Inspection of Youth Offending Work
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To:	Mil Vasic, Chair of Kingston upon Hull Youth Justice Service Management Board and Director of Children's Services
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From:	Alan MacDonald, Assistant Chief Inspector (Youth Justice)
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Report of Short Quality Screening (SQS) of youth offending work in Kingston upon Hull

The inspection was conducted from 14-16 March 2016 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 33 cases of children and young people who had recently offended and were supervised by Kingston upon Hull Youth Justice Service (YJS). 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 Kingston upon Hull was 48.2%. This was worse than the previous year and worse than the England and Wales average of 38.0%.

Overall, we found skilled and committed staff who worked hard to deliver the order of the courts. Assessments and planning needed to improve in respect of addressing the understanding of the reasons for offending, future risk of harm behaviour, safety and well-being. Kingston upon Hull YJS had experienced changes in leadership during the past 18 months and structural and regime changes were yet to be embedded, this had affected confidence for some. Kingston upon Hull YJS had commenced the transition to AssetPlus (the new assessment and planning interventions framework) in February 2016 and they were making good headway, but inevitably this was work in progress at the time of the inspection.

Commentary on the inspection in Kingston upon Hull:

1. Reducing reoffending

1.1. Pre-sentence reports, where provided, were comprehensive, although inspectors found the assessment of the degree of risk of harm was not fully recognised in almost half of the cases reviewed. Assessment of mental health and well-being needs required

[1] The reoffending rate that was available during the fieldwork was published January 2016, and was based on binary reoffending rates after 12 months for the April 2013-March 2014 cohort. Source: Ministry of Justice

improvement and case managers struggled to access appropriate services and interventions from Child and Adolescent Mental Health Services (CAMHS) in just over one-third of the relevant cases inspected.

1.2. Oral court reports were provided in many instances where the individual had been recently managed by Kingston upon Hull YJS; while this practice expedited sentencing, it was not always clear what information had influenced the court's decision-making. In some instances this had resulted in inappropriate decisions. One inspector commented: "*A pre-sentence report was not requested, therefore, the court imposed a youth rehabilitation order with 100 hours unpaid work, this has been difficult to deliver due to the young person's drug use*".

1.3. Full reports were prepared for referral order panels and there was evidence of good engagement with parents/carers and the child or young person. "*The case manager has developed a very positive relationship with the child and mum, and this has had an impact on his level of engagement and openness with his case manager.*" In some instances the number of requirements was ambitious and one inspector observed: "*The plan is not achievable – he has fortnightly appointments as he is 'standard' but the referral order contract requires weekly sessions, if they are to complete the required work*".

1.4. Planning was generally sound and there were good examples of case managers tailoring interventions to meet the needs of the child or young person, for example: "*They had a diagnosis of Asperger syndrome and the case manager had considered this when delivering the intervention, so that this was appropriate and at a proper level*".

1.5. Reviews of assessments were not always undertaken sufficiently in one-quarter of the cases inspected and these mostly were not undertaken following a significant change of circumstances. The outcome measure of reducing reoffending was disappointing. Inspectors observed no identifiable change or improvement in most of the cases inspected, with nearly half coming to the attention of the police during their period of supervision.

2. Protecting the public

2.1. The assessment of the risk of harm that the child or young person posed to others was judged to be sufficient in just over two-thirds of cases we inspected, however, the planning and work to manage the assessed risks was less good. Management oversight of the risk of harm posed to others was judged to be effective in just over one-third of cases. Some case managers reported they lacked confidence to revisit an assessment once it had been approved by management or that they could not make a change without senior practitioner approval.

2.2. A notable number of the cases inspected contained convictions for violence; many of these acts had arisen against a parent/carer or professional. In such instances there were examples that had not taken account of past patterns of behaviour, with an insufficient assessment of future risk of harm behaviour to others. One inspector commented: "*The risk of serious harm was deemed low and in my assessment should have been medium given the broken bone and the victim reporting feeling vulnerable*".

