Inspection of Youth Offending
Archwilio Rhaglen Troseddwyr Ifanc

Criminal Justice Joint Inspection
Arolygiad ar y Cyd Cyfiawnder Troseddol

Core Case Inspection of youth offending work in England and Wales

Report on youth offending work in:

Leeds

ISBN: 978-1-84099-373-8

2011

Foreword

This Core Case Inspection of youth offending work in Leeds took place as part of the Inspection of Youth Offending programme. We have examined a representative sample of youth offending cases from the area, and have judged how often the Public Protection and the Safeguarding aspects of the work were done to a sufficiently high level of quality.

We judged that the Safeguarding aspects of the work were done well enough 84% of the time. With the Public Protection aspects, work to keep to a minimum each individual's *Risk of Harm to others* was done well enough 76% of the time, and the work to make each individual less likely to reoffend was done well enough 83% of the time. A more detailed analysis of our findings is provided in the main body of this report, and summarised in a table in Appendix 1. These figures can be viewed in the context of our findings from Wales and the regions of England inspected so far – see the Table below.

Overall, we consider this a very creditable set of findings. We were impressed with the range of interventions provided by the YOS and by the way that it worked with partners to develop and provide a broad range of services to respond to the complex and varied needs of children and young people living in a large city.

Andrew Bridges
HM Chief Inspector of Probation

January 2011

	Scores from Wales and the English regions that have been inspected to date			***Scores for Leeds***
	Lowest	**Highest**	**Average**	
'Safeguarding' work *(action to protect the young person)*	*38%*	*91%*	*67%*	***84%***
***'Risk of Harm to others'* work** *(action to protect the public)*	*36%*	*85%*	*62%*	***76%***
'Likelihood of Reoffending' work *(individual less likely to reoffend)*	*50%*	*87%*	*69%*	***83%***

Acknowledgements

We would like to thank all the staff from the YOS, members of the Partnership Board and partner organisations for their assistance in ensuring the smooth running of this inspection.

Lead Inspector	*Ian Menary*
Inspectors	*Mark Boother; Yvonne McGuckian; Anne Proctor; John Llewellyn Thomas*
Practice Assessor	*Hannah Doughty*
CCI Assessors	*Marie Anne Hall; Greg Maguire*
Support Staff	*Zoe Bailey*
Publications Team	*Alex Pentecost; Christopher Reeves*
Editor	*Alan MacDonald*

Contents

Scoring – and Summary Table

This report provides percentage scores for each of the 'practice criteria' essentially indicating how often each aspect of work met the level of quality we were looking for. In these inspections we focus principally on the Public Protection and Safeguarding aspects of the work in each case sample. Accordingly, we are able to provide a score that represents how often the *Public Protection* and *Safeguarding* aspects of the cases we assessed met the level of quality we were looking for, which we summarise here. We also provide a headline 'Comment' by each score, to indicate whether we consider that this aspect of work now requires either **MINIMUM, MODERATE, SUBSTANTIAL** or **DRASTIC** improvement in the immediate future.

***Safeguarding* score:**	
This score indicates the percentage of *Safeguarding* work that we judged to have met a sufficiently high level of quality. This score is significant in helping us to decide whether an early further inspection is needed.	
Score:	***Comment:***
84%	***MINIMUM improvement required***

Public Protection – Risk of Harm score:	
This score indicates the percentage of Risk of Harm work that we judged to have met a sufficiently high level of quality. This score is significant in helping us to decide whether an early further inspection is needed.	
Score:	***Comment:***
76%	***MINIMUM improvement required***

Public Protection - Likelihood of Reoffending score:	
This score indicates the percentage of Likelihood of Reoffending work that we judged to have met a sufficiently high level of quality.	
Score:	***Comment:***
83%	***MINIMUM improvement required***

We advise readers of reports not to attempt close comparisons of scores between individual areas. Such comparisons are not necessarily valid as the sizes of samples vary slightly, as does the profile of cases included in each area's sample. We believe the scoring is best seen as a headline summary of what we have found in an individual area, and providing a focus for future improvement work within that area. Overall our inspection findings provide the 'best available' means of measuring, for example, how often each individual's *Risk of Harm to others* is being kept to a minimum. It is never possible to eliminate completely Risk of Harm to the public, and a catastrophic event can happen anywhere at any time – nevertheless a 'high' *RoH* score in one inspected location indicates that it is less likely to happen there than in a location where there has been a 'low' *RoH* inspection score. In particular, a high *RoH* score indicates that usually practitioners are 'doing all they reasonably can' to minimise such risks to the public, in our judgement, even though there can never be a guarantee of success in every single case.

