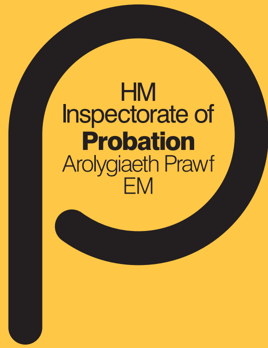

Full Joint Inspection of Youth Offending Work in **Doncaster**

An inspection led by HMI Probation

independent inspection of youth offending work

September 2015

Foreword

This inspection of youth offending work in Doncaster is one of a small number of full joint inspections that we undertake annually with colleagues from the criminal justice, social care, health and learning and skills inspectorates.

We chose to inspect in Doncaster primarily because of issues with the quality of custodial data and high custody rates which were substantially above national averages.

The most recent published[1] reoffending data showed a slight increase in Doncaster at 34.5% however it remained below the latest figure for England and Wales which was 36.6%. The latest custodial figures were not available at the time of the inspection, however the YOS was able to provide data showing a significant decrease in numbers from 43 children and young people in the year 2013/2014 to 19 in the year 2014/2015.

There was some good work in Doncaster by individual case managers and other staff to reduce reoffending, protect the public and safeguard the child or young person. Assessment of the factors contributing to offending was good, as was engagement with children and young people and their parents/carers. Compliance work was carried out efficiently. Education, training and employment was a strength.

Other aspects of the work were not carried out well enough, often enough. Assessment, planning and work to manage both the risk of harm to others and vulnerability needed to improve, as did interventions which too often did not follow on from the assessment or the plan. Court work and pre-sentence reports also needed to become more effective in helping magistrates ensure that the child or young person received the most appropriate sentence. Many of these issues had already been recognised by the YOS manager and the team and work to address them had started before the inspection.

The YOS Management Board had been ineffective. There was sporadic attendance by some members. Little useful data was received other than the national indicators and there was no evidence of scrutiny, challenge or joint problem solving. There was no indication that the Board had had any impact on the operational work of the YOS. This had been recognised by the new Chair of the Management Board and the YOS manager who were both keen to improve the work of the Board.

The recommendations made in this report are intended to assist Doncaster in its continuing improvement by focusing on specific key areas.

Paul Wilson CBE

HM Chief Inspector of Probation

September 2015

1 Published April 2015 based on binary reoffending rates after 12 months for the July 2012 – June 2013 cohort. Source: Ministry of Justice

Key judgements

Summary

Reducing reoffending

Overall work to reduce reoffending was unsatisfactory. Assessment of the factors leading children and young people to offend was largely carried out well. Education, training and employment work was a strength and we saw some good quality planning and interventions by individual case managers. Overall however, planning was not good enough and interventions did not always follow on from either the assessment or the plan. Custodial work in particular needed to improve. There had been recognition prior to the inspection that some changes to processes were needed and these had already begun.

Protecting the public

Overall work to protect the public and actual or potential victims was unsatisfactory. We found some good public protection work carried out by individual case managers. However, the assessment of the risk of harm posed to others, and the subsequent planning to manage that risk and protect actual or potential victims was not always carried out well enough. In too many cases, plans were passive and vague and the consideration of victims was not always apparent. Too often, interventions did not address the identified risks. Management oversight had not been effective.

Protecting children and young people

Overall work to protect children and young people and reduce their vulnerability was unsatisfactory. We found some good safeguarding work by individual case managers and, overall, case managers were contributing to children's social care services safeguarding meetings. There was little joint work with children's social care services however and referrals from YOS case managers were rejected, sometimes on the grounds that the YOS could deliver the necessary services. This had not been effectively challenged. Assessments of vulnerability lacked understanding of the potential consequences of identified factors and planning was, too often, vague, with gaps in some identified areas of concern. Interventions did not always follow from the assessment or the plan. Management oversight of this area of work had not been effective.

Ensuring the sentence is served

Overall work to ensure that the sentence was served was satisfactory. Engagement with children and young people and their parents/carers was a strength during the assessment stage of the work. The recognition of diversity and individual needs was generally good, although the impact of age and maturity was not always recognised. Engagement during the rest of the order, including planning, was not as good. Compliance work was carried out efficiently but there was not always a sufficient exploration of the reasons for non-compliance.

Governance and partnerships

Overall, the effectiveness of governance and partnership arrangements was poor. The YOS Management Board had been ineffective. There was sporadic attendance by some agencies. There was no evidence of scrutiny, challenge or joint problem solving. There was little performance data, other than the basic national indicators, either requested or submitted. Some members had little idea of the operational delivery in the YOS within their sphere of activity. We judged that any good operational work was as a result of operational staff and managers, rather then being driven or supported by the Board. The need for change had already been recognised by the YOS manager and the new Chair of the Board, and had already begun.

Court work and reports

Overall, the work in court and on report writing was unsatisfactory. There was a dedicated court team who were knowledgeable and valued by the court. Information was available swiftly due to good IT links. Court work was process driven however, with little proactive intercession by court staff. We found some good, insightful pre-sentence reports with appropriate proposals, but largely they were too long and contained irrelevant information. Proposals were too often unimaginative. Too often, they seemed to propose a sentence that moved up the sentencing hierarchy rather than meeting the needs of the case. Management oversight of court work and the quality assurance of reports had been ineffective. There was no data collected to analyse performance. Strategic links had reduced following the abolition of the court user group.

Recommendations

Post-inspection improvement work should focus particularly on achieving the following outcomes within 12 months following publication of this report:

The Chair of the YOS Management Board should ensure that:

- children and young people receive services from children's social care services where appropriate
- the number of children and young people receiving custodial sentences is reduced to the national average or below
- data is commissioned, scrutinised and used to evaluate and improve outcomes for children and young people who have offended
- partner agencies are represented at an appropriate level of seniority on the YOS Management Board and work together effectively
- links between the strategic and operational work of the YOS are understood and work effectively
- police IT systems are available within the YOS
- children and young people have access to mental health services
- there is a magistrate, trained in youth justice, at all meetings of the out of court disposals scrutiny panel where cases of children and young people are considered.

The YOS manager should ensure that:

- the assessment of both the risk of harm posed to others, and the vulnerability of children and young people, are of good quality
- children and young people, and their parents/carers, are fully involved in the planning for their interventions
- plans to manage risk of harm posed to others and vulnerability are outcome focused
- police intelligence is used routinely in all relevant cases
- custodial assessment, planning and work with children and young people is improved and is delivered as an integrated sentence
- interventions are of good quality and address the areas identified in assessment and planning
- rejected referrals to children's social care services are escalated, if appropriate
- management oversight and quality assurance are effective
- non-compliance is understood and appropriate action taken to improve engagement prior to return to court
- operational court work is proactive and integrated into the wider work with children and young people
- pre-sentence reports are effective in helping to achieve appropriate sentencing.

Please note – throughout this report all names referred to in the practice examples have been amended to protect the individual's identity.

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Reducing reoffending

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Theme 1: Reducing reoffending

What we expect to see

As the purpose of the youth justice system is to prevent offending by children and young people we expect youth justice partners to increase the likelihood of successful outcomes by undertaking good quality assessment and planning, delivering appropriate interventions and demonstrating both positive leadership and effective management.

Case assessment score

Within the case assessment, overall 56% of work to reduce reoffending was done well enough.

Key Findings

1. Assessment of the reasons for reoffending was largely carried out well enough.
2. Planning for work to help children and young people stop offending was, too often, not good enough.
3. Interventions did not always follow from the assessment or plan. Where they did, generally they were of good quality.
4. Case recording was inconsistent.
5. There was some good, and excellent, work carried out by individual case managers.
6. Work to reduce reoffending was not good enough in too many cases.
7. Education, training and employment (ETE) work was a strength.
8. Custodial work was disproportionately represented in those cases in need of improvement.
9. There had been recent recognition by managers of the need to review some processes and changes had started to be made.

