



Inspection of  
Youth  
Offending

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Arolygiad ar y Cyd Cyfiawnder Troseddol

# Core Case Inspection of youth offending work in England and Wales

Report on youth offending  
work in:

**Kingston Upon Hull**

ISBN: 978-1-84099-368-4

2010



## Foreword

This Core Case Inspection of youth offending work in Kingston Upon Hull took place as part of the Inspection of Youth Offending programme. We have examined a representative sample of youth offending cases from the area, and have judged how often the Public Protection and the Safeguarding aspects of the work were done to a sufficiently high level of quality.

We judged that the Safeguarding aspects of the work were done well enough 69% of the time. With the Public Protection aspects, work to keep to a minimum each individual's *Risk of Harm to others* was done well enough 60% of the time, and the work to make each individual less likely to reoffend was done well enough 74% of the time. A more detailed analysis of our findings is provided in the main body of this report, and summarised in a table in Appendix 1. These figures can be viewed in the context of our findings from the regions inspected so far – see the Table below.

We found a service that had developed a wide range of interventions to address likelihood of reoffending and to promote children's safety. It was evident that children and young people had made progress and factors linked to reoffending had reduced. By contrast, sentence plans and reviews needed to better reflect the actual work being undertaken and give a clear set of aims and objectives.

Work is also needed to improve the quality of initial assessments and subsequent planning for *Risk of Harm to others* and Vulnerability. Increased management oversight will be critical to this.

Overall, we consider this a relatively encouraging set of findings which match the Youth Justice Service's own assessment of the areas of practice to be improved.

*Andrew Bridges*  
*HM Chief Inspector of Probation*

*October 2010*

|  | Scores from Wales and the English regions that have been inspected to date |         |         | Scores for Kingston Upon Hull |
|--|--|---------|---------|-------------------------------|
|  | Lowest   | Highest | Average |                               |
| <b>'Safeguarding' work</b><br><i>(action to protect the young person)</i>              | 38%  | 91%     | 67%     | <b>69%</b>                    |
| <b>'Risk of Harm to others' work</b><br><i>(action to protect the public)</i>          | 36%  | 85%     | 62%     | <b>60%</b>                    |
| <b>'Likelihood of Reoffending' work</b><br><i>(individual less likely to reoffend)</i> | 50%  | 87%     | 69%     | <b>74%</b>                    |

## **Acknowledgements**

We would like to thank all the staff from the YJS<sup>1</sup>, members of the Management Board and partner organisations for their assistance in ensuring the smooth running of this inspection.

|                           |   |
|---------------------------|---|
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<sup>1</sup> This is a YOT as constituted under the Crime and Disorder Act 1989 but is known as the Youth Justice Service and hence this terminology is used throughout the report.

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## Scoring – and Summary Table

This report provides percentage scores for each of the 'practice criteria' essentially indicating how often each aspect of work met the level of quality we were looking for. In these inspections we focus principally on the Public Protection and Safeguarding aspects of the work in each case sample. Accordingly, we are able to provide a score that represents how often the *Public Protection* and *Safeguarding* aspects of the cases we assessed met the level of quality we were looking for, which we summarise here. We also provide a headline 'Comment' by each score, to indicate whether we consider that this aspect of work now requires either **MINIMUM, MODERATE, SUBSTANTIAL** or **DRASTIC** improvement in the immediate future.

| <b><i>Safeguarding score:</i></b>   |  |
|---|--|
| This score indicates the percentage of <i>Safeguarding</i> work that we judged to have met a sufficiently high level of quality. This score is significant in helping us to decide whether an early further inspection is needed. |  |
| <b><i>Score:</i></b><br><b>69%</b>  | <b><i>Comment:</i></b><br><b>MODERATE improvement required</b> |
| <b><i>Public Protection – Risk of Harm score:</i></b>   |  |
| This score indicates the percentage of <i>Risk of Harm</i> work that we judged to have met a sufficiently high level of quality. This score is significant in helping us to decide whether an early further inspection is needed. |  |
| <b><i>Score:</i></b><br><b>60%</b>  | <b><i>Comment:</i></b><br><b>MODERATE improvement required</b> |
| <b><i>Public Protection - Likelihood of Reoffending score:</i></b>  |  |
| This score indicates the percentage of <i>Likelihood of Reoffending</i> work that we judged to have met a sufficiently high level of quality.   |  |
| <b><i>Score:</i></b><br><b>74%</b>  | <b><i>Comment:</i></b><br><b>MINIMUM improvement required</b>  |

We advise readers of reports not to attempt close comparisons of scores between individual areas. Such comparisons are not necessarily valid as the sizes of samples vary slightly, as does the profile of cases included in each area's sample. We believe the scoring is best seen as a headline summary of what we have found in an individual area, and providing a focus for future improvement work within that area. Overall our inspection findings provide the 'best available' means of measuring, for example, how often each individual's *Risk of Harm to others* is being kept to a minimum. It is never possible to eliminate completely Risk of Harm to the public, and a catastrophic event can happen anywhere at any time – nevertheless a 'high' *RoH* score in one inspected location indicates that it is less likely to happen there than in a location where there has been a 'low' *RoH* inspection score. In particular, a high *RoH* score indicates that usually practitioners are 'doing all they reasonably can' to minimise such risks to the public, in our judgement, even though there can never be a guarantee of success in every single case.

