Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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Publication date:	16 December 2015

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

The inspection was conducted from 23 -25 November 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 14 cases of children and young people who had recently offended and were supervised by Calderdale Youth Offending Team (YOT). 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 Calderdale was 46.4%. This was six percentage points worse than in the previous year and substantially worse than the England and Wales average of 37.9%. Binary reoffending rates are liable to fluctuation, and the data is historic. The YOT have adopted real-time tracking of live cases which will provide them with more current data.

Overall, we found that that assessment work was carried out well and that there was good engagement with children and young people. Staff were enthusiastic, knew their cases well and it was clear they had been encouraged to work innovatively. The quality and timeliness of planning and delivery of interventions needed to improve as did, more generally, reviews of practice. More robust management oversight of these areas was also required.

Commentary on the inspection in Calderdale

1. Reducing reoffending

1.1. Inspectors examined just three pre-sentence reports (PSRs), of which two were judged to be of good quality. A lack of analysis and insufficient assessment of risk of harm were

[1] Published October 2015 based on binary reoffending rates after 12 months for the January 2013 – December 2013 cohort. Source: Ministry of Justice

issues in one example, but the small number of reports does make it difficult to draw wider conclusions. Stand down reports or verbal updates were used to inform the court in most instances. In a small number of cases a PSR would have allowed supervising case managers to present more tailored recommendations, for example in respect of the content or duration of an order.

1.2. The quality of assessment of offending was found to be sufficient in the vast majority of cases (12 out of 14) in the sample. There was scope for some improvement in incorporating education, training and employment (ETE) and lifestyle related factors, but otherwise assessments were consistently good enough. Diversity factors were assessed well.

1.3. The picture in terms of planning was more mixed, with just over one-third of cases not having sufficient plans in place to reduce reoffending in the community. A lack of clear objectives, a failure to give sufficient attention to victims' views and not addressing assessed needs were the main deficiencies in the plans we looked at. There was a sufficient review in just under three-quarters of relevant cases.

1.4. The case sample contained two custodial cases. We found that planning throughout the custodial phase of the sentence was sufficient in both. There was good evidence that case managers had attended and contributed to planning and review meetings. It was pleasing to see that all custody cases were not only reviewed at internal YOT meetings but were included in the Children's Services Vulnerable Young People's Panel.

1.5. It was evident from discussions with case managers and their managers, that staff were being encouraged to innovate and develop new provision and we saw some good examples of this in practice. Effective liaison and communication with other agencies was also a feature of many of the cases inspected, although in a few instances there had been barriers in either engaging or accessing partner services.

2. Protecting the public

2.1. Assessments of risk of harm to others were also completed well in the large majority of cases (11 out of 14). The screening of risk of harm was not of good enough quality in the three insufficient examples. Two of the three PSRs looked at gave a sufficient analysis of risk of harm.

2.2. Planning was satisfactory in over three-quarters of relevant cases, and in 9 out of 12 cases in which there was an identifiable victim, risk had been managed sufficiently. Both custodial cases evidenced sufficient planning to address risk of harm. Reviews of risk of harm to others had taken place in eight out of ten relevant cases.

2.3. We found some positive, creative examples of joint agency working to reduce risk of harm to others. In one case a young man with a history of domestic violence participated in a planned four-way meeting with his YOT worker, girlfriend and a worker from a local women's centre who was supporting her. This facilitated joint communication and while some interventions took place on a confidential individual basis, the two workers were able to share their assessment and understanding of issues and risks, thus complementing the work each was doing. There had been no reports or records of the young man's violent behaviour towards his girlfriend for some months.

2.4. In some other cases, however, we found that work to address risk of harm to others was not being implemented quickly enough and that management oversight arrangements had failed to identify and actively redress the issues.

3. Protecting the child or young person

3.1. All three PSRs contained a clear explanation and understanding of the vulnerability factors relating to the child or young person. In a few cases which had been sentenced without reports, sentencers may have benefitted from a more detailed appraisal of the child or young person's vulnerability.