Explanation of findings

1. Good assessment of the reasons for offending is crucial to being able to carry out effective work with children and young people who have offended. In Doncaster, the case managers had made the effort to understand those reasons in most of the cases we inspected and had kept them under regular review to monitor change and progress.
2. Where this was not the case, it was usually as a result of insufficient or unclear evidence. Most notable was a lack, in some cases, of an understanding of emotional or mental health issues. There was also a small number of cases where there had been no consideration of the age or maturity of the child or young person or their speech, language and communication needs.
3. Most reviews were judged to be of good enough quality, although some were copies of previous reviews with little update. We saw a number where the reviews were a description of events and activity rather than an analysis of the child or young person's current situation.
4. Planning was not of as good a quality as assessment. We found a number of cases where there was no plan at all and too many that did not meet the needs that had been identified. Areas that were not covered well enough were family and personal relationships, emotional or mental health, thinking and behaviour, attitude to offending and motivation to change. Restorative justice did not occur regularly enough. Where it did feature, it was not always clear what the objectives were and they were not

reviewed often enough or well enough. Planning in custodial cases, both in and out of custody, was worse and work to address reoffending was considered to be inadequate in two-thirds of cases.

Example of notable practice

Michael was sentenced to a four month detention and training order (DTO). There were positive links between the workers in custody and in the community. In particular, substance misuse and ETE workers communicated well and coordinated their planning, meaning that interventions were coherent across the sentence. The case manager recognised that, on release from custody, Michael would benefit from additional support to maintain distance from his previous friends. The case manager therefore prioritised ETE, in order that Michael had some structure and constructive activity to reduce contact with those associates. This was arranged while he was in custody and a placement was available immediately on release.

5. Interventions, the work carried out with children and young people to help them stop offending, were not consistent with either the reasons for offending or the planning in nearly half of the cases. Too often, we saw cases being monitored but with limited provision of constructive interventions. We judged that interventions had contributed to reducing reoffending in less than half of the cases inspected. This was considerably worse in custodial cases, where we judged that there had been no contribution to reducing reoffending by interventions in any of them.
6. The work by the YOS, during custody and following release, was not delivered as an integrated sentence. In particular, interventions following release were often not coherently planned or delivered. Again, monitoring was more evident than constructive work. Recording was poor in a small number of cases and in those it was not clear what had been delivered.
7. Notwithstanding this, where the correct interventions were delivered and recorded, they were largely of good quality, were delivered as their design intended and were reviewed regularly. We saw some good, and better than good, work carried out by individual case managers across assessment, planning and interventions. We also saw examples of some skilled joint work between the YOS and the Barnardos Junction project with children and young people who had carried out sexually abusive behaviour.

Quotes from children and young people

"*Yeah we did loads, at the start we did loads about the offence and when I could have stopped the situation and that.*"

"*It's made me realise the consequences and how close I was to jail.*"

"*They've helped with quite a few things like when I used to take cannabis, there was substance misuse work and stuff like that.*"

"*They just helped me to get off cannabis and spice and stuff like that.*"

Example of notable practice

We observed a supervision session with Ian who was being supervised under a youth rehabilitation order. It was immediately clear that there was a good professional relationship between the case manager and Ian. The case manager had a warm, welcoming style and demonstrated good listening skills. The session was clearly planned and followed a structure of checking and reviewing Ian's understanding as it progressed, then continuing and summarising. There was flexibility in this and the case manager was responsive to Ian's contributions. The case manager used a motivational approach throughout, reflecting and summarising Ian's input and praising responses appropriately to reinforce progress. Consequently, Ian participated fully throughout the session.

Example of notable practice

We observed three case management reviews where the child or young person was present along with those practitioners who had any meaningful contact with them. Their parents/carers were also invited. The focus of the meeting was the intervention plan and the progress made. In all of the meetings we observed, the child or young person was treated as an important member of the meeting and was encouraged to give their views. The meetings were effectively chaired and the child or young person was enabled to contribute. Significant progress had been made in all of the cases we observed.

8. In the cases we inspected, progress had been made on a number of factors but there were gaps. In particular, less progress had been made in family and personal relationships, substance misuse, emotional and mental health and the crucial areas of thinking and behaviour, attitude to offending and motivation. Too often, exit strategies were not considered nor was thought given to ensuring that progress was sustainable.

9. Overall, we judged that interventions, the work to address reoffending, were good enough in less than half of the cases inspected. Managers had already recognised that some areas of practice needed to improve and were in the process of reviewing some processes. Some changes had already been made.

10. Doncaster YOS had commissioned a specialist organisation, REMEDI, to deliver restorative justice, reparation and victim awareness sessions. The organisation had provided training to both staff and referral panel volunteers about restorative justice. We were told that the amount of restorative work carried out was increasing, however it did not feature in half of the cases we inspected. Referral panel members also told us that the number of victims attending referral panels had declined.

11. Where required, YOS careers advisors carried out initial assessments of children and young people's English and mathematics skills at the beginning of their order. They built a holistic picture of prior attainment by contacting previous education and training providers. They also provided careers advice and guidance to children and young people aged 16 or over, helping them to produce clear and realistic action plans. There were good opportunities to develop job search skills, build CVs and complete job applications. Dyslexia screening was also available.

Quotes from children and young people

"*Yeah, they have got me a careers worker at the YOS. She is helping me with getting into college and that.*"

"*I stopped doing home education they kept reminding me to do it.*"

"*They got me into training in the first place.*"

"*Yeah, they've helped me to get into YMCA and stuff, and getting interviews for plastering courses and stuff.*"

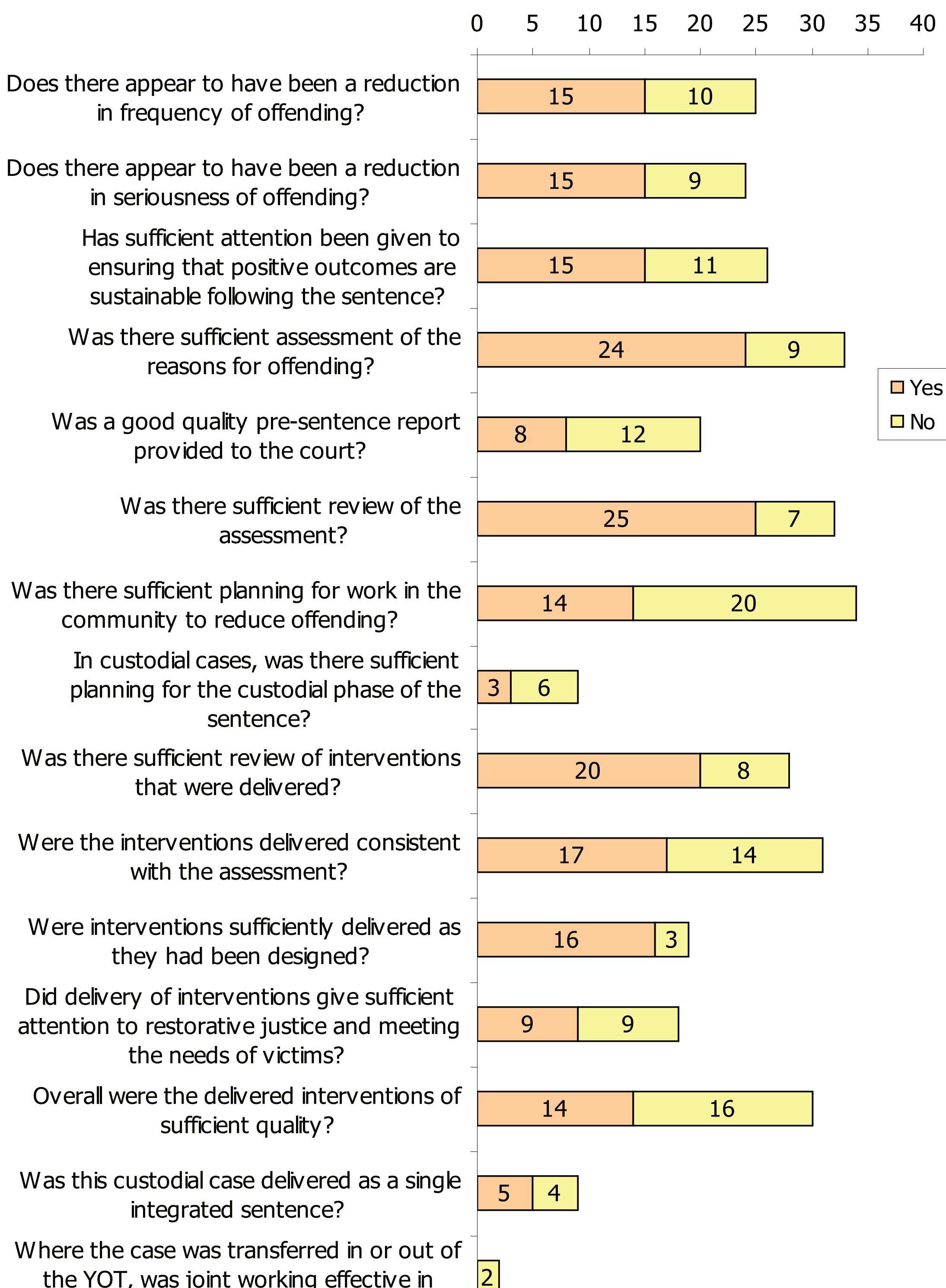
"*They found me a new placement for school, the school I was in before I never attended, I never liked it…. they just put me in a better placement, where I was actually learning and actually did things I enjoyed.*"