## **Recommendations** (primary responsibility is indicated in brackets)

Changes are necessary to ensure that, in a higher proportion of cases:

- (1) a timely and good quality assessment and plan, using Asset, is completed when the case starts (YJS Manager)
- (2) specifically, a timely and good quality assessment of the individual's vulnerability and *Risk of Harm to others* is completed at the start, as appropriate to the specific case (YJS Manager)
- (3) as a consequence of the assessment, the record of the intervention plan is specific about what will now be done in order to safeguard the child or young person from harm, to make them less likely to reoffend, and to minimise any identified *Risk of Harm to others* (YJS Manager)
- (4) the plan of work with the case is regularly reviewed and correctly recorded in Asset with a frequency consistent with national standards for youth offending services (YJS Manager)
- (5) there is evidence in the file of regular quality assurance by management, especially of screening decisions, as appropriate to the specific case (YJS Manager).

## **Next steps**

An improvement plan addressing the recommendations should be submitted to HM Inspectorate of Probation four weeks after the publication of this inspection report. Once finalised, the plan will be forwarded to the Youth Justice Board to monitor its implementation.

## Service users' perspective

### Children and young people

Twenty children and young people completed a questionnaire for the inspection.

- ◆ Thirteen children and young people knew what a sentence plan was and their YJS worker had discussed what was expected of them. All nine of the relevant respondents remembered having been given a copy of the plan.
- ◆ All children and young people felt that staff had listened to them, and that staff had taken time to make sure that they knew how the YJS could help them.
- ◆ When asked what had got better in their lives as a result of going to the YJS, over half of the children and young people said school, training and getting a job had improved. Other areas included making better decisions, family and relationships, understanding their offending and lifestyles. Only one young person felt that nothing had improved. Representative comments included: *'I stopped smoking and drinking and I stopped taking any drugs when the yot helped me'*; *'Feel healthier, not as tired'* and *'I have started going to Hull Fish Trades Boxing Club'*.
- ◆ When asked what had made them less likely to reoffend, one young person told us: *'Working through the box wise course and the youth offending courses have helped me get a better understanding of what opportunities I have and also have learned to control my emotions'*.
- ◆ Another young person said *'I've had a good time with yot they have helped me change myself so big thanks to the yot team'*.

### Victims

Fifteen questionnaires were completed by victims of offending by children and young people.

- ◆ Twelve people had been told about the service the YJS could offer them and said that their needs had been taken into account. They had had the chance to talk through any worries they had about the offence or the young person who had committed it.
- ◆ From the ten people who had concerns about their safety, seven felt that these had been responded to.
- ◆ Two of the fifteen people stated that they had benefited from the work done by the child or young person who had committed the crime.
- ◆ Respondents were asked to rate the service they had received from the YJS, two people were completely satisfied, ten were mostly satisfied and three were generally satisfied.



## Sharing good practice

Below are examples of good practice we found in the YJS.

|  |   |
|--|---|
| <b>Assessment and Sentence Planning</b><br><br><b>General Criterion:<br/>1.2.f</b>     | Ben, a 17 year old young man, was in custody serving a sentence for a violent offence. He posed a <i>RoH</i> and needed a specialist placement to work on his behaviours. The case manager and Ben's social worker undertook thorough and detailed assessments of his needs, and identified a suitable residential placement. Staff from the placement undertook visits with the case manager to enable Ben to get to know his new care staff. There was good joint work to move Ben on in his life and prepare him for adulthood. Ben had been able to move into semi-independent accommodation and has worked on his behaviour and attitudes to reduce his <i>RoH</i> . It was notable that the case manager continued to be actively involvement with Ben, despite his case being transferred to another YOT.  |
| <b>Delivery and Review of Interventions</b><br><br><b>General Criterion:<br/>2.2 a</b> | The Wilberforce Youth Development programme offered a 12 week course for 16 to 18 year olds. Designed for children and young people who were outside of school, education or training, the programme included a 30 hour induction, six weeks of activities, a two week sailing challenge and work taster opportunities. Those who attended were able to develop confidence, build new skills, learn to follow instruction and work as part of a team.   |
| <b>Outcomes</b><br><br><b>General Criterion:<br/>3.2 a</b>                             | Lorna, a 17 year old young woman, had significant emotional and mental health needs which were linked both to her <i>RoH</i> and to herself. She had repeatedly taken overdoses, resulting in frequent admissions to hospital. Lorna refused to work with CAMHS and therefore relevant services could not be accessed. However, the case manager demonstrated persistence in working with Lorna to ensure that when she felt she would overdose contact would be made with CAMHS. After five months and significant input from the case manager, Lorna eventually contacted CAMHS. This enabled a joint care plan with CAMHS, Family Intervention Project, A&E liaison and the case manager to be drawn up which clearly defined actions, roles and responsibilities to manage the risk she posed to herself. A review was also arranged with a Consultant Child and Adolescent Psychiatrist to inform her imminent transition to adult services. |

## 1. ASSESSMENT AND SENTENCE PLANNING

### 1.1 Risk of Harm to others (RoH):

**General Criterion:**

*The assessment of RoH is comprehensive, accurate and timely, takes victims' issues into account and uses Asset and other relevant assessment tools. Plans are in place to manage RoH.*