Recommendations (primary responsibility is indicated in brackets)

Changes are necessary to ensure that, in a higher proportion of cases:

(1) a timely and good quality assessment and plan, using Asset and informed by an appropriate self assessment, is completed when the case starts and then reviewed as required. The plan should clearly sequence the delivery of interventions (YOS Head of Service)

(2) specifically, a timely and good quality assessment of the individual's vulnerability and *Risk of Harm to others* is completed at the start, which takes full account of the safety of victims, as appropriate to the specific case (YOS Head of Service)

(3) as a consequence of the assessment, a good quality plan is completed, when the case starts, to safeguard the child or young person from harm and to minimise any identified *Risk of Harm to others* (YOS Head of Service)

(4) quality assurance by management, especially of screening decisions and those cases with a raised vulnerability or *Risk of Harm to others,* is effective and clearly recorded on the case record (YOS Head of Service).

Furthermore:

(5) the performance of the YOIS case management system should support effective case management (YOS Partnership Board).

Next steps

An improvement plan addressing the recommendations should be submitted to HM Inspectorate of Probation four weeks after the publication of this inspection report. Once finalised, the plan will be forwarded to the Youth Justice Board to monitor its implementation.

Service users' perspective

Children and young people

One hundred and fifty-four children and young people completed a questionnaire for the inspection.

- Almost all children and young people understood why they had to come to the YOS, and what would happen whilst they were there.
- All except two had discussed their referral order contract or supervision plan with their YOS worker. However only two-thirds remembered having been given a copy to keep. Three-quarters of those who had attended the YOS for long enough said that their plan had been reviewed with them.
- When asked whether the YOS had taken action to deal with the things that they needed help with, almost all said that they had.
- The overwhelming majority said that the YOS made it easy to understand the work that was being done with them. A significant proportion said that YOS workers explained things clearly, and repeated explanations if necessary. Others mentioned the use of language that they understood, having things read to them where appropriate, using a range of different methods and staff being willing to answer questions.
- Some children and young people identified things that made it harder for them to take a full part in their sessions with YOS workers. Almost all then said that the YOS had taken action to help them take part. One had difficulty getting to the YOS office because the bus route passed through an ASBO restriction area, so the YOS worker undertook more home visits and arranged appointments at other locations. Another wrote that he had received help with reading and writing.
- Nineteen children and young people said that there were things in their life that made them feel afraid. Three-quarters of these said that the YOS had helped them deal with these issues.
- Over two-thirds of children and young people recognised that they had received help to better understand their offending or make better decisions. Help with drugs use, alcohol use, emotional or mental health, lifestyle, family relationships and housing were all acknowledged by a significant proportion of children and young people.
- Of those who had a problem with school, college or getting a job, over two-thirds said that this had improved. One wrote "*I wasn't in school...but my YOT worker has helped me sort my life out and get back to a full weekly timetable for my school".*
- When asked whether their health had improved over half of those who had a problem said that it had improved. Some said that their fitness had improved through going to the gym or engaging in other activities, and many said that their use of drugs or alcohol had reduced.

- Almost three-quarters said that something had got better in their life as a result of their work with the YOS. A broad range of areas of improvement were identified; in particular a significant proportion said that they had stopped offending and many said that their family relationships had improved. One wrote "*I have a better relationship with my family because I spend more time with them now, instead of just with my friends"* and another wrote "*I now know how upset my mum will be if I offend".*
- The great majority of children and young people said that they were less likely to offend as a result of their work with the YOS. A significant proportion said that one reason for this was because they understood the impact of their offending on themselves and others. One wrote "*I now know the consequences. Attending the brain injury unit made me think about what I did".*

Victims

Twenty-two questionnaires were completed by victims of offending by children and young people.

- Victims were satisfied that their individual needs had been taken into account in all except one case.
- All except one victim had the opportunity to talk about any worries that they had concerning the offence or the offender. One wrote "*[The victim worker] really changed my view on the offence. [S/he] was helpful and knowledgeable and gave good tips on coping with the offence".*
- Only just over one-quarter of victims had directly benefited from work done by the child or young person who had committed the offence.
- Of those victims who had a concern about their safety, all except one said that the YOS had paid attention to this.
- The overwhelming majority of victims were mainly or completely satisfied with the service that they had received from the YOS. One wrote "*...I have got over the crime much quicker because of [the victim worker]"*; however another commented on the importance of being sensitive to the victim's feelings when explaining the child or young person's views.

