Inspection of Youth Offending Work
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From:	Helen Mercer, Assistant Chief Inspector (Youth Justice)
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Report of Short Quality Screening (SQS) of youth offending work in Bexley

The inspection was conducted from 08-10 June 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 are 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 Bexley 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 Bexley was 31.4%. This was better than the previous year and better than the England and Wales average of 36.1%.

Bexley YOT had done well to make a marked improvement since HMI Probation's last inspection in 2011. The YOT had found a healthy balance between protecting the public and enhancing the safety and well-being of the children and young people with whom it worked. Case managers linked well with other agencies and used a wide range of approaches in order to achieve the best possible outcomes. Overall, we found the performance of the YOT to be highly commendable.

Commentary on the inspection in Bexley

1. Reducing reoffending

1.1. Case managers had a good understanding of the children and young people whose cases they were managing. They were unafraid to investigate and follow-up on issues, drawing on and analysing relevant sources of information to identify factors linked to offending behaviour and what could be done to reduce the likelihood of reoffending.

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

1.2. Pre-sentence reports (PSRs) are written to help the court with their sentencing decisions. A PSR was prepared in ten of the cases we looked at. The great majority of these were of good quality. We were pleased to see that the local template included a discrete section for outlining the impact of the offence on the victim. PSR writers made helpful and sometimes innovative proposals for sentencing that balanced the importance of protecting the public with the potential for long-term, positive outcomes for the child or young person who had offended. Good quality reports were also written for youth offender panels.

1.3. While case managers were continually assessing the needs in a case, they were not documenting this as often as they should have been. We would expect to see assessments reviewed and updated, especially after a significant change in the circumstances of a child or young person. This was not always happening.

1.4. In most instances, planning to reduce the likelihood that the child or young person would reoffend met the needs of the case, whether this be in custody or the community. The London Integrated Action Plan template was helpful for highlighting the child or young person's perspective. Some plans would have benefited from a little more detail, such as target outcomes, timeframes, and the sequence in which tasks should be completed.

1.5. We looked at a small number of referral order contracts (outlining the work the child or young person agreed to undertake during their sentence). These often contained relevant information but were written in an official style, making it difficult to identify the perspective and aspirations of the child or young person.

1.6. We assessed that by the time of our inspection, many of the children and young people whose cases we had looked at were less likely to offend.

2. Protecting the public

2.1. Case managers had done enough work to understand and explain the risk of harm the child or young person posed to others in 9 of the 14 cases we looked at. They were not always able to recognise escalating patterns of violence or the wider impact the offending behaviour could have. Victim issues were not analysed consistently to enough depth and case managers were not always able to articulate possible future risk of harm, especially in cases where protective factors, such as peers being in custody, were not sustainable. In two cases this led to the level of risk of harm being underestimated.

2.2. This affected the quality of planning, so that in some cases there was too little emphasis on work to address risk of harm. In cases where a specific plan had been drafted to manage risk of harm, most were comprehensive, containing good ideas for meeting the needs of the case. However, they tended to be bulky and complex making it hard to identify how specific issues were to be addressed and which should take priority.

2.3. We looked at one case managed through Multi-Agency Public Protection Arrangements (MAPPA). This case was being hosted by a YOT in another area. It was clear that Bexley YOT was working hard and successfully to build an effective relationship with the host YOT. This helped to coordinate the complexity of the case and continuously plan and adjust the multi-agency response to the risk of harm posed.

2.4. Generally, assessments and plans were reviewed when they should have been and updated to reflect changes in the case.

2.5. In some cases, oversight by management had not ensured that work to manage risk of harm was good enough.

3. Protecting the child or young person

3.1. We were pleased to see the amount of attention paid by Bexley YOT to understanding and explaining the safeguarding and vulnerability issues for the children and young people with whom they worked. We saw a need for further assessment in only three cases. In each of these, case managers had not used all the information available to them to gain an accurate picture of the emotional or mental health issues in the case. As a result, they had underestimated the level of vulnerability of the child or young person.

3.2. We would have liked to have seen more documented reviews. There were 13 cases where a review should have taken place. There was no evidence that this had happened in five, two of which had seen significant change since the previous assessment.