**Score:**

**67%**

**Comment:**

**MODERATE improvement required**

**Strengths:**

- (1) A RoSH screening had been completed in all but six cases (90%) and on time in 79% of cases.
- (2) Classifications of risk levels were correct in 79% of cases. Where we judged that the classifications were incorrect, the risk level was too low.
- (3) Where the screening had indicated that a full analysis should be undertaken, they had been completed and on time in all but one case.
- (4) RMPs had been completed in 74% of cases where one was needed.
- (5) Discussion with case managers showed that they usually understood, and could describe how children and young people's behaviours, attitudes and lifestyles contributed to their RoH and as a result knew who to make referrals to secure the correct interventions. This information was not routinely recorded on the YOIS system.
- (6) Decisions to refer cases to MAPPA were appropriate, ensuring that the right cases were notified and referred.
- (7) Information to manage RoSH to others had been shared effectively in 90% of the cases we assessed; this had often been done verbally.
- (8) The risk management panel focused on the multi-agency management of cases, ensuring that all agencies knew about those children and young people that posed a risk to others.

**Areas for improvement:**

- (1) 62% of RoSH screenings were accurate. Screening information focused too narrowly on the current offence, and did not reflect previous cautions and convictions or worrying harmful behaviours.

- (2) The full analysis of risk was accurate in half of the cases; most common omissions were not having considered previous relevant behaviour, risk to victims and classifications being too low.
- (3) Full analysis of risk identified 19 cases where there should have been an RMP, 14 had been completed, and only eight had been completed on time. In some cases a RMP had been written, but late into the supervision of the order.
- (4) Only five of the RMPs were completed to a sufficient standard. There was no single reason why plans were insufficient, but often they failed to describe planned responses or assign clear roles and responsibilities. Some plans listed the risk issues but not what needed to be done to reduce the risk. Plans did not clearly link to sentence plans objectives. Plans appeared to be detached from the actual work being done.
- (5) Management oversight of risk management and plans had not been used effectively to improve the quality of screenings, assessment and plans.

## 1.2 Likelihood of Reoffending:

### **General Criterion:**

*The assessment of the LoR is comprehensive, accurate and timely and uses Asset and other relevant assessment tools. Plans are in place to reduce LoR.*

### **Score:**

**69%**

### **Comment:**

**MODERATE improvement required**

### **Strengths:**

- (1) The initial assessment of LoR had been completed in 95% of cases; 78% were done on time.
- (2) There had been active engagement with the child or young person in 69% of cases. Parents/carers had been involved in 76% of cases.
- (3) In most cases positive factors and diversity issues had been identified at the time of the initial assessment.
- (4) Assessments were routinely informed by information from other relevant agencies including children's services (82%); physical health (100%); secure establishments (92%); police (87%); ASB team (80%); and ETE providers (79%).
- (5) Community intervention plans were completed in all but one case (98%), 74% had been done on time. Plans sufficiently addressed issues linked to reoffending in 77% of cases. It was positive to note that consideration had

been given to attitudes to offending (98%); thinking and behaviour (97%); substance misuse (93%); ETE (84%); and lifestyle (81%). Health needs had been considered in all relevant cases.

- (6) ETE issues were routinely assessed and recorded, with the education worker copying information and details of work undertaken, directly onto the case management system. Information from other workers was not as readily evident on the system.
- (7) Intervention plans generally reflected the purposes of sentencing and national standards.
- (8) Intervention plans for those in custody were in place for 13 of 17 relevant cases, with ten being completed on time. In these plans, attention had always been paid to ETE needs, substance misuse, physical health, thinking and behaviour.
- (9) Custody plans contained clearer objectives than community plans. In relevant cases, 90% were inclusive of Safeguarding needs and 83% were sensitive to diversity issues.
- (10) Intervention plans had been reviewed in 92% of custody cases.
- (11) Other key agencies had been actively and meaningfully involved in the planning processes throughout the sentence. In all cases, where it was needed, the intensive resettlement service had ensured that for those leaving custody, accommodation and support had been available.
- (12) Case managers had worked well with staff in the secure establishments in all cases. Children's social care had been actively involved in 80% of relevant cases, and we saw examples of very good practice. In other cases case managers had been persistent in their attempts to co-work with social workers and staff in residential units.
- (13) Emotional and mental health needs, at Tier 1 and 2, were responded to quickly by the nurses working at the YJS. Access to Tier 3 services, via CAMHS, was slower and case managers had to do a lot of 'supporting work' to enable children and young people to access these services.

### **Areas for improvement:**

- (1) Just over half of the initial assessments of LoR were of sufficient standard. Factors that most often caused the assessments to be insufficient were the failure to identify vulnerability concerns; unclear or insufficient evidence recorded on the file; and assessments that missed some of the key factors that had led to offending.
- (2) Learning styles questionnaires were not used consistently and had been completed in only 34% of cases. Similarly, the *What do YOU think?* questionnaire informed work with the child and young person in only 14% of cases.
- (3) Although 77% of the intervention plans broadly covered the areas of work to be completed by children and young people, most read as a list of referrals to other agencies or workers. Most plans lacked clear well defined aims and objectives.

