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From:	Julie Fox, Assistant Chief Inspector
Publication date:	20th November 2013

Report of Short Quality Screening (SQS) of youth offending work in Liverpool

This report outlines the findings of the recent SQS inspection, conducted during 28th-31st October 2013. We carried this out as part of our programme of inspection of youth offending work. This report will be 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

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.

Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. The purpose of the SQS inspection is to assess the quality and effectiveness of casework with children and young people who have offended, at the start of a sample of 34 recent cases supervised by Liverpool Youth Offending Service. Wherever possible this is undertaken in conjunction with the allocated case manager, thereby increasing the effectiveness as a learning opportunity for staff.

We gather evidence against the SQS criteria, which are available on the HMI Probation website - http://www.justice.gov.uk/about/hmi-probation.

Summary

Overall, we found a positive picture in Liverpool YOS. The previous inspection had taken place just over four years ago and that had identified the need for improvements in several key areas of work. We were pleased to note that significant progress had been made in the quality of assessments and plans being undertaken by practitioners. Staff were committed and well supported. In general, they produced good quality reports, assessments and plans. They used an appropriate range of services to good effect. There was scope for further improving the quality of work by ensuring that, when required, both the risk of harm to others that a young person posed, and their vulnerability, were effectively kept under review.

Commentary on the inspection in Liverpool:

1. Reducing the likelihood of reoffending

1.1. In all but 3 out of the 22 relevant cases, we found that good quality pre-sentence reports (PSRs) had been provided to the court. Management oversight of the quality of reports was generally effective. An inspector commented on one PSR: "*From the outset there was extensive and effective partnership work in this case. Information from the social worker was crucial to informing the PSR, which had been written for serious offences being heard before the Crown Court. The quality of the joint work meant that the Court was offered a credible proposal for a community penalty. The subsequent joint work with the young person saw him make significant positive changes in both his behaviour and circumstances, and there had been no further offending in this case*".

1.2. Over three-quarters of the initial assessments of what was likely to make a child or young person offend were on time and were of good enough quality.

1.3. The family and personal circumstances of many children and young people can change quickly. As a result, assessments need to be reviewed in order that they keep pace with the changing situation. A majority of the reviewed assessments we looked at had been completed well enough. However, there were several reviews that were just a copy of a previous assessment. The lack of an update to historical information meant that the assessments did not did not reflect the current circumstances of the child or young person.

1.4. Following on from assessment, we expect to see a plan of work to help reduce the likelihood of reoffending. Over three-quarters of the initial plans were of a sufficient standard but less than two-thirds had been reviewed well enough. In one case we noted: *"In this case the assessment of offending related factors was good, as was the assessment of risk of harm. Work was undertaken due to concerns about the potential risk the young person might pose to his younger brother. Review assessments were timely and informed by information from partner professionals such as education, training and employment and substance misuse services. The young person achieved some positive initial outcomes and fully complied with the order and with the services offered. The case manager delivered a structured violent offender programme of work and the young person completed his reparation hours. Levels of contact maintained a good balance between interventions that supported positive change for the individual e.g. educational input, or put some boundaries around their behaviour, e.g curfews".*

1.5. Where the child or young person was serving a custodial sentence, we found sufficient planning during the custodial phase of the sentence to reduce the likelihood of that individual reoffending in seven out of the nine relevant cases.

2. Protecting the public

2.1. There was a clear and thorough assessment of risk of harm to others outlined in 19 out of 22 cases where there had been a PSR.

2.2. A good quality assessment of risk of harm to others was seen in 27 out of 34 cases. In three cases the assessment had not been done, in two, previous violent offences had not been taken into account and in another two the classification of risk of harm was too low. These assessments had not been adequately reviewed in almost one-third of cases. For example, four reviews were copies of earlier assessments that had not been updated to reflect what had recently happened in the child or young person's life.

2.3. Where a child or young person may pose a risk of harm to others, we expect to see a plan to minimise the likelihood of this happening. In 23 out of 29 cases, planning was done well enough to manage the risk of harm and planning was satisfactory for all of the custodial cases. Where plans were insufficient, it was mainly because potential changes in risk of harm were not anticipated and the planned response to any increase in risk of harm was unclear. We also found three cases where sharing of information with other agencies (for example the Anti-Social Behaviour Team or the police) was not sufficient.

2.4. In 11 out of 26 cases, plans to address the risk of harm to others had not been reviewed to a satisfactory standard. For example, in five cases a review had not taken place and in four the review was not of sufficient quality.

2.5. Where there was an identifiable victim or potential victim, we were pleased to see that the risk of harm they faced had been effectively managed in the great majority of cases.

2.6. Management oversight of risk of harm work had not been effective in over one-third of the relevant cases. We saw several cases where important deficiencies in assessment and planning had not been addressed by management intervention. This led to several practitioners being surprised when we pointed out the deficiencies in their assessments or plans, as the work had been approved by their managers.

