the situation is monitored and, if significant changes occur, that assessments are then reviewed. We saw effective reviews of Risk of Serious Harm assessments in just under two-thirds of relevant cases. In two cases where a review was done, these were not updated sufficiently and did not include all the relevant information. In two other instances, the case manager did not recognise and respond to significant changes in the risk of serious harm, and failed to complete a review.

2.4. Risk management plans were sufficient in three-quarters of relevant cases. We thought that plans could be improved through developing robust and specific contingency plans.

We saw two cases where the planning was focused too narrowly on identified victims and needed to broaden its scope to include potential future victims.

2.5. Effective management oversight is an important part of accurate risk assessment and appropriate risk management planning. We judged the management oversight as effective in just over half of the relevant cases. In three cases, deficiencies in assessment had not been identified by managers, and in another three, deficiencies in planning had not been addressed. We were encouraged to see that new risk review meeting arrangements had been put in place, and that there was a focus to improve practice in this area.

3. Protecting the child or young person

3.1. All but one of the PSRs we looked at had a thorough assessment of vulnerability. Following sentence, vulnerability assessments were sufficient in most cases. Where they were not, we felt case managers could improve their vulnerability assessments by ensuring they obtained all relevant information from all the agencies involved with the child or young person. In another case, relevant information concerning vulnerability had not led to a necessary further specialist assessment despite management oversight of the case. Case managers were good at including the child or young person, parents/carers and others important to the child or young person in the assessments; we saw evidence of this in all cases.

3.2. Planning to address vulnerability issues and reduce the risk of serious harm to children and young people is a key task for case managers and we found it was done well in most cases. Plans were generally thorough and identified both the issues and what needed to be done to address them. For example: "*The case manager had recognised that Jim was being sexually exploited. A robust vulnerability management plan was put in place which included an abduction order on the perpetrator, monitoring of Jim, one-to-one work, and encouraging Jim's parents to keep him safe. Social Care was made aware and ongoing work was planned through the child in need and child protection processes.*"

3.3. We saw one case which could have been improved through the development of a thorough contingency plan to address potential issues rather than the present situation. There was one case without a plan.

3.4. The vulnerability of a child or young person can change as their circumstances change and just less than three-quarters of assessments were reviewed appropriately in response to changes or when required. In the three cases where they were insufficient, we found that in two a significant event had not prompted a review of vulnerability, and in one the review was insufficiently updated with new information.

3.5. Plans to manage vulnerability were reviewed to a good standard in all but two cases. In one case, the review did not address all the relevant issues in the case; in the other, the review was not completed when required.

3.6. The YOT had decided there was a need to improve management oversight of vulnerability prior to this inspection. The risk review meetings were one of the measures put in place to address this. We found management oversight to be effective in more than half of the cases. However, oversight processes did not identify deficiencies in the vulnerability assessment in two cases, and in the management plan in one case. We also saw two cases where there was no evidence of management oversight where we would have expected there to have been.

4. Ensuring that the sentence is served

4.1. Diversity factors and barriers to engagement were identified in the large majority of cases. We saw evidence these issues were incorporated in the majority of assessments, and plans devised to address those barriers.

4.2. Case managers were excellent at engaging with children and young people and building the trust needed to do the work to address their offending and reduce the potential for reoffending. The views of parents/carers and other significant people in the child or young person's life were sought and valued by case managers and influenced assessments and plans. We were impressed by the quality of the work in this area.

4.3. Health issues were addressed effectively in all but one case and case managers were quick to identify the relevant medical support needed for children and young people.

4.4. There were six cases in which the child or young person did not comply with the requirements of the order. In four of these cases, the case managers worked with the children and young people and were able to overcome their lack of engagement without returning them to court in breach. Two cases were returned to court, one of which was resentenced to a further order.

Operational management

The YOT had recently restructured its management team in order to boost its approach to quality assurance. We found that just over two-thirds of case managers had an understanding of the principles of effective practice. All staff understood organisational policies and procedures concerning risk management, safeguarding and compliance. However, two-thirds of staff felt that the management oversight of risk of serious harm and safeguarding needed to be more effective. Although most felt supported by their line manager, half of the staff interviewed felt their line manager needed to develop further the skills required to assess the quality of their work or help them to improve the quality of their work. Quality assurance arrangements through supervision had a positive impact in only half of the cases we inspected. The great majority of staff felt that training provided had only been partially successful in enabling them to do their job. Two-thirds of staff identified the need for further training in speech, language or communication needs, and two-thirds felt adequately trained to recognise and act on potential discriminatory factors.

Key strengths

- High quality reports were produced and provided for the courts and referral order panels.
- Vulnerability management plans were thorough and identified relevant issues and methods for reducing the vulnerability of children and young people.
- Staff were excellent both at engaging children and young people and their parents/carers and at building trusting relationships with children and young people, which led to good attendance and compliance.

Areas requiring improvement

- The YOT should continue to develop effective management oversight to quality assure all assessments and plans.
- Staff should ensure that all reviews of assessments and plans are updated sufficiently and not copies of older assessments.
- Risk management plans and vulnerability management plans should contain well developed contingency plans.

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 Jonathan Nason. He can be contacted at jonathan.nason@hmiprobation.gsi.gov.uk or on 07768 073286.

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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.