Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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To:	Mike Bowden, Chair of Bath & North East Somerset Youth Offending Team Management Board
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From:	Alan MacDonald, Assistant Chief Inspector (Youth Justice)
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Report of Short Quality Screening (SQS) of youth offending work in Bath & North East Somerset

The inspection was conducted from 22-24 February 2016, 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 nine cases of children and young people who had recently offended and were supervised by Bath & North East Somerset 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 Bath & North East Somerset was 37.5%. This was higher than the previous year but slightly lower than the England and Wales average of 38.0%.

Bath & North East Somerset is among the smallest YOTs in England. Due to the low caseload, we looked at a smaller sample of cases than usual. Our sample consisted of five referral orders and four youth rehabilitation orders. We were pleased to see that there had been overall improvements in the work of the YOT since our last inspection in 2010, and that many of our previous recommendations had been addressed. Compliance with orders was excellent, and reflected the skill and commitment of case managers. Work to reduce reoffending and to protect children and young people was sound, and was well supported by a wide range of partner organisations. Further improvement is needed in the quality of risk assessment and risk planning, and management oversight of public protection needs to be more robust.

[1] The reoffending rate that was available during the fieldwork was published January 2016, and was based on binary reoffending rates after 12 months for the April 2013 – March 2014 cohort. Source: Ministry of Justice

Commentary on the inspection in Bath & North East Somerset:

1. Reducing reoffending

1.1. We saw six cases where written reports had been provided for courts. They were all of a good standard, and the proposals were followed by sentencers. Reports for courts and referral order panels could be improved by including a clearer explanation of risk of serious harm and vulnerability.

1.2. In all the cases, initial assessments were completed promptly following the start of an order. Every effort was made to engage with parents/carers, to involve them in assessments, particularly at referral order panels.

1.3. Following on from the assessment, we expect to see a plan of work to order and coordinate the delivery of interventions, thus maximising the likelihood of reducing reoffending. All the plans we saw covered the key areas which needed attention. We were pleased to note that for two intensive referral orders, the contracts proposed to court were sufficiently robust to allow custody to be avoided. One referral order contract was written in the words of the young person, with targets such as '*I will keep out of trouble*'. Other plans could be improved by using a format and language that is accessible and meaningful for children and young people, and by explaining how any diversity factors or possible barriers to compliance would be addressed.

1.4. We saw evidence of good quality victim work in the youth rehabilitation order cases. Considerable effort was made to engage with all victims, including local businesses. Where a meeting with the victim was not appropriate, a range of intermediate actions was used to ensure that the child or young person understood the impact of their offence on the victim. Victims could also make representations about the nature of any reparation undertaken.

1.5. There was good access to a range of other services to address needs related to offending, such as substance misuse, education, speech and language, and mental health. This was illustrated in one case we looked at: "*Thomas[2], who was 17 years old, had made it clear from the start that he did not want to talk about his offending or engage with the YOT. In spite of this, he complied with an intensive period of supervision, including attending a music project for a period of over six months, which was his first sustained involvement in education for many years*".

2. Protecting the public

2.1. We look for a detailed assessment of the risk of harm a child or young person poses to others. In five cases, we found that this had not been done well enough, and in three of these we thought that the risk of serious harm classification had been set too high.

2.2. We were pleased to see that staff recognised the relevance of previous known behaviour, as well as convictions, when considering the potential for the child or young person to cause serious harm in the future. Assessments could be improved by ensuring that more detailed information is included about any previous behaviour, and by thorough analysis of links between previous behaviour and the likelihood of causing serious harm.

2.3. Following an assessment of risk of harm, we expect the YOT to put in place plans to manage any behaviour likely to lead to harm being caused, and try to prevent it taking place. In half of the cases where this was needed, these plans did not set out all the

[2] The names in this document have been changed to protect the identity of the child or young person.

actions needed in relation to the individual risk factors. This included cases where there were known risks of sexual harm, and risk of violence to family members.

2.4. Management oversight of cases was not effective in identifying shortcomings in risk assessments, and did not ensure that risk management plans covered all of the risk factors that had been identified.

2.5. We saw one case that had been referred to Multi-Agency Public Protection Arrangements (MAPPA), and that case was well managed. The inspector noted: "*At the pre-court stage, a significant amount of intelligence was received from the police which gave the case manager cause for concern. She appropriately referred the case to MAPPA for a more multi-agency approach to management of the issues*".

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 found that the initial assessment of safeguarding and vulnerability issues was done well in seven of the inspected cases. We were pleased to see that case managers recognised the raised vulnerability of children and young people who were Looked After by the local authority, or who were making themselves vulnerable through their own behaviour.

3.2. We expect to see a regular review of vulnerability issues, because children and young people's lives can change very quickly. We saw cases where changes in circumstances, such as dropping out of educational provision, rightly triggered a review of vulnerability.

3.3. The staff we met appeared to fully understand local safeguarding children policies. In several cases we saw evidence of good joint work with children's social care, where children or young people were Looked After by the local authority. In one complex case, where the young person was showing sexually harmful behaviour, it was noted: "*there was good liaison with other agencies, including attendance at Child Protection meetings. The case manager and the social worker took a shared approach to risk management. Clear decisions have been made about who undertakes specific pieces of work with Dylan, to avoid him having to work with too many different people*".

3.4. **Ensuring that the sentence is served**

3.5. Performance in this area was very strong. Case managers built positive working relationships with children and young people, and with their parents/carers. In almost all cases, the child or young person complied with the requirements of their order. There was just one case where formal breach action had been necessary, and the case had been returned to court promptly.

3.6. In the cases we looked at, the range of reparation activities undertaken was limited, but children and young people responded well to the work they undertook. In the single case with an unpaid work requirement, there was a lack of clarity about how this should be delivered.

Operational management

We interviewed three case managers, who all told us they felt supported by their line managers, and said that their line managers had the skills and knowledge to help them to improve the quality of their work. We saw a good level of management oversight of the work of the YOT. There were clear policies for oversight of risk management plans and vulnerability management plans. We thought managers did not always distinguish clearly between the likelihood of reoffending and risk of serious harm, and this meant that risk thresholds were too high.

Key strengths

- Good quality reports were provided to courts.
- Comprehensive assessments were completed promptly at the start of orders.
- The referral order panel process was robust, and fully engaged children and young people, and their parents/carers.
- Strong and positive working relationships led to a very good level of compliance with orders.
- Case managers were skilled at recognising the vulnerabilities of children and young people, and at working with others to keep them safe.

Areas requiring improvement

- Intervention plans and referral order contracts should be written in a style and language that is appropriate for the child or young person, and they should receive a copy.
- Risk assessments should clearly explain how previous offences or behaviour are linked to the likelihood of causing serious harm.
- Plans to manage risk of serious harm should cover all the risk factors that have been identified.
- Management oversight should ensure that assessed levels of risk of serious harm are explained and supported by evidence.

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 Liz Smith. She can be contacted at liz.smith@hmiprobation.gsi.gov.uk or on 07827 663397.

Copy to:

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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.