- (4) Plans included objectives in the RMP in only 18% of cases.
- (5) Living arrangements and family and personal relationships had been considered in just under half of the relevant cases. This figure was only slightly better for plans for children in custody.
- (6) The initial assessment was reviewed at appropriate intervals in 52% of community cases.
- (7) Community sentence plans usually failed to outline clear objectives and only 34% were prioritised according to RoH, 47% took into account victims issues and 48% were sequenced appropriately. 67% of these plans were sensitive to diversity issues and 69% included appropriate Safeguarding work. Only 30% of custody plans took account of victim issues.
- (8) Intervention plans for Looked after Children, were often not co-ordinated with wider plans relating to the same child, including those written by children's services. This was of particular importance where offending had occurred in residential homes.
- (9) Records on the YOIS and S drive systems did not reflect the work being undertaken, or the discussions between workers and case managers. The S drive system was particularly difficult to extract information from.

| <b>1.3 Safeguarding:</b>  |   |
|---|---|
| <b>General Criterion:</b>   |   |
| <i>The assessment of Safeguarding needs is comprehensive, accurate and timely and uses Asset and other relevant assessment tools. Plans are in place to manage Safeguarding and reduce vulnerability.</i> |   |
| <b>Score:</b><br><b>67%</b>   | <b>Comment:</b><br><b>MODERATE improvement required</b> |

### **Strengths:**

- (1) Assessments of vulnerability and Safeguarding needs were routinely undertaken in 90% of cases. 76% had been completed on time.
- (2) Where vulnerability needs had been noted, and a VMP produced, we found that an intervention had been identified and that secure establishments were made aware of Safeguarding concerns.
- (3) In three-quarters of relevant cases, a contribution had been made to other assessments and plans designed to safeguard the child or young person and copies other agencies plans had been available.

### **Areas for improvement:**

- (1) Less than half of the vulnerability assessments were of sufficient quality, often focusing too narrowly on risk of self harm and suicide or risk if the child or young person went into custody, rather than how such risks should be managed. This meant that case managers could clearly describe factors that made children and young people vulnerable, but that these factors were not always recorded, and that the process of assessment had not triggered a formal response where it was clearly needed.
- (2) Of the case sample we judged that in half of the cases (31) the child was vulnerable and that a VMP should have been completed. Twelve VMPs had been produced, just over half of these had been completed on time and half were completed to a sufficient quality.
- (3) Assessments did not always include information provided from other agencies including children's services and health.
- (4) Some of the VMP's had been completed very late into the sentence, occasionally it was months before a plan was written.
- (5) Management oversight of vulnerability assessments was poor. Too often cases, where it was agreed children were vulnerable, had not resulted in a plan being produced. The management team did not have an effective method to gate-keep vulnerability assessments.
- (6) Safeguarding was reviewed as needed in 62% of cases.

### **OVERALL SCORE for quality of Assessment and Sentence Planning work: 68%**

#### **COMMENTARY on Assessment and Sentence Planning as a whole:**

The quality of planning needed to improve so that it matched the actual work done. In too many cases plans were 'detached' from interventions, and as a result were written in a minimal way, relisting issues rather than ascribing clear roles and responsibilities. This had resulted in some cases of work not being done in cooperation with other agencies including children's services. Systems were needed to ensure that initial screening processes are used in a consistent and effective manner to correctly trigger further actions.

## 2. DELIVERY AND REVIEW OF INTERVENTIONS

### 2.1 Protecting the public by minimising Risk of Harm to others (RoH):

**General Criterion:**

*All reasonable actions have been taken to protect the public by keeping to a minimum the child or young person's RoH.*

**Score:**

**58%**

**Comment:**

***SUBSTANTIAL improvement required***

**Strengths:**

- (1) When there had been changes in *RoH* these had been identified swiftly and action taken in 64% of cases.
- (2) Victim awareness work had been undertaken with some children and young people and we found examples of a range of tools being used. The work covered responses to individual victims and more general victim awareness.
- (3) MAPPA were used effectively in the four cases where it was needed (although decisions were not always clearly recorded) and actions were reviewed and implemented through the risk management panel. The work of other agencies was effective in working to reduce *RoH*.
- (4) Appropriate resources had been allocated according to *RoH* in 87% of cases.

**Areas for improvement:**

- (1) *RoH* had been reviewed in-line with the required time scales in 41% of cases, and in 58% of cases where there had been a significant change that might cause concern.
- (2) Changes in *RoH* and acute factors had been anticipated in a one-third of cases.
- (3) Case managers had not always contributed effectively to MAPPA processes. The role of the risk management board duplicated some actions, and in some cases added an additional layer of responsibility. This had meant that case managers did not always clearly understand their contribution in managing risk.
- (4) Specific interventions to manage *RoH* had been delivered as planned in 61% of cases in the community and in 62% of cases in custody.

