Inspection of Youth Offending Work
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To:	Sara Tough, Chair of Dorset Combined Youth Offending Service Management Board and Director of Children's Services, Dorset County Council
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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 the Dorset Combined Youth Offending Service

The inspection was conducted from 12-14 September 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 Dorset Combined Youth Offending Service (YOS) was created by the merger of Bournemouth and Poole YOS and Dorset Youth Offending Team in July 2015. The YOS had also taken on a new case management recording system in May 2016, and the new YJB assessment and planning framework, AssetPlus in June 2016. Each of these changes could have a potentially significant impact on service delivery as staff and managers adapted to new structures and processes.

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 20 cases of children and young people who had recently offended and were supervised by the Dorset Combined YOS. Wherever possible, this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff. The most recent published reoffending rate[1] was 35.1% for Dorset Combined YOS, compared to 37.8% for all England and Wales.

Summary

Staff and managers had a good understanding of the children and young people they supervised and aimed to provide services to meet their specific diverse needs. Caseloads were manageable with staff having the time to work intensively with children and young people when this was appropriate. Case managers and line managers did, however, need a sharper focus on practice relating to reviewing and managing risk of harm. The YOS was well integrated with statutory partners in each of the three local authorities they covered, with good access to a range of

[1] The reoffending rate that was available during the fieldwork was published in July 2016, and was based on binary reoffending rates after 12 months for the October 2013 - September 2014 cohort. Source: Ministry of Justice.

services to tackle offending. The YOS had only come together as a single entity in the last 15 months, nevertheless good progress had been made in forging a single identity.

Commentary on the inspection in Dorset Combined Youth Offending Service:

1. Reducing reoffending

1.1. In nearly all cases sufficient efforts had been made to understand why the child or young person had offended and what actions may be taken to reduce the likelihood of this happening again.

1.2. In eight of the inspected cases the YOS had been asked to provide a pre-sentence report for the court. Seven of these were of a high quality, sufficiently covering the reasons for offending behaviour, the risk of harm posed by the child or young person and any issues of safeguarding and vulnerability. We also found that reports for referral order panels were generally of a good quality.

1.3. There was sufficient planning to reduce the likelihood of reoffending in the community in 12 of the 19 relevant cases. Where planning was not sufficient, it had not been completed at all, was completed too long after the start of the order or focused on issues that should not have been prioritised.

1.4. We judged that there had been significant enough changes to the circumstances of the child or young person to warrant a review of the reason for their offending and what might be done to reduce it in 12 cases. Of these, there had been such a review in only five, with plans being updated as necessary in only four.

1.5. Case managers had access to a good range of services to assist in bringing about change and supporting children and young people. Reparation activities were nearly always delivered as part of interventions, with young people being encouraged to develop skills in a workshop. One activity involved making items that could be sold via a local retail outlet, with the proceeds going to charities, sometimes nominated by the victim of the offence.

1.6. Children and young people were also offered the opportunity to work with staff and volunteers, who acted as good role models, on a range of activities designed to constructively use leisure time and build skills for the future. Examples of such activities included artwork, tennis and sailing.

1.7. We judged that all case managers had a sufficient understanding of the principles of effective practice and the factors that contribute to a reduction in reoffending.

2. Protecting the public

2.1. Sufficient effort had been made by the YOS to understand and explain the risk of harm to others posed by the child or young person in 12 of the 19 cases we inspected. Of the seven cases we found that did not meet our expectations, the main reasons were that there had been insufficient account taken of potential victims, the assessment of risk of harm had not been completed early enough or had not happened at all.

2.2. Sufficient planning to manage the risk of harm presented by the child or young person was completed at the start of the sentence in 9 of the 16 applicable cases. We found seven cases that were correctly assessed as presenting a medium or high risk of serious harm where there was no clear risk management plan.

2.3. Where there were serious identified risks of harm to others that did not relate to the offence for which the child or young person had been convicted, these were not always investigated thoroughly or given sufficient priority.

