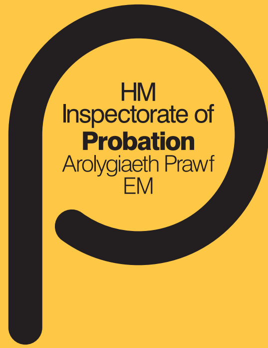

# Full Joint Inspection of Youth Offending Work in **Lambeth**

## An inspection led by HMI Probation

independent inspection of youth offending work

**January 2015**

# Foreword

This inspection of youth offending work in Lambeth is one of a small number of full joint inspections that we are undertaking annually with colleagues from the criminal justice, social care, health and education, children's services and skills inspectorates.

Lambeth Youth Offending Service (YOS) was chosen for inspection because of a poor previous inspection and long-standing performance concerns by the Youth Justice Board, which in turn had led to support being provided.

Recently, Lambeth had achieved a reduction in the number of children and young people entering the youth justice system. However, reoffending rates remained high. The published rate for children and young people in Lambeth at the time of inspection was 42.5%. This was worse than the average performance for England and Wales (35.4%).

Since the last inspection in 2011 Lambeth YOS had made encouraging progress. Whilst it had not yet achieved an overall satisfactory level of performance there was evidence to show that the YOS had worked hard to improve its service delivery. YOS staff were enthusiastic about their work and showed considerable skill in being able to positively engage with children and young people and their parents/carers. We found a commitment from partner agencies to invest in the work of the YOS but the absence of a workforce strategy to address an alarming trend in staff turnover, vacancies and the use of short term agency staff, left the YOS in a precarious situation. Until these workforce issues are dealt with as a matter of urgency, there will remain deficits in effective governance, safeguarding work, reducing reoffending and public protection.

The recommendations made in this report are intended to assist Lambeth Youth Offending Service in its continuing improvement by focusing on specific key areas.

**Paul McDowell**

HM Chief Inspector of Probation

January 2015

**Key judgements**

**Reducing reoffending**

**Protecting the public**

**Protecting children and young people**

**Ensuring the sentence is served**

**Governance and partnerships**

**Interventions to reduce reoffending**

# Summary


### Reducing reoffending

*Overall work to reduce reoffending was unsatisfactory.* Insufficient priority was given to work to reduce reoffending. The ongoing churn in staff turnover at operational and management level prevented effective continuity of service delivery. Initial assessments were largely done well but plans and reviews did not flow from information held by, and available to, the YOS. Health service provision was generally good but there was a lack of substance misuse provision. Referrals from case managers to health, and education, training and employment provision were neither consistently made nor overseen sufficiently to identify gaps.

### Protecting the public

*Overall work to protect the public and actual or potential victims was unsatisfactory.* Assessments and plans to reduce the risk of harm that some children and young people posed were underdeveloped. Victim work had recently become more coordinated but had not yet been embedded. There was a positive culture of intelligence sharing between the YOS police officers and case managers. Staff members across the service were not always clear about the work carried out by specialist gangs workers.

### Protecting children and young people

*Overall work to protect children and young people and reduce their vulnerability was unsatisfactory.* As with other work, it continued to suffer from long-standing gaps in the staffing establishment. Planning for work to manage safeguarding and vulnerability was not consistent. Case managers were not always clear about how to use the planning template in these assessments. Health assessments were good and joint work with case managers showed promise. A number of case managers did not fully understand how to make referrals to the local authority when there were safeguarding concerns, or the importance of some policies to safeguard children and young people. Management oversight was not always effective to ensure that the risks to children and young people were properly addressed.

### Ensuring the sentence is served

*Overall work to ensure that the sentence was served was good.* The contribution of health provision was very good in most areas and making a difference to improved outcomes. Case managers established good working relationships with children and young people and their parents/carers. Appropriate action was taken to respond to diversity needs and innovative interventions were used to overcome barriers to engagement. The YOS took appropriate enforcement action when this was required.

### Governance and partnerships

*Overall, the effectiveness of governance and partnership arrangements was unsatisfactory.* Effective governance arrangements were not embedded. The YOS Management Board had failed to fully or adequately address some of the key structural issues affecting the effective operation of the service. In particular, long-standing workforce problems had not been dealt with and whilst a strategy was in development, it was not finalised. Membership and attendance at board meetings had been inconsistent for some partners, although there was a commitment to joint working and improvement. The Board regularly monitored the YOS performance against the national key indicators and it was encouraging to see a specific local target around education, training and employment. More use needed to be made of data available for strategic and operational planning purposes.

**Interventions to reduce reoffending**

*Overall the management and delivery of interventions to reduce reoffending was unsatisfactory.* We found a range of appropriate interventions available to children and young people. We were pleased to see that some of these had been tailored to meet specific learning needs. Assessments of suitability for appropriate interventions were not always done well and referrals were not systematically made. Often, the planned interventions were not delivered and there was no substance misuse service currently in place. Staff members delivering interventions were skilled practitioners and managers had recognised a gap in their monitoring and evaluation of the impact of these interventions on reducing reoffending.

# Recommendations

Post-inspection improvement work should focus particularly on achieving the following outcomes within 12 months following publication of this report:

1. The YOS Management Board should ensure that reoffending is reduced, the standard of work in the YOS is of good quality and positive outcomes are achieved across all types of interventions. (Chair of the YOS Management Board)
2. As a matter of urgency the YOS Management Board should resolve the workforce management issues identified in this report. (Chair of the YOS Management Board)
3. Referrals to interventions to reduce reoffending should be consistently made, monitored and impact assessed. (YOS Manager)
4. All staff within the YOS should have sufficient up to date safeguarding training and understand children's social care referral procedures and protocols, particularly relating to missing children and young people. (YOS Manager and Chair of the Local Safeguarding Children Board)
5. Case managers should ensure that assessments, plans and reviews are properly informed by dynamic information to keep children and young people safe and protect the public. (YOS Manager)
6. Management oversight should be consistently effective and meaningful across casework. (YOS Manager)
7. In order to maximise their impact on reducing gang related crime and the safety of children and young people, all staff should be clear about the role of the Gangs Violence Reduction Unit. (YOS Manager)
8. The YOS and local authority should work together to improve the attendance at and progress in attainment, education, training and employment placements for post-16 children and young people. (Chair of the YOS Management Board)

Please note – throughout this report all names referred to in the case illustrations have been amended to protect the individual's identity.

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# Reducing reoffending

# 1

# Theme 1: Reducing reoffending

### What we expect to see

As the purpose of the youth justice system is to prevent offending by children and young people we expect youth justice partners to increase the likelihood of successful outcomes by undertaking good quality assessment and planning, deliver appropriate interventions and demonstrate both positive leadership and effective management.

### Case assessment score

Within the case assessment, overall 58% of work to reduce reoffending was done well enough.

### Key Findings

1. Reoffending rates remained high and not enough attention was given to work to reduce reoffending.
2. The delivery of interventions to reduce reoffending showed promise but were not consistently outcome focused.
3. Assessments produced for pre-sentence reports (PSRs) were good, drawing on a wide range of information to identify the root causes of the child or young person's offending.
4. Planning for work in custodial cases was good.
5. There was a valuable Children and Adolescent Mental Health Service (CAMHS) and Speech and Language Therapy (SALT) in the Youth Offending Service (YOS).
6. Too many children and young people were not systematically referred to health services or education, training and employment (ETE) facilities.
7. Sufficient reviews of assessments, plans and, in particular, interventions were not undertaken.
8. Insufficient focus was given to victims and restorative justice.

### Explanation of findings

1. The work of the YOS was not yet having a lasting impact on reducing reoffending. Over recent years Lambeth had seen some fluctuations in its reoffending rates. Whilst there had been some evidence of marginal reductions over this period, why this was happening was not clearly understood.
2. In a number of cases, we found that interventions to directly reduce reoffending had been delivered well. These included work to enable children and young people to develop their perception of self and others, explore their life experiences and examine the thinking and behaviour which had contributed to their offending.
3. PSRs were mostly of a good quality, provided suitable proposals and contained an appropriate range of information to advise the sentencing court. We saw some examples of effective management oversight to ensure that these reports were purposeful. Reports prepared for youth offender panels were not as good and required some clarification from youth offender panel members before contracts were agreed.
4. Assessments in identifying the factors that had, and could have, contributed to further offending had been carried out well in the majority of cases. However, planning for work to reduce reoffending and reviews of assessments had been done less well. Plans did not consistently meet the assessed needs of the case, sequencing of interventions was not properly considered and plans were not focused on

reducing reoffending. In addition, reviews were too often copied from previous assessments; they provided limited value and were not always carried out following a significant change in circumstances.

