Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
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To:	Julian Wooster, Chair of Somerset Youth Offending Team Management Board and Director of Children's Services
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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 Somerset

The inspection was conducted from 09-11 May 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 20 cases of children and young people who had recently offended and were supervised by Somerset Youth Offending Team (YOT). Normally we would assess both community and custody cases but in this instance none of the custodial sentences met our sampling criteria. As such, the findings outlined below only relate to cases being managed in the community. Wherever possible, our case assessments were undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

The published reoffending rate[1] for Somerset was 32.3%. This was better than the previous year and better than the England and Wales average of 37.8%.

Overall, we found that practitioners were very good at engaging with children and young people and understanding their individual needs. They had a clear understanding of the benefits of restorative justice and worked well with others to achieve positive outcomes, particularly in cases presenting complex educational, or emotional and mental health needs. We found gaps, however, at the start of the order in the quality of assessments relating to the risk of harm to others and safeguarding and vulnerability, and were not assured that plans met the requirements of each case. There was also a need for more consistently effective management oversight of practice.

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

Commentary on the inspection in Somerset

1. Reducing reoffending

1.1. Practitioners had a good understanding of the children and young people whose cases they were supervising but were not recording this often and well enough in their assessments. The YOT's clinical psychologist was integral to the assessment process and we saw good evidence of the positive impact she was making. The main gaps in assessment were substance misuse, living arrangements or neighbourhood and how these impacted on the child or young person's behaviour.

1.2. Both the court and referral order panels sought advice from the YOT to help inform their decisions. Pre-sentence reports were produced by the YOT in seven of the cases we looked at. All but one of these were of a good quality, paying due regard to diversity and barriers to engagement, and providing sufficient advice to the court. In the one exception, the report writer failed to analyse sufficiently why the child or young person had offended. We looked at six reports written for referral order panels. Two of these were well written, setting out a clear analysis of offending behaviour, the risk of harm the child or young person posed to others and factors relating to safeguarding and vulnerability. The others lacked essential detail and analysis so that it was difficult to understand the reasons for the proposed interventions.

1.3. Planning to reduce the likelihood that the child or young person would reoffend varied in quality. In three cases there was no plan at the start of the order and we considered that two had been completed unreasonably late. In seven cases the plan did not address issues that had been identified during assessment. Practitioners were making referrals to substance misuse services but their intention to do so was not always included in the intervention plan. We found few recorded objectives relating to victim awareness. On the other hand we saw some excellent examples of planning for restorative justice conferencing, with good attention given to preparing parties to participate in this.

1.4. The YOT often took the lead in identifying appropriate educational provision. They worked well with Targeted Youth Support and the educational psychologist in order to secure placements, even for some of the children and young people with the most complex needs.

1.5. Assessments were reviewed when and how they should have been in almost every case that needed this, and plans in almost three-quarters.

1.6. We were pleased to see that Youth Justice Board data showed that reoffending rates for children and young people in the county had decreased. We also noted that many of the children and young people whose cases we looked at were less likely to offend by the time of this inspection than they had been at sentence.

2. Protecting the public

2.1. Work at the start of an order to understand and explain the risk of harm the child or young person posed to others was sufficient in less than half of the 19 applicable cases (the initial assessment in one case had been completed by another YOT). In a fair proportion of cases, practitioners had not identified and analysed the risks to actual and potential victims. In some, they were too focused on offences and did not explore the significance of other behaviours.

2.2. These omissions affected the quality of planning, so that practitioners sometimes placed too little emphasis on work to address risk of harm. Planning was good enough in just over half of the 16 cases where there were factors to manage. Many plans comprised

high level actions and lacked essential details including, for example, the roles of other workers and agencies. In about one-quarter of the cases, it was not easy to tell what the plan of action was, or the planned response was insufficient. In some instances there was too little focus on how victims would be kept safe.

2.3. In many cases, the quality of assessment and planning for risk of harm to others improved as sentences progressed. Assessments were reviewed appropriately in 8 of the 11 cases that needed it, and planning in 7 of 9.

3. Protecting the child or young person

3.1. Practitioners were good at identifying issues relating to safeguarding and vulnerability and referred for specialist assessments where necessary. They were not as effective, however, at analysing and explaining how a child or young person's vulnerability linked to their offending. Poor recording was responsible in part for this. Practitioners often understood the substance misuse, or emotional and mental health issues in a case but did not always evidence this in their assessments. Overall, assessment was of sufficient quality in 11 of the applicable 19 cases.

