Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
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To:	Kevin Jones, Chair of South Gloucestershire YOT Management Board
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From:	Helen Mercer, Assistant Chief Inspector (Youth Justice)
Publication date:	07 October 2015

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

The inspection was conducted from 14 –16 September 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 South Gloucestershire 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 South Gloucestershire was 33.3%. This was marginally worse than the previous year and better than the England and Wales average of 37.4%.

Overall, we found that South Gloucestershire YOT was delivering excellent work to reduce reoffending, protect the public, keep children and young people safe and ensure that sentences were served. Staff were skilled, with a good knowledge of the children and young people with whom they were working and were ably supported by middle managers, who provided high quality and effective management oversight to support desistance.

Commentary on the inspection in South Gloucestershire:

1. Reducing reoffending

1.1. Assessments of why children and young people had offended were excellent. Case managers had taken time to fully understand the reasons behind the offending that had brought the child or young person to the attention of the courts. Pre-sentence reports contained a good balance of analysis and a description of what needed to take place for desistance to become embedded. The potential impact of custody was well evidenced.

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

1.2. Reviews of assessments were carried out thoroughly. They were both timely and produced after a significant change in circumstances for the child or young person. In one particular case, following a remand into secure accommodation, the case manager had reviewed her assessment and actively engaged with staff at the unit to ensure that the offending behaviour work that had been undertaken in the community continued in custody.

1.3. Planning for work to reduce the likelihood of further offending was equally strong in both custodial and community cases. Considerable efforts had been made by case managers to prepare plans that were largely accessible to children and young people. In one case of a vulnerable and chaotic young person, however, engagement by him in planning was limited. Whilst the objectives identified were wholly appropriate, they were not personalised. An inspector wrote: "*it was not clear to see what level of engagement there had been from the young person to produce a plan that he fully understood and owned*".

1.4. The inspection team concluded that half the cases inspected were less likely to reoffend than at the start of the sentence. This was as a direct result of the quality of interventions that children and young people were receiving and the holistic approach being taken by case managers. The engagement of partner agencies to jointly support desistance was impressive.

1.5. Case managers demonstrated a solid understanding and application of the principles of effective practice.

2. Protecting the public

2.1. We expect to see a meaningful and detailed assessment of the risk of harm a child or young person presents to others. We were delighted to find that in every inspected case this had been done thoroughly. Case managers had made considerable efforts to understand and explain the risk of harm to others in the assessments they had produced. These assessments included an analysis of all relevant offending, took account of information held by other agencies and integrated the needs of actual and potential victims.

2.2. The personal circumstances of children and young people can change very quickly and purposeful reviews need to take place in order to ensure that the risk of harm to others is managed effectively. Again, we were pleased to find that in every case where and when a review was required, this had been done very well. An inspector wrote: "*following information from a parent about her son not staying at home as required by his curfew, the case manager set up a 'Team Around the Child' meeting given that relationships had deteriorated and the risk of harm to others had increased. The case manager gathered different agencies involved with the young person and produced actions to respond to the change in circumstances.*"

2.3. Planning to manage the risk of harm to others was done well in all except one case. Overall, plans were very good and completed on time, work to increase victim empathy had been identified and information sharing arrangements were clear.

2.4. Reviews of plans were consistently carried out when required and the quality of the risk management plans was particularly good. They contained a clear examination of all the available information, were analytical and contained actions to reduce the risk of harm to others.

2.5. Management oversight was effective in all the cases inspected. It had impacted on producing assessments and plans that were meaningful and most likely to reduce the risk

of harm to others. Additionally, case managers had been given good advice and this had been followed through in line management arrangements.

3. Protecting the child or young person

3.1. All the children and young people we looked at were vulnerable. We found that case managers had taken the necessary steps to understand why the children and young people they were supervising were vulnerable. This had been done for all the inspected cases and was most impressive. Their assessments of safeguarding and vulnerability and subsequent plans were excellent.

3.2. When we asked case managers to explain what actions they were taking to protect children and young people their responses were consistent with the actions necessary to keep children and young people safe. They said they maintained ongoing contact with parents/carers, had regular liaison with children's social care, verified the address details of residence, carried out home visiting and undertook work on healthy relationships.