5. Case managers needed to take a more reflective approach in reviewing and planning for work to reduce reoffending. Too often we saw the focus on 'following processes' and 'completing' the plan rather than identifying the critical areas that would impact on behaviour. We were pleased to note an acknowledgement of this from practitioners during the course of our feedback.
6. Planning for work with children and young people who had been sentenced to custody was good in the majority of cases. Custodial plans had been produced in a timely manner; most plans did include work to reduce reoffending and were informed by assessments carried out by YOS staff.

**Case illustration**

Eight months before release from a three year custodial sentence for armed robbery, the case manager had arranged for Sloan to be seen by the YOS resettlement officer. This officer discussed with him the options for his living arrangements on his release from custody. Six months before his release Sloan received a joint visit by his case manager and the YOS probation officer as part of his transition between the YOS and adult probation. During this same period he undertook the 'boyhood to manhood' programme as part of the preparation for release. Sloan made excellent progress and at the time of the transition was well prepared for the community phase of his licence.himself nor committed further offences.

7. The involvement of the ETE team when children and young people left custody was not consistently timely. Case managers did not always involve the ETE team in the resettlement of children and young people back into the community. On some occasions the involvement came after release from custody, therefore, planning for ETE needs was delayed and likely to contribute to reoffending.

8. We were pleased to find a number of cases where the case manager had clearly tried to undertake effective work to reduce reoffending. In one example, the case manager had used the language of the young person in the integrated planning document which was used by the YOS to bring together assessment and planning information. When positive outcomes had been achieved the case manager then referred back to the integrated plan so that the young person could see how what he had said he was going to do had been done. This reinforced positive outcomes and provided the impetus for the young person to continue engaging with the supervisory process.

**Case illustration**

Horace, a 16 year old male had been sentenced to a 12 month youth rehabilitation order and was required to attend a weapons awareness course following his second conviction for being in possession of a bladed article. When he started the weapons course he was reluctant and pretended to fall asleep in the session. He tried this again in the second session. At this session he was given a formal warning that his behaviour was inappropriate and warned that failure to take the course seriously would result in him having to go back to court. He participated fully following the warning. Horace lacked boundaries in his life and had been used to doing what he wanted. This approach set down his options and as a result, he completed an appropriate course aimed at helping him stay safe and in reducing the chances of him reoffending.

9. Too many children and young people did not have an ETE package in place. The data presented to us by the Chair of the YOS Management Board suggested that at any one period 60% to 70% of children and young people had a placement. This was not far from Lambeth's own target of 70%. However, this meant that between 30% and 40% of children and young people supervised by Lambeth YOS did not have an ETE placement. This equated to approximately 90 children and young people and was not satisfactory as constructive activity can help reduce offending behaviour.

10. Referrals and the sharing of information within the YOS where ETE was identified as a concern were not systematically managed. Case managers did not consistently refer all the children and young people to the ETE team where ETE had been identified as a factor linked to their offending behaviour. This meant that not all those who required support were receiving the interventions that they needed to gain and sustain an ETE place. While the ETE team did not have the capacity to intervene in every case, the lack of a clear and transparent referral process that was consistently applied hindered targeting the work of the team to where it could be most effective.

11. If a child or young person met the threshold for a health intervention then a referral was expected to be made to the relevant team. However, there appeared to be a lack of monitoring of this process which meant that the YOS could not be sure that all relevant referrals had been made. YOS information for April and May 2014 showed that 40 cases were eligible for referral to CAMHS and 9 referrals had been made[1]. Therefore the YOS had no picture of the true level of need and whether needs were being assessed and met.

12. We saw good evidence of information sharing with other providers to help ensure that children and young people's health needs were met and that they received the support needed. For example, we saw evidence that the SALT team had engaged with schools to implement strategies to support children and young people with their communication needs. We also found that they ensured information was shared with other SALT providers where a child or young person had moved out of the area. One case manager told us that the SALT team was assertive in holding partner agencies to account to help meet the needs of children and young people.

13. Case managers had received training on restorative justice although its take up within statutory case management had been inconsistent. Victim contact was systematically carried out by one of the YOS police officers and we saw several examples of letters of apology that had been prepared by children and young people. However, it was not clear from case records what direct victim work had been done with children and young people, nor how case managers could reinforce or support this, or how it might impact on reoffending.

**Quotes relating to victim work**

*"We were told at the outset of the process that there would be a restorative justice meeting. We have since heard nothing so we haven't been involved with any activity."* (parent)

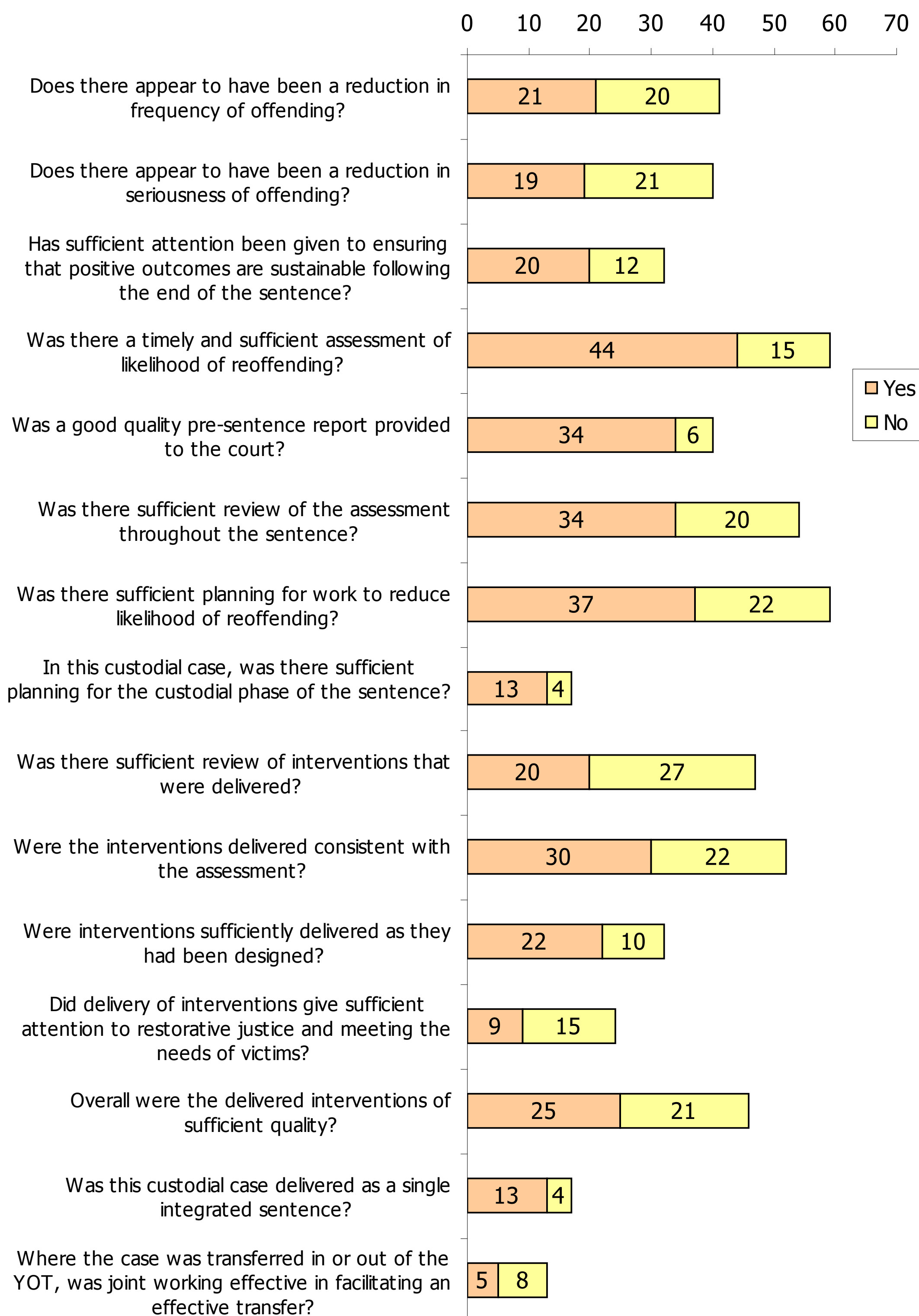
*"Mostly I am so happy because of all the help I have been getting - I have the options with people coming to me - too many options for me at once but thank you so much."* (victim)

*"I did a victim awareness course I found useful. They tried to make it how does the victim feel – that you shouldn't make people feel bad."* (young person)

1 These figures do not take into account whether the child or young person had already received an intervention.

## Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 61 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



# Protecting the Public

# 2

# Theme 2: Protecting the Public

### What we expect to see

Victims, and potential victims, of crime have the right to expect that everything reasonable is done to manage the risk of harm posed by children and young people who have offended. We expect to see good quality assessment and planning with the delivery of appropriate interventions, and positive leadership, effective management and partnership work which reduces the risk of harm to others.

