Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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To:	John Sinnott, Chair of Leicestershire Youth Offending Service Management Board
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From:	Julie Fox, HM Assistant Chief Inspector
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Report of Short Quality Screening (SQS) of youth offending work in Leicestershire

This report outlines the findings of the recent SQS inspection, conducted from 24th-26th February 2014. 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 this inspection was to assess the quality and effectiveness of recent casework with children and young people who had offended. In order to do this, we examined 20 cases supervised by Leicestershire Youth Offending Service (YOS). Wherever possible this was undertaken in conjunction with the allocated case manager, thereby increasing the effectiveness as a learning opportunity for staff. Please note that names used in this report have been amended to protect the anonymity of the individual.

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 that practitioners in Leicestershire YOS were highly committed to their work and we saw positive working relationships with children and young people. The level of compliance with orders was excellent. There had been encouraging improvements since our last inspection in 2012. The recent introduction of the 'Risk Profile' document that set out plans to manage risk of harm and vulnerability had brought clear improvements in some cases, and a planned review of the tool will give an opportunity to maximise its use and effectiveness.

There was scope for further improvement in public protection work, including planning to manage specific risks to identifiable individuals. We found that more could be done to assess and manage the vulnerability of some children and young people. Management oversight needed to be more robust to ensure that all case managers understood and achieved the standard of work that was required.

Commentary on the inspection in Leicestershire:

1. Reducing the likelihood of reoffending

1.1. We expect to see good quality reports provided to courts in relevant cases. Of the ten cases where written reports were provided, nine were of good quality. Where verbal information was given to the courts to assist sentencing, we did not find any record of what had been said. The court needs to hear a full account of issues of risk and vulnerability as this could impact on the suitability of the child or young person for sentences such as curfews. This information also needs recording so that future case managers can consider it.

1.2. In 14 of the inspected cases we found a sufficient and timely initial assessment of factors related to the likelihood of reoffending. Where assessments were judged not to be sufficient, this was because of delays in completing the assessments in three cases and key information being missing or out of date in five.

1.3. In two-thirds of relevant cases we found that reviews of the likelihood of reoffending had been completed when required, and to a good standard.

1.4. All cases had an intervention plan in place and all, except four, were found to be sufficient. We saw plans that were comprehensive and written creatively, but also some where objectives were not set out in ways that would have been clear and meaningful to the child or young person, or where the work planned did not address all of the key factors.

2. Protecting the public

2.1. We look for a detailed assessment of the risk of harm a child or young person poses to others. In 16 cases, we found that this had been done well enough, which is a significant improvement since the last inspection. Two assessments were not completed promptly and, in one case, no analysis of risk of harm was completed. We found three cases where ongoing risk to actual or potential victims was not addressed.

2.2. In six of the ten cases where a review of the risk of harm to others was deemed necessary, a review had been completed to a good enough standard. In the other four cases, the assessments were not comprehensively updated following significant changes.

2.3. Following an assessment of risk of harm, we would expect the YOS to put in place plans to manage any behaviour likely to lead to harm being caused, and try to prevent it taking place. In 9 out of 17 cases we found that the plans in Risk Profiles were clear. One case had no risk management plan, and in two the plans took too long to complete. In three cases we found that risks to identifiable victims, including family members, were not being managed well enough.

2.4. In both of the custodial cases we looked at, there was sufficient planning in place to reduce the risk of harm to others.

2.5. In one case, an inspector said "*Chloe was sentenced to a short Detention and Training Order (DTO). During the custodial phase, the case manager undertook significant information-gathering, which facilitated more robust risk management plans upon release. She was moved to a new placement which better managed the risks around potential sexual exploitation, substance misuse and association with negative peers, alongside protecting her mother who was the victim of the majority of the offending. The YOS used the opportunity of sentencing, for an offence which pre-dated the DTO, to secure a concurrent Youth Rehabilitation Order with a stand-alone curfew. This complemented the*

licence conditions and served to effectively control Chloe's behaviour and further manage her risks and vulnerabilities".

2.6. Regular management oversight was recorded on the case record in all 14 cases where it was required, but in nine of those cases, we found that it was ineffective. Shortcomings in assessment and planning were not always identified, and we did not see systematic follow-up by managers to ensure that remedial actions they had identified were followed through.