Sharing good practice

Below are some examples of good practice we found in the YOS.

Assessment and Sentence Planning **General Criterion: 1.3c**	**Safeguarding a mother and baby** Jade gave birth shortly after a sentence for violence. Therefore the referral order panel was delayed. The case manager liaised actively with the health visitor and midwife, and undertook work on the effect that violence can have on a baby. Jade responded to the order. Mother and baby were safeguarded.
Assessment and Sentence Planning **General Criterion: 1.2h**	**Looked After Child wrote own plan** Jordan was looked after and felt that she had lost control over decisions affecting her life. The case manager ensured that Jordan attended all meetings where decisions were made about her, so that she could have an input. Having discussed the intervention plan with Jordan the case manager then asked Jordan to write the plan in her own words, and this was the version which was signed and recorded.
Delivery and Review of Interventions **General Criterion: 2.2a**	**Understanding the impact on others** Chris received a referral order for violence. The case manager used a broad range of approaches to develop insight into the impact of Chris' behaviour on others. These included linking together outcomes from different worksheets and self-assessments; which were then reinforced by direct observation of a brain injury unit as part of a reparation project.
Delivery and Review of Interventions **General Criterion: 2.2a**	**Use of reparation to support case management** Tom spent many years in care. He found it difficult to make eye contact and to talk about his past. He attended a dog walking reparation project. Walking the dog removed the need for eye contact and gave Tom a safe place to talk to his case manager. Through this deeper understanding the case manager was able to deliver more appropriate interventions.
Outcomes **General Criterion: 2.3f & 3.1a**	**Improved Family Relationships** Family issues were a significant factor in Carly's offending. The case manager focused on home visits, during which she worked with Carly and her mother to improve their relationship and develop a positive outlook. She fed back positive comments about Carly's progress. Relationships improved and a cycle of improvements in behaviour had commenced.

All names have been altered.

1. ASSESSMENT AND SENTENCE PLANNING

1.1 Risk of Harm to others (RoH):	
General Criterion: *The assessment of RoH is comprehensive, accurate and timely, takes victims' issues into account and uses Asset and other relevant assessment tools. Plans are in place to manage RoH.*	
Score: ***77%***	***Comment:*** ***MINIMUM improvement required***

Strengths:

(1) An initial screening of *RoH* was completed in all except two cases and the great majority of these were timely.

(2) A full RoSH analysis had then been completed in most cases where this was required, and most of these were also timely.

(3) We agreed with the RoSH classification as recorded by the YOS in the great majority of cases.

(4) An RMP had been completed in well over three-quarters of those cases where one was required.

(5) Where there was no requirement for an RMP, or an RMP had not been produced, the need for planning to address *RoH* issues had been recognised and acted upon in three-quarters of relevant cases.

(6) A small number of cases met the criteria for MAPPA and needed to be referred. Referral had been made in all except one case, and all referrals made were timely. We agreed with the initial MAPPA level in all except one case.

(7) Details of the RoSH assessment and management had been appropriately communicated to all relevant staff in the great majority of relevant cases.

Areas for improvement:

(1) Just over one-quarter of cases did not include a *RoH* screening that was accurate, and one-third of relevant cases did not include a full RoSH analysis that was of sufficient quality. The main reasons for this, apart from when the screening or analysis had not been done or was late, were that the risk to victims or previous relevant behaviour had not been fully considered, and the

assessment had not drawn adequately on all information that was available. For example, in one case there was information on the case diary from the previous final warning relating to possession of an offensive weapon, intimidation of female staff and allegations of domestic violence. However, the case manager who undertook the screening was unaware of this information.

(2) In another example there was intelligence elsewhere in the file that the child or young person may belong to a racist gang and had used a sledge hammer in the past; but this was not pulled through into the RoSH assessment, neither was the accuracy of it checked.

(3) Where we disagreed with the RoSH classification this was usually because it was too low. This included a number of custodial cases where the classification during the custodial period did not reflect the RoSH that the child or young person would be to the community on release.