"*When I was in education, in the six week holidays, they had like an educational thing on and I got invited to that and they helped me with education and stuff like that.*"

12. There was evidence of successful support to help children and young people improve their attendance at school or other education provision. ETE links with prisons and secure training centres were in place and information was provided at custodial planning and review meetings. Recording of progress made towards ETE objectives was fragmented and unclear however, and this made it difficult to interpret.
13. Health professionals were co-located with the YOS. There was a system in place to ensure that all children and young people on a court order received a health screening, although there were different expectations as to when this assessment should be completed. The assessment was detailed and covered areas such as height, weight, diet and known health conditions, however it contained limited detail on speech, language and communication needs.
14. It was positive to see that health practitioners were having input into arenas such as the resource allocation meeting, where decisions were made about the work to be carried out, and intensive supervision and surveillance meetings, where cases were reviewed and tasks allocated. Many of the interventions we observed were interactive and appropriate, for example, smoking cessation and health promotion including sexual health and healthy relationships. The YOS also had a systemic family psychotherapist who had carried out good support work with families.
15. There was insufficient provision for children and young people needing assessment and intervention from Child and Adolescent Mental Health Services (CAMHS). At the time of the inspection, nine children and young people were waiting for an assessment. Additionally, there was a lack of clarity about those children and young people who had emotional or mental health needs but did not meet the threshold for CAMHS support. Case managers also received limited support from CAMHS. There was conflicting information about dual diagnosis cases, where both a mental health and substance misuse need had been identified. CAMHS stated that these cases would be co-worked, however we were advised that this did not happen. For those who needed crisis intervention, 24 hour access was available through the community CAMHS team.
16. It was felt by the YOS that having internal substance misuse workers allowed them to take a more flexible approach to engaging with children and young people. Interventions included groups on alcohol, novel psychoactive substances (legal highs) and cannabis. We were told that consideration was given to group dynamics before sessions were delivered. Four week programmes were also carried out with children and young people on a one-to-one basis. Other services included urine screening, although this was not mandatory, and auricular therapy (applying pressure to specific points on the ear).

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Protecting the Public

2

Theme 2: Protecting the Public

What we expect to see

Victims, and potential victims of crime, have the right to expect that everything reasonable is done to manage the risk of harm posed by children and young people who have offended. We expect to see good quality assessment and planning with the delivery of appropriate interventions, and positive leadership, effective management and partnership work which reduces the risk of harm to others.

Case assessment score

Within the case assessment, overall 65% of work to protect the public was done well enough.

Key Findings

1. The assessment of the risk of harm posed to others was not good enough in too many cases.
2. Planning to manage the risk of harm posed was insufficient in over half of the inspected cases.
3. Interventions to address the risk of harm did not always address the risks posed.
4. We found some good public protection work by individual case managers.
5. Overall, we judged that the work to manage the risk of harm posed to others was done well enough.
6. Management oversight of this area of work was ineffective.

Explanation of findings

1. To protect actual and potential victims and the wider public, the YOS must first assess what the child or young person might do, in what circumstances and when, who the victim might be and what might trigger the event. When that assessment has been made, a plan can be put together to try to prevent the circumstances or triggers occurring. In one-third of cases inspected, we judged that the assessment of the risk of harm that the child or young person posed to other people was not good enough. The proportion considered insufficient in custody cases was higher; we saw no consideration of the risk of harm that was posed to other children and young people in custody or to custodial staff.
2. We found three cases which should have had a full assessment of the risk of harm posed, where none had been carried out. In some assessments, relevant convictions or other behaviour had been ignored and although reviews were largely undertaken, significant changes were not always recognised. The biggest concern was that actual or potential victims were not taken into account. Too often the assessment did not clearly specify exactly what risk of harm the child or young person posed and to whom. We found little exploration of what might be triggers to offending or the circumstances in which reoffending might occur.
3. It was perhaps not surprising therefore, that over half of the inspected cases did not have sufficient planning to manage the identified risk of harm. There were a small number, where risk of harm to others had been identified, which did not have plans at all. It was not always evident that case managers knew exactly what behaviour or circumstances they were trying to manage, or help the child or young person to manage or avoid. There were too many plans where the proposed responses were either insufficient or unclear, and we judged that they were unlikely to protect actual or potential victims. This was also the case in custodial cases.

4. As a consequence of the deficiencies in some assessments and plans, interventions to address the risk of harm did not always address the risks posed and we saw no active protection of actual or potential victims.
5. Joint working with other agencies was evident in some cases although not always well coordinated. For example, the Deter Young Offenders meeting, which considered those assessed as posing a high risk of harm to others, was not attended by outside agencies but was restricted to YOS case managers and other YOS workers. It had already been recognised that this needed to change. Conversely we observed some group work carried out jointly with Doncaster Safer Communities Team, which was well delivered.

Example of notable practice: The Getting On programme

The Getting On pilot programme was aimed at abusive behaviour by teenagers towards their parents/carers. Two groups ran alongside one another – one for parents/carers and one for children and young people. Participants had three preparatory sessions. These assessed their motivation to change and also ensured that there was a familiar face to meet them at the first group meeting. Both groups took part in nine sessions aimed at understanding the abusive behaviour, learning new skills to avoid or prevent it happening, and receiving support to make changes.

The programme was developed by Doncaster YOS in conjunction with Leeds YOS, was supported by Doncaster Safer Communities Team and facilitated jointly by the YOS and Doncaster Metropolitan Borough Council.

Feedback from parents/carers included:

"*Invaluable meeting women in [the] same environment, informative and relevant to my needs*."

"*I find coming to this programme very helpful. It helps me get a lot out of my system plus help with ideas with my son. I am glad I am attending this class*."

"*It did make me realise how my actions needed to be changed as well as my son's.*"

Feedback from children and young people included:

"*I listen to her [mother] more, do as I'm told more, I help more*."

"*I'm more calm and if I do get mad I can now deal with my anger in a safe, responsible way*."

"*I've got better with my sister*."

6. We also saw some good risk management work where changing circumstances had been recognised and acted upon and some good interventions aimed at changing behaviour that was causing harm to others.