3.2. Planning to address safeguarding and vulnerability had been completed well enough in less than half of the 18 cases that required it. In some cases it was difficult to decipher exactly what was going to be done while in others it was clear that not enough action was planned. Plans needed greater clarity about how substance misuse or emotional and mental health issues would be addressed. There was also a need for more consistency in recording how and when information would be shared with other workers and agencies.

3.3. Work to protect the child or young person improved as their sentences progressed. Assessment and plans were reviewed sufficiently throughout the sentence in nearly three-quarters of the cases we looked at.

3.4. The YOT was completing the child sexual exploitation assessment tool and, where they identified that the child or young person was at risk, had taken appropriate action in the large majority of cases.

4. Making sure the sentence is served

4.1. This was an area of strength for the YOT. Practitioners used a range of approaches to help build positive relationships with children and young people and their parents/carers. In the main this enabled them to identify and understand family dynamics and the individual needs and circumstances of the case. It was encouraging to see the YOT's strong focus on health and welfare, especially where this was important to the successful completion of orders. Practitioners recognised the importance of consistency and trust. As such, they sought to manage cases which could have been transferred across the county in order to encourage or maintain a child or young person's engagement with the YOT.

4.2. Children and young people and their parents/carers had been involved sufficiently in planning in only half of the cases we inspected. Plans were not always written in a way that met individual need. We assessed one case involving a young person who presented with speech, language and communication needs, whose plan included high level technical wording that would have held little meaning for him. In contrast, we found cases in which practitioners had taken determined steps to identify and include the priorities of the child or young person and present objectives in their own words.

4.3. Children and young people had struggled to engage with the requirements of their sentences in 11 cases. The YOT responded appropriately in each of these and, in eight, this led to improved compliance.

Operational management

Both managers and practitioners felt that the implementation of their new case management system (AssetPlus) had had a temporary but considerable impact on working practices. All of the practitioners we interviewed, however, had sufficient understanding of effective practice and the YOT's policies for risk of harm, safeguarding, engagement and compliance. It was clear that overall they placed the needs of the children and young people at the heart of their work and focused on achieving positive outcomes for them. Generally they felt they had received enough training to help identify diversity and individual needs. A small number advised that they would benefit from more training, effective management support and oversight of their practice. Our findings support this. We considered that staff supervision or quality assurance arrangements had had a positive impact on just over two-thirds of the cases we looked at. Management oversight had made sure work to manage risk of harm, and safeguarding and vulnerability was effective in about half of the inspected cases. We were glad to see high risk cases being discussed at relevant case planning meetings but there was little evidence to suggest that these had the required impact; that decisions made were incorporated into plans or, in some cases, that discussions at meetings were translated into appropriate action.

Key strengths

- Pre-sentence reports provided the courts with good quality information about why a child or young person offended and made sound, individualised proposals for sentencing.
- The YOT engaged well with children and young people and their parents/carers to build effective relationships and understand the needs of a case.
- Appropriate measures to address issues of non-compliance were taken and in many cases enhanced engagement.
- The YOT had built effective links with the county's educational psychologist and clearly valued and integrated the advice of its clinical psychologist to enhance practice and outcomes.
- Restorative justice conferencing was utilised well to enhance the well-being of victims and change the attitudes of the children and young people who participated.

Areas requiring improvement

- Assessments at the start of order of risk of harm, safeguarding and vulnerability and all relevant behaviours need to be thorough and take account of the victim perspective.
- Planning at the start of an order should contain sufficient detail to reflect individual needs and barriers to engagement.
- Management oversight processes should be consistent and effective and make sure that assessment and planning are properly recorded in the case files.

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

Copy to:

YOT Head of Service	*Tom Whitworth*
Local Authority Chief Executive	*Patrick Flaherty*
Lead Elected Member for Children's Services	*Frances Nicholson*
Lead Elected Member for Crime	*Anna Goskop*
Police and Crime Commissioner for Avon and Somerset	*Sue Mountstevens*
Chair of Local Safeguarding Children Board	*Sally Halls*
Chair of Youth Court Bench	*Simon Williams*
YJB Business Area Manager	*Lisa Harvey-Messina*
Ofsted – Further Education and Skills	*Paul Joyce*
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Care Quality Commission	*Jan Fooks-Bale*
YJB link staff	*Lisa Harvey-Messina, Paula Williams, Linda Paris, 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.