- (5) In 62% of cases purposeful home visits had been carried out throughout the sentence in accordance with the levels of *RoH* posed and Safeguarding issues.
- (6) A full assessment of victims needs was evident in 26% of cases, and high priority given to victim safety in 41% of cases.
- (7) There had been effective management oversight of *RoH* in 54% of custody cases and in 36% of community cases.

| <b>2.2 Reducing the Likelihood of Reoffending:</b>  |  |
|---|--|
| <b>General Criterion:</b>   |  |
| <i>The case manager coordinates and facilitates the structured delivery of all elements of the intervention plan.</i> |  |
| <b>Score:</b><br><b>82%</b>   | <b>Comment:</b><br><b>MINIMUM improvement required</b> |

### **Strengths:**

- (1) Children and young people were able to access a range of good quality interventions delivered by the YJS and its partner agencies. There was a group offending behaviour programme and three different interventions to address anger management. The interventions had been designed to reduce the LoR, were of good quality and incorporated most diversity needs.
- (2) Appropriate resources had been allocated according to the assessed LoR in almost all cases.
- (3) Staff actively motivated and supported children and young people, both in custody and the community. Throughout the sentence, staff had reinforced positive behaviours in 95% of community and 94% of custody cases. We noted examples of how this had been achieved through meetings, praising of achievements and especially in the work undertaken to provide direct education sessions at the YJS office. The Cat Zero Project had been very positive for those children and young people who had attended, enabling the development of team working and cooperation. Equally the art and sports programmes had been good at developing self esteem.
- (4) In all of the custody cases parents/carers had been encouraged and enabled to be engaged in the sentence. Contact was established and maintained, with support being offered through the parenting workers as needed.
- (5) For those children and young people requiring additional support, the Intensive Resettlement Service, worked to ensure a smooth transition from custody to community. This included ensuring the provision of suitable accommodation. This support remained in place for up to six months following the end of the sentence.



### **Area for improvement:**

- (1) Just over half of the interventions were sequenced appropriately and just under a half were reviewed. In some cases the lack of sequencing had meant that for some children and young people there was the possibility of being 'overloaded' with interventions.

| <b>2.3 Safeguarding the child or young person:</b>   |  |
|--|--|
| <b>General Criterion:</b><br><i>All reasonable actions have been taken to safeguard and reduce the vulnerability of the child or young person.</i> |  |
| <b>Score:</b><br><b>79%</b>  | <b>Comment:</b><br><b>MINIMUM improvement required</b> |

### **Strengths:**

- (1) All necessary immediate action, including referrals to children's services, had been taken to safeguard and protect young people in all custody cases and all but two community cases. In all but one case immediate action had been taken to protect other affected children and young people.
- (2) The Safeguarding and well-being of children and young people had been promoted through effective joint working between the YJS and other agencies. ETE and health (physical, emotional, mental and substance misuse) had been particularly proactive in their approach, including consideration of sexual health and healthy lifestyles. This was evident for children and young people in the community and in custody cases.
- (3) Interventions had been provided to ensure Safeguarding was addressed in custody cases where a VMP had not been produced.
- (4) In almost all cases, staff from the YJS had worked with relevant agencies to ensure continuity in the provision of mainstream services when children and young people were in transition from custody to the community.

### **Areas for improvement:**

- (1) Joint planning and review of interventions for children and young people who were looked after by the local authority were not always evident.
- (2) Specific interventions to promote Safeguarding were reviewed as needed in 33% of community cases and 57% of custody cases.

**OVERALL SCORE for quality of Delivery and Review of Interventions work: 74%**

**COMMENTARY on Delivery and Review of Interventions as a whole:**

The evidence in advance and discussions with the management team showed that they were aware of the work that needed to be undertaken to improve the delivery and review of *RoH* practice. Operational policy and procedures were in place and the risk manager had already identified areas to develop quality assurance systems. Children and young people had access to a wide range of good quality interventions, developed to meet local needs. Further work is needed to ensure the work done is supported by clear, coordinated and effective joint planning and timely reviews.

## 3. OUTCOMES

Our inspections include findings about initial outcomes, as set out in this section. In principle, this is the key section that specifies what supervision is achieving, but in practice this is by necessity just a snapshot of what has been achieved in only the first 6-9 months of supervision, and for which the evidence is sometimes only provisional.

### 3.1 Achievement of outcomes:

**General Criterion:**

*Outcomes are achieved in relation to RoH, LoR and Safeguarding.*

**Score:**

**71%**

**Comment:**

**MINIMUM improvement required**

**Strengths:**

- (1) All reasonable action had been taken to keep the child and young person safe in 96% of cases.
- (2) From the cases in the sample there appeared to be a reduction in the frequency of offending in 63% of cases and in the seriousness of offending in 74% of cases.
- (3) The factors linked to reoffending had been reduced in 54% of cases; most notably motivation to change, ETE, lifestyle, living arrangements, thinking and behaviour and attitudes to offending had improved.
- (4) There had been a reduction in factors linked to Safeguarding in almost half of cases assessed.

**Area for improvement:**

- (1) In 47% of the cases children and young people complied with the requirements of the sentence. The YJS had a range of measures in place to support ongoing compliance including taking enforcement action, meetings and by changing the way work was delivered.

### 3.2 Sustaining outcomes:

**General Criterion:**

*Outcomes are sustained in relation to RoH, LoR and Safeguarding.*

**Score:**

**89%**

**Comment:**

**MINIMUM improvement required**

**Strengths:**

- (1) In 70% of cases *RoH* had been effectively managed.
- (2) Full attention had been given to community integration issues in 94% of custody cases and in 92% of community cases.
- (3) In 94% of custody and 84% of community cases, action had been taken to ensure that positive outcomes were sustained

**Areas for improvement:**

- (1) Where *RoH* had not been effectively managed this was mainly due to insufficient assessment and planning.
- (2) Joint plans to ensure positive outcomes were sustained were not in place especially for looked after children and young people.