### Case assessment score

Within the case assessment, overall 56% of work to protect the public was done well enough.

### Key Findings

1. PSRs contained an appropriate assessment of the risk of harm.
2. More focused attention needed to be given to victims.
3. Assessments of risk of harm to others did not take account of ALL relevant factors.
4. Reviews of assessments and plans to manage and reduce the risk of harm were insufficient.
5. There was an established culture of intelligence sharing between the police and case managers in the YOS.
6. The risk/vulnerability management panels were not always effective.
7. The work of the Gangs Violence Reduction Unit (GVRU) was not sufficiently understood by some YOS staff.
8. ETE staff had good knowledge of the children and young people with whom they were working and provided appropriate placements.
9. Oversight by managers was not active and consistently effective.
10. The revised quality assurance processes were not yet embedded.

### Explanation of findings

1. There was a thorough assessment and analysis of risk of harm to others in the vast majority of PSRs. This meant that courts were provided with an appropriate level of information regarding the risk the child or young person posed to others.
2. Appropriate attention was given to assessing and addressing the risk of harm to known victims in just under half the relevant cases. Sometimes the victim had not been identified but we found no evidence to suggest that these victims were at direct risk as a result of this lack of attention. Overall, we found that work to keep to a minimum the risk of harm posed to others by the child or young person was done well in almost three-fifths of cases. Better assessment and planning would have significantly improved the response and focus of case managers.
3. The majority of staff reported that they understood local policies for the management of risk of harm work. However, we were disappointed to find that this was not always demonstrated in casework. Just over two-thirds of assessments relating to risk of harm to others had been done well. In a number of cases the quality of screening was limited, insufficient account had been taken of the needs of potential victims, relevant behaviour had been overlooked and the risk of serious harm classification was too low.

4. Thereafter, the quality of plans and reviews deteriorated. Almost half the assessments had not been reviewed as required. These lacked robustness, were often not completed, significant changes did not always trigger a review and some of the reviews were copied from previous assessments. It is important to review assessments and plans as children and young peoples' lives change quickly; missing this could result in steps not being put into place to try to prevent harm being done.

**Quote from a victim**

*"I have no idea as to what is being done or what process is being followed - they have offered for me to meet the offender which I have taken on board and am looking forward to."*

5. Planning for work at the start of the sentence to manage risk of harm to others was not done well in almost half the cases. In a number of high risk cases, the planned response lacked direction and purpose, risk management plans were not completed or not completed on time, the contingency plans were limited and victim issues had not been integrated into the plans. In custodial cases, plans to manage the risk of harm to others were better.
6. There was evidence that a culture of intelligence sharing was established in the YOS and that case managers were asking for, and being provided with, intelligence to inform case management, public protection and the management of risk. Intelligence was also being provided by case managers to the police to inform police action. Some case managers were more proactive than others in requesting and providing intelligence; for some, intelligence requests were being made at key points in the order, for example during reviews, rather than to routinely inform the management of the case. The YOS police officers' role in providing intelligence was also evident elsewhere; for example they researched and provided intelligence to the YOS risk management panel. In one inspected case there was clear evidence to demonstrate that intelligence sharing had made a tangible difference to protecting the public.

**Case illustration**

Jonty had been assessed as being of high risk of reoffending and a high risk of harm to others. Additionally he was a 'child in need'[2] The case manager regularly undertook 'Framework-I' (social care case management system) checks and maintained regular contact with the social worker. As a result of information received from another young person, the case manager liaised with the YOS police officer to request a check on a property and intelligence about Jonty possibly associating with two older men known to adult probation. This led to a timely one-to-one interview with Jonty followed immediately by a home visit (to check for weapons) by police officers. This ensured Jonty's own safety and effectively managed the potential risk of harm to others.

7. There was a weekly risk/vulnerability management panel in place which should have ensured effective oversight to raise the standard of risk of harm work. Its membership was multi-agency and there was a clear strategy in place to identify appropriate cases for the panel. The case manager and practice manager presented the case, accompanied by a series of documents, and members reached agreements to support next steps. The effectiveness of this process needed to be evaluated.
8. Intelligence sharing was not effective in relation to some work with gangs. The lack of intelligence sharing between some gangs workers, the police and case managers undermined effective risk management and case management decisions.
9. The Gangs Violence Reduction Unit (GVRU) appeared to be effective in gathering intelligence from a range of sources to reduce gang related crime. However their role, and the role of the YOS seconded officer in the unit, was not widely understood by YOS staff.

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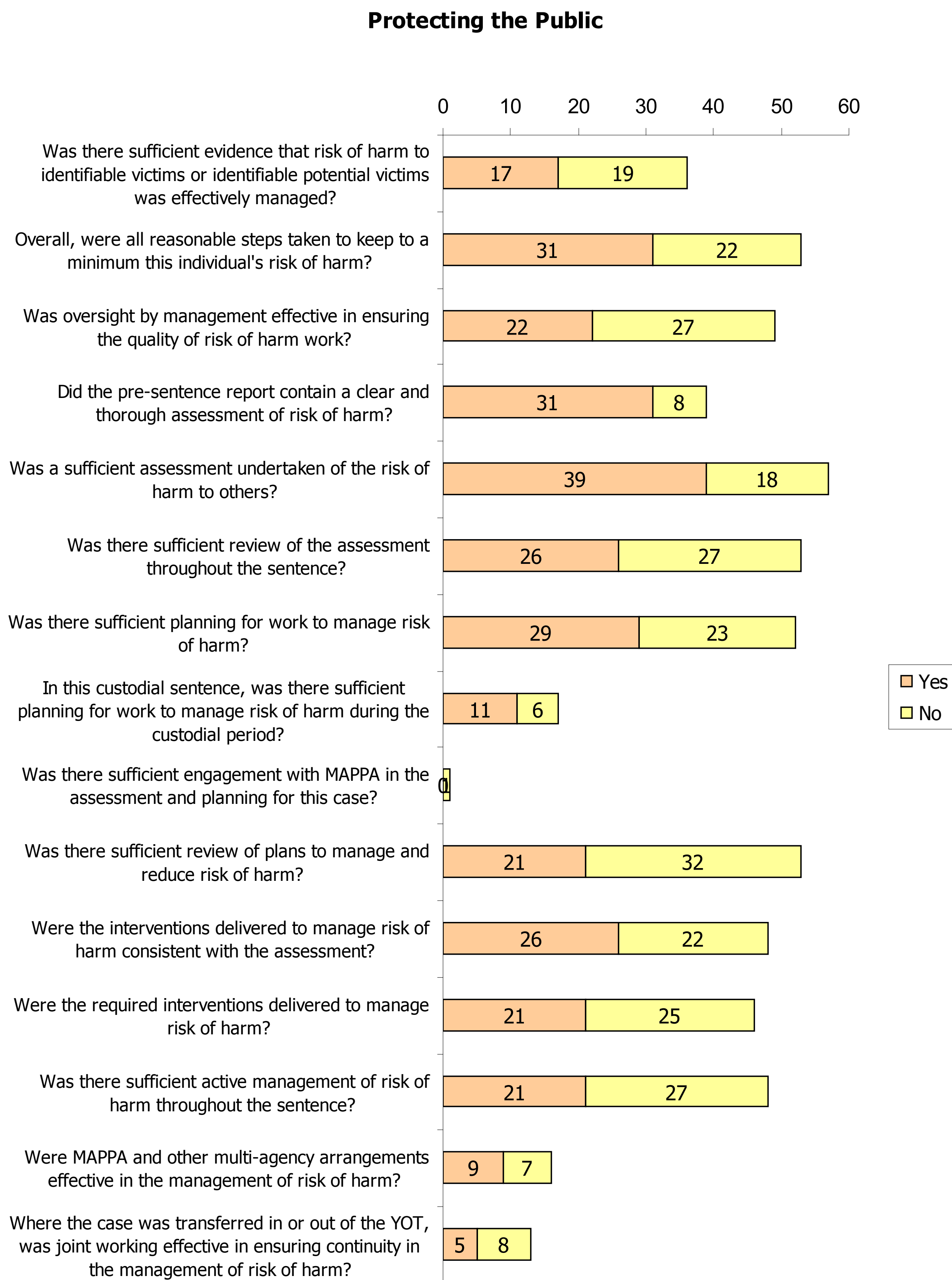
2 Children who are assessed as requiring additional services in order to reach or keep up a reasonable standard of health or development.