3.3. We saw a good level of planning to promote safeguarding and address areas of vulnerability, with case managers being responsive to changes in circumstances and adapting plans accordingly. As with risk of harm, specific plans tended to be comprehensive, but cumbersome. We noted that in one complex case, where a young person was vulnerable to being sexually exploited and there was a need for clear and detailed planning, it was difficult to identify the mechanisms to be used to monitor the situation and safeguard the young person.

3.4. The YOT had a solid relationship with Bexley Children's Social Care Service and there was evidence of integrated, joint working where there was a need for this. The YOT had the confidence to use its escalation process where necessary and we saw an example of how this had been used successfully to gain additional, appropriate support for a family.

3.5. Appropriate initial measures were taken where there were indicators that a child or young person could be the victim of sexual exploitation; case managers and the YOT nurse built trusting relationships before tackling issues with at risk children and young people, and there was a good joint agency approach to sharing relevant information.

3.6. Overall, there was effective management oversight of the YOT's work relating to safeguarding and vulnerability.

4. Ensuring that the sentence is served

4.1. Case managers and other workers in the YOT used a range of approaches to build relationships and identify and better understand the individual needs of the children and young people with whom they worked.

4.2. In the majority of cases, there was sufficient engagement with the child or young person and their parent/carer to assess, and plan to address, issues linked to offending. We were pleased to see that plans indicated the preferred learning styles of children and young people. However, while case managers often had a good understanding of the wider diversity issues and potential barriers to engagement in a case, they did not always consider the benefits of including this information in plans.

4.3. Considerable efforts were made to enhance the health and well-being of children and young people. The YOT nurse proactively used the Comprehensive Health Assessment Tool (CHAT[2]) to identify, share relevant information about, and address pertinent issues.

4.4. In more cases than not, children and young people complied with the requirements of their sentences. Where they did not, the YOT took appropriate action. Children and young people were given clear boundaries and fair warnings and every reasonable effort was

[2] CHAT, recently developed as part of the Healthy Children, Safer Communities strategy, is a combined, comprehensive tool for screening the health and well-being of children and young people in the criminal justice system

made to help them comply. Three children or young people were appropriately returned to court when these efforts failed.

Operational management

Case managers had a sufficient and often good understanding of the principles of effective practice. They felt their managers were skilled and knowledgeable, and supported them well to improve the quality of their work, providing good supervision and, in the main, enough training.

There were several mechanisms in place for providing oversight of cases. Cases were discussed in supervision and managers had a good understanding of the issues pertaining to individual children and young people. Bexley YOT also facilitated risk management panels and attended the Serious Violence Prevention Panel. Case managers felt these enhanced joint working and helped to inform their decisions in a case. However, we saw little evidence that panel meetings culminated in multi-agency action. Such panels have the potential to provide effective oversight, especially in complex cases, helping to set strategic direction and agree joint agency plans to meet agreed objectives. We consider that this does not happen in Bexley to be a lost opportunity.

Key strengths

- PSRs were relevant and analytical. They provided the courts with good quality information about why a child or young person had offended and made sound, individualised proposals for sentencing.
- Case managers used investigative and innovative approaches to identify and understand key issues in a case and make effective plans for working with children and young people.
- The YOT built effective relationships with children and young people and their parents/carers, planning work carefully to help children and young people complete their sentences successfully and taking appropriate measures to address issues of non-compliance.
- YOT workers went the extra mile to take account of and address health and well-being factors that could affect how well a child or young person completed their sentence.
- The YOT linked well with children's social care services and the local Thriving Families initiative in order to identify and address safeguarding and vulnerability issues.

Areas requiring improvement

- Assessments of the risk of harm a child or young person poses to others need to be thorough, accurate and clear about both current and potential future risk of harm.
- Planning to reduce risk of harm to others should meet the current and potential future needs of a case.
- Management oversight of risk of harm to others should identify and address gaps in assessment and planning.
- The style of referral order contracts should reflect the level of understanding of the child or young person and their individual perspective and aspirations.

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 Vivienne Clarke. She can be contacted at Vivienne.Clarke@HMIProbation.gsi.gov.uk or on 07972 273026.

Copy to:

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Lead Elected Member (Crime and Children)	*Councillor Philip Read*
Deputy Mayor (London) for Policing and Crime	*Stephen Greenhalgh*
Chair of Local Safeguarding Children Board (interim)	*Simon Evans-Evans*
Chair of Youth Court Bench	*Carole Poll*
YJB Business Area Manager	*Adam Mooney/Liz Westlund*
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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.