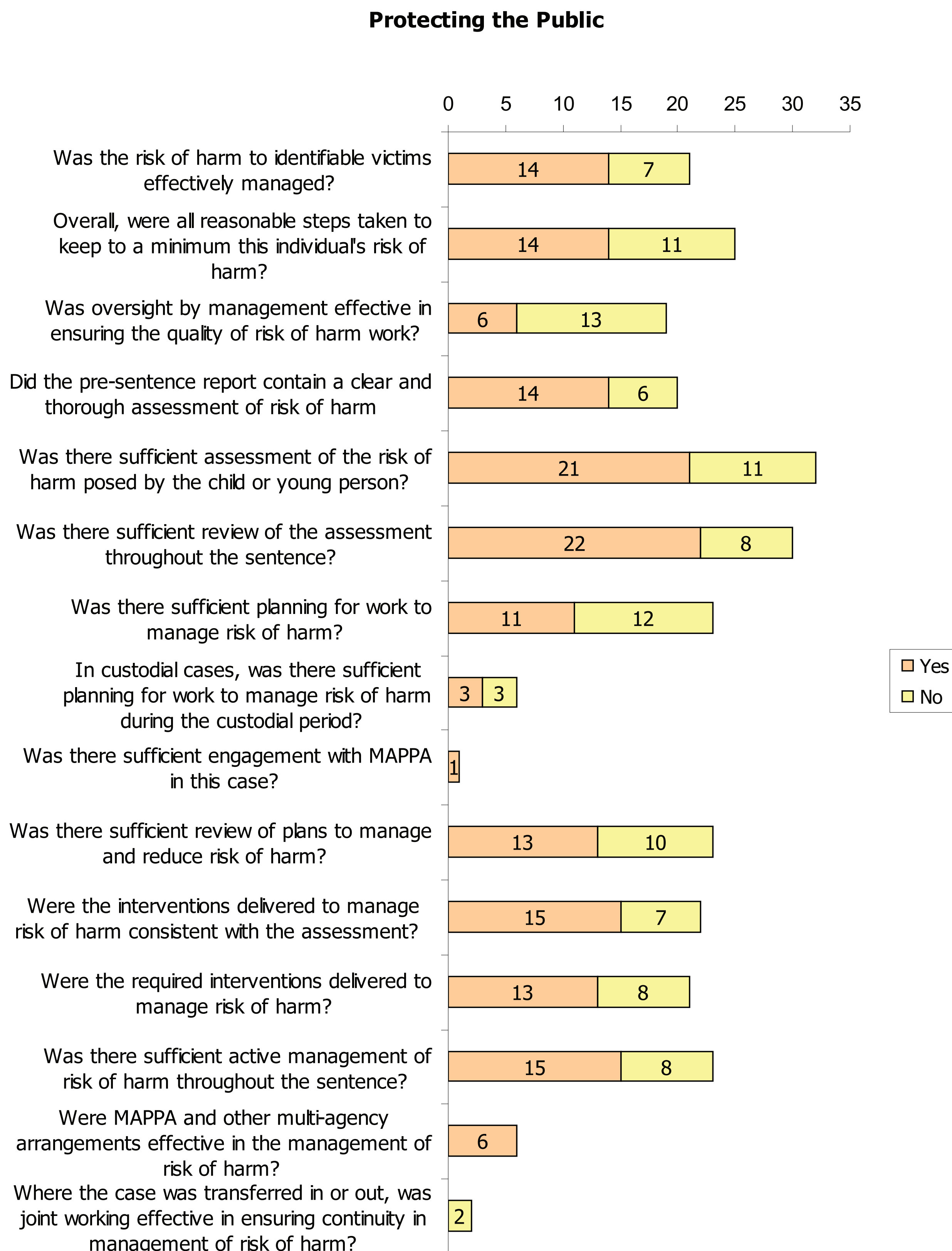
Example of notable practice

During his order, Shane was arrested and bailed for an offence against his mother. The details of the offence and the bail conditions were appropriately integrated as part of the risk management plan, and the case manager continued to monitor the progress of this allegation.

7. However, we judged that in one-third of cases there had not been sufficient active and effective case management of public protection work, in particular where there were actual or potential victims identified. The YOS had done enough to keep the risk of harm posed to others to a minimum in only just over half of the inspected cases.
8. The use of police intelligence was not consistent across the cases that we inspected. It relied upon individual case managers requesting information from the YOS police officers rather than it being proactively collated and disseminated. The result of this was that there was use of intelligence on some cases and not on others. We were told that there was joint working with the police Public Protection Unit, and there was evidence of this within police records, but it was not recorded within the YOS and so would not have been accessible to managers overseeing cases or to other case managers if the case had been transferred.
9. Management oversight of this area of work had not been effective. It was missing entirely from some cases and, in others, inadequate assessment and planning had been countersigned.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Protecting the child or young person

3

Theme 3: Protecting the child or young person

What we expect to see

Whether the vulnerability of children and young people is due to the consequences of their own behaviour or the behaviour of others, we expect to see that they are kept safe and their vulnerability is reduced. This should be through good quality assessment and planning with the delivery of appropriate interventions, positive leadership and management, and an effective contribution to multi-agency Child Protection arrangements.

Case assessment score

Within the case assessment, overall 67% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

10. Case managers contributed to children's social care services safeguarding meetings.
11. Children's social care services had rejected referrals on the basis that the child or young person was involved with the YOS.
12. The assessment of vulnerability lacked analysis or understanding of the consequences of identified factors.
13. Planning was insufficient with gaps in some identified areas of concern.
14. Interventions were not always consistent with the assessment or the plan.
15. We found some good safeguarding work by individual case managers.
16. There was little joint work with children's social care services.
17. Management oversight of this area of work was judged to be ineffective.

Explanation of findings

1. Case managers demonstrated an understanding of safeguarding responsibilities, policies and procedures. Case managers routinely contributed to Child Protection conferences, core group meetings and Looked After Children statutory reviews. They made timely and appropriate referrals to children's social care services. When referrals were rejected and the YOS did not agree with the decision, there was no evidence that concerns were escalated by the YOS under the dispute resolution protocol however. This meant that identified vulnerabilities went unassessed by children's social care services.
2. Health staff had received safeguarding training at the appropriate level and had a good understanding of issues and how to make referrals. The physical health nurse had access to health records which included information on immunisations, hospital appointments and A&E admissions. We saw some good transfer of substance misuse information between YOS health staff and custodial establishments.
3. The assessment of vulnerability is made through vulnerability screenings; these were not of a good enough quality in over one-third of the cases we inspected. The factors most often missing were emotional or mental health, care arrangements and previous social care history, and ETE. Moreover, while factors were often recognised, the understanding of what the consequences might be was vague and often unspecified. For example, it was not always recognised that destructive behaviour

could also be a response to feelings of distress. In one case, anger management had been identified as an intervention while the fact that the behaviour might have been a response to distressing family circumstances had gone unconsidered.

4. Most vulnerability screenings were reviewed regularly, however a small number were not and some were copies of previous screenings with insufficient update.
5. The planning to protect the child or young person, which is carried out via vulnerability management plans, was not of a good enough quality in over one-third of cases. In particular, there were gaps in planning for emotional and mental health, physical health and alcohol misuse. The planning was not reviewed properly in nearly half of the cases we inspected. A small number of relevant cases did not have plans at all. For example, we saw a case where, although it was known that threats of suicide had been made and anti-depressants prescribed, there was no plan in place for six months.
6. An understanding of the legal status of children and young people who were living away from home was not sufficiently evidenced on the YOS electronic record. For example, where a child or young person was subject to private fostering arrangements, plans did not reflect understanding either of contact or of the permanence of the arrangements.
7. In nearly one-quarter of cases, the interventions to safeguard were not consistent with either the assessment or the plan. Particular gaps were in emotional and mental health, physical health and alcohol misuse.
8. Conversely, we saw cases where complex vulnerability had been recognised and supportive action taken to address it.

Example of notable practice

Jasmine had recently discovered that her carers were not her biological parents. Her case manager realised that she had emotional difficulties which were related to her need to understand why she had been brought up by relatives. The case manager consulted with the adoption team to investigate useful approaches and worked with Jasmine to help her understand, and deal with, her emotional responses and behaviour. In addition Jasmine was offered mentoring as part of her education package through the women's centre.

Example of notable practice

John was a Looked After Child placed in Doncaster. His initial assessment had highlighted that he had a diagnosis of Asperger syndrome and attachment difficulties. This meant that John would struggle to attend large groups. As a consequence, the YOS education worker both found and facilitated a placement offering one-to-one support for John in order to meet his needs.

9. We found other good examples of YOS safeguarding work, however when a joint response was needed from both the YOS and children's social care services, there was less evidence that this had been delivered.

Example of notable practice

Kevin, a 14 year old, was living with his grandparents when he received an 8 month youth rehabilitation order with intensive supervision and surveillance for a violent offence.