10. Information about the arrest and voluntary attendance of children and young people for police interviews, across London, over the past 24 hours was collated by the YOS police officers and uploaded to the shared drive daily. Some case managers were unsure how to access this information and important case management information was being missed.
11. ETE staff knew their individual cases well and the status of the children and young people on their caseload, where they were doing well or where placements had broken down. However, the recording of interventions work was not always complete, making it hard to gauge the progress that was being made. Contacts were not always recorded on the case management system. This meant that live information was not easily accessible to case managers when reviews were taking place.
12. Oversight of risk of harm work by managers was not effective and consistent in just over half the cases. Whilst there was evidence through countersigning to show that managers had seen the work, important deficiencies in assessment or planning had not been addressed as necessary. Several case managers reported that they were being given different advice by different managers. In one example a case manager was concerned that there was a risk of harm to a family member, a known victim, from the young person and she wanted to pay a home visit but was concerned about her safety. One manager advised her to not go on the home visit and another advised her to visit with the YOS police officer.
13. We were pleased to learn that there was a quality assurance framework in the YOS which underlined a commitment to ensuring that the key tasks were examined at appropriate intervals. However, we were concerned that these processes were not clearly understood by all involved and that there may have been duplication. Whilst changes have recently been introduced to tackle these issues, it is too early to comment on their effectiveness.

### Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 61 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



# Protecting the child or young person

# 3

# Theme 3: Protecting the child or young person

**What we expect to see**

Whether the vulnerability of children and young people is due to the consequences of their own behaviour or the behaviour of others, we expect to see that they are kept safe and their vulnerability is reduced. This should be through good quality assessment and planning with the delivery of appropriate interventions, positive leadership and management, and an effective contribution to multi-agency Child Protection arrangements.

**Case assessment score**

Within the case assessment, overall 62% of work to protect children and young people and reduce their vulnerability was done well enough.

**Key Findings**

1. PSRs generally contained clear assessments of safeguarding and vulnerability.
2. Assessments of safeguarding and vulnerability were sufficient in the majority of cases.
3. Planning for work to manage safeguarding and vulnerability was not consistent.
4. Reviews of work to manage safeguarding and vulnerability were not robust.
5. Oversight by managers was effective in half of the cases.
6. Case managers were unclear about children's social care referrals and procedures.
7. Where the case was transferred in or out of the YOS, joint working was not always effective.
8. Health provision to assess and manage vulnerability was largely effective.

**Explanation of findings**

1. The majority of PSRs contained the necessary information to inform the court about the safeguarding and vulnerability needs of the child or young person. This was encouraging and demonstrated the priority that the YOS gave to these matters.

2. We saw good evidence of health teams providing information to courts and preparing reports where requested. They also provided information such as their opinion and advice on the suitability of placements. This helped to address risk of harm and vulnerability issues and ensured the needs of children and young people were met.

3. The timeliness of assessments and the risk of children and young people coming to harm was done well in three-quarters of the cases but the quality of these was often variable. Our main concerns were that the span of vulnerability factors that existed in a case had not been recognised. Information from other agencies had not been properly integrated into the assessments.

4. Planning for work to address safeguarding and vulnerability was inconsistent, with the appropriate actions not being taken in almost two-fifths of cases. We were not satisfied that the tool to develop the integrated action plan was fully understood by all staff. In particular, this related to how safeguarding and vulnerability issues should be best integrated to highlight themes and determine actions.

**Case illustration**

Lottie was a 17 year old female who had been a Looked After Child since she was 14 years old. There were a number of concerns about her vulnerability, although there was little evidence as Lottie was very skilled at keeping information from professionals. Work with her was planned in a way that focused on building a trusting relationship with her YOS worker in the first instance. This started to prepare her for engaging more fully in offending behaviour work and offered more opportunities to explore and promote safeguarding discussions. This approach had produced some progress as Lottie started to disclose information of a more personal nature to her YOS worker.

5. Planning for work to address safeguarding and vulnerability was significantly better during the custodial phase of a sentence. Here, all plans bar one had been completed well. The custodial institution had been informed of all known safeguarding and vulnerability needs at the start of the sentence, case managers contributed to the plan in a meaningful way and information was appropriately drawn from children's social care.

6. Where children and young people were involved with both children's social care and the YOS, plans were not sufficiently integrated to ensure that the specialist skills of each agency were utilised properly. For example, social care plans frequently contained a target for the child or young person to 'work with the YOS'. The YOS did not routinely share their plans with social workers.

7. There were insufficient reviews in two-fifths of cases and these varied considerably in quality. The personal circumstances of children and young people can change very quickly and it is therefore critical that reviews are carried out when these changes come to light. In Lambeth there were several cases where a significant change did not trigger a review.

8. Managers had worked hard to achieve some improvement in the quality of safeguarding and vulnerability work, although this was not yet consistent or sustained across the whole team. We found that management oversight was effective in around half of the cases in the sample. Interventions from managers were not always proactive and there was often a focus on countersigning rather than making decisions to reduce vulnerability and protect children and young people from harm. Deficiencies in assessment and planning were not always addressed and in a small number of cases, managers did not ensure that the required services were delivered.

9. Social care representation at risk management meetings was largely effective in ensuring that high risk cases that met the threshold for social care intervention were properly escalated and services provided. However, the existing protocols between social care and the YOS were not sufficiently robust or understood by case managers. As a result, it was not clear if the safeguarding needs of all children and young people were properly recognised. Case managers were unclear about how to make referrals to the Multi-Agency Safeguarding Hub and the outcomes of these referrals were not properly monitored by case managers and their line managers. Not all case managers understood the local child sexual exploitation multi-agency strategy and at the time of the inspection, the YOS had made only one direct referral to the specialist child sexual exploitation assessment service. Links between the local missing children processes and the YOS were not sufficiently clear. In some cases where the YOS had requested a warrant for the arrest of the child or young person for failure to attend appointments, insufficient consideration had been given about why the child or young person had gone missing and whether any other action needed to be taken to ensure their safety. As a result of the findings of the inspection, the local authority took immediate action to address these issues.

10. We found some evidence of good work between social workers and case managers in trying to engage children and young people and their families through joint home visiting and sharing information. The turnover of staff in both agencies and some misunderstanding between social workers and case managers about their specific roles and responsibilities, led to inconsistent practice in some cases.

11. Where cases were transferred into or out of the YOS, joint working to secure continuity of service delivery was not done well in almost three-fifths of cases. This meant that local protocols for transfer were not met and the required information was often not exchanged appropriately.

12. A CAMHS service was available for 24 hours a day within Lambeth allowing children and young people access outside of office hours when there was a need.

**Case illustration**

A CAMHS worker had been working with Iftikhar, a 14 year old male who had been the victim of a serious assault. As a result of pressing charges, he had received threats to his life. The CAMHS worker was concerned about Iftikhar and the risks posed due to where he was living and the impact of this on his health and well-being. The worker subsequently wrote a letter to the housing department and the family were offered a new property and were due to move imminently thus helping to reduce the young person's vulnerability and having a positive effect on their mental health. During the inspection the CAMHS worker was observed at a risk management panel where inspection staff felt that they had gone "above and beyond" their role to help support this young person's needs.