**OVERALL SCORE for quality of Outcomes work: 78%**

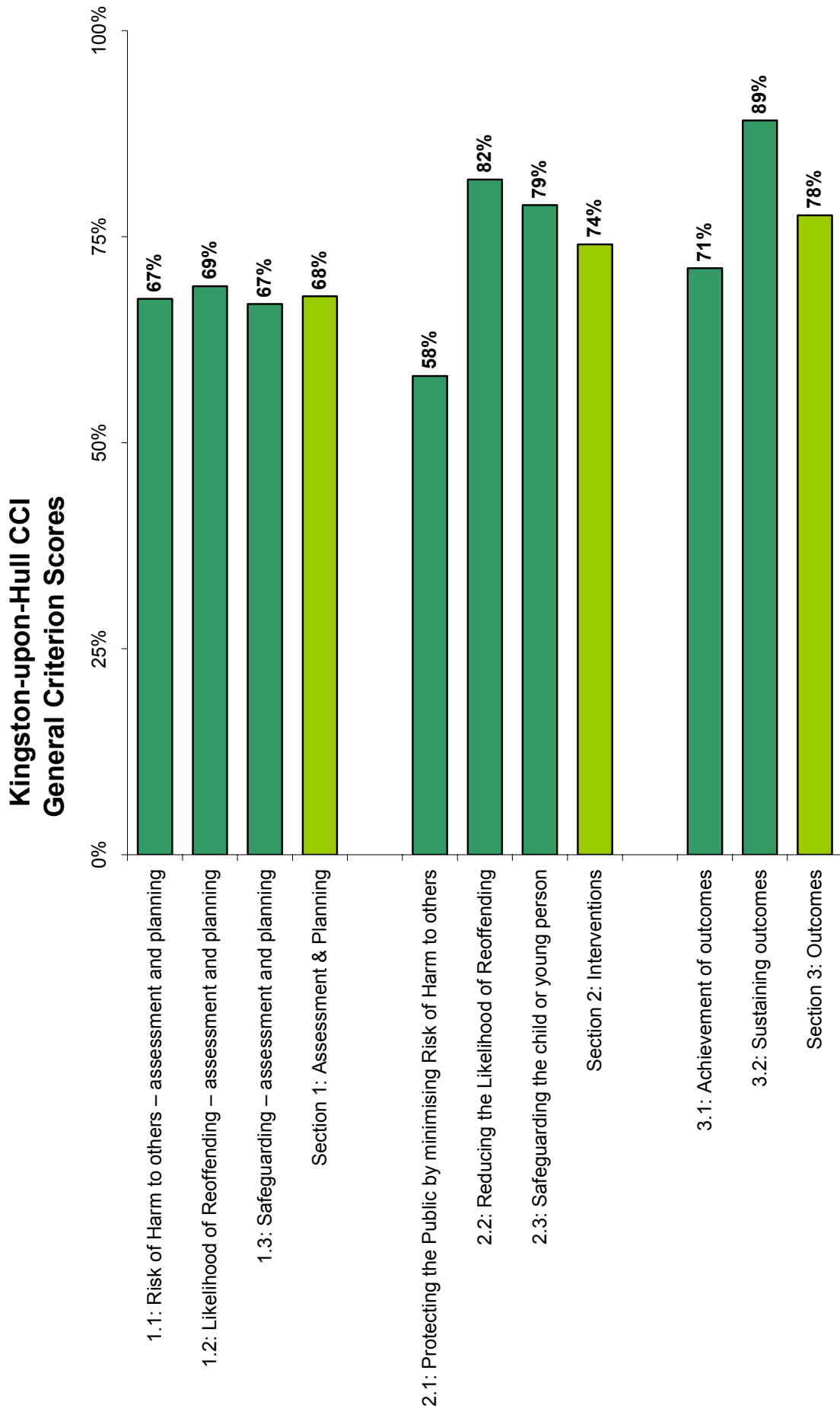
**COMMENTARY on Outcomes as a whole:**

It was very positive to note the work undertaken to sustain work with children and young people once the order had finished.

In terms of outcomes, we saw some good individual efforts, by staff, with children and young people who were difficult to engage, resulting in positive changes.

However, the lack of outcome-focused objectives at the planning stages presented difficulties for staff when reviewing and identifying progress. A sharper focus on planning needs to be provided to clarify, both for the staff and children and young people themselves, what they are working towards.

## Appendix 1: Summary



## **Appendix 2: Contextual information**

### **Area**

Kingston Upon Hull YJS was located in the Yorkshire & Humberside region of England.

The area had a population of 243,589 as measured in the Census 2001, 11.1% of which were aged 10 to 17 years old. This was higher than the average for England/Wales, which was 10.4%.

The population of Kingston upon Hull was predominantly white British (97.7%). The population with a black and minority ethnic heritage (2.3%) was below the average for England/Wales of 8.7%.

Reported offences for which children and young people aged 10 to 17 years old received a pre-court disposal or a court disposal in 2008/2009, at 73 per 1,000, were above the average for England/Wales of 46.

### **YJS**

The YJS boundaries were within those of the Humberside police area. The Humberside Probation Trust and the Hull Primary Care Trust covered the area.