2.4. Of the ten cases where we expected to see a review of the risk of harm due to changes in the circumstances of the child or young person, this had happened to a sufficient standard in only five.

2.5. All of the case managers we spoke to had a good understanding of local policies and procedures for the management of risk of harm. The YOS had established 'Risk Assessment Panels' overseen by operational managers to enable information sharing between relevant partners. Where instigated, this process seemed to work well.

2.6. We judged that 12 of the cases we inspected should have a degree of management oversight to make sure that work to protect the public was done to a sufficient standard. In two of these cases there had been no management oversight, and in a further six it had not been effective.

3. Protecting the child or young person

3.1. Nearly all pre-sentence reports addressed safeguarding and vulnerability issues thoroughly. Overall, in 17 of the 20 cases sufficient effort had been made to understand and explain the safeguarding and vulnerability needs that applied to the child or young person.

3.2. Of the nine cases where we expected to see a review of the assessment of safeguarding and vulnerability factors due to changes in the circumstances of the child or young person, this had happened to a sufficient standard in only three.

3.3. We judged that there was sufficient planning at the start of the sentence to address safeguarding and vulnerability issues in 13 of the 19 relevant cases we inspected. Of the ten cases where the plan should have been updated, this had only happened in five.

3.4. There were three cases in our sample that had been sentenced to custody, in each of these we assessed that there was sufficient planning in place throughout the custodial period for work to address safeguarding and vulnerability.

3.5. Nearly all staff had a sufficient understanding of local policies and procedures in relation to safeguarding.

3.6. Management oversight of safeguarding was effective in just 7 of the 13 cases where we judged it to be necessary.

4. Making sure the sentence is served

4.1. In all but one case we found that case managers explored and understood the diversity factors that might act as a barrier to the child or young person engaging with the YOS to complete their sentence effectively. In nearly all cases, parents/carers and significant others were involved in a process to assess how to best to engage the child or young person, either at the pre-sentence stage or at the start of the contact with the YOS.

4.2. Planning was undertaken collaboratively, involving parents/carers as appropriate, taking into account the diversity needs of children and young people in nearly all cases.

4.3. Where children and young people had difficulty keeping to the terms of their court order, case managers made every reasonable effort to help them comply. We judged that enforcement action was necessary in three of the cases we inspected, all of which were returned to court.

Operational management

Case managers understood the principles of effective practice and were generally able to apply these to the children and young people they worked with. They were confident they had the necessary skills and training to deliver services. They were also sufficiently aware of the relevant local procedures and practices, and nearly all expressed confidence in their managers. Despite this, we found that there was an absence of a systematic approach by line managers to make sure that basic case management processes were undertaken. This resulted in assessments, planning and reviews often being completed late, or in some instances not at all, as noted earlier. We also saw evidence that case managers did not always complete actions that had been identified as necessary by their managers.

Key strengths

- The YOS was sufficiently well resourced to enable them to undertake good initial assessments and tailor interventions to the individual needs of children and young people.
- There was evidence that the YOS had good relationships with statutory partners and shared information appropriately.
- Staff found practical ways to support children and young people to achieve their objectives, such as making sure they had the necessary identification documents to allow them to apply for work.
- Most interventions contained an element of practical reparation.

Areas requiring improvement

- Case managers should review their assessments and plans, particularly as they relate to the management of risk of harm and safeguarding, as the circumstances of the children and young people develop.
- Line managers should develop a systematic quality assurance process to make sure that cases have been reviewed appropriately and any actions identified for the case manager are completed in a timely fashion.
- All cases that are assessed as presenting a medium or high risk of serious harm to others should have a clear risk management plan that identifies the potential triggers to escalating risk and the contingencies that will be put in place should they arise.

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 make sure 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 Mark Boother. He can be contacted at Mark.boother@hmiprobation.gsi.gov.uk or on 07771 527326.

Copy to:

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Police and Crime Commissioner for Dorset	*Martyn Underhill*
Chair of Local Safeguarding Children Board	*Sarah Elliott*
Chair of Youth Court Bench	*Martin Simms*
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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.