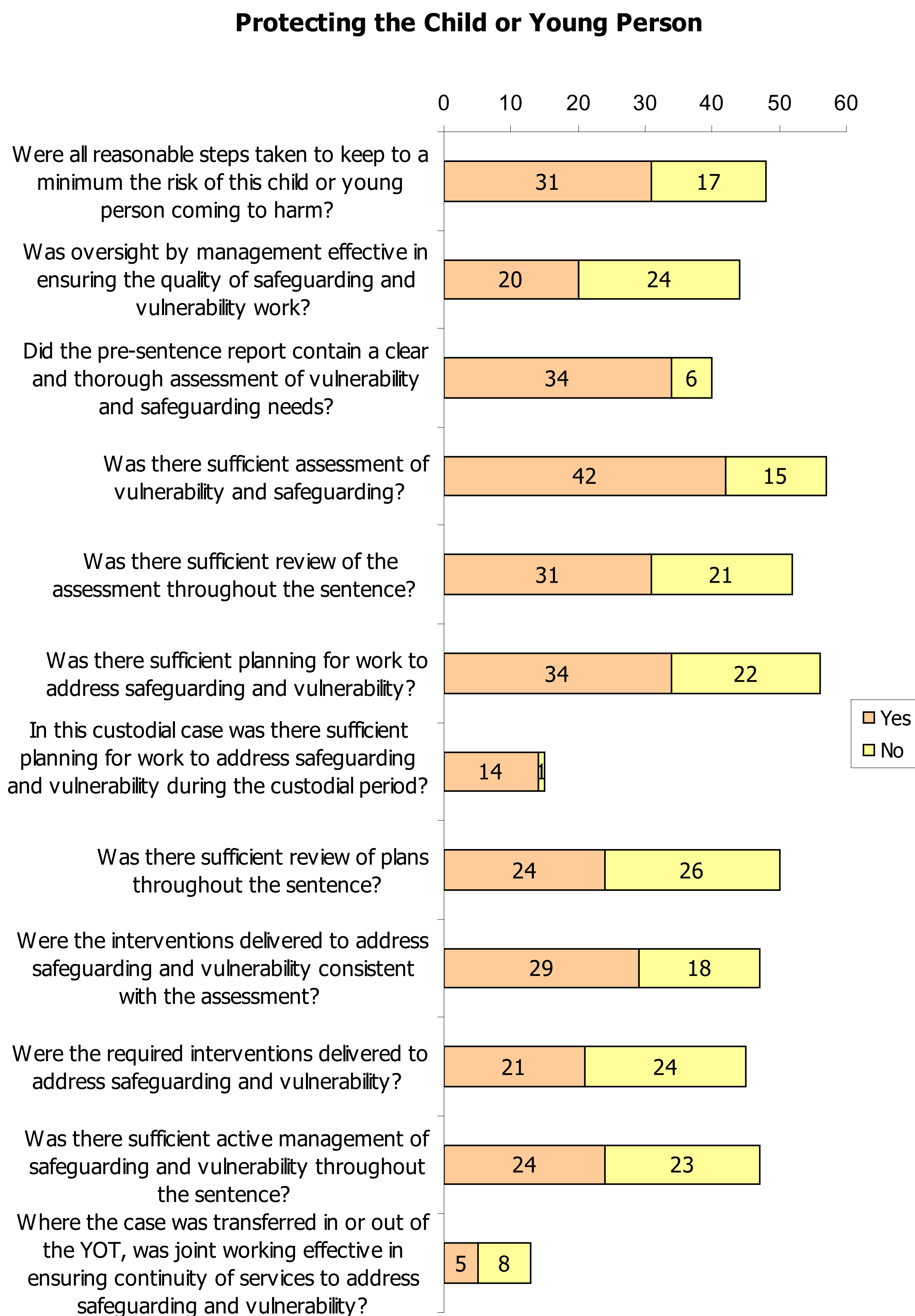
13. There were systems in place to ensure recording and sharing of information between YOS case managers and social work staff. A relevant and up to date information sharing protocol was in place. Health workers had access to their own databases as well as those used by the YOS. As a minimum, they recorded attendance at appointments and a summary of the session. Where appropriate, and with the agreement of the child or young person, they also shared other key information and we saw detailed notes of sessions completed. Health staff also had access to Framework-I, the social care case management system. This helped to ensure they were able to view up to date records and be aware of significant information. CAMHS also had a clear data set about what information they could routinely share with staff to ensure a consistent approach. We also saw evidence of information being sent to the child or young person's general practitioner (GP) about interventions provided as well as including any further recommendations.

14. Although we saw detailed information on the contact entries log on the YOS case management system, not all information about communication needs had been integrated into assessments. This meant that there was the potential for information about a child or young person not to be passed on appropriately.

15. Six YOS based staff were trained in condom distribution. In addition, the GP offered sexual health screening one day a week. However, the GP service was relatively new and was not having a high level of children and young people attending appointments. Therefore, the main referral path to access mainstream services remained. Further attention needed to be given to the sexual health of children and young people to tie-in with the continuing drive to lower teenage pregnancy within the local authority as this was a missed opportunity to work with this group.

## Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 61 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



# Ensuring that the sentence is served

# 4

# Theme 4: Ensuring that the sentence is served

### What we expect to see

Children and young people should serve their sentences as the court intends. We expect that the YOS will maximise the likelihood of successful outcomes by effective engagement with them and their families, responding to relevant diversity factors including paying attention to their health and well-being, and taking appropriate action if they do not comply.

### Case assessment score

Within the case assessment, overall 82% of work to ensure the sentence was served was done well enough.

### Key Findings

1. Children and young people and their parents/carers were actively involved in the development of PSRs, assessments and plans.
2. Case managers were largely able to identify and respond to barriers to engagement and diversity needs.
3. Joint working between the SALT team and case managers was effective.
4. ETE provision for secondary school children was better than for post-16 young people.
5. The initial response to incidents of non-compliance was appropriate in the majority of cases.

### Explanation of findings

1. There was good engagement with children and young people and their parents/carers in the development of PSRs, assessments and plans. This ensured that children and young people were at the heart of contributing to what they considered to be the root causes of their offending and what they had to do to bring about lasting change. There were a small number of cases where parents/carers were not actively engaged but this was primarily due to the child or young person living away from the family home and parents/carers not wanting contact. It was encouraging to see a range of methods being used by case managers to facilitate engagement with children and young people and their parents/carers. This included home visiting, using meaningful language in plans (the words of the child or young person) and regularly asking the child or young person to repeat their understanding of what was expected from them. Also some children and young people were asked to comment on how they would know if things were going well and what might be different.

**Examples of statements used by Izzy (a young person) in an integrated action plan to assess his needs and to say how he would know things were becoming better.**

*Strengths:*

I have always had contact with my parents but my granddad has taken care of me; I used to play football a lot and I am very talented at it; I have a safe place to live with my grandparents; I know that my cannabis smoking is a bad habit and want to think about stopping it.

*Concerns:*

I think my parents could have done more to look after me in the past; different family members have been violent to me; I don't get along with my mother's current partner and I blame him for my cannabis use; my granddad says that if I do not stop smoking then I will be thrown out of home as he cannot cope.

*Examples:*

My attendance level (at school) increases; I know I am spending less money on cannabis; I feel more remorseful about my actions; I get fitter and healthier.

2. Case managers were able to identify and respond appropriately to diversity needs as well as barriers to positive engagement in the majority of cases. In one specific example an inspector reported on the creative way in which the specific needs of a young woman had been met. There was also good evidence of where the SALT team had developed tools to facilitate better engagement with children and young people.

**Case illustration**

Serena, an 18 year old woman had been working with YOS staff for just under a year to address her offending behaviour. She found it difficult to talk about and understand her behaviour and how she reacted in different situations. The case manager took this on board and used a specific approach (Cognitive Behavioural Therapy) to help Serena understand the consequences of her actions. Over a number of sessions, the case manager used a box of animal figures and asked Serena to choose animals that were like her. Initially she chose animals that were strong and powerful (Lion/tiger/dinosaur) - then she chose a cat. The case manager encouraged Serena to talk about how the cat was like her and Serena talked about the cat being sly and mean. This lead to the first meaningful discussion about Serena and her bullying and intimidation of others that had been critical to her offending. The case manager was able to use the animals in other discussions when she was discussing behaviour.

**Development of tools**

The SALT team had developed a more visual version of the 'What do YOU think?' form which captured the views of a child or young person. They had also developed vocabulary sheets for children and young people around the key phrases used in the criminal justice system to help them understand and therefore increase their engagement.