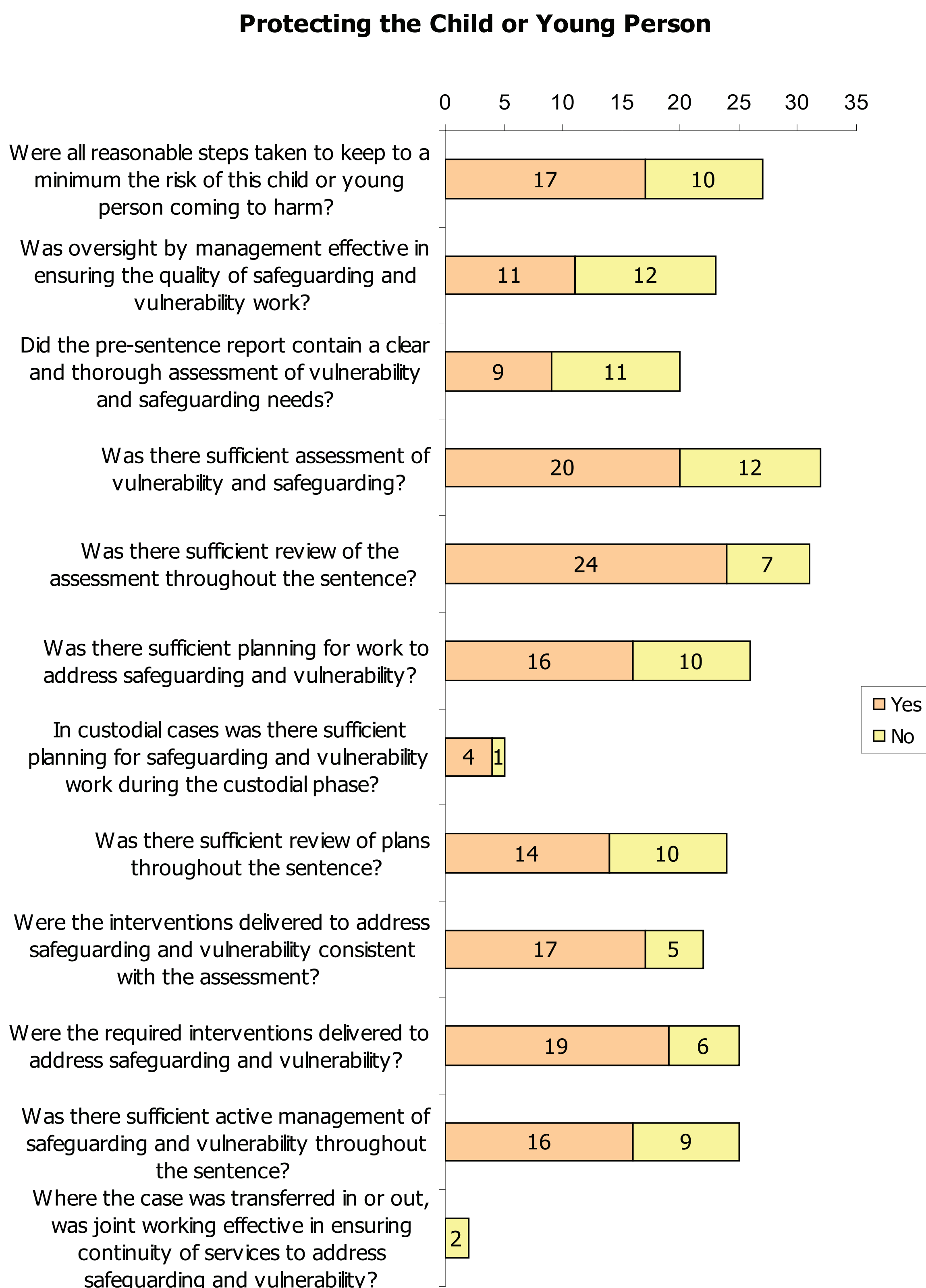
He had poor school attendance and regularly went missing at night. His mother was a heroin user and he was also using drugs. A referral to children's social care services was rejected on the basis that the YOS programme was sufficient to manage his vulnerability.

As a result of breaching a court imposed curfew, Kevin was returned to court and was sentenced to custody.

10. Overall, we judged that vulnerability was not actively and effectively managed in over one- third of the cases we inspected and that the YOS had not done enough to keep the child or young person safe in those circumstances.
11. Management oversight was judged to have been ineffective in over half of safeguarding work. This was either due to a lack of oversight or deficiencies in assessment or planning being overlooked.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Ensuring that the sentence is served

4

Theme 4: Ensuring that the sentence is served

What we expect to see

Children and young people should serve their sentences as the court intends. We expect that the YOS will maximise the likelihood of successful outcomes by effective engagement with them and their families, responding to relevant diversity factors including paying attention to their health and well-being, and taking appropriate action if they do not comply.

Case assessment score

Within the case assessment, overall 70% of work to ensure the sentence was served was done well enough.

Key Findings

1. Engagement with children and young people and their parents/carers was good during the assessment process.
2. Recognition of diversity and individual needs was generally good at this stage.
3. Age and maturity were not always recognised as factors or taken into account.
4. Engagement during planning and delivery of the sentence was less good.
5. Planning was largely a process. Plans were created for children and young people rather than with them.
6. Compliance work was carried out efficiently but the reasons for non-compliance were not always fully explored.

Explanation of findings

1. Unless the child or young person themselves is trying to stop offending, the work of the YOS and other agencies is likely to be ineffective. The case manager must engage the interest and involvement of both the child or young person and their parents/carers, where appropriate, if the work is to be successful. This cannot be done without recognising the individuality or diversity of the child or young person, and of the parents/carers and responding accordingly. Clear communication, good quality assessment and planning and home visits are all contributors to good engagement.
2. In Doncaster we found that engagement with children and young people and parents/carers to facilitate assessment was good and, as a consequence, the recognition of diversity and individual needs was good enough generally. There was a gap however, in the lack of recognition of the impact of age and maturity, a significant feature of working with children and young people. We saw a case where this had been recognised.

Example of notable practice

At the start of his order, Mark struggled to attend appointments. He had a history of neglect and, although 17 years old, his case manager recognised that he was immature. He was living with his mother, who had alcohol problems, and lacked the parental support or organisational skills to manage his order. He was frequently caring for his younger siblings when he should have been at appointments. The case manager supported him with reminder phone calls, and discussed with his mother the difficulties of his caring responsibilities. His attendance improved significantly.

Example of notable practice

In the case of Simon, his parents were previously seen by services as being difficult to engage. Initially, there were difficulties, with Simon's parents missing arranged appointments. However, the case manager spent a considerable amount of time building a relationship with them, which included regular updates on progress, and listening, and responding, to their concerns. In time this led to indications that his parents were reinforcing messages to Simon about work undertaken with the YOS. The case manager remained sensitive to his parents' feelings about other statutory services and was clear about their own role and that of other agencies. This had a positive impact on safeguarding and information was still appropriately shared.

Quotes from parents/carers

"*I know that he's been doing life skills. He's been doing work around drugs and alcohol misuse. They ring me up and tell me what he's doing, and then they give me feedback on if it's gone well or not.*"

"*They've educated him to learning about consequences and choices, drugs, everything. With the drug education they've reinforced everything I've tried to tell him so he knows it's not just me trying to talk rubbish. They've pushed him to come on leaps and bounds and they're very supportive with him. They've been absolutely brilliant.*"

3. Engagement in the planning process was not as good. In nearly two-thirds of the cases we inspected, we judged that the child or young person and parents/carers had not been involved in the planning. In too many instances, plans had been created by case managers and then explained, rather than carried out with the child or young person. Not all plans were understandable or meaningful to children and young people, nor was their voice discernible. Planning did not always pay enough attention to the things that got in the way of successful work to reduce reoffending, the barriers to engagement.

