Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

HM Inspectorate of Probation
6th Floor, Trafford House, Chester Road, Stretford, Manchester M32 0RS
0161 869 1300 www.justice.gov.uk/about/hmi-probation

Louise Taylor
Chair of YOT Management Board
Lancashire Youth Offending Team

13th February 2013

Dear Louise Taylor,

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

This report outlines the findings of the recent SQS inspection, conducted during 7th-9th January 2013. We carried this out as part of our programme of inspection of youth offending work. This report will be published on the HMI Probation website. A copy will be provided to Ofsted to inform their inspections, and to the Youth Justice Board (YJB).

Context

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.

Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. The purpose of the SQS inspection is to assess the quality and effectiveness of casework with children and young people who have offended, at the start of a sample of 47 recent cases supervised by the Youth Offending Team. Wherever possible this is undertaken in conjunction with the allocated case manager, thereby increasing the effectiveness as a learning opportunity for staff.

We gather evidence against the SQS criteria, which are available on the HMI Probation website - http://www.justice.gov.uk/about/hmi-probation.

Summary

Lancashire YOT Management Board recognised that management support and oversight were critical to the achievement of consistent and high quality work. Sufficient resources had been allocated to an appropriate management structure and quality assurance processes but the impact on work was not always clear, as the focus was on the process rather than the quality of work undertaken. Advice and support to courts, assessment and planning for those in custody, and engagement and enforcement had received attention and, consequently, performance was good. Case managers generally knew and understood the needs of the children and young people they were working with and were good at engaging them at the start of orders. Compliance was used to re-engage those who lost motivation, resulting in some positive outcomes for children and young people.

In contrast, we found a wide variation in the quality of assessments, planning and reviews and inconsistency in the use of recognised assessment tools to support effective case management.

Commentary on the inspection in Lancashire:

1. Reducing the likelihood of reoffending

1.1. Half of the assessments of the likelihood of a child or young person reoffending were of a good enough quality. Most had been done on time but half had missed some important factors such as offending-related vulnerability and the emotional and mental health of the child or young person. We saw a number of examples where the child or young person was struggling to cope with their emotions after being separated from their family; this had led them to becoming upset, confused, angry and frustrated. In these cases, children and young people had either begun to drink alcohol or take drugs, or hurt care staff. Case managers often recorded that it was the desire to buy alcohol and drugs that resulted in offending but they had not made the link with the underlying emotional trigger. When we spoke to case managers they often knew this but had not used the assessment tool to support a thorough assessment. The impact was that some cases were underscored and insufficiently recorded in key areas leading to a lack of focused planning for critical offending factors.

1.2. Courts were provided with good advice and quality pre-sentence reports (PSR) in three-quarters of cases, but where PSR were insufficiently analytical, management oversight had not rectified this. PSRs were balanced, accurate and proposed robust alternatives to custody.

1.3. Planning for children and young people in custody was sufficient in all but one case; we saw some very effective joint work between case managers and staff in custody. This included joint planning to improve relationships between children and young people and their families which enabled them to return home on release. In one example the case manager recognised that the success of a child's release from custody would depend on him repairing his relationship with his parents. The case manager undertook joint planning with the custody staff which enabled both the parents and the child to use the time in custody to learn how to talk with each other and resolve problems.

1.4. There was a sufficient plan in place to outline what work needed to be done in 60% of community cases. There was no single reason that caused the other plans to be insufficient; we found six cases where a plan had not been completed; six plans that did not meet the assessed needs; five plans that did not focus on reducing reoffending; and insufficient attention to emotional or mental health and substance misuse in eight plans.

1.5. Although timely periodic reviews had been completed, significant events in the child or young person's life, such as being released from custody or losing their accommodation, did not trigger a review when it should have done.

1.6. It was interesting to note that in half of the cases in our sample we identified that the child or young person had a disability. Case managers knew about the disability and often worked in a way that lessened the impact but, again, this was rarely recorded or addressed in the assessment or plan. When case managers had identified issues, they had usually ensured referrals had been made to support children and young people and had adapted the way they worked in response to the disability.

2. Protecting the public

2.1. Half of the assessments of risk of harm to others were sufficient, provided a clear view of the risk of harm that the child or young person posed to others and had resulted in the

provision of the right interventions. A range of issues caused the others to be insufficient. In some cases an assessment had not been undertaken at all. A number of initial risk screenings focused too much on the index offence and did not consider previous relevant offences and behaviours. In some cases, where a full assessment had not been completed, it would have helped the case manager to record and analyse the risks fully.

2.2. Reviews of risk harm to others were insufficient in over half of the cases, often due to the failure to undertake a review at all or, as outlined previously, following a significant change in the child or young person's circumstances.

2.3. Half of the plans to manage risk of harm were sufficient, providing a clear plan of actions that enabled YOT staff and partners to recognise and respond appropriately to behaviours that might result in harm to others. However, there were seven cases where a risk management plan was not completed when it should have been and some plans did not cover risk to victims or anticipate changes.

2.4. In two out of eight relevant cases, planning to manage risk of harm for those in custody was not good enough. In one case there was no plan and in the second the plan had not been reviewed in preparation for release.