(4) Completion of the RMP was not timely in just over one-quarter of cases where an RMP was required, and just over one-third of relevant cases did not include an RMP of sufficient quality. The main reasons for this were that roles or responsibilities were not clear, or the planned response was unclear or inadequate. There were also examples where RMPs were not completed for children and young people during the custodial phase of the sentence due to a mistaken belief that these were not required.

(5) Management oversight of the RoSH assessment and the RMP had not been effective in over one-third of relevant cases. The most common reason identified for this, apart from when the assessment or RMP was not completed, was that inadequate assessments or RMPs had been countersigned.

1.2 Likelihood of Reoffending:	
General Criterion: *The assessment of the LoR is comprehensive, accurate and timely and uses Asset and other relevant assessment tools. Plans are in place to reduce LoR.*	
Score: ***81%***	***Comment:*** ***MINIMUM improvement required***

Strengths:

(1) An initial assessment of LoR had been completed in all except one case.

(2) The great majority of cases included an initial assessment of LoR that was timely.

(3) There was active engagement with the child or young person to carry out the initial assessment in well over three-quarters of cases, and with parents/carers in the great majority of relevant cases.

(4) The case manager had assessed the learning style of the child or young person in more than three quarters of cases.

(5) A speech and language specialist worked across the YOS to advise case managers, to ensure that communication difficulties were recognised and addressed and to advise on programme materials. Examples were found where the case manager had engaged the YOS speech and language therapist to further assess the child or young person's needs, with the outcomes from this reflected in both the assessment and intervention plan.

(6) Initial assessments drew on information from a broad range of sources. They were informed by contact with, or previous assessments from, emotional or mental health services in all relevant cases; children's social care services in almost all cases; and substance misuse services in almost all relevant cases. Information from ETE providers and the police had contributed to the initial assessment in well over three-quarters of relevant cases. In a significant proportion of cases the assessment was also supported by contact with other relevant agencies such as accommodation providers.

(7) All custody cases included a custodial sentence plan, and this was always completed on time. Most custodial sentence plans addressed the key factors related to the offending. All relevant plans addressed ETE, substance misuse or physical health needs. The overwhelming majority of relevant plans addressed living arrangements, and thinking and behaviour. All plans took into account Safeguarding needs and most included positive factors where relevant.

(8) In most cases YOS workers were actively and meaningfully involved throughout the custodial planning process.

(9) A referral order contract or intervention plan had been produced in all except one case in the community. The great majority of these were timely and almost all sufficiently addressed the offending related needs.

(10) Most community intervention plans took into account Safeguarding needs where appropriate and included positive factors. Almost all focused on achievable change, reflected the sentencing purpose and set relevant goals.

(11) The great majority of community intervention plans were sensitive to diversity issues and took account of victim's issues. Practice in recognising and responding to diversity issues was generally strong; including examples around bereavement, young carers and learning styles. A number of examples were found where case managers had actively promoted choice and independence for Looked After Children. In one example of a 17 year old engaged in domestic violence the case manager adapted materials from the Probation Service as these were more appropriate to his maturity and learning style.

(12) The child or young person and, where appropriate, their parents/carers had been actively and meaningfully involved in the planning process in the great majority of cases.

(13) There was active and meaningful involvement from a broad range of relevant agencies in the planning processes throughout the sentence.

(14) Interventions plans were reviewed as required in almost all cases in custody and in just over three-quarters of cases in the community.

Areas for improvement:

(1) Almost one-third of cases did not include an initial assessment of LoR that was of sufficient quality. The most common reason for this was that evidence, including the link to LoR, was unclear or insufficient. In some cases where this was required we found a blank mental health screening that had never been completed.

(2) Less than half of initial assessments were informed by a *What do YOU think?* or other appropriate self-assessment.

(3) Almost one-third of cases did not include reviews of the initial assessment that were timely or of a sufficient quality. Asset reviews were sometimes not undertaken as required throughout the custodial period of sentences and some case managers were not aware that this was required.

(4) Half of relevant custodial sentence plans did not integrate the RMP and almost half did not incorporate the child or young person's learning needs or style where this was relevant. This also applied to one-third of community intervention plans. Custodial plans took insufficient account of victim's issues.

(5) Over one-third of community intervention plans were not realistic. For example, some referral order contracts included many more interventions than could be delivered within the available contact time.