The YJS was located within City Safe.

The YJS Management Board was chaired by the Head of Children's Services. All statutory partners attended.

The YJS Headquarters were in Hull. The operational work of the YJS was based in Hull. ISSP was provided by the Hull YJS.

### **YJB National Indicator Performance Judgement**

The YJB National Indicator Performance Judgement available at the time of the inspection was dated 10 May 2010.

There were five judgements on reoffending, first time entrants, use of custody, accommodation, education, training and employment.

On these dimensions, the YJB scored Kingston upon Hull 16 of a maximum of 28 (for English YOTs); this score was judged by the YJB to be performing adequately.

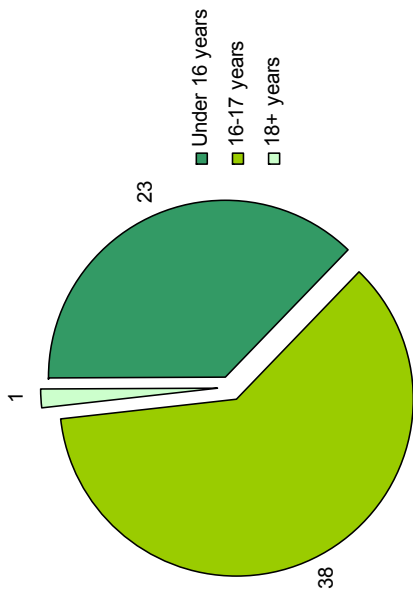
Kingston upon Hull's reoffending performance was judged by the YJB to be static and significantly worse than similar "family group" YOTs.

For a description of how the YJB's performance measures are defined, please refer to:

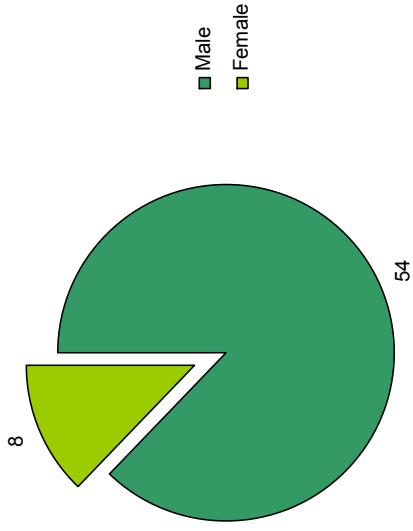
<http://www.yjb.gov.uk/en-gb/practitioners/Monitoringperformance/Youthjusticeplanning/>

### Appendix 3a: Inspection data chart

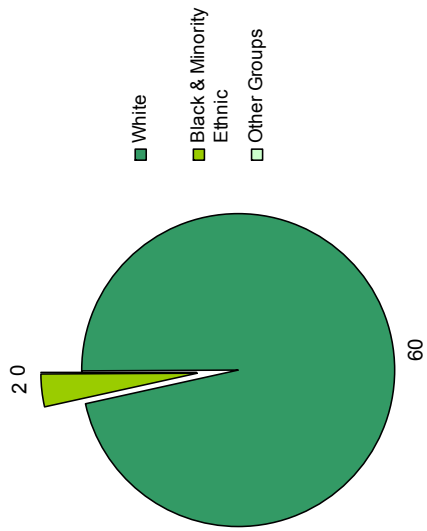
Case Sample : Age at start of Sentence



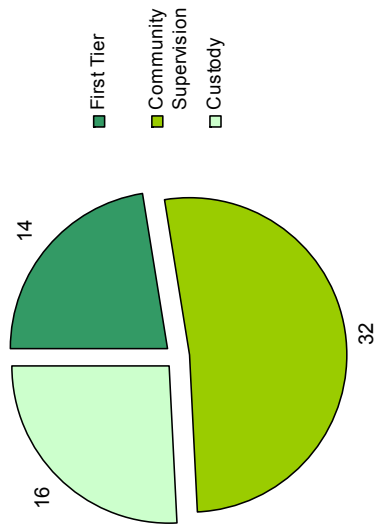
Case Sample : Gender



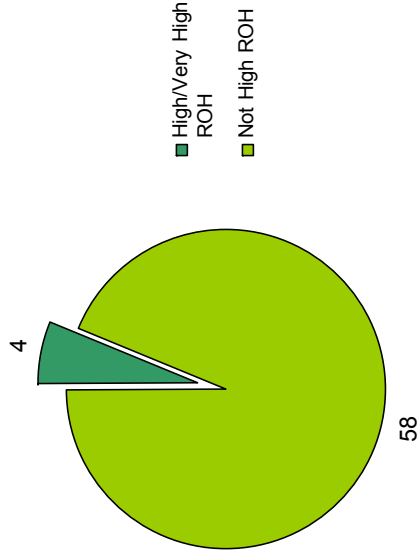
Case Sample : Ethnicity



Case Sample : Sentence Type



Case Sample : Risk of Harm



## **Appendix 3b: Inspection data**

Fieldwork for this inspection was undertaken in July 2010.

The inspection consisted of:

- ◇ examination of practice in a sample of cases, normally in conjunction with the case manager or other representative
- ◇ evidence in advance
- ◇ questionnaire responses from children and young people, and victims

We have also seen YJB performance data and assessments relating to this YJS.

