Inspection of Youth Offending Work
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To:	Pete Moore, Chair of Lincolnshire Youth Offending Service Management Board
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From:	Helen Mercer, Assistant Chief Inspector (Youth Justice)
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Report of Short Quality Screening (SQS) of youth offending work in Lincolnshire

The inspection was conducted from 30 November – 02 December 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 34 cases of children and young people who had recently offended and were supervised by Lincolnshire 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 Lincolnshire was 32.2%. This was worse than the previous year but better than the England and Wales average of 37.9%.

Overall, we found the YOS committed to achieving positive outcomes. It provided good advice to courts for sentencing, engaged well with children and young people, and their parents/carers, and demonstrated much good practice. However, there was work to be done to ensure practice was consistently effective, especially when managing risk of harm and vulnerability.

The YOS will be disappointed that performance has dipped since our last inspection. However, we were encouraged by its commitment to improvement and trust, as it enters a time of stability after restructure, that it will use the findings of this SQS to further inform its development.

Commentary on the inspection in Lincolnshire:

1. Reducing reoffending

1.1. Practitioners had a good understanding of the children and young people whose cases they were managing and we were pleased to see how well they drew links between, for

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

instance, physical health and a child or young person's offending behaviour. Despite this, in a small number of cases there was either no assessment or this had been completed too late.

1.2. Pre-sentence reports (PSRs) are written to help courts with their sentencing decisions. A PSR was prepared in 16 of the cases we looked at. These were all of appropriate length and made balanced judgements, helping sentencers understand why the children or young people had offended. However, too many failed to provide enough information about risk of harm or vulnerability issues. We saw a number of good reports written for referral order panels with case managers working well with children and young people, and their families, to produce clear and concise information about the offending behaviour and its context.

1.3. While practitioners were continually assessing the needs in a case, they were not documenting this as often as they should have been. We would expect to see assessments reviewed and updated, especially after a significant change in the circumstances of a child or young person. In many cases, this had not happened.

1.4. Planning to reduce the likelihood that a child or young person would reoffend varied in quality between not good enough and excellent. Many plans included important sentence requirements, such as exclusions or reparation, but failed to highlight how they would prevent further offending. Too many plans did not adequately address emotional and mental health needs and some were written in too formal a style and language. Conversely, we saw a good number of plans that provided a holistic, sequenced approach to meeting the needs of the child or young person and clear explanations for why work had to be undertaken.

1.5. We found indicators that many of the children and young people whose cases we looked at had offended, or were more likely to do so, since being sentenced.

2. Protecting the public

2.1. Case managers had done enough to understand and explain the risk of harm the child or young person posed to others in 19 of 33 applicable cases. In some cases, there was either no written assessment of risk of harm or it had been completed too late. The true nature of risk was not always apparent and, in four cases, this led to the level of risk of harm being underestimated. Some of these involved sexually harmful behaviour.

2.2. This affected the quality of planning, so that practitioners sometimes placed too little emphasis on work to address risk of harm. In cases where a specific plan had been drafted to manage risk of harm, many provided good detail about what should be done and by whom, but some merely reiterated sentence requirements and did not consider work to manage wider issues.

2.3. There was a need to take greater account of victims and possible future victims in both assessment and planning. There was little detail on plans about how victims would be kept safe, and a need to give more consideration to the role of restorative justice.

2.4. Written assessments and plans were not being reviewed often and well enough. However, in many cases, the YOS worked well with other agencies and departments to monitor and review risk of harm as the case progressed.

2.5. Multi-Agency Public Protection Arrangements (MAPPA) were not being used to enhance case management. There was no system to ensure that MAPPA eligibility and level were identified and reviewed effectively. The need for MAPPA was not always being recognised and, in one case, there had been no consideration as to whether an increased MAPPA

level could strengthen multi-agency work to ensure a young person complied with the restrictive requirements of his order.

