Inspection of Youth Offending Work
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Report of Short Quality Screening (SQS) of youth offending work in Leeds

The inspection was conducted from 01-03 June 2015 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 46 cases of children and young people who had recently offended and were supervised by Leeds Youth Offending Service (YOS). Wherever possible, this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

The published reoffending rate[1] for Leeds was 35.6%. This was worse than the previous year (34.7%) but better than the England and Wales average of 36.1%.

Overall, we found a mixed picture. Some work was completed to a very high standard, including diversity; pre-sentence reports (PSRs); engagement work; responses to non-compliance; and work with children and young people in custody. However, there were important aspects of assessment and planning to address risk of harm and vulnerability which required improvement. Better management oversight of these processes was also needed to identify and redress these gaps and support improvement.

Commentary on the inspection in Leeds: Reducing reoffending

1.1. The initial assessment of the reasons for children and young people's offending was sufficient in a majority of cases, although variable overall. Education, training and employment, substance misuse and physical health were assessed well. The main gaps were a failure to identify factors linked to offending, unclear or insufficient evidence, or replicated assessments without appropriate updates being made. Offending related vulnerability was not adequately assessed in a small number of cases. Where a review of assessments was required they were sufficient in just under three-fifths of those cases. Of the residual two-fifths, reviews had either not taken place, were not timely, or had quality

[1] Published January 2015 based on binary reoffending rates after 12 months for the April 2012 and March 2013 cohort. Source: Ministry of Justice

issues similar to those noted above. Half of the reviews were found to be largely copies of the previous assessment with insufficient updates.

1.2. PSRs were provided to the courts in 24 cases, with a large majority being of good quality. There was also evidence that PSRs had been quality assured and received management oversight. A particular strength of PSRs was their excellent consideration of alternatives to custody which we found in 20 of 22 relevant reports.

1.3. Plans to reduce offending were found to be variable in quality, with just over half judged as sufficient. A lack of clear objectives, plans not meeting assessed needs and lack of clear sequencing of planned interventions were the main gaps. About one-third of those judged as insufficient did not have enough focus on reducing reoffending or take adequate account of victims and restorative justice. Of those plans requiring review, about two-thirds were completed satisfactorily.

1.4. For children and young people in custody, planning for the custodial phase was done well in a large majority of cases. There was evidence of regular liaison between the YOS and relevant institution, and of active participation in planning meetings, although these were chaired in the main by staff from the secure estate. Some documentation relating to final planning meetings was missing in a small number of cases although the YOS had made requests for it.

2. Protecting the public

2.1. The majority of assessments gave a satisfactory explanation of the risk of harm posed by the child or young person. In those cases which were not sufficient, there was no single feature which emerged and we found a diverse range of factors which had impinged on the quality of assessments. Of the 28 cases in which reviews were indicated, 18 were judged as sufficient. Again, half of the remainder were copies of previous assessments which had not been adequately updated.

2.2. PSRs were again an area of strength with almost three-quarters of those sampled containing a clear and thorough assessment of the risk of harm. By way of example, an inspector judged that; "*The PSR was of a good standard and was analytical. It flowed well and was easily understood. It is clear that the case manager had a (clear) grasp on the risk factors that underpin this case.*"

2.3. Planning for work to address risk of harm was found to be variable. While a majority of plans inspected were sufficient, there were deficits in a substantial minority. The most prominent of these was that contingency plans were not commensurate with the level of risk identified, meaning that planned responses were inadequate.

2.4. In custodial cases however, planning for risk of harm work was good with 9 of the 13 cases inspected being judged sufficient.

2.5. A diverse range of factors had affected the quality of assessment and planning to address risk of harm. Management oversight had not been effective in identifying or redressing these deficits. We judged that management oversight was sufficient in just under half of the relevant cases.

3. Protecting the child or young person

3.1. A sufficient assessment of safeguarding and vulnerability was found in a majority of cases. However, in a significant number of cases the screening of vulnerability was not of a good enough quality, the nature or level of vulnerability was unclear or relevant behaviour was not adequately taken into account. Nonetheless, there was good evidence that specialist assessments had been undertaken as required. Reviews of assessments were adequate in just over half of the cases with the failure to update previous assessments standing out as the main gap.