Quotes from chidren and young people

"*No, they never [asked what would help to stop reoffending]. They never asked that really.*"

"*No, they never asked [for input into my sentence plan].*"

"*No [I wasn't involved in my sentence plan] no, I just got told what to do.*"

"*They asked me if I am willing to do [my sentence plan] and I said yeah…they just put it down on paper really and said 'you gotta do that.*"

4. Interventions followed a similar pattern. Less than two-thirds of children and young people and their parents/carers were considered to be meaningfully involved in the delivery of the sentence. In a small number of cases, the response to barriers to engagement was not good enough; this was largely as a result of deficiencies in assessment and planning.
5. Health workers went on home visits which they used to meet parents/carers and explain interventions to the family. Support was also given to the wider family to help them address the needs that were impacting on children and young people.

6. Overall, the YOS gave sufficient attention to the well-being of children and young people.
7. Compliance work, ensuring that the child or young person carries out the sentence of the court, was carried out efficiently. In nearly all of the cases we inspected where a child or young person failed to comply, enforcement was enacted promptly. Engagement and compliance are closely linked; where engagement fails, compliance with the order can be a problem and the child or young person can be returned to court to be sanctioned or resentenced. This can ultimately increase the chances of a child or young person receiving a custodial sentence. We saw some cases where the underlying causes of non-compliance were not fully explored to improve engagement. This had been recognised and compliance panels had recently been replaced with engagement panels to address this.

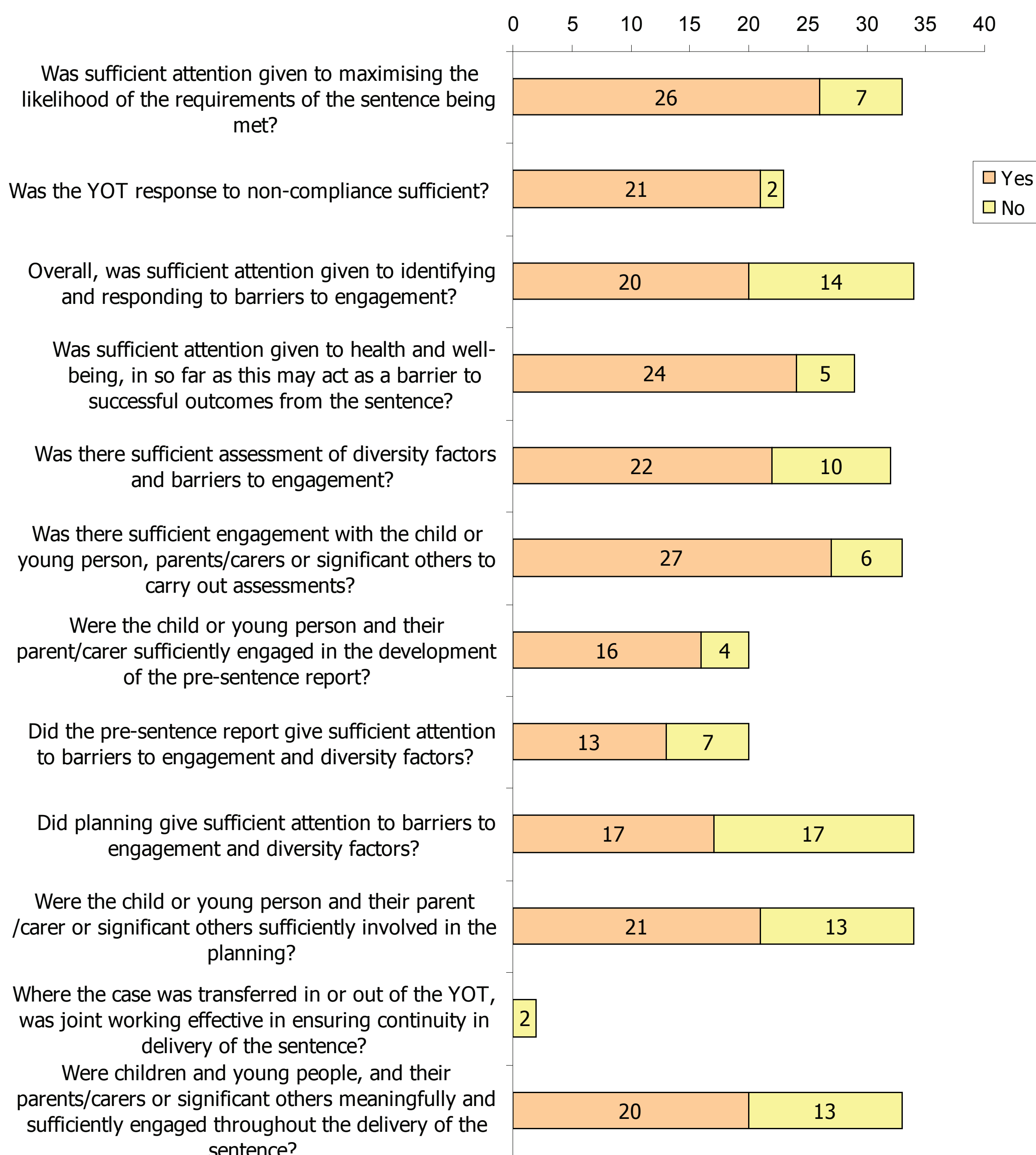
Example of notable practice

Fourteen year old Darren was breached and returned to court while subject to a youth rehabilitation order with intensive support and surveillance. There had been a number of barriers to compliance which had not been fully considered or acted upon. There was no change in the approach to working with him following the breach and he was subsequently breached again and received custody.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]

Ensuring that the Sentence is Served



Governance and partnerships

5

Theme 5: Governance and partnerships

What we expect to see

Effective governance, partnership and management arrangements are in place. These enable the YOS to meet national and local criminal justice and related objectives, and to deliver and maintain good quality services.

Key Findings

1. Doncaster Children's Services Trust had been in place less than a year and had only recently taken over the Chair of the YOS Management Board.
2. The Management Board had been ineffective. There was no evidence of scrutiny, challenge or joint problem solving.
3. Meaningful performance data was not being collected. The Board had relied on basic national indicators and had not required any change to this until the most recent meeting in April 2015.
4. Some Board members did not know what operational work was being carried out within their own sphere of activity.
5. Where good operational work existed, this could not be consequentially linked to the activities of the Board.
6. The need for the work of the Board to improve had already been recognised and there was evidence, in the most recent meeting, that change had commenced.

Explanation of findings

1. Leadership and governance – offending is reduced and other criminal justice and related objectives are met

1.1. Doncaster Children's Services Trust was created in September 2014 to deliver children's social care services on behalf of Doncaster Metropolitan Borough Council. The Council delegated the delivery of youth offending services to the Trust.

1.2. The strategic management of the YOS remained with the YOS Management Board which was made up of the statutory partners, and other members who had been asked to join, to ensure that partnership work could be effectively delivered.

1.3. The YOS Management Board met four times a year although in 2014 the December meeting was cancelled. Consequently the Board did not meet from September 2014 (when there had been only four attendees including the YOS manager) until the following April 2015. With the exception of the probation and health members, attendance had been sporadic at the Board.

1.4. There was little local performance data either requested or received by the Board other than the national indicators, and there was no evidence of any scrutiny of what had been presented.

1.5. What data there was at an operational level had not always been reported to the Board. For example, in health, some outcomes were being measured which were required nationally around substance misuse, but this information had not been provided to, or discussed at, the YOS Management Board. Data to judge the ETE performance of the YOS had only recently started to be provided. The data prior to the last quarter was fragmented and of limited value and current data was not sufficiently well developed. The absence of children's social care services data meant that

the response to YOS referrals was not properly understood, nor could consideration be given as to whether thresholds to access services were too high.

1.6. The Board agenda was largely determined by the YOS. We saw no evidence of joint problem solving or planning. For example, health was not a standing agenda item and minutes showed that little attention has been paid to this area. There were some key areas which the representatives were not aware of and it appeared that the Board had not been informed about concerns around provision.

1.7. There was evidence that the Chair of the Management Board and the YOS manager understood the need to make the Board more effective and to obtain more useful data. In the most recent Board meeting, the YOS manager had specifically noted that the Board needed to challenge the YOS more. Senior Trust managers were clear about the need to improve the information provided to the Board.