3. Protecting the child or young person

3.1. In many cases, children and young people who have offended are also vulnerable themselves, and we expect to see that this has been taken into account. In 13 of the cases we inspected, there was a sufficient initial assessment of vulnerability and safeguarding issues. Case managers did not always recognise the increased vulnerability of children and young people who were estranged from their families, acting as carers for others, or putting themselves at risk through substance misuse.

3.2. In eight cases, the Risk Profile was used well and made clear plans to address the vulnerability of the child or young person. In four other cases, where planning to manage vulnerability was required, it was not done well enough.

3.3. We expect to see a regular review of vulnerability issues, because children and young people's lives can change very quickly. In seven relevant cases, we found that this was completed when required. In four cases, a review had not been completed following a significant change in the child or young person's circumstances, such as breakdown of a care placement, or being subject to bullying while in custody.

3.4. Management oversight of vulnerability and safeguarding issues was only effective in 6 out of the 16 cases where it was needed. Where it was ineffective, as above, the reasons were that shortcomings were not identified or followed-up.

3.5. All but 1 of the 12 staff interviewed were aware of local safeguarding children policies. In one case, we found an example of good work in escalating a referral to children's social care services, which resulted in the young person becoming subject to an interim care order when his Child Protection Plan broke down.

3.6. In one case, an inspector noted "*Tom was a very vulnerable young man, living with a parent who was not meeting his basic needs for accommodation and food, and who was encouraging him to offend. He was on a Child Protection Plan for neglect and emotional harm, but that was not effective, mainly due to the non-cooperation of his parent. The case manager, with the support of her team manager, escalated concerns to Children's Services and an Interim Care Order was made. This resulted in him being placed with foster carers out of the area, where he was starting to thrive*".

4. Ensuring that the sentence is served

4.1. In order to maximise the likelihood of children and young people complying with their supervision, we expect to find a thorough assessment of diversity factors and possible barriers to engagement. We found that this had been done well enough in 16 cases. We found evidence of strong and positive relationships being made with children and young people. In four cases, we felt that more could have been done to engage with parents/carers.

4.2. The overall compliance of children and young people with their orders and licences was very good. We found that case managers made sound judgements when dealing with

failures to comply, and there was only one case where we judged that the response of the YOS to unacceptable failures was not good enough.

4.3. We found that in some cases the level of contact made with children and young people did not meet what was needed or planned for. There did not seem to be consistent arrangements for cover of cases over holiday periods or for other staff absences.

Operational management

We interviewed 12 practitioners who all said that they felt supported in their work and viewed their managers as skilled and knowledgeable. All stated that their training and development needs were fully or partially met.

The amount of management oversight had improved considerably since our last inspection, and most case records we looked at had a number of entries from managers. However, managers needed to develop their skills to identify shortcomings in assessments and plans and then ensure that case managers implemented the actions identified.

To their credit, prior to the inspection being announced, Leicestershire YOS had already contacted HMI Probation to arrange a benchmarking workshop to ensure that they fully understood the expected standards for their service. The majority of staff saw the YOS as an organisation with a culture of learning, and this is an encouraging position from which to build on progress achieved so far.

Key strengths

- There were strong and positive working relationships with all children and young people.
- There was very good compliance with orders.
- The introduction of the 'Risk Profile' to support planning for risk of harm and vulnerability.

Areas requiring improvement

- Information presented verbally at court, including proposals made and the reasons for them, should be clearly recorded on case files to aid the case manager's work with the young person.
- Intervention plans address all of the issues raised in assessments, and are written in a way that is appropriate to the age and maturity of the child or young person.
- Management countersigning ensures that 'Risk Profiles':
    - ♦ distinguish factors linked to risk of harm from those linked to vulnerability
    - ♦ set out clear plans to manage all the risks of harm in the case, including to existing and potential future victims
    - ♦ set out clear plans to manage all the factors related to vulnerability in the case.
- Staff's understanding of vulnerability includes the impact on children and young people of issues such as caring responsibilities and estrangement from families and other support networks.

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 Liz Smith. She can be contacted at liz.smith@hmiprobation.gsi.gov.uk or on 07827 663397.

Copy to:

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Lead Elected Member for Children's Services	*Ivan Ould*
Lead Elected Member for Crime	*Joe Orson*
Police and Crime Commissioner for Leicestershire and Rutland	*Sir Clive Loader*
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