3. Protecting the child or young person

3.1. In over three-quarters of cases, vulnerability and safeguarding needs were sufficiently assessed. These issues were fully addressed in all but five of the PSRs. In a number of cases we felt that vulnerability had been underestimated. This was mainly because relevant factors had not been taken into account or a narrow view of vulnerability was applied. We noted occasions where practitioners were taking a relative view of vulnerability, rather than an absolute view. For example, this led to a situation where a practitioner, who had noted vulnerability issues, had decided these did not need attention as the situation for the young person was "*no worse than was being experienced by many young people in the area*".

3.2. The majority of reviews of safeguarding and vulnerability throughout the sentence were of an acceptable standard. In one case an inspector noted "*This case presented significant child protection issues arising out of a family being targeted by a group of local young people. YOS staff quickly responded to these rapidly escalating concerns and worked with other agencies to implement a joint plan to ensure the family were relocated to an area that helped to minimise the risks to the children in the family*".

3.3. In 22 out of 31 cases planning for work to manage and reduce vulnerability was adequate. In five cases where we felt there should be a plan to manage the vulnerability one had not been produced and in three cases we found that the planned response was insufficient. In a further three cases the contingency plan was unclear. Planning was satisfactory in all of the eight relevant custody cases.

3.4. Only half of the cases we examined could show that there were adequate reviews throughout the sentence to address safeguarding and vulnerability needs. In six cases the review was not of sufficient quality and in three cases we felt that a review of protecting children issues should have been completed after a significant change.

3.5. In 20 out of 29 cases management oversight was effective in ensuring the quality of work to address safeguarding and vulnerability. There was evidence of management oversight taking place in most cases. However, in a number of cases, we noted that more attention was required to ensure that deficiencies in assessment and planning were addressed.

4. Ensuring that the sentence is served

4.1. The great majority of assessments of diversity factors and barriers to engagement were sufficient. Appropriate attention had been given to these issues in all but two of the PSRs.

4.2. The child or young person or parent/carer was involved in the preparation of all but one of the PSRs. In all but two of the cases there was good engagement with the child or young person and parents/carers to carry out further assessments and plans. One inspector noted: "*This case saw consistent demonstration of good quality multi-agency work and information-sharing between the YOS and a number of partner agencies. Despite this individual living in chaotic circumstances, and presenting challenging behaviours, the case manager and other YOS staff displayed great persistence in providing services and interventions to engage the young person. This ultimately resulted in the successful completion of the order and the emergence of a positive working relationship*".

4.3. Whilst we found attention was being paid in most plans to diversity factors and potential barriers to engagement, it was not always considered or explored in relation to Looked After Children and children and young people where there might be speech, language and communication needs.

4.4. In almost all cases we reviewed, where relevant, sufficient attention had been given to the health and well-being of the child or young person.

4.5. Sixteen children or young people had complied with the requirements of their sentence. In all cases where the child or young person had not complied, the response of the YOS was appropriate.

Operational management

Despite the previous inspection being some time ago, we found that Liverpool YOS had responded to that inspection by implementing a range of measures aimed at improving the quality of their work. This included developing practice guidance for work that tackled risk of harm to others, vulnerability, compliance and engagement. Case managers had welcomed these developments and had incorporated them into their practice.

Case managers also valued the improved arrangements for management oversight of practice. All but one described countersigning and management oversight of risk of harm and safeguarding work as effective processes. We judged that staff supervision and quality assurance arrangements had made a positive impact in over two-thirds of the cases inspected.

The great majority of staff said that they received appropriate and effective supervision and that their line manager had the skills and knowledge to help them to improve the quality of their work. They felt that managers were able to assess their work and staff, in general, felt supported by managers. Most staff reported having received recent training to enable them to do their current job, but several said they had not had enough training in delivering interventions. In addition, several staff felt that their needs for future development had not been met. We found that almost all of the practitioners were aware of local polices and procedures that related to compliance, vulnerability and risk of harm and how the principles of effective practice applied in their work with children and young people.

Key strengths

The best aspects of work that we found in Liverpool included:

- the quality of PSRs prepared for the courts
- the engagement of children and young people and parents/carers in assessments

- the assessment and consideration of diversity factors
- there were several examples of positive initial outcomes for children or young people.

Areas requiring improvement

The most significant areas for improvement were:

i. review of work to manage risk of harm to others and reduce vulnerability

ii. management oversight of the quality of assessments and plans.

We strongly recommend that you focus your post-inspection improvement work on these particular aspects of practice.

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 Joseph Simpson. He can be contacted on 07917 084764, and by email at joe.simpson@hmiprobation.gsi.gov.uk.

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