3.2. Work to assess safeguarding and vulnerability related factors was carried out well enough in the majority of cases (11 out of 14). It was the ETE related needs of children and young people which were taken account of least satisfactorily.

3.3. About one-third of the cases inspected had been a Looked After Child at some point during the course of their order. We saw good evidence of liaison between the YOT, children's social care and, in relevant cases, residential workers. However, in one such case frequent changes of placement in successive care homes out of area, management of the care order, decisions regarding movements and last minute communications directly impacted on both the YOT capacity to manage the order and outcomes for the young person.

3.4. We judged that reviews were required in ten cases and found that seven had been completed appropriately. In two cases no review had been undertaken while the third was not timely.

3.5. The quality of planning to address safeguarding and vulnerability was more mixed. We judged that a sufficient plan was in place for only 8 out of 13 relevant cases. A lack of planning to address emotional and mental health (four cases), care arrangements (four cases) and ETE (five cases) were the main areas of deficit. However, planning in both the custodial cases inspected was sufficient.

3.6. We judged that 10 of these 13 cases should have been reviewed but found that this had taken place in only 6 instances. Either plans had not been revised as required or reviews had not taken place in the residual four cases. The previous section commented on delays in commencement in the delivery of work. The observation also applies to this section. Cover arrangements for absent staff were weak and as a consequence, interventions had either not been delivered or not implemented fully enough.

4. Ensuring that the sentence is served

4.1. Effective work with children and young people must be grounded in effective engagement. Where compliance is problematic, re-engagement work which identifies and redresses barriers to participation should take place. We found this work had been completed satisfactorily across the entire sample. Parents/carers were also involved appropriately in all but one case.

4.2. Diversity factors were identified well in assessments and all except two plans contained sufficient measures and interventions. Staff worked flexibly and creatively with children and young people to help them overcome barriers to participation and promote compliance.

4.3. We also found that the voice of the child or young person was taken into account in the work which was planned. This extended to approaches taken to address compliance. In one case, following a series of missed appointments, the case manager reassessed key elements of the supervision plan with which the young person had been struggling. A change of unpaid work placement, run by a member of staff they knew and trusted, and a change in intervention delivery to address a recently completed learning styles questionnaire, represented an excellent re-engagement plan which had had immediate results.

4.4. The YOT response to incidents of non-compliance was sufficient in all seven cases where this had been an issue. Only two cases in the sample recorded a charge and/or reconviction for new offences following the start of their order.

Operational management

The nine case managers we interviewed were generally very positive about the level of supervision and support they received from their line managers, and all thought that the oversight of risk of harm and safeguarding was an effective process. A number had been encouraged by managers to develop and deliver new programmes which they had found interesting and rewarding. A reservation expressed by some staff was that training on specific issues or themes was not always accessible.

Inspectors found that management oversight had sometimes failed to identify and redress deficiencies in assessment and planning. Furthermore, managers had not identified, monitored or adequately addressed the lack of progress in delivering interventions, which inspectors had found in some cases.

Key strengths

- Assessment practice was consistently good enough across each key inspection theme.
- Engagement work was good. Within this, diversity factors were well understood and accounted for in planning, and delivery and compliance issues were dealt with constructively.
- There were good examples of innovation and joint working.
- Work with children and young people in custody was of good quality.

Areas requiring improvement

- The quality of planning, particularly around safeguarding required improvement.
- Reviews did not always take place in a regular or timely way. Reviews should be conducted more regularly, especially in cases with identified risk and vulnerability factors.
- Interventions work had not commenced as planned in a number of cases. Delivery of planned work should begin at the start of sentence.
- Existing management arrangements had not identified, and consequently had not adequately addressed, these deficiencies in practice. Management oversight should ensure the quality of assessments and plans and ensure that they are implemented expeditiously.

We are grateful for the support that we received from staff in the YOT 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 07825 420119.

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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.