Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
HM Inspectorate of Probation
1st Floor, Manchester Civil Justice Centre, 1 Bridge Street West, Manchester M3 3FX
0161 240 5336 - www.justiceinspectorates.gov.uk/hmiprobation

To:	Ian Johnson, Chair of Derbyshire Youth Offending Service Management Board and Director of Children's Services
Copy to:	See copy list at end
From:	Alan MacDonald, Assistant Chief Inspector (Youth Justice)
Publication date:	09 March 2016

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

The inspection was conducted from 15-17 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 34 cases of children and young people who had recently offended and were supervised by Derbyshire 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 Derbyshire was 36.2%. This was worse than the previous year but better than the England and Wales average of 38.0%.

Overall, we found that staff and managers were working hard, and successfully in most cases, to engage children and young people. Information sharing and joint working with other agencies started swiftly and continued throughout the court order. Assessments and planning needed to improve in some cases, including the assessment and planning to manage the risk of harm posed to others. Enforcement was not entirely consistent across the YOS. Management oversight of these areas needed to improve.

Commentary on the inspection in Derbyshire

1. Reducing reoffending

1.1. The majority of assessments of children and young people were detailed and considered. Over two-thirds were reviewed appropriately and well enough. Where children and young

[1] Published January 2016 based on binary reoffending rates after 12 months for the April 2013 – March 2014 cohort. Source: Ministry of Justice

people had multiple problems, however, not all the assessments analysed the information sufficiently to clearly identify the reasons for offending and the priorities for planning.

1.2. Plans were in place for all but three children and young people and were of good enough quality in two-thirds of cases. Where plans were not sufficient this was sometimes the result of the lack of clarity in a number of the assessments. Planning tools, including a grid for engaging children and young people and a formal plan, had recently been introduced. It was evident that some staff had yet to understand the link and utilise them properly. As a result, in some cases, children and young people were not fully involved in the planning, objectives were not clear, the language was not child friendly and the plans themselves were not useful tools for either the case manager or the child or young person. Nearly one-third did not take into account diversity issues or discuss ways to overcome any barriers. Plans were not reviewed in over half of the cases.

1.3. Pre-sentence reports were not judged to be of a good enough quality in two-fifths of the cases. This was for a number of reasons including insufficient analysis of the risk of harm that the child or young person posed to others, and a lack of attention to vulnerability and the possible impact of custody. Local management arrangements for ensuring the quality of court reports had been ineffective in those cases.

2. Protecting the public

2.1. The assessment of the risk of harm that the child or young person posed to others was judged to be good enough in most of the cases we inspected. Where reviews were required, however, nearly one-third had not been carried out. In a small number of cases relevant behaviour, as opposed to convictions, had not been included in the assessments, and, therefore, were not taken into account. There was confusion among some staff about how to consider alleged offences.

2.2. A new tool had been introduced to incorporate the planning to manage both the risk of harm posed to others and the actions needed to safeguard the child or young person. All but four cases had plans to manage the risk of harm posed, however, in just over one-quarter of cases, the planning was judged to be inadequate for the purpose. Plans were not always reviewed when necessary.

2.3. We judged that the risk of harm posed to identifiable and/or potential victims had been effectively managed in three-quarters of cases; however this left five cases where it had not because the assessment or plan had been inadequate. Management oversight of the risk of harm posed to others was judged to be ineffective in over one-third of cases.

3. Protecting the child or young person

3.1. The assessment of vulnerability of the child or young person was of good enough quality in most of the cases we inspected. Most had also been reviewed where required. In a small number of cases indicators of child sexual exploitation had been recognised by the case manager, but it was not always clear how this had been dealt with.

3.2. In three-quarters of cases the planning to manage vulnerability and safeguard the child or young person was judged to be good enough. In the remaining cases potential changes were not always considered and there was a lack of contingency planning. In nearly one-third of cases planning was not reviewed.

3.3. Joint work with other agencies, in particular children's social care services, was evident and routine in most cases we inspected. This started as soon as the order was made and continued throughout. It was clear that case managers viewed safeguarding as an integral part of their work.

3.4. Factors linked to safeguarding had not reduced in over half of the inspected cases and management oversight of this work was judged to be ineffective in over one-third of cases.

4. Ensuring that the sentence is served

4.1. In most cases we inspected, case managers had paid attention to the health and well-being outcomes of children and young people.

4.2. Court orders commenced swiftly, with case managers ensuring that appropriate checks were carried out, referrals were made and contact established with other professionals involved with the child or young person. In one referral order case, we saw work start immediately after the order was made in court, and well before the referral order panel sat, which we felt was good practice.

4.3. Engagement was a strength and it was evident that case managers knew the children and young people well and were committed to understanding, and helping them to resolve, their problems. Most children and young people had complied fully with the requirements of their order. In four cases they had not and while every attempt had been made to engage them, the YOS had not enforced the order quickly or well enough.

Operational management

There was evidence of regular management oversight, however, it was less clear how qualitative and effective it had been, as deficiencies in assessments and planning were not always identified or remedied. Additionally, it was unclear whether managers had helped case managers explore new approaches when it was obvious that interventions were not working.

Overall, case managers were positive about the supervision and support that they received, although a small number talked about the amount and pace of change that the YOS had gone through and some said that morale had suffered.

Key strengths

- The prompt commencement of work after the court appearance.
- The commitment of YOS staff to engaging children and young people.
- Information sharing and joint work with other agencies.

Areas requiring improvement

- The quality of assessments and the identification of priorities for planning.
- Enforcement of court orders when engagement has failed.
- The consistency of management oversight.

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 Jane Attwood. She can be contacted at jane.attwood@hmiprobation.gsi.gov.uk or on 07973 614573.

Copy to:

YOS Manager	*Dave Bond*
Local Authority Chief Executive	*Ian Stephenson*
Lead Elected Member for Children's Services	*Jim Coyle*
Lead Elected Member for Crime	*Dave Allen*
Police and Crime Commissioner for Derbyshire	*Alan Charles*
Chair of Local Safeguarding Children Board	*Andy Stokes*
Chair of Youth Court Bench	*Linda Brooks*
YJB Business Area Manager	*Gary Oscroft*
Ofsted – Further Education and Skills	*Paul Joyce*
Ofsted – Social Care	*Mary Candlin, Carolyn Adcock*
Ofsted – Links	*Lynn Radley, Caroline Prandas*
Care Quality Commission	*Fergus Currie*
YJB link staff	*Lisa Harvey-Messina, Paula Williams, Linda Paris, Julie Fox, Rowena Finnegan*
YJB Communications	*Ali Lewis, Rachel Brown, Summer Nisar, Adrian Stretch*

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.