3.2. Only half of those plans inspected were judged as sufficient. In four cases, no vulnerability management plan had been prepared. In the main, however, it was the lack of robustness in contingency planning and responses to vulnerability which were the most prominent areas of deficiency. Reviews of plans were sufficient in 14 of 24 cases which required them. No review had been undertaken in two cases which required them, but in the majority of insufficient cases reviews were not of adequate quality.

3.3. Safeguarding and vulnerability were assessed clearly and thoroughly in PSRs. This may suggest that, while case managers did have a good grasp of relevant safeguarding issues, they were not consistent in reflecting this in assessments and plans. Management oversight did not adequately identify or redress these matters and was sufficient in just under half of the cases.

3.4. Planning for safeguarding and vulnerability in cases of children and young people in custody was good with 10 of 13 being judged as sufficient. In one case, an inspector found good evidence of transition planning; "*Theo had turned 18 while in custody and the YOS were now transferring his case to probation. The case manager had arranged a joint visit to Theo with his new probation officer to assist with the transfer process and help to explain how things would change as a result.*"

4. Ensuring that the sentence is served

4.1. Overall this was an area of considerable strength. The assessment of diversity, and potential barriers to engagement, was done well enough in the vast majority of cases. PSRs addressed diversity issues and barriers to engagement in 19 of the 24 examples we looked at. There were also good examples of how potential barriers to engagement were addressed creatively including some excellent specific interventions for girls and young women. As one inspector found; "*…evidence of a female gender specific approach in this case…This appeared to have contributed to (the case manager) having a positive relationship with Marie which has previously been a problem…(who had) stated that she doesn't generally work well with females.*"

4.2. We also found high levels of engagement with children and young people, parents/carers and significant others in both assessment and planning processes.

4.3. However, while plans to address engagement or diversity matters were sufficient in two-thirds of cases, there were some gaps. Speech, language and communication needs were assessed well, but plans did not always reflect the work that needed to be done to address them. This was also the case with other assessed needs.

4.4. Pleasingly, virtually all cases in the sample demonstrated that sufficient attention had been given to the child or young person's health and well-being outcomes. Substance misuse work and interventions from the YOS nurse appeared to be extremely well embedded.

4.5. Case managers had responded appropriately and effectively to instances of non-compliance in 22 of 24 relevant cases.

Operational management

We also found that a large majority of case managers had a sufficient understanding of the principles of effective practice, as well as local policies to address the management of risk of harm, safeguarding and compliance. Case managers were extremely positive about their line manager's ability to oversee the quality of their work and support improvement. They also strongly felt that the management oversight of risk of harm and safeguarding was effective, although our findings run somewhat counter to this. Practitioners also confirmed that supervision was provided on a regular basis (between every four and six weeks). Case managers overwhelmingly felt that their training and skills development needs to do their jobs were met, although there was some scope for improvement in meeting future development needs and delivery of interventions. Most felt adequately trained to recognise speech, language and communication needs and other diversity factors, although about one-fifth indicated that they felt that more was required.

Key strengths

- PSRs were of a consistently good quality.
- Diversity work was extremely well embedded into practice and was of a high standard. Good use was made of speech, language and communication screening tools.
- The YOS's response to non-compliance was consistently good.
- There was good evidence of effective involvement and engagement of children and young people, parents/carers and significant others in assessment and planning.
- Assessment and planning work for children and young people in custody was good.

Areas requiring improvement

- Management oversight of the quality of assessments and plans should be a priority area for improvement.
- Assessments of risk of harm and vulnerability require improvement.
- Plans should better reflect actions which specifically address assessed needs and risks.
- Attention should be given to improving responses to risk and vulnerability in plans.
- Reviews of assessment and plans require improvement.

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 Colin Barnes. He can be contacted at colin.barnes@hmiprobation.gsi.gov.uk or on 07826 905352.

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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.