Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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

This report outlines the findings of the recent SQS inspection, conducted from 9th–11th December 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 partner inspectorates 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 this inspection was to assess the quality and effectiveness of recent casework with children and young people who had offended. In order to do this, we examined 34 cases supervised by Kirklees Youth Offending Team (YOT). 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

Overall, we found a committed and enthusiastic staff group working with a challenging range of children and young people. Staff engaged extremely well, not just with the children and young people but also, importantly, with their families and carers. Assessments and plans were adequate but not consistently thoroughly reviewed. Management oversight of this work was cursory and poorly evidenced. We considered that there was scope for improvement by ensuring that, when required, both the risk of harm to others that a child or young person posed, and their vulnerability, were effectively kept under review. Nonetheless, the strong partnerships developed by the YOT staff ensured that an effective network of support was in place for children and young people.

Commentary on the inspection in Kirklees:

1. Reducing the likelihood of reoffending

1.1. The initial assessment of the child or young person's likelihood of reoffending was sufficient in 26 out of the 34 cases sampled. While all 34 assessments were factually accurate and identified positive influences on the children and young people, three contained unclear or insufficient evidence and three were not updated properly.

1.2. Pre-sentence reports (PSRs) were provided to the court in 14 cases; over three-quarters of these were of a good standard. However, we found six reports that had been signed off as acceptable, despite three containing an inadequate assessment of the child or young person's vulnerability and three which were not sufficiently analytical. We considered that management arrangements had not been effective in ensuring the quality of eight reports in total.

1.3. Plans to reduce the likelihood of reoffending were satisfactory in all but one custodial case and in three-quarters of the community cases. We particularly noted that staff had identified the benefits, to the children and young people, of keeping in contact through many home visits (both single and joint agency), with them and their families.

1.4. The personal circumstances of many children and young people change quickly, so assessments need to be reviewed to keep up. We considered that almost one-quarter of assessments and over one-third of plans relating to the likelihood of reoffending had not been reviewed well. The lack of an update to historical information meant that the assessments did not reflect the current circumstances of the child or young person.

2. Protecting the public

2.1. In three-quarters of cases, the assessment of risk of harm to others posed by the child or young person was sufficient. Where there were gaps, these arose because the initial screening was late, was not good enough, the assessment had not taken into account relevant behaviour or the level of harm posed had been classified as too low. Reviews of these assessments were sufficient in three-quarters of relevant cases.

2.2. We were pleased to see that a clear and thorough assessment of the risk of harm to others was included in all but 1 of the 14 PSRs.

2.3. Planning to address these risks was not sufficient in over one-third of cases where this was an issue. Plans were generic and vague. In five cases, a formal plan had not been completed. In five out of eight relevant custody cases there was sufficient planning to address the risk of harm. However, several inspectors noted that they "*saw positive examples of joint planning and working in complex cases where children and young people had mental health, learning disability, education and substance misuse needs*".

2.4. Almost half of the plans to address the risk of harm to others had not been reviewed well; there were weaknesses in ten cases, arising from the review not taking place (four cases), not being sufficiently thorough (four cases) or not amending the plan in response to changing circumstances.

2.5. Where there was an identifiable victim or potential victim, the risk of harm they faced had been effectively managed in almost two-thirds of all relevant cases.

2.6. Effective management oversight of risk of harm work was not evident in almost two-thirds of cases. The guidance issued by the local risk (and vulnerability) management meetings on a number of cases was not retained, leading to repeated instructions of the same actions that were not followed-up. On other cases, assessments and plans that we

considered insufficient had been countersigned by the manager without addressing the weaknesses. Staff interviewed said they would have appreciated more detailed feedback being given to them about the quality of their work. Most staff interviewed had sufficient understanding of local policies and procedures for managing risk of harm to others.

3. Protecting the child or young person

3.1. There was a satisfactory initial assessment of vulnerability in over half of the cases, but such assessments were not thoroughly reviewed throughout the sentence. However, staff generally liaised particularly well with other specialist services, such as mental health, learning disabilities and substance misuse.

3.2. Satisfactory plans were in place to manage vulnerability in half of the relevant cases, both in custody and the community. Where gaps arose, these were primarily because there was no plan; the planned response was insufficient or unclear; or contingency planning was lacking. Almost half of the reviews of plans to address safeguarding and vulnerability were not good enough, or did not happen at all.

3.3. Similar to the risk of harm, oversight of the vulnerability work was not effective in two-thirds of cases, because important gaps in assessments and plans had not been addressed. We considered that more attention was required to ensure that deficiencies in assessment and planning were addressed.

3.4. Most staff interviewed had sufficient understanding of local policies and procedures for managing vulnerability and safeguarding. An inspector said "*This was well evidenced in several cases where case managers had identified safeguarding concerns regarding either the child or young person with the order, or other children and young people. Appropriate referrals were made to children's social care services which had led to investigations which we considered contributed to their safety*".

4. Ensuring that the sentence is served

4.1. Performance in this area was extremely strong. In the great majority of cases, staff had assessed well and made good plans to address the child or young person's diverse needs and any barriers to engagement. Case managers were attentive to the child or young person's health and well-being in almost all cases. Similarly, there had been effective engagement with the child or young person, and their parent/carer, to complete the assessment. The great majority of the reports examined paid attention to how barriers to engagement would be overcome and the majority of cases had proper plans on how to overcome those barriers. One inspector particularly commended "*the support offered to key family members, for example supporting them to teach the child or young person to cook, or providing information following bereavement*".

4.2. Learning styles were regularly assessed and taken into account when planning how the work would be delivered.

4.3. In nearly two-thirds of cases, children and young people complied with the requirements of their sentence, some after initial difficulties. This was a testament to the commitment of case managers, given the chaos which prevailed in many of the children and young people's lives. Where they did not fully comply, the response was satisfactory in most cases.

4.4. An element of good practice seen was where a case manager of the same ethnicity and culture had been matched to the child or young person and his family. An inspector noted that "*this enabled the case manager to be a positive role model for the young person. There were language difficulties on the part of the young person's father, so the case*

manager was able to converse in Punjabi on home visits. Further good work was evident in arranging and undertaking specific interventions around illegal motoring and the consequences - which had a much greater impact than more generalised offending behaviour work".

Operational management

Over two-thirds of staff interviewed were positive about learning and development opportunities, although some felt that supervision by managers was not always fully effective. Our view was that management supervision and other quality assurance processes made a positive difference to the quality of work in only one-third of the cases, which left room for improvement. It is commendable that the YOT has already identified this and has plans in place to address it shortly. Managers and staff had also worked hard to address the challenges posed by a new (national) software package, including the planned use of a consultant to improve effective use of the system by staff.

Key strengths

- Strong partnership working. Good use was made of a wide range of specialist services such as family mediation, substance misuse, mental health and the local Fire Service.
- The engagement of children and young people and parents/carers in assessments and planning.
- There were many examples of staff 'going the extra mile' for the children and young people with whom they worked. The commitment of staff and managers to the use of repeated and regular home visits, including to children and young people who were Looked After Children who had been transferred out of the area, was highly commendable. The enthusiasm for their work was palpable and resulted in some of the most challenging children and young people making progress while under their supervision.

Areas requiring improvement

- Planning for work to manage vulnerability and risk of harm to others.
- Management oversight of the quality of assessments and plans.

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 Caroline Nicklin. She can be contacted on 07766 290969 or by email at caroline.nicklin@hmiprobation.gsi.gov.uk.

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