3. The provision for secondary school age children and young people in Lambeth was generally of good quality, but the quality of provision for those aged over 16 years old was less good. Given the high proportion of 17 year olds supervised by the YOS, securing suitable placements for them remained a challenge.
4. The Pupil Referral Unit at Park Campus Academy provided good quality education for children and young people and the YOS had developed effective working relationships. The outcomes that children and young people achieved at the Pupil Referral Unit were good and improving with an increasing proportion of children and young people gaining five GCSEs including English and mathematics. Its own data showed that in the core subjects of English, mathematics, science and information and communications technology most children and young people supervised by the YOS who attended the academy made the expected progress for their age. The ETE team responded well when placements broke down through, for example, the use of commissioned providers in neighbouring authorities. They tailored individual education packages based around the specific circumstances and needs of children and young people well. In addition, there were incidents when case managers also took proactive action themselves in order to engage the child or young person with education.

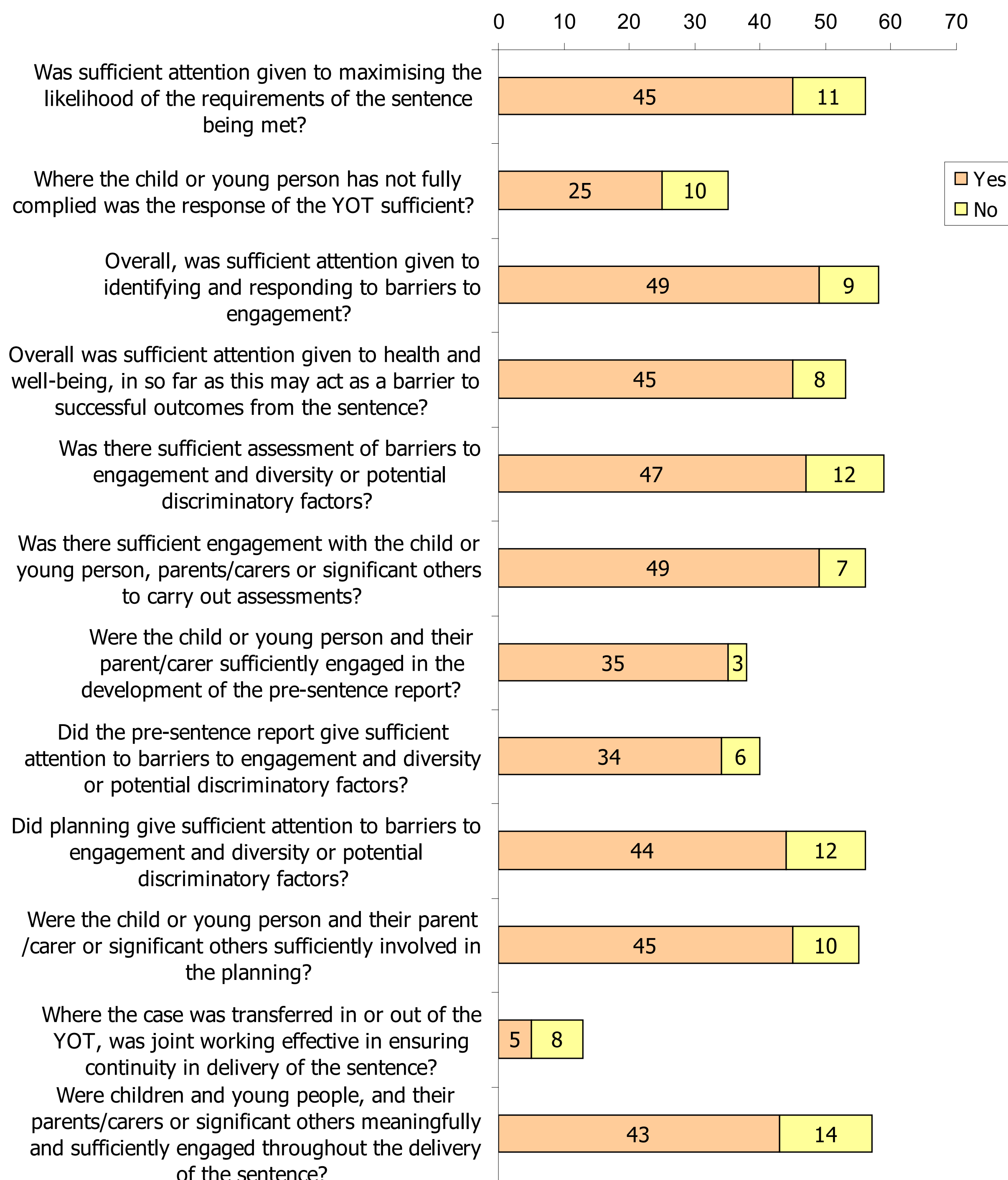
**Case illustration**

Logan, a 15 year old male had not been attending school. When he did attend he only stayed for 15 minutes at a time three times a week. Through monitoring and liaison with the school, the case manager arranged a meeting with Logan, the YOS ETE worker, the Education Welfare Officer, an attendance monitoring officer at the school, and the school's head of year. Actions were agreed to re-engage Logan with his attendance. The school committed itself to paying regular home visits and the Education Welfare Officer, agreed to meet the family. All the staff worked well together resulting in an improvement in Logan's attendance.

5. Inspectors found a couple of occasions where children and young people had been excluded from school when committing offences out of school wearing their school uniform. This unnecessarily interrupted their education.
6. At the time of the inspection the YOS had two dedicated speech and language therapists who were providing a good service to children and young people. A speech and language screening tool, including an assessment of basic cognition, had been developed for case managers. Unfortunately, this was not being routinely used on all children and young people, meaning that some children and young people's needs may not have been identified. If concerns were identified using this screening tool then the SALT team carried out a full assessment and detailed reports were produced. These included what tests had been carried out, the results and meaning of these as well as what support the child or young person needed. They also included guidance for when children and young people were in court and how they could be helped to understand the process. It was positive to see that a report specifically for the child or young person was produced highlighting their strengths, what they found 'tricky' and how staff could help them.
7. We were pleased to find that almost every case manager interviewed understood the local policies and procedures for responding to non-compliance. This was evidenced in enforcement decisions being taken appropriately in the majority of incidents when this was necessary. There were a small number of cases where unacceptable behaviour had not been addressed and the decision to breach had been too slow. There appeared to be confusion between some staff about whether health appointments could be classed as statutory attendances. In our view they can be if they form part of an intervention plan to reduce reoffending. This confusion may have led to inconsistent approaches for non-engagement of these appointments and had an impact on breach proceedings.

### Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 61 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



# Governance and partnerships

# 5

# Theme 5: Governance and Partnerships

**What we expect to see**

Effective governance, partnership and management arrangements are in place. These enable the YOS to meet national and local criminal justice and related objectives, and to deliver and maintain good quality services.

**Key Findings**

1. The YOS did not have a stable workforce.
2. There was an over-reliance on temporary agency staff across operational management and practitioner levels. This had led to inconsistency of practice, management oversight and had undermined the embedding of policies and procedures.
3. There was a constant turnover of staff and the YOS had not been able to adequately train new staff. When these staff moved on, the YOS not only lost the worker but also the organisational capital invested in them.
4. The YOS Management Board received regular performance information against the youth justice national indicators and also monitored some local targets.
5. There had been a recent improvement in the headline reoffending figures and a narrowing of the gap between Lambeth and the other London authorities' performance. There was scope for greater interrogation of data and challenge in order to look beneath these headline figures.
6. Whilst the YOS had a comprehensive range of policies and procedures in place, including those for quality assurance, safeguarding and management of risk, these were not consistently applied in practice. The Board did not have a collective understanding of these systemic weaknesses and improvement was not being driven at a strategic level.
7. Attendance and representation of some partners at Board meetings was inconsistent.
8. Whilst there had been considerable structural and organisational change affecting many partners, the recent re-alignment of roles and responsibilities within the local authority presented an excellent opportunity to improve joint working across service areas.
9. The YOS was well represented on a number of multi-agency boards.
10. Multi-Agency Public Protection Arrangements (MAPPA) were working well.
11. The YOS was represented on the Local Safeguarding Children Board (LSCB) and had a standing agenda item about the performance of the YOS.
12. Although at a very early stage, there had been discussions about how the views of YOS service users could best be represented at YOS Management Board meetings.

