Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
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To:	Lucy Butler, Chair of Oxfordshire YOS Management Board
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From:	Helen Mercer, Director (Youth Justice)
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Report of Short Quality Screening (SQS) of youth offending work in Oxfordshire

The inspection was conducted from 16 to 18 February 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 20 cases of children and young people who had recently offended and were supervised by Oxfordshire Youth Offending Service (YOS). Wherever possible this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff. There were no custody cases in the sample, as Oxfordshire YOS had no recent custodial sentences.

Summary

The published reoffending rate[1] for Oxfordshire was 35.5%. This was better than the previous year and better than the England and Wales average of 36.1%.

Overall, we found that staff engaged well with children and young people and their parents/carers to develop the initial assessments and plans, and used this information effectively to inform decisions in court. This good engagement with children and young people also reflected itself in the high levels of compliance of children and young people with their court orders to ensure that their sentences were served. Work to assess and manage the risk of harm had improved since the previous inspection in 2011, though safeguarding work had deteriorated. Management oversight needed to be more consistent and robust.

Commentary on the inspection in Oxfordshire:

1. Reducing reoffending

1.1. Pre-sentence reports (PSRs) and panel reports are the principal means by which the sentencing courts and panels, that oversee referral orders, are advised about the causes of offending and the work required to address that. All of the PSRs submitted to the court to inform sentencing were of a good quality overall, and the child or young person and

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

their parents/carers were engaged in the development of all PSRs. Panel reports were less consistent, though positively the YOS had developed a restorative approach to these.

1.2. The initial assessment of the child or young person's likelihood of reoffending was done well in over two-thirds of the cases in the sample. Most were thorough and provided a full picture of the child or young person's circumstances, such as how living arrangements, family and personal circumstances and education might impact on reoffending. An inspector commented: "*Within the assessment, the case manager divided the evidence box into the following sections; evidence, likelihood of reoffending, risk of harm, vulnerability, diversity and positive factors so that all areas were considered.*"

1.3. Children and young people's lives can change very quickly and, as a result, assessments need to be reviewed. There had been a good enough review of initial assessments in almost two-thirds of cases. Where there were gaps, this was mostly because reviews had not been undertaken following significant events, such as a change in where the child or young person lived, or following a change in the frequency of contacts.

1.4. There was sufficient planning to minimise reoffending in the great majority of cases. In almost all cases the child or young person and their parents/carers were involved in this activity. An inspector noted: "*The plan that was shared with the young person was very clear and concise and meant that the young person understood what they were signing up to.*"

1.5. Reviews of plans to reduce reoffending were also done well in over three-quarters of cases. In the two plans which were not reviewed sufficiently well, one review was not undertaken, and one plan was not revised as required.

2. Protecting the public

2.1. We expect to see a thorough assessment of the risk of harm a child or young person poses to others. This should cover all relevant information, including past offending behaviour, and impact on victims. We found that this had been done well in more than two-thirds of cases in the sample. Where it was not, this was mostly because the assessment was not timely, or of insufficient quality.

2.2. Having assessed the risks, plans should be put in place to manage them. This had been done sufficiently well in 15 of the 17 relevant cases. Of the remainder, this was either because the plan was not completed, or was not timely. An inspector noted: "*Sam was subject to case formulation planning which allowed all professionals involved with him to come together and share historic and current information about him and his family where appropriate. This enabled all agencies to have a holistic view of the young person/family and for a joint plan to be formulated.*"

2.3. The assessment of risk of harm to others had been reviewed well enough in almost two-thirds of cases. Where they had not, this was because they were either not undertaken as required, or had not been reviewed following significant changes. Plans to manage risk of harm had been reviewed well enough in 8 of the 11 relevant cases.

2.4. The risk of harm to victims who had been identified was managed effectively in 86% of cases. It was pleasing to see restorative work being undertaken with victims of crime.

2.5. Management oversight in ensuring the quality of risk of harm work was effective in 10 out of the 14 relevant cases. Where it was not, important deficiencies in assessment and planning had not been addressed, or management oversight was not timely.

3. Protecting the child or young person

3.1. This is the weakest area of work we found in this YOS. Children and young people can be at risk of being harmed by others or as a result of their own behaviour, by placing themselves in dangerous or potentially harmful situations. It is the YOS's role to work with others to help protect them. Initial assessment of safeguarding and vulnerability had been done well enough in less than two-thirds of inspected cases. Where this was not done well enough this was mostly because screening was not timely, was of insufficient quality, or because other relevant behaviour had been missed.