2.3. Victim awareness interventions and restorative justice were embedded well and there were some impressive examples. In respect of shoplifting: "*The case manager and victim worker arranged a restorative justice conference with the manager of the store. Powerful messages were imparted about the impacts on staff and financial costs to even large companies, the young person wrote a letter of apology. In response the store has lifted the ban on her entering their stores*".

2.4. For cases inspected where there were indications of child sexual exploitation, Kingston upon Hull YJS operated a multi-agency operational child sexual exploitation meeting where cases could be discussed and information shared, and we found examples where this had worked well. Case managers, however, said that they would welcome further learning and guidance and were not always clear about indicators and whether a case should be escalated for further attention.

3. Protecting the child or young person

3.1. The assessment of safeguarding and vulnerability of the child or young person was of good quality in the large majority of cases we inspected. Reviews of planning, however, were not undertaken where required in one-third of cases, with oversight by management found to be effective in only half of the relevant cases. The recently introduced 'Pod discussions' supported good practice, with an example where support was provided ahead of a referral order panel, which had been delayed due the mother's ill health.

3.2. Joint work with other agencies varied. There were examples of good communication with children's services and case managers made good use of access to CareFirst records (children's services case management system), and communicated reliably with education providers. In one-third of cases, however, planning to address emotional or mental health needs was assessed as insufficient. The response to referrals to CAMHS was observed to be unhelpful and case managers were not confident to challenge further. For example: "*The case manager made a referral to CAMHS, but the response was dismissive and provided no assistance or guidance stating they 'did not meet their criteria'*". In some instances case managers presented as passive and were not seeking out relevant risk information from the police when the child or young person had been arrested.

4. Ensuring that the sentence is served

4.1. Compliance and engagement was an area of strength and there was good engagement with the child or young person and their parents/carers to carry out assessments in most cases. Court orders commenced promptly and there were effective measures in place to encourage compliance and follow through with enforcement where appropriate.

4.2. There was imaginative use of enforcement to secure the safety and well-being of the child or young person. In one instance where a young person's accommodation had broken down and they had gone missing, the case manager utilised a breach warrant. The young person was found, the warrant was withdrawn and the case manager secured new accommodation, coordinating communication across a range of agencies effectively.

4.3. Kingston upon Hull YJS acquired the Kastor Centre in 2015 and were developing this useful resource to deliver reparation work and a wide range of interventions in a more child/young person friendly setting to improve compliance and engagement.

4.4. The approach to engaging with the family was positive and staff were implementing recent training in systemic practice, with evidence of the child or young person and their parents/carers involved in planning in most instances. The genogram methodology was widely used to gather a full understanding of the family and this supported assessments.

Operational management

Kingston upon Hull YJS was implementing a significant change programme, which was not yet fully embedded and this had impacted on the confidence of some staff. Policies and procedures had been overhauled and updated and were easily accessible. Case managers gave mixed views about the supervision and support they received. While there was evidence of management oversight

and countersigning, there was a need to move from process compliance to encourage reflection and investigation to address the needs of the child or young person. Recording and attention to commencement, compliance and enforcement were well organised and reliable. Management was attentive to the transition to AssetPlus and there was an effective system in place to capture issues and share learning.

Key strengths

- The systemic approach and practice to engage the child or young person and their parents/carers.
- Case managers worked carefully to address barriers to engagement.
- Commencement of the court order, the management of compliance and enforcement were consistent and delivered well.
- A wide range of interventions were in place and could be tailored to individual needs.

Areas requiring improvement

- The quality of assessments and planning addressing reducing reoffending, risk of harm and safety and well-being.
- Access to services to address mental health and well-being needs.
- The quality and consistency of management oversight, staff engagement and support.

We are grateful for the support that we received from staff in Kingston upon Hull Youth Justice Service 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 Tessa Webb OBE. She can be contacted at Tessa.webb@hmiprobation.gsi.gov.uk or on 07920 818943.

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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.