**Explanation of findings**

1. **Leadership and Governance – offending is reduced and other criminal justice and related objectives are met**

1.1. It was acknowledged that this inspection had taken place against the backdrop of a sustained period of change and significant reorganisation.

1.2. Organisational changes and realignment of roles and responsibilities may have impacted on some partners' capacity to engage and participate in the YOS Management Board as fully as required. Consequently, there had been issues of attendance, consistency of representation and seniority

of attendees at board meetings. The lack of appropriate participation had impacted on the overall effectiveness of the YOS Management Board as a whole.

1.3. Representation by children's social care had been inconsistent and the absence of a regular senior probation presence had recently become more evident. Police representation had changed on a number of occasions but the quality of hand-over and understanding of the YOS Management Board function had been good.

1.4. Public health and CAMHS were represented on the YOS Management Board at the correct level. There was no representation from the Clinical Commissioning Group.

1.5. In the case of children's social care, there did not appear to be strong evidence that issues of concern around safeguarding and the YOS/social care interface highlighted elsewhere in this report, had been properly or fully addressed at board level.

1.6. The monitoring of offending by children and young people who were 'Looked After' by the local authority was not sufficiently robust. Although the levels of offending by Looked After Children was low in 2013, data provided by the authority during the inspection showed that there had been a significant increase in the first nine months of 2014. This had not been recognised by the local authority or the YOS Management Board. Within the sample, we saw cases of children and young people who had been convicted of minor offences within residential placements, without intervention from agencies to consider alternatives to a criminal justice sentence.

1.7. Specific attention had not been given at a strategic level to fully understand and prepare for the impact of the Transforming Rehabilitation agenda on the YOS. By way of a specific example, the YOS caseload now had an increased age profile with proportionately higher numbers of 17 year olds making up the cohort. This group also tended to include those presenting higher risk of harm and with more complex needs. The Board had not fully debated the implications of such changes, (for example transfer protocols) or considered if they were fit for purpose or in need of review/revision under the new arrangements.

1.8. Performance information against the national indicators for youth justice was regularly presented to the Board and it was encouraging to see that there had been a recent improvement in the reoffending figure. This had resulted in a closing of the gap between Lambeth and the average for other London authorities.

1.9. The Board had appropriately enhanced its local reoffending performance measure to provide more up to date, tracked information to complement the national data set. Additionally, there were plans in place to utilise the Youth Justice Board's (YJB) reoffending toolkit in order to further support improved analysis of local reoffending figures.

1.10. We were pleased to see that the Board had taken the decision to continue to monitor the ETE measure and had adopted a local target of ensuring that in 70% of cases children and young people had a specific ETE provision.

1.11. Greater use needed to be made of the information which was available. In particular, there was a need to go beyond headline performance and take into account more qualitative sources to provide a consistent narrative account to accompany core data. Deeper interrogation and analysis of performance information seemed to be lacking and was not sufficiently forensic or analytical.

1.12. We found that the YOS was appropriately represented on other key forums. Linkages to, and participation in, MAPPA was found to be good, and the YOS was reasonably well represented at the LSCB.

1.13. It was pleasing to see that the YOS had a standing item on LSCB agendas. The Head of YOS was a full member of the LSCB. The LSCB monitored the progress of the YOS through regular reporting but evidence of challenge of the YOS Management Board's work was not apparent. It was not clear how the work of the YOS Management Board was disseminated to front-line workers through, for example, the dissemination of learning from Serious Case Reviews.

1.14. We were delighted to hear about the plans to have the voice of young people heard at board meetings.

## 2. Partnerships – effective partnerships make a positive difference

2.1. There had been a time of significant resource reduction across the local authority but a commitment had been made by partners to preserve the resources dedicated to the YOS.

2.2. There was strong partnership working between the different areas of health within the YOS. As a result of a Health and Well-being Needs Assessment, a sub-group had been developed to establish further services to fill the gaps identified.

2.3. Partners had ensured that the YOS had access to a comprehensive range of specialist staff and provision. Access to health provision was particularly good and encompassed the Speech and Language Therapy (SALT) Team, GP sessions held at the YOS, and CAMHS. A Multi-Systemic Therapy service providing intensive, family-based interventions had also recently been established in the authority and was accessible to the YOS. However, there was a lack of substance misuse provision.

2.4. A dedicated probation officer was seconded to the YOS. Their caseload mainly comprised of young people aged 17 years or over who were likely to be transferred to probation. The probation officer also led on overseeing transfers.

2.5. The local authority seconded only one social worker to the YOS who had access to relevant training to ensure their professional development but did not benefit from having direct links to the department. We saw a training audit carried out in June 2014 for the Local Safeguarding Children Board which showed that all permanent members of staff had completed Level 2 safeguarding training between September and November 2013. Given the turnover in staff it is essential that there is no slippage in providing an appropriate level of safeguarding training. The YOS would benefit from more qualified and seconded social workers with active links back into social care.

2.6. The YOS provided, and had access to, a comprehensive range of intervention programmes, some delivered by the voluntary and community sector. Where this was the case, it was normal practice for a YOS worker to co-facilitate sessions.

2.7. There were dedicated services for girls and young women provided through the Beth Centre and Gaia Centre.

2.8. Lambeth had higher than average violent and weapons-related offending by children and young people. Much of this was associated with gang activity. The YOS had a dedicated gangs work coordinator who worked closely with children and young people who were identified as being at risk of becoming involved with gangs.

2.9. At the time of inspection, the YOS had four seconded police staff led by a police sergeant. We found that the officers played an important role in promoting information and intelligence sharing, especially around gang activity and membership, as well as disseminating information about overnight arrests of children and young people.

2.10. We were concerned to find that some staff were unclear about key safeguarding practice and procedures. A particular issue emerged around the protocol for referring children and young people at risk of child sexual exploitation to the Multi-Agency Safeguarding Hub. We found that specific procedures set down in the protocol were not being consistently followed and that some staff did not have some basic information, such as the relevant e-mail address, for making referrals.

## 3. Workforce management - effective workforce management supports quality service delivery

3.1. Workforce management had not been addressed as a matter of priority despite ongoing problems. This was absolutely the most critical area in which strong governance and leadership was required.

3.2. The full staffing capacity for Lambeth YOS should have been, we were advised, 84. At the time of our inspection the team comprised of 52 permanent staff, 15 agency workers and the service was carrying 17 vacancies. Recruitment had been restricted. Hence almost a fifth of staff were temporary locums and another fifth of posts were vacant.

3.3. Of the seven operational practice manager posts, one was vacant, one was held by a permanent member of staff whilst the remaining five were filled by agency staff.

3.4. Whilst we recognise that this is an issue across several London boroughs, we have not seen the problem to this extent elsewhere. Concerns about the turnover of staff were expressed at strategic and operational management levels, by practitioners, and across partner agencies. Our inspection of cases illustrated how this had impacted on service delivery, management, partnership working, training and development, as well as staff morale. It was an issue which resonated throughout the YOS.

3.5. Constant changes in staffing at managerial and practitioner level had inhibited consistency of practice, quality of management oversight, support, the embedding of positive practice, establishment and maintenance of effective working relationships and networks. This resulted in a repeated loss of organisational capital, for example: - staff had been recruited, training invested, working relationships developed, new practice and procedures introduced. Yet time and time again, this investment was repeatedly lost, and had to be renewed, leaving the service in a position of constantly trying to back-fill posts, re-deliver training, and plugging the knowledge/experience gaps created, all whilst striving to maintain delivery.

3.6. There was no workforce strategy in place although we were advised that work had begun to produce one. This was a major failing of the YOS Management Board.

## 4. Learning organisation - learning and improvement leads to positive outcomes

4.1. We were pleased to note from our discussions with members of the YOS Management Board, YOS manager, operational managers, and practitioners that there was an open recognition that the service needed to improve. We witnessed a commitment to raise standards and a realistic understanding about which areas, (specifically workforce development and systems/procedures) needed to be prioritised.

4.2. We noted that the YOS had begun to set aside time with managers and operational staff to develop greater reflection in practice.

4.3. We saw a real pride and commitment to achieving positive outcomes for children and young people in Lambeth.

4.4. We found evidence to show that the SALT team, the Assessment, Intervention and Moving on project practitioner[3] and CAMHS had monitored outcomes of interventions for children and young people. This information was not systematically passed to the Board nor brought to the Board by the relevant representative. Key information about the health needs of children and young people and interventions delivered was not being used to help inform future services. We were advised that this information would be discussed at other integrated commissioning groups which included people who sat on the YOS Management Board. However, this was not specific to the health provision at the YOS. Information updates given to the Board did not regularly include health information.