3.2. The safeguarding needs of children and young people change over time and need to be kept under review. Satisfactory reviews of safeguarding and vulnerability assessments had been completed in half of the cases in the sample. The most frequent deficits were reviews of insufficient quality, and reviews not undertaken following significant changes in the child or young person's life.

3.3. Suitable plans were put in place at the start of the sentence to manage safeguarding and vulnerability issues in 11 out of 20 cases. Plans were reviewed sufficiently well in less than half of relevant cases. Where there were gaps, this was mostly because reviews had not been undertaken, or were of insufficient quality. While there was evidence in some cases of positive joint working between the YOS and social care, an inspector commented: "*Joint supervision between YOS/social care was mentioned but there was no evidence in relation to the outcomes of these meetings or what had been discussed.*"

3.4. Management oversight in ensuring the quality of safeguarding and vulnerability work needed to be more robust. We found it to be effective in less than half of relevant cases. This was mostly because deficiencies in assessment and planning had not been addressed, because oversight was not provided as required, or was not timely.

4. Ensuring that the sentence is served

4.1. This is the strongest area of work we found in this YOS. We expect to see that the YOS is doing what it can to help children and young people to complete their sentences successfully. This includes engaging them and their parents/carers in the assessment and planning processes; identifying and addressing barriers to engagement; and putting measures in place to ensure that they comply with the requirements of their sentence. An inspector noted: "*The case manager recognised that Simon resided a significant distance from the YOS and therefore*, *in order to maximise contact with the young person, appointments were arranged where they had to make an effort to attend, but not go to the opposite end of the county.*"

4.2. There was a high level of engagement in all but three cases in the sample between case managers, children and young people and their parents/carers in carrying out the initial assessment, and in almost all cases in the planning process. This was a strength of the YOS.

4.3. Diversity issues and other barriers to engagement had been assessed sufficiently well and incorporated into plans where relevant in almost all cases. In the large majority of cases, case managers also gave attention to health and well-being, in so far as this may act as a barrier to successful outcomes from the sentence.

4.4. The YOS responded appropriately to children and young people who did not comply with the requirements of their sentence in five out of six relevant cases, for example; issuing formal warnings or breach proceedings. This included an extension to a referral order where a young person had not complied with their contract.

Operational management

We found that staff had sound knowledge of effective practice in working with children and young people. Generally, case managers had a good understanding of local policies and procedures for managing risk of harm, and safeguarding. Most were positive about the management oversight of risk of harm and safeguarding work. However, as outlined above, we found evidence to suggest this was not always effective. Staff spoke positively about their managers, although some indicated that they would welcome more challenge. Almost all case managers said their training and skills development needs were met for their current role. However, a gap identified by staff was training in recognising and responding to speech, language and communication needs. It was positive to hear that staff had received training in recognising risk factors which may indicate child sexual exploitation, though processes for screening, referral and assessment were not always being completed in a timely manner.

Key strengths

- Pre-sentence reports submitted to the courts to inform sentencing were of a good standard.
- Initial assessments of the likelihood of reoffending were mostly thorough and well structured.
- Children, young people and their parents/carers were engaged well in the initial assessment and planning processes.
- Staff worked well with children and young people to ensure their compliance with the requirements of their sentence.
- Staff were motivated, had good skills and knowledge and we saw evidence of some positive programmes to engage children and young people; for example the Modelling Change programme for girls, and substance misuse work.

Areas requiring improvement

- Management oversight should ensure the quality and timeliness of safeguarding and vulnerability assessments, plans and reviews so that children and young people are protected.
- Case managers should be more attentive to changes in circumstances so that reviews of assessments and plans are carried out when required, particularly when working to help protect the child or young person.
- Management oversight should be more consistent and more robust, including active management and sign-off of relevant assessments and plans, and there should be processes in place to ensure these remain current and are of good quality.

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 Sue McGrath. She can be contacted at susan.mcgrath@hmiprobation.gsi.gov.uk or on 07557 848458.

Please note – throughout this report all names referred to in the inspector comments have been amended to protect the individual's identity.

Copy to:

YOS County Manager	*Amrik Panaser*
Local Authority Chief Executive	*Joanna Simons*
Director of Children's Services	*Jim Leivers*
Lead Elected Member for Children's Services	*Melinda Tilley*
Police and Crime Commissioner for Thames Valley	*Anthony Stansfeld*
Chair of Local Safeguarding Children Board	*Maggie Blythe*
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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.