(6) Objectives were not prioritised according to *RoH* in one-third of relevant custodial and community intervention plans. They were not sequenced according to offending related needs in just over one-third of community intervention plans and just under one-third of custodial plans. This has been recognised by the YOS in their current APIS improvement plan.

(7) There were examples where ASB teams were not sufficiently involved in assessment and planning.

(8) Practice in recording plans to address diversity considerations was inconsistent. Neither was there a consistent approach to recording outcomes from assessments of learning styles onto the electronic record.

1.3 Safeguarding:

General Criterion:

The assessment of Safeguarding needs is comprehensive, accurate and timely and uses Asset and other relevant assessment tools. Plans are in

place to manage Safeguarding and reduce vulnerability.	
Score: ***81%***	***Comment:*** ***MINIMUM improvement required***

Strengths:

(1) An Asset vulnerability screening was completed in all except one case. The great majority of these were timely.

(2) Safeguarding needs were reviewed as appropriate in the great majority of cases.

(3) Most VMPs that had been produced were both timely and of sufficient quality.

(4) When a VMP had been produced it contributed to and informed interventions in almost all cases, and informed other plans in all cases where this was relevant.

(5) The secure establishment had been made aware of relevant vulnerability issues prior to, or on, sentence in all except one case.

(6) Copies of other relevant plans were on file in the great majority of cases.

(7) In all except one relevant case the YOS had made a contribution to other assessments and plans designed to safeguard the child or young person; for example, through the CAF.

(8) Most managers and case managers were proactive and persistent in seeking to engage children's social care services, and to ensure that they provided services to children and young people when required.

Areas for improvement:

(1) Just over one-third of cases did not include a vulnerability screening of sufficient quality. The most common reason for this was that insufficient regard had been given to reckless behaviour.

(2) A VMP had not been produced in one-third of cases where we assessed that this was needed. This included some cases where the case manager had correctly assessed vulnerability as medium, and was undertaking some appropriate actions, but had not recognised the need for a coherent and shared plan to manage vulnerability.

(3) The reasons why some VMPs were of insufficient quality were primarily that roles and responsibilities were not clear or that the planned response was unclear or inadequate.

(4) In just over one-third of cases management oversight of the vulnerability assessment and planning had not been effective. The most common reason

given for this was that oversight had not ensured that relevant vulnerability issues were identified and VMPs produced.

OVERALL SCORE for quality of Assessment and Sentence Planning work: 81%

COMMENTARY on Assessment and Sentence Planning as a whole:

We were very concerned about the performance of the YOIS case management system. It was often very slow. This had a significant impact on the work of case managers and on the ability of YOIS to support effective case management.

The YOS had developed a broad range of clear and comprehensive policies and procedures covering many aspects of practice including case management, recording, quality assurance, risk management and management oversight. These formed a good basis to inform the delivery of effective and high quality practice.

A multi-agency risk management panel process was in place within the YOS. Each panel was chaired by an operational manager. Its work was focused on children and young people with a raised RoSH or vulnerability.

Leeds YOS had a fulltime specialist worker for children and young people who exhibited sexually inappropriate behaviour. This worker contributed to assessments and plans for relevant children and young people, and worked alongside case managers where appropriate.

2. DELIVERY AND REVIEW OF INTERVENTIONS

2.1 Protecting the public by minimising Risk of Harm to others (RoH):	
General Criterion: *All reasonable actions have been taken to protect the public by keeping to a minimum the child or young person's RoH.*	
Score: ***78%***	***Comment:*** ***MINIMUM improvement required***

Strengths:

(1) Changes in *RoH* acute factors were anticipated where feasible in just over three-quarters of cases. They were clearly and swiftly identified once they had occurred in most instances, and appropriate actions then followed in more than three-quarters of cases.

(2) Effective use was made by the YOS of MAPPA arrangements in all except one relevant case. Decisions made by MAPPA were always clearly recorded, followed through and acted upon, and reviewed appropriately.

(3) Case managers and all other relevant YOS staff contributed effectively to MAPPA processes in all relevant cases in both custody and the community. The contribution of other agencies to MAPPA was effective in all except one relevant case.

(4) Other multi-agency meetings had been held in a significant proportion of cases, either in custody or in the community. Case managers and other relevant staff contributed effectively to these in all except one case.

(5) Purposeful home visits were carried out, in accordance with the level of *RoH* posed, in more than three-quarters of cases.

(6) Almost all cases had an appropriate level of resources allocated to them, according to the *RoH* posed in that case.