3. Protecting the child or young person

3.1. In many of the cases we looked at there were gaps in the assessment of a child or young person's vulnerability and how this related to their offending behaviour. We were pleased to see specialist assessments undertaken where necessary and a number of responsible officers taking pains to actively and determinedly explore safeguarding issues. However, in some cases there was no written assessment or we found it hard to identify the nature and level of vulnerability of a child or young person.

3.2. There was a need for planning to address safeguarding and vulnerability issues in 30 of the 34 cases we looked at. Written plans were either missing or had been completed too late in over one-third of these. We were pleased to see that the YOS had produced appropriate plans in the two custody cases we assessed.

3.3. Gaps in assessment of, and planning for, vulnerability were more evident in some areas than in others. The most significant omissions related to emotional and mental health, the child or young person's care arrangements and the risk that they were being sexually exploited.

3.4. There were potential issues relating to child sexual exploitation in seven of the cases we looked at and more to be done to address this in four. We acknowledge the YOS's quick and effective response to the concerns we raised in one case.

3.5. In many instances, assessments and plans were not being reviewed as they should have been, even when there had been a significant negative change in circumstances.

4. Ensuring that the sentence is served

4.1. The YOS used a range of approaches to help build relationships with children and young people and their families, often using their home as a base for the work that had to be undertaken. As a result, most assessments and many plans were inclusive, and represented the views of the child or young person. It was clear that in some plans, however, the YOS had made all the decisions about what work should be completed during the sentence and it was hard to see how the child or young person would relate to this.

4.2. Not all YOS officers made enough effort to understand factors that could enhance, or negatively affect, engagement and compliance. We saw examples of good attention given to cultural issues and learning styles but, on the other hand, we found some significant deficits, such as not taking communication needs into account which had potentially contributed to a lack of compliance.

4.3. In half of the cases we looked at, the children and young people had struggled to comply with the requirements of their sentences. The YOS took steps to address this in nearly every instance. Compliance panels were held and breach processes used effectively. However, case managers did not always explore the reasons behind the non-compliance well enough and, in some instances, could have sought more creative solutions.

Operational management

Lincolnshire Youth Offending Service had seen considerable organisational and staff changes since April 2015 that were still bedding in. The YOS recognised that information did not flow consistently

well between children's social care services and the YOS and we noted the impact of this in a small number of cases.

Most case managers had a sufficient understanding of the principles of effective practice but a small number needed to understand better the YOS's policies for safeguarding and the management of risk of harm. They felt their managers supported them in their work but many identified a training need in case management and to help them identify and respond to the individual needs of children and young people. Management oversight was variable in quality and was not sufficiently effective in ensuring all cases were managed well. Case managers were committed to achieving the best possible outcomes for children and young people and were not always receiving the appropriate management advice to help them do this. The split between pre-sentence and post-sentence practitioner responsibility acted as a potential barrier to engagement for children and young people who had to repeat their story to, and build a relationship with, more than one YOS practitioner.

Key strengths

- PSRs provided the courts with good quality information about why a child or young person offended and made sound, individualised proposals for sentencing.
- The YOS engaged well with children and young people and their parents/carers to understand the needs of a case.
- Measures to address issues of non-compliance were taken quickly and effectively.
- The YOS demonstrated that it was able to facilitate high quality case management.

Areas requiring improvement

- Assessment and planning relating to the risk of harm a child or young person poses to others, and vulnerability including potential child sexual exploitation, need to be thorough, accurate and meet the needs of the case.
- Practitioners should ensure they review progress in their cases, change plans where necessary and document this work.
- Management oversight should improve the quality of work to manage risk of harm and vulnerability.
- YOS practitioners should have the skills and knowledge to understand and fulfil their roles effectively.
- YOS managers should ensure that there is a consistent level of good quality practice across all cases.

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 Vivienne Clarke. She can be contacted at Vivienne.Clarke@hmiprobation.gsi.gov.uk or on 07972 273026.

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Chair of Local Safeguarding Children Board	*Chris Cook*
Chair of Youth Court Bench	*Michael Page*
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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.