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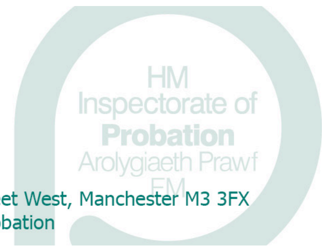

To:	Pete Dwyer, Chair of North Yorkshire YJS Management Board
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From:	Julie Fox, HM Assistant Chief Inspector
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Report of Short Quality Screening (SQS) of youth offending work in North Yorkshire

This report outlines the findings of the recent SQS inspection, conducted from 10th-12th 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 34 cases supervised by North Yorkshire Youth Justice Service (YJS). Wherever possible, this was 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 YJS that expected its staff to produce work of good quality, held them to account for doing so, and a staff group with high standards that was keen to learn and improve. We were pleased to find that the good standard of work found in our last inspection in 2011 had been improved upon, including through comprehensive oversight by managers, although there was further room for development. Case managers worked creatively and we found examples of good or innovative practice in a high proportion of the cases that we inspected.

Commentary on the inspection in North Yorkshire:

1. Reducing the likelihood of reoffending

1.1. Assessments of the likelihood of reoffending were generally of a high standard. They used a broad range of sources and verified that information. They were comprehensive and analytical. However, a small number were not timely. In referral order cases, the report

presented to the community panel is the main means by which they are made aware of the YJS assessment. Three-quarters of these met the needs of the case, but in two cases the report did not sufficiently reflect the assessment. All completed assessments gave enough attention to any diversity factors that existed in the case. Where assessments needed to be reviewed, the great majority were done as required. However, there were some that had not been reviewed following sentence.

1.2. An electronic self-assessment tool was used which engaged children and young people well. It could be repeated throughout the sentence and was useful in understanding changes in the child or young person's perspective.

1.3. A new pre-sentence report (PSR) was provided to the sentencing court in just over one-third of cases. These were all good and had been subject to appropriate management oversight. They were, in general, more concise than we often find and all contained an appropriate proposal that was presented well. A range of other options were also used to advise the sentencing court, such as specific sentence reports, breach reports and verbal updates. In most cases these provided sufficient advice and were supported by liaison with defence solicitors and the Crown Prosecution Service. However, there were some cases where it was unclear what, if any, advice had been provided to the court.

1.4. Plans for work to reduce likelihood of reoffending had been produced in almost three-quarters of the cases. A range of creative methods had been used to develop these with children and young people, including use of mind maps to assist the child or young person in making the link between the reasons for their offending and what needed to be done to stop it recurring. However, in one-quarter of the cases there was either no evidence of a recorded plan or this was not timely. Faster attention sometimes needed to be given to the development of plans for short sentences and licences to ensure that maximum use could be made of the limited time available. While the overwhelming majority of completed plans met the needs of the case, some did not work effectively as a means of clearly communicating the plan to all who may need to know it.

1.5. This is an example of good practice: "*A case allocation meeting (CAM) was held prior to the deadline for completion of the plan. The case manager presented the assessment, sentence plan and where appropriate the risk of harm assessment, risk management and vulnerability management plans. These were quality assured with a manager. Required improvements were made in a timely manner, before the manager would sign them off.*" This was not used consistently; however, where used, it was effective in ensuring the quality of work.

2. Protecting the public

2.1. Assessment of the risk of harm to others posed by the child or young person was good enough in just under three-quarters of the cases. In a few cases, relevant behaviour was not reflected in the assessment and, in some, the assessment was not timely. Most assessments were then reviewed as required; although there were a few that had not been reviewed following a significant relevant event. An inspector commented positively that "*in one case of potential extremist behaviour the case manager had researched relevant procedures and information and used this to inform the assessment and multi-agency planning*".

2.2. We were pleased to find that all inspected PSRs included an appropriate explanation of the child or young person's risk of harm to others.

2.3. Planning for work to manage the risk of harm to others was sufficient in most cases. Many plans contained clear actions, responsibilities and timescales. However, there were

also plans where the intended actions and contingency arrangements needed to be much clearer. Most plans were reviewed as required.

2.4. In one case an inspector noted that "*Lee had begun to make positive changes in his life and had begun to understand his behaviour. The risk management and vulnerability management plans clearly recorded his understanding of the triggers for his risk of harm and vulnerability, and identified the strategies agreed with him for managing the situations when they occurred. This contributed to gaining Lee's engagement in managing his own situation and reinforcing the progress that had been made*".

2.5. Multi-agency work to manage risk of harm to others was positive. This included both multi-agency public protection arrangements (MAPPA) and local information sharing meetings (ISMs) in other cases that would benefit from a multi-agency approach. Links were also made, where appropriate, to the management of vulnerability.

2.6. We were pleased to see substantial evidence of management oversight of risk of harm work. Managers would query the work and, where appropriate, require improvements. This was sufficient in over three-quarters of the cases. However, sometimes greater care was needed to ensure that the initial assessment and plan were good enough.

3. Protecting the child or young person

3.1. The sentencing court had been provided with an appropriate assessment of the child or young person's vulnerability in all PSRs that we inspected.