2.5. The risk of harm to victims had not been effectively managed in just under half of the cases; often victims' issues had not been identified in the assessment and subsequently not planned for. In one case, a young person's behaviour in the home was aggressive towards their parent and yet, the impact on a younger brother in the house was not considered, despite evidence from the school about their delayed development and anxiety.

2.6. Management oversight had not been effective in addressing gaps in assessments and plans, as it focused on process rather than quality.

3. Protecting the child or young person

3.1. Assessments of safeguarding and vulnerability were good enough in just over half of the cases. Vulnerability screenings were always done on time, but often did not include all of the vulnerability factors highlighted either in the assessment or that were known by the case manager. Some screenings focused too much on self-harm and vulnerability, or on the impact of custody. Some focused on the issues of the index offence and did not draw in other relevant behaviours, including use of drugs or consumption of excess alcohol.

3.2. Plans to manage vulnerability were good enough in only half of the cases and it was a concern that there were 13 cases where we judged that a plan should have been in place but was not. We saw inconsistencies in the quality of vulnerability management plans. Some were thorough and robust, clearly specifying what the issues were and what needed to be done, when and by whom; but others were unclear, confusing risk of harm to others with risk of harm to themselves. Some did not provide contingency for events that were likely to happen or cover issues of emotional and mental health. Plans were not always reviewed and management oversight did not rectify these deficiencies.

3.3. Planning for children and young people in custody was much better and often covered work that needed to be completed during custody to help give the child or young person the best chance when they were released. A strong feature of this was the focus on repairing or maintaining relationships with parents/carers.

3.4. Significant events had not prompted reviews of vulnerability plans. Children and young people's lives can change rapidly and it is important to check if plans are still relevant. As an illustration of this, some case managers reduced the child or young person's level of

vulnerability if children's social care services became involved in the case, rather than produce compatible plans to keep children and young people safe.

3.5. Case managers understood the local policies and procedures for the management of safeguarding, but some were confused about what they were expected to do and record. The case management review process had not yet helped those who, during the inspection, gave us an accurate account of the particular vulnerabilities of the child or young person and what they were doing, but who did not record this in judgements or records.

3.6. Children and young people in custody were assessed as being a 'Child in Need'. In a number of cases this had not made any difference in the management of the case, which subsequently became a problem when the child or young person was preparing for release and had nowhere to live.

4. Ensuring that the sentence is served

4.1. Work to enable the child or young person to complete their sentence was good with case managers engaging with children and young people at the start of the order, which is the period of work assessed on this inspection programme.

4.2. There was good engagement with the child or young person and parents/carers during the initial assessment and in the development of the PSR in most cases.

4.3. All case managers understood the local policies and procedures for supporting effective engagement and responding to non-compliance. Nearly three-quarters of the children and young people in our sample complied with the requirements of their sentence, and for those that did not, actions were taken which meant that all but two then complied.

4.4. There was sufficient attention given to health and well-being in just over two-thirds of cases. This included involvement of the YOT nurse to provide a fuller assessment and to identify if specialist interventions were needed. In some cases, referrals were not made to the health services but this was usually when the health issues had been missed in the assessment of vulnerability. For example, there was no consideration of the impact of a 14 year old boy regularly drinking three litres of cider a day.

4.5. Lancashire is a diverse area, and case managers generally understood the specific profile of the area in which they worked. There was a sufficient assessment of diversity factors in almost three-quarters of cases and these needs were reflected in pre-sentence reports. The diversity factor which was not identified by the assessment or included in the planning tended to be around disability.

Operational management

Case managers were aware of local policies and procedures and understood the priorities of the organisation. Most of the staff interviewed felt that the culture of the organisation promoted learning and development and that their training needs were met. Case managers were generally positive about the management oversight of the quality of their work and of the skills their line managers had, although they were less sure about the effectiveness of management oversight of risk of harm and safeguarding work. Discussions with case managers showed that they would welcome more involvement and discussion of the details of their thinking and judgements involved in the work through the case management review process. This has been recognised by the YOT Management Team and a case review programme is set to address this.

Areas requiring improvement

The most significant areas for improvement were:

i. the quality of assessment and planning in community cases for work to protect the public and reduce the vulnerability of children and young people

ii. the assessment of physical, emotional and mental health needs

iii. quality assurance and management oversight with a focus on assessment and planning

iv. a review of assessment and plans should be undertaken in response to significant changes

We strongly recommend that you focus your post-inspection improvement work on those particular aspects of practice.

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 Yvonne McGuckian. She can be contacted on 07973 295475 or by email at yvonne.mcGuckian@hmiprobation.gsi.gov.uk.

Yours sincerely,

Julie Fox
HM Assistant Chief Inspector of Probation

Copy to:
Lisa Gregoire-Parker, Temporary Head of Youth Offending, Fostering and Adoption.
Phil Halsall, Chief Executive Lancashire County Council
Louise Taylor, Director of Specialist Services
Helen Denton, Director of Children's Services
Mark Perks Lead Member Children
Susie Charles Lead Member Children
Mike Calvert Lead Member Crime
Liza Durkin, Business Area Manager YJB
YJB link staff with HMI Probation
Ofsted

Note: please contact our Publications department on 0161 869 1300 for a print out of this report.