4.5. We saw some examples of good practice from which other areas could learn, especially in health provisions. The YOS had some very skilled and committed staff and managers who, with the right corporate strategic leadership and supporting plans and actions, had the potential to develop into an exceptional service.

4.6. Health staff felt supported and received supervision from the YOS as well as clinical supervision from their respective agency where appropriate. Regular meetings also occurred between SALT workers, their manager and the YOS manager with responsibility for the health staff, but left a gap as it did not take place for the CAMHS team.

4.7. Health staff were able to access mainstream training at the YOS as well as from their respective agency which helped to ensure that they were kept up to date with developing practice. We saw that health staff had carried out presentations and delivered training to YOS staff as well as other criminal justice agencies.

3 A qualified practitioner who carries out an initial assessment and intervention for children who display sexually harmful behaviour.

# Interventions to reduce reoffending

# 6

# Theme 6: Interventions to reduce reoffending

### What we expect to see

This module focuses specifically on interventions intended to reduce the likelihood of reoffending. We expect to see a broad range of quality interventions delivered well, coupled with appropriate assessments and plans which maximise the likelihood of sustainable outcomes being achieved. Effective leadership and partnership work needs to be evident in the delivery of interventions.

### Case assessment score

Within the case assessment, overall 63% of work relating to interventions to reduce reoffending was done well enough.

### Key Findings

1. There was a range of interventions available to children and young people which had expanded over time.
2. There were some strengths in the way that interventions were delivered.
3. YOS intervention practitioners and managers understood effective group work methodology.
4. Assessments of suitability for appropriate interventions and referrals were inconsistent.
5. Planned interventions were not systematically delivered.
6. Reviews and the monitoring of the impact of interventions were limited.
7. There was no substance misuse intervention currently in place.
8. Materials and other resources used in the interventions were good.

### Explanation of findings

1. The YOS had a range of interventions available to reduce reoffending coupled with an interventions strategy and had developed some encouraging partnerships to deliver these. YOS group work practitioners supported the sessions and were a direct communication link with case managers. This provided case managers with ongoing reporting on progress. The jointly delivered Pandora's Box Programme provided good evidence of this strength.

### Case illustration from observation

The Pandora's Box Programme, an intervention aimed at self-development for girls, provided evidence of the positive contribution of the YOS group worker in supporting children and young people to fully access the group. This was the second group meeting and the first had been challenging with two of the girls entering into a conflict. In this second session the girls needed support from someone who knew them in order to appropriately engage with the materials and understand the process of the group. The YOS group worker provided this and then communicated the outcome of the session to the two relevant case managers.

2. We were impressed with not only the dedication of interventions staff but their skill in delivering difficult sessions. They understood the principles of effective group work and maximised involvement of the children and young people. Engagement was promoted before, during and after the intervention for

both parents/carers and children and young people. Support was offered from the referral stage, with one-to-one meetings to assess motivation and readiness to join groups. When a child or young person was not able to access a group, we saw evidence of interventions being offered and delivered on a one-to-one basis. We were pleased to see how well the Speech and Language Therapy team had worked with the interventions team to adapt approaches where necessary. This was particularly good in the specific interventions designed for work with young women.

3. Children and young people who were not initially ready to join groups had appropriately been coached over a period of time before they accessed a group. Staff were able to develop positive relationships with them and were clear about what was expected whilst they were participating in a group.
4. We saw evidence of a process in place to ensure that children and young people were screened for appropriate matches in interventions. This was initially done through the database for practitioners which directly matched interventions with assessments. The screening was then followed up in group work through the referral process. However, case managers did not consistently assess the suitability of an intervention with the child or young person. In just over one-third of the inspected cases the assessment was insufficient. Furthermore, when an assessment was carried out a timely referral was not made. There was a considerable distance to be travelled to improve this area.
5. There were significant gaps in interventions not being delivered. We found that almost half of the planned interventions had not been delivered.
6. There was both a Speech and Language Therapy (SALT) team and a Child and Adolescent Mental Health Team (CAMHS) based at the YOS. The latter included a consultant psychiatrist for one day a week and a practitioner who ran the programme for Lambeth Borough children who had committed sexually harmful behaviour. Staff were dedicated and strived to improve the health outcomes for children and young people. They used a variety of methods and were flexible in their approaches to engage children and young people. Positive comments were received from case managers about health staff. These included: "excellent" and "SALT and CAMHS do a brilliant job".
7. Managers in the interventions team were clear about the pathways to accessing interventions and had pulled together a range of internal and external options for children and young people. Expectations on external providers were clear and robust in respect of information relayed back to the YOS. There was ongoing development to source a greater range of interventions and priority areas had been identified in robbery, theft from shops and offence specific work. The interventions team had produced a menu of options.
8. The review and monitoring of the impact of interventions was underdeveloped. Whilst managers had begun to consider a quality assurance framework, the absence of analysis made it difficult to make judgements about the positive outcomes for children and young people being achieved.
9. There were no current substance misuse interventions in place. Whilst some contingencies had been put in place following the departure of a team member overseeing this work, we did not consider that these were adequate. The response of the YOS was too slow.
10. The materials and resources included in the content of the interventions we saw were good and the impact on one young person was clear.
11. Children and young people of statutory school age were well supported to maintain their education.

**Quote from Tamara, a young person being supervised by Lambeth YOS**

*"I feel like I shouldn't reoffend in the future because I have learnt that this deteriorates your chances of getting a job and you're looked at a certain way in society".*

# Appendices

Appendices

# Appendix 1 - Background to the inspection

### Inspection arrangements

The Full Joint Inspection (FJI) programme inspects youth offending work, predominantly in statutory community and custodial cases, in a small number of local authority areas each year.

The majority of the Youth Offending Teams selected for these inspections are those whose performance – based on reoffending rates, National Youth Justice Outcome Indicators and supported by other information, such as recent inspections – is of significant concern. Periodically, we also include high performing areas to establish a benchmark of good practice.

The primary purpose of the Youth Justice System is to reduce offending. This is the main theme of the inspection. The other core themes are protecting the public, protecting the child or young person, ensuring the sentence is served and governance and partnerships.

### Criteria

A copy of the inspection criteria is available on the HMI Probation website:

http://www.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/

### Methodology

YOTs are informed approximately 11 working days prior to the inspection taking place.

Fieldwork for this inspection was undertaken on the weeks commencing:

15 September 2014 and 29 September 2014

In the first fieldwork week we looked at a representative sample of 61 individual cases up to 12 months old, some current, others terminated. The sample included a number of those who are a high risk of harm to others, are particularly vulnerable, are young women, or are black and minority ethnic children and young people. Cases were assessed by a team of inspection staff. They examined these wherever possible with case managers, who were invited to discuss their work in depth, explain their thinking and identify supporting evidence in the record.

We also received copies of relevant local documents.

During the week in between, the data from the case inspections was collated and a picture about the quality of the work of the YOS developed.

The second fieldwork week is the joint element of the inspection. HMI Probation was joined by colleague inspectors from police, health, social care and education. We explored the lines of enquiry which emerged from the case inspections. The leadership, management and partnership elements of the inspection were assessed, with a particular focus on reducing offending.

We also gathered the views of others, including strategic managers, staff and service users – children and young people, parents/carers and victims, and observed work taking place.

At the end of the second fieldwork week we presented our findings to local strategic managers, the YOS Management Team, YOS staff and other interested parties.

### Scoring Approach

Details of how our inspection judgements are made can be found on our website.

http://www.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/

### Publication arrangements

A draft report is sent to the YOS for comment three weeks after the inspection, with publication approximately six weeks later. In addition, a copy goes to the relevant Ministers, other inspectorates, the Ministry of Justice Policy Group and the YJB. Copies are made available to the press and placed on our website.

FJI reports in Wales are published in both Welsh and English.

Further details about how these inspections are conducted can be found on our website in the document *'Framework for FJI Inspection Programme'* at:

http://www.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/

### Role of HMI Probation and Code of Practice

Information on the role of HMI Probation and our Code of Practice can be found on our website:

www.justiceinspectorates.gov.uk/hmiprobation

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

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# Appendix 2

## Acknowledgements


| | |
|---|---|
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ISBN: 978-1-84099-680-7