2. Partnerships – effective partnerships make a positive difference

2.1. The Local Safeguarding Children Board (LSCB) had established joint safeguarding training which was well attended by the YOS. This helped ensure that YOS workers were fully conversant with their safeguarding responsibilities. Regular training about the work of the YOS was provided by the YOS to children's social care services.

2.2. Arrangements were in place for YOS attendance at children's social care services monthly management meetings, however YOS attendance had been limited. This was a missed opportunity to explore emerging themes and issues in the joint planning and delivery of services

2.3. It was unclear how the YOS contributed to the joint housing protocol in deciding a child or young person's housing entitlement. Case managers reported that in some instances children and young people in need of accommodation had been advised by children's social care services to progress this themselves. The YOS were unable to provide information to establish the prevalence of this problem.

2.4. The provision for further education within the Doncaster area was good, with a wide variety of provision including independent training providers. The main general further education college was graded 'Good' by Ofsted in 2013. Appropriate alternative provision for children and young people under 16 years old was in place. The variety of opportunities for them outside of the main college provision to engage with short, flexible vocational courses was generally good. Services within the local authority helped to source and tailor placements to meet the individual needs of children and young people, including finding suitable work placements. The YOS ETE workers were co-located and case managers valued their input, describing them as "*very positive and a mine of information*".

2.5. The health contribution comprised a general nurse who was specifically employed by the Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) to work at the YOS. This resource was valued by case managers who described the nurse as "*hands on*" and prepared to see children and young people on different days and times and in different venues despite being part-time. The CAMHS service was also commissioned through RDaSH. Difficulties had occurred in the delivery of mental health work, which had not been addressed expeditiously, and this had impacted on the service to children and young people. There was a substance misuse coordinator and a substance misuse support worker had just started at the time of the inspection.

2.6. There were twice yearly youth panel meetings to which the YOS was invited and it was felt that operational links were good. Strategic links with the courts had reduced considerably however since the court user group had been discontinued. There was no vehicle for court users to meet together to improve performance through joint problem solving. For example, there was no forum for partners to discuss the amount of time children and young people spent in cells or how to reduce the number of unaccompanied appearances at court.

2.7. We observed the out of court disposals scrutiny panel where, among other things, youth cautions and conditional cautions were discussed. The aim of the panel is to ensure that there is consistency

in the use of such disposals across South Yorkshire. Findings from the panel are fed back to the police via the Chair who is a police inspector. The findings are given to the officer concerned and any learning is built into future training for officers. The panel was made up of the Chair of the magistrates' bench from each of the four districts in South Yorkshire, a YOS representative and a member of Victim Support. It was of concern that there was no youth court magistrate on the panel. Magistrates who sit on youth courts receive specific training and have specialist knowledge about children and young people and youth justice processes.

2.8. The contribution of police officers to the YOS by South Yorkshire Police was valued by case managers. The officers did not have ready access to police IT systems within the YOS. They had to either contact the intelligence unit by telephone or physically attend the police station to research or enter intelligence logs on to the system. The lack of IT access also limited their ability to ensure that they were kept fully up to date on crime, custody and other incidents overnight. As a consequence, the officers were not aware of what was happening on a day-to- day basis across Doncaster. They were not deployed in accordance with the national guidance produced by the College of Policing and the Criminal Justice Board in 2014 and we felt that the YOS was not making the best use of their knowledge and partnership links.

2.9. The recently produced YOS Child Sexual Exploitation policy supported effective planning and joint information sharing but impact was not yet demonstrated. One of the police officers had been appointed as the single point of contact for child sexual exploitation.

3. Workforce management – effective workforce management supports quality service delivery

3.1. Case managers felt that their training and development needs were being met and that they received good support from their managers who were accessible. Supervision of cases was inconsistent however, with case managers telling us that some managers reviewed all cases in supervision, and some only reviewing those assessed as posing a high risk of harm to others. In 24 out of the 34 cases we inspected we judged that supervision or quality assurance arrangements had resulted in no positive impact on the management of the case.

3.2. Health staff received both clinical and joint managerial supervision from the YOS and CAMHS where relevant, although we found that not all supervision had been effective. There was no link between clinical supervisors, the YOS and CAMHS meaning that the YOS were not aware of the quality of interventions. RDaSH monitored the professional registration of nurses, helping to ensure that staff were up to date with training and knowledge.

3.3. There was a detective sergeant who had responsibility for the police officers within the YOS. The sergeant maintained regular contact with the YOS police officers and attended the weekly intensive supervision and surveillance meetings to share intelligence on children and young people managed under that system. Day to day management of the YOS police officers was provided by the YOS managers.

3.4. The safeguarding role within the YOS was ineffective and underdeveloped. There was no clear understanding about how the role was to be used to support other professionals within the YOS. The Trust had plans to develop the role and strengthen the interface between the YOS safeguarding lead and the LSCB.

4. Learning organisation – learning and improvement leads to positive outcomes

4.1. There was no evidence that the YOS or the Management Board used performance data or other information such as feedback from children and young people to improve practice or outcomes.

4.2. There was evidence that the YOS manager and operational managers had recently started to make changes to improve processes and practice. Staff told us that they were happier with the more recent direction of the YOS and confident that, if the changes were maintained and progressed, their ability to work with children and young people would be enhanced.

Interventions to reduce reoffending

6

Theme 6: Court work and reports

What we expect to see

We expect to see good quality reports to ensure that the court is enabled to make the most appropriate sentence. We also expect to see proactive work in court, which is integrated with the wider work with children and young people and is aimed at them having the best chance of refraining from offending. To enable us to judge the effectiveness of court work and reports, we observed a youth court and inspected an additional sample of pre-sentence reports (PSRs).

Key Findings

1. There was a dedicated court team of staff who were knowledgeable and valued by the court.
2. Information was available to the court when required. Good IT links enabled court staff to access information swiftly.
3. Court work was process driven with too little proactive intercession by court staff.
4. We saw unaccompanied children and young people dealt with in court.
5. There were some good, insightful PSRs with sensible and appropriate proposals.
6. Reports were generally too long and contained too much irrelevant information.
7. Proposals did not always follow logically from the body of the report; too often they were the most obvious 'next step' rather than an attempt to meet the needs of the case.
8. We found that children and young people had received custodial sentences without an up to date PSR.
9. Data on court processes and outcomes was not collected.
10. Management oversight of this area of work and the quality assurance of PSRs was judged to be ineffective.
11. Strategic links with courts had been diluted by the abolition of the court user group.

Explanation of findings

1. YOS court work is extremely important and can have a substantial impact on the lives of children and young people. Where it is carried out well, it can help magistrates to sentence in a way that protects the public and sanctions children and young people where necessary while helping them to stop offending and providing them with protection and support. Where it is done less well, it is merely a process. Where it is not done well at all, it contributes to progressing children and young people through a system that leads inevitably to custody for some, sometimes unnecessarily.
2. Many things contribute to good court work. Among them are: knowledgeable and proactive staff, availability of up to date information, good relationships between YOS staff and other court users and good quality reports.
3. In Doncaster, the court was well resourced by dedicated and knowledgeable YOS staff who were clearly valued by magistrates and other court staff. This was evidenced by the way that they interacted and were referred to by magistrates. They were also proactive in offering information and had obviously prepared prior to being in court. Their communication with children and young people and parents/carers was respectful.