3.3. Reviews of safeguarding and vulnerability were carried out when required in all the inspected cases. The content of the reviews was very good and had been triggered by a change in circumstances or when the review was due.

3.4. Case managers demonstrated that they were able to not only explain but implement local procedures for the management of safeguarding. The management of children and young people who had been identified as being at risk of child sexual exploitation was very good. Case managers were making the right decisions and ensuring that amidst the chaos in the lives of some of the children and young people the child sexual exploitation issue remained central. In one particular case an inspector wrote: "*Despite the court order coming to an end, the case manager had continued a voluntary period of supervision until she was satisfied that all the agencies working with the young person had covered all the child sexual exploitation issues.*"

3.5. The management oversight provided in all the inspected cases to address safeguarding and vulnerability was meaningful and effective.

4. Ensuring that the sentence is served

4.1. Overall, case managers had developed strong and purposeful relationships with the children and young people they were supervising. The knowledge they had of these children and young people was exceptional. An inspector commented: "*The case manager had excellent knowledge of the young person. She was able to answer a range of questions which would not have been possible had she not have known him so closely. Additionally, she understood the wider needs of the family.*" In a small minority of cases, however, insufficient attention had been given to the impact that some diversity issues, were having on maximising engagement. While case managers had been able to identify a range of diversity issues, they did not always use this knowledge to inform what they would do differently. For example, how they would manage the barriers to engagement resulting from these diversity issues.

4.2. In the vast majority of cases engagement with children and young people and their parents/carers was very good. This was supported by both the quality and quantity of supervisory contact. The level of home visiting was appropriate and ensured that a holistic approach was being taken to gather information from different sources. In two cases the views of the children and young people in preparing their plans was not clear and their parents/carers were not fully engaged with this process.

4.3. Case managers worked hard to ensure compliance with the sentence of the court and when enforcement action was needed this was applied properly in every inspected case. This was a particular strength in the YOT. We saw evidence of case managers supporting children and young people to fully understand the requirements of their sentences and explaining to them the consequences of not complying. Good decisions and choices made by children and young people were praised. This strengthened compliance.

4.4. Every case manager interviewed was able to explain the local policies and procedures for supporting effective engagement and responding to non-compliance. This was evidenced in all the inspected cases.

4.5. We saw a measured response from case managers in relation to transitions to adult services with children and young people approaching 18 years of age. This was appropriately scaled with the needs of the child or young person remaining central.

Operational management

We found that case managers at South Gloucestershire YOT were enthusiastic, dedicated, well-trained and skilled reflective practitioners. Supervisory arrangements were exceptional with all case managers receiving regular and meaningful supervision. Management oversight was consistently effective and case managers appreciated the additional value of management advice, leadership and direction. The countersigning of risk of harm work and safeguarding was a meaningful process which contributed to keeping the public and children and young people safe. Not all case managers were able to say with confidence that they fully recognised speech, language and communication needs. Additionally, they were not all clear about the priorities of the organisation in terms of how these specifically affected their role.

Key strengths

- Case managers were highly skilled at recognising vulnerability factors and keeping children and young people safe.
- Risk of harm assessments were consistently thorough.
- Case managers knew the children and young people they were working with exceptionally well.
- The quality of risk management plans was consistently good.
- Supervisory arrangements were excellent.
- Case managers were able to use reflection as a tool to improve their practice.
- Management oversight was both effective and meaningful.

Areas requiring improvement

- There should be collaborative engagement with every child, young person and parent/carer in the completion of all assessments and plans.
- Diversity needs identified should be fully integrated into how work is to be carried out.

We are grateful for the support that we received from staff in the South Gloucestershire 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 Avtar Singh. He can be contacted at avtar.singh@hmiprobation.gsi.gov.uk or on 077969 48325.

Copy to:

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Lead Elected Member for Crime	*Cllr Heather Goddard*
Police and Crime Commissioner for Avon and Somerset	*Sue Mountstevens*
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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.