## **Appendix 4: Role of HMI Probation and Code of Practice**

Information on the Role of HMI Probation and Code of Practice can be found on our website:

**<http://www.justice.gov.uk/inspectors/hmi-probation>**

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

*HM Chief Inspector of Probation  
2nd Floor, Ashley House  
2 Monck Street  
London, SW1P 2BQ*



## Appendix 5: Glossary

|   |  |
|---|--|
| ASB/ASBO  | Antisocial behaviour/Antisocial Behaviour Order  |
| Asset   | A structured assessment tool based on research and developed by the Youth Justice Board looking at the young person's offence, personal circumstances, attitudes and beliefs which have contributed to their offending behaviour   |
| CAF   | Common Assessment Framework: a standardised assessment of a child or young person's needs and of how those needs can be met. It is undertaken by the lead professional in a case, with contributions from all others involved with that individual   |
| CAMHS   | Child and Adolescent Mental Health Services: part of the National Health Service, providing specialist mental health and behavioural services to children and young people up to at least 16 years of age  |
| Careworks   | One of the two electronic case management systems for youth offending work currently in use in England and Wales. See also YOIS+   |
| CRB   | Criminal Records Bureau  |
| DTO   | Detention and Training Order: a custodial sentence for the young   |
| Estyn   | HM Inspectorate for Education and Training in Wales  |
| ETE   | Employment, training and education: work to improve an individual's learning, and to increase their employment prospects   |
| FTE   | Full-time equivalent   |
| HM  | Her Majesty's  |
| HMIC  | HM Inspectorate of Constabulary  |
| HMI Prisons   | HM Inspectorate of Prisons   |
| HMI Probation   | HM Inspectorate of Probation   |
| Interventions; <i>constructive</i> and <i>restrictive</i> interventions | <p>Work with an individual that is designed to change their offending behaviour and/or to support public protection.</p> <p>A <i>constructive</i> intervention is where the primary purpose is to reduce Likelihood of Reoffending.</p> <p>A <i>restrictive</i> intervention is where the primary purpose is to keep to a minimum the individual's <i>Risk of Harm to others</i>. Example: with a sex offender, a <i>constructive intervention</i> might be to put them through an accredited sex offender programme; a <i>restrictive intervention</i> (to minimise their <i>Risk of Harm</i>) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case. NB. Both types of intervention are important</p> |
| ISSP  | Intensive Supervision and Surveillance Programme: this intervention is attached to the start of some orders and licences and provides initially at least 25 hours programme contact including a substantial proportion of employment, training and education   |
| LoR   | Likelihood of Reoffending. See also <i>constructive</i> Interventions  |
| LSC   | Learning and Skills Council  |
| LSCB  | Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality.  |

|                                    |  |
|------------------------------------|--|
| MAPPA                              | Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher <i>Risk of Harm to others</i>  |
| Ofsted                             | Office for Standards in Education, Children's Services and Skills: the Inspectorate for those services in England (not Wales, for which see Estyn)   |
| PCT                                | Primary Care Trust   |
| PPO                                | Prolific and other Priority Offender: designated offenders, adult or young, who receive extra attention from the Criminal Justice System agencies  |
| Pre-CAF                            | This is a simple 'Request for Service' in those instances when a Common Assessment Framework may not be required. It can be used for requesting one or two additional services, e.g. health, social care or educational  |
| PSR                                | Pre-sentence report: for a court   |
| RMP                                | Risk management plan: a plan to minimise the individual's <i>Risk of Harm</i>  |
| RoH                                | <i>Risk of Harm to others</i> . See also <i>restrictive Interventions</i>  |
| 'RoH work', or 'Risk of Harm work' | This is the term generally used by HMI Probation to describe work to protect the public, primarily using <i>restrictive interventions</i> , to keep to a minimum the individual's opportunity to behave in a way that is a <i>Risk of Harm to others</i>   |
| RoSH                               | Risk of Serious Harm: a term used in Asset. HMI Probation prefers not to use this term as it does not help to clarify the distinction between the <i>probability</i> of an event occurring and the <i>impact/severity</i> of the event. The term <i>Risk of Serious Harm</i> only incorporates 'serious' impact, whereas using ' <i>Risk of Harm</i> ' enables the necessary attention to be given to those offenders for whom lower <i>impact/severity</i> harmful behaviour is <i>probable</i> |
| Safeguarding                       | The ability to demonstrate that all reasonable action has been taken to keep to a minimum the risk of a child or young person coming to harm.  |
| SIFA                               | Screening Interview for Adolescents: Youth Justice Board approved mental health screening tool for specialist workers  |
| SQIFA                              | Screening Questionnaire Interview for Adolescents: Youth Justice Board approved mental health screening tool for YOT workers   |
| VMP                                | Vulnerability management plan: a plan to safeguard the well-being of the individual under supervision  |
| YJB                                | Youth Justice Board for England and Wales  |
| YOI                                | Young Offenders Institution: a Prison Service institution for young people remanded in custody or sentenced to custody   |
| YOIS+                              | Youth Offending Information System: one of the two electronic case management systems for youth offending work currently in use in England and Wales. See also Careworks   |
| YOS/T                              | Youth Offending Service/Team   |
| YJS                                | Youth Justice Service  |