4. There was room for court work to improve however. For example, we observed a case where a 16 year old young woman appeared in court on a charge of fighting with her sister. She was already subject to a referral order and the YOS court officer reported that she was doing well. The magistrates stated that they wanted her to have increased supervision and required a stand down report which was adjourned for a week. We would have liked to have seen a suggestion from the YOS that increased supervision could be provided under the referral order rather than another order being made. If successful, that would have avoided a delay in sentencing, another appearance in court for the young woman and another order on her record. In another case, we saw a PSR that had an unlawful proposal in it; this was drawn to YOS attention by the defence solicitor but should have been picked up under YOS quality assurance arrangements prior to the court date.
5. On the day that we observed the youth court, we saw two unaccompanied (without parents/carers) young people appear, one of these was for sentencing. Both had social workers and both were known to the YOS, yet neither agency had ensured that they were accompanied. This was poor practice by both agencies.
6. There was good information available at court including electronic links to the YOS database. We saw YOS staff making good use of this, not only to advise the court, but also to make and check appointments for children and young people. There was private space to allow for confidential discussions. YOS staff ensured that reporting instructions were given after court where necessary. Efforts we observed to ensure that children and young people understood what had happened were not robust enough however. For example, accepting a 'yes' after asking if they had understood, without checking out further.
7. While children and young people and parents/carers were sufficiently involved in the preparation of PSRs, we saw no evidence that any efforts had been made to discuss the contents prior to their court appearance. This was left to the defence solicitor. We were told that PSR writers often came to court for sentencing although we saw no evidence of this.
8. We saw some good, insightful reports with well-argued proposals which reflected both the needs of the child or young person and the requirements of sentencing.
9. Largely however, the narrative had been pulled through from the Asset on the YOS database and had not been converted into a coherent, relevant report, as opposed to a catalogue of information. Overall, reports were too lengthy and descriptive. In one report we saw two and a half pages of description of an incident without any analysis. There was a substantial amount of irrelevant information in reports ranging from, "*Sian does not have any health issues*" and, "Billy smokes cigarettes", to a description of a friend's funeral and an account of an on/off relationship with a girlfriend. It was evident that not all report writers understood the purpose of a PSR or had thought about how much personal information it was right or necessary to put into a court document.
10. The PSR should realistically assess a number of things, not least the likelihood of the child or young person responding to the proposed sentence. If the report does not do that, then it is reduced to merely fulfilling part of a process rather than aiding effective sentencing.

Example of notable practice

Children's social care services had been involved with Evan since 2002 and he had been on a Child Protection plan since 2014 due to emotional abuse. His mother had both mental health and alcohol problems and had been subjected to domestic violence. Evan was on a referral order for criminal damage within the home after an emotional outburst. He did not attend the referral panel and he did not attend any appointments under the referral order. When he was returned to court, he failed to appear for his PSR interview so the report was written without contact with him. The report failed to explore the reasons for his non-attendance and proposed a nine month youth rehabilitation order.

Evan failed to report under his youth rehabilitation order.

11. There was a failure to analyse and explain the risk of harm that the child or young person posed to others. In a number of reports, we saw a phrase quoting the Youth Justice Board definition of serious harm followed by, "*I therefore assess him to be a medium risk of serious harm*". This is of no help to the court. The assessment of risk of harm posed should tell the court what the PSR author thinks the child or young person's behaviour might be, in what circumstances and when, whether there are any potential victims and what might be done to reduce or manage that risk.
12. In a number of reports, we saw another phrase where the PSR author was describing the impact of custody, advising that the secure establishment should implement protective protocols. Again, this does not help the court to sentence. If the child or young person is assessed as likely to be vulnerable in custody, and if there is a possibility of a custodial sentence, the report should be clear about what the concern is. This gives the court the information it needs to properly balance the sentencing decision as well as enabling the custodial establishment to deal with individual needs.
13. Conclusions and proposals often did not convincingly follow from the body of the report. We saw none that argued for a sentence other than one which magistrates would have found immediately acceptable; sentences generally concurred with the proposal. There were a number of reports (where there were no public protection issues) which we felt had proposals that were not in line with the seriousness of the offence, the aim of reducing reoffending, or the needs of the child or young person. We felt that the court's routine use of requesting 'all options' to be covered when requesting a report had contributed to this and we would have liked to see this practice discussed at the YOS Management Board. Of the 20 PSRs in the case file sample, and the additional sample of 8, we judged that only 8 were of good enough quality.
14. Of the 16 community orders we inspected, 9 were made without the use of a PSR specifically requested for the purpose. In itself this was not necessarily a cause for concern, however we judged that in over one-third of the cases in the sample, the court was not provided with enough information about the child or young person's situation[2].

Example of notable practice

Sixteen year old Lester was sentenced to a six month youth rehabilitation order on the basis of a verbal update about his progress on a referral order. A specific PSR was not requested. There were significant issues regarding the health of his carers at the time of sentence which should have been picked up and taken into account when sentencing. Shortly after the order was made both carers died and he was left both homeless and bereaved.

15. We were surprised to note that, of the nine custodial cases we inspected, only five had had PSRs specifically requested for sentencing. From records there was no way of knowing whether the YOS had tried to persuade the court to obtain a PSR. Secure establishments rely heavily on information in assessments and PSRs from YOTs, especially during the first night in custody, in order to carry out initial assessments. These are used, among other things, to enable them to safeguard and protect children and young people where necessary.

Example of notable practice

At 17 years old, Andy was sentenced to a 12 month DTO without a PSR or an up to date assessment relating to the offence, which was one of rape. Andy entered custody with little detail of his current circumstances and individual needs, including his emotional and mental health. The nature of the offence made him potentially vulnerable to assault and, possibly, in need of extra protection.

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2 We did not inspect the case records of the PSRs in the additional sample therefore we did not make a judgement about the information before the court.

16. Management oversight of operational court work and quality assurance of PSRs had been ineffective. There was a complete lack of operational data to provide any insight into performance. The only remand data that we were provided with referred mainly to cost. Breach rates had not been investigated. While work had been done to reduce custodial rates, there had been no in-depth analysis of causes or trends; the YOS relied only on the national indicator.
17. What we found in Doncaster was administrative court work rather than a proactive, integrated extension of wider work with children and young people. We saw some good PSRs among those we inspected but too many were ineffective. In essence, too often, both the work and the reports 'served' the court process rather than proactively contributing to reducing reoffending, protecting the public and helping children and young people.

Appendix 1 - Background to the inspection

Inspection arrangements

The Full Joint Inspection (FJI) programme inspects youth offending work, predominantly in statutory community and custodial cases, in a small number of local authority areas each year.

The majority of the Youth Offending Teams selected for these inspections are those whose performance – based on reoffending rates, National Youth Justice Outcome Indicators and supported by other information, such as recent inspections – is of significant concern. Periodically, we also include high performing areas to establish a benchmark of good practice.

The primary purpose of the Youth Justice System is to reduce offending. This is the main theme of the inspection. The other core themes are protecting the public, protecting the child or young person, ensuring the sentence is served and governance and partnerships.

Criteria

A copy of the inspection criteria is available on the HMI Probation website:

http://www.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/

Methodology

YOTs are informed approximately 11 working days prior to the inspection taking place.

Fieldwork for this inspection was undertaken on the weeks commencing:

22 June 2015 and 06 July 2015.

In the first fieldwork week we looked at a representative sample of 34 individual cases up to 12 months old, some current, others terminated. The sample included a number of those who are a high risk of harm to others, are particularly vulnerable, are young women, or are black and minority ethnic children and young people. Cases were assessed by a team of inspection staff. They examined these wherever possible with case managers, who were invited to discuss their work in depth, explain their thinking and identify supporting evidence in the record.

We also received copies of relevant local documents.

During the week in between, the data from the case inspections was collated and a picture about the quality of the work of the YOT developed.

The second fieldwork week is the joint element of the inspection. HMI Probation was joined by colleague inspectors from police, health, social care and education. We explored the lines of enquiry which emerged from the case inspections. The leadership, management and partnership elements of the inspection were assessed, with a particular focus on reducing offending.

We also gathered the views of others, including strategic managers, staff and service users, children and young people, parents/carers and victims, and observed work taking place.

At the end of the second fieldwork week we presented our findings to local strategic managers, the YOT Management Team, YOT staff and other interested parties.

Scoring Approach

Details of how our inspection judgements are made can be found on our website.

http://www.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/

Publication arrangements

A draft report is sent to the YOT for comment three weeks after the inspection, with publication approximately six weeks later. In addition, a copy goes to the relevant Ministers, other inspectorates, the Ministry of Justice Policy Group and the YJB. Copies are made available to the press and placed on our website.

FJI reports in Wales are published in both Welsh and English.

Further details about how these inspections are conducted can be found on our website in the document 'Framework for FJI Inspection Programme' at:

http://www.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/

Role of HMI Probation and Code of Practice

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

www.justiceinspectorates.gov.uk/hmiprobation

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:

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