3.2. Assessment of vulnerability was sufficient in just under two-thirds of cases. The screening needed to be used more effectively to present a coherent assessment of the broad range of vulnerability factors that existed, including by drawing on information available from other sources. Sometimes a review should have been undertaken following a significant change and in others the review did not reflect changes well enough. However, case managers did undertake the required actions to protect the child or young person.

3.3. Case managers clearly understood what needed to be done to address safeguarding needs and reduce the vulnerability of children and young people. Written plans usually reflected the needs of the case and were sometimes very good. However, one-quarter were not good enough and others could have been improved, mainly because they did not clearly articulate the plan (including a contingency plan in case circumstances changed) in a way that ensured it was clear to others who may need to use it. Sometimes the clarity was masked by too much repetition of the assessment. Comments in this report about risk management and vulnerability management plans generally applied to both domains.

3.4. There was substantial evidence of management oversight; however, more attention was needed to ensure that plans were of good quality.

3.5. YJS staff and those from children's social care services worked together well. Planning meetings were sometimes undertaken jointly, particularly for Looked After Children, addressing both the care planning and the work with the YJS.

3.6. One inspector cited this example of good practice: "*Jo was a looked after child who was to spend Christmas with his family. The case manager recognised that Jo needed clear support on how to respond if problems arose over the holiday period.* [She] *produced a calendar with Jo, using pictures and colour that identified who would be working on each day, so that he knew who he could contact. This included relevant contact numbers. The case manager ensured that these were also saved on Jo's phone. A copy of the calendar was shared with all of the staff involved and with the local police station*".

4. Ensuring that the sentence is served

4.1. Case managers had a good understanding of the broad range of diversity or potential discriminatory factors that may apply to children and young people who have offended, including those factors that may be prevalent in their local area.

4.2. Assessment of diversity factors and barriers to engagement was therefore very strong. An inspector noted that "*Liam's child had been born whilst he was in custody. Recognising that this was an important protective factor the case manager obtained letters and photographs related to the birth and the baby.* [She] *provided these to Liam in custody. They were very well received and supported a positive ongoing engagement with Liam*".

4.3. Children and young people and their parents/carers were sufficiently engaged in the overwhelming majority of assessments. Where a clear plan had been created for work in the community, children and young people and their parents/carers were effectively involved in its development.

4.4. The quality of engagement with children and young people and their parents/carers in the development of PSRs was substantially better than we often find. The following is an example of good practice: "*Case managers arranged an additional home visit specifically to explain the PSR, ensure that the reasons for the proposed sentence were clearly understood, explore any potential barriers to engagement with the sentence and agree appropriate plans to support effective engagement*". These meetings were clearly recorded in the case record, helped ensure that PSRs gave attention to overcoming any barriers to engagement, and supported effective planning for work in the case.

4.5. Sufficient attention was given to health and well-being outcomes whenever this was required, for example by undertaking a speech and language assessment, even though the sentence was drawing to a close, to inform the ongoing work of other agencies.

4.6. The YJS took a positive and appropriate approach to ensuring compliance with the requirements of the sentence and taking enforcement action. Cases were returned to court for resentencing whenever this was required. Following failures to comply, compliance meetings between YJS staff, the child or young person and their parent/carer were used well to understand the causes and to inform future actions; although sometimes, the outcomes from these meetings could be recorded more clearly.

Operational management

Staff had, without exception, a good understanding of the principles of effective practice for work with children and young people who have offended. They understood what was expected of them. They spoke very positively about their understanding of the priorities of the YJS and their role in delivering these, and about the skills of their managers. Their training and skills development needs were broadly met, including when specialist training was needed. However, half said that they needed more training in delivering offending behaviour interventions. The recent addition of speech and language therapists into the YJS team was viewed as a very positive development.

Key strengths

- PSRs were of consistently high quality.
- Assessments were of a high standard and used a wide range of sources of information.
- Staff knew their cases well and had a good understanding of the children and young people.
- Work to address diversity factors and overcome potential barriers to engagement was strong.
- Children and young people and their parents/carers were well engaged in assessment and planning.
- There was substantial evidence of management oversight of casework.

Areas requiring improvement

- Staff should be trained in the delivery of offending-related interventions used by the YJS.
- Assessments of vulnerability should be used to gather all vulnerability factors present in the case together into a single coherent assessment, to inform effective planning. They should be reviewed whenever significant events occur that may affect the level of vulnerability.
- Recorded plans (intervention plans, risk management plans and vulnerability management plans) should clearly articulate the case manager's intentions for work in the case, including any contingency plans, to all who may need to know them.
- Plans should be timely.

We are grateful for the support that we received from staff in the YJS 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 Ian Menary. He can be contacted at ian.menary@hmiprobation.gsi.gov.uk or on 07917 183197.

Copy to:

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Director of Children's Services and Chair of YJS Management Board	*Pete Dwyer*
Lead Elected Member for Children's Services	*Cllr Tony Hall*
Lead Elected Member for Crime	*Cllr Carl Les*
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