(7) Where specific interventions had been planned to manage *RoH* during the community phase of sentences they had then been delivered as planned in most cases. This had also happened in all except one relevant case in custody. Specific interventions to manage *RoH* were always reviewed following significant change during the custodial phase of sentences.

(8) Management oversight of *RoH* had been effective during the delivery of interventions in most cases during the custodial phases of sentences and in over three-quarters of cases during the community phase of sentences.

Areas for improvement:

(1) *RoH* had not been reviewed thoroughly in-line with required timescales in just over one-quarter of cases. It had not been reviewed thoroughly following a significant change in one-third of relevant cases. For example, an allegation of an individual threatening someone with a knife in a children's home had not been responded to nor linked to other violent offending.

(2) Proactive consideration to the safety of victims had not been carried out in slightly more than half of relevant cases. In many instances, case managers were not aware whether contact had been made with the victim in order to explore whether they had any concerns, nor where to find relevant information on the electronic case record.

(3) High priority had not been given to victim safety throughout the sentence in just over one-third of cases. For example in two custodial cases licences were not enforced where there was evidence of increased risks to victims, due to misunderstanding of the circumstances in which enforcement could be undertaken.

2.2 Reducing the Likelihood of Reoffending:	
General Criterion: *The case manager coordinates and facilitates the structured delivery of all elements of the intervention plan.*	
Score: ***90%***	***Comment:*** ***MINIMUM improvement required***

Strengths:

(1) The overwhelmingly majority of delivered interventions in the community were clearly designed to reduce the LoR, and almost all were of good quality and incorporated all diversity issues.

(2) In the great majority of cases delivered interventions were implemented in line with the intervention plan and were appropriate to the learning style of the child or young person.

(3) Leeds YOS had a specialist worker for children and young people who committed sexual offences or demonstrated sexually inappropriate behaviour. Engagement between case managers and this worker contributed to the delivery of high quality interventions and to case managers feeling supported.

(4) YOS workers were proactive in making use of community resources to extend the range of interventions available to them. There were a number of

examples where children and young people with significant lifestyle needs were supported in accessing a gym or other sporting facilities.

(5) The YOS was sufficiently involved in the review of interventions in custody in all except one case.

(6) The initial Scaled Approach intervention level was always correct. Examples were seen of the appropriate use of professional override to modify the intervention level indicated by Asset scores.

(7) The overwhelming majority of cases had an appropriate level of resources allocated to them throughout the sentence, according to the LoR.

(8) Sufficient attention had been given to implementing all requirements of the sentence in all except one youth rehabilitation order.

(9) The YOS worker actively supported and motivated the child or young person throughout the sentence, and reinforced positive behaviour where relevant, in all except one case in custody and in almost all cases in the community. There were examples of good use being made of the time in custody to develop positive relationships with children and young people, and to encourage them to reflect on what they wanted to be different when they were released; along with motivational conversations from both case managers and drugs or health workers.

(10) Parents/carers were actively engaged by the YOS in the great majority of relevant cases. There were a number of examples where family relationships were a significant offending related factor and where the case manager had sought to engage the parent/carer specifically to address this need.

(11) The delivery of interventions by the programmes team included good examples of methods being adapted to match children and young people's learning styles. In one example of a young person with significant concentration difficulties the case manager worked with the burglary programme facilitator to ensure that the programme was activity based, then continually monitored and reviewed which exercises had most impact. They then adapted their approach to reinforce learning.

Area for improvement:

(1) Just over one-quarter of delivered interventions had not been sequenced and reviewed appropriately. The YOS had recognised the need for improvements to this aspect of their work.

2.3 Safeguarding the child or young person:	
General Criterion: *All reasonable actions have been taken to safeguard and reduce the vulnerability of the child or young person.*	
Score: ***90%***	***Comment:*** ***MINIMUM improvement required***

Strengths:

(1) Immediate action had been taken to safeguard and protect the child or young person in every relevant case during the custodial phase of the sentence, and in all except one relevant case in the community. Immediate action to protect any other affected child or young person had been taken in all relevant cases during the custodial phase of the sentence.

(2) Purposeful home visits had been carried out, in accordance with the level of Safeguarding needs, in well over three-quarters of cases.

(3) Necessary referrals to ensure safeguarding had been made to other relevant agencies in the great majority of cases during both the custodial and community phases of sentences.

(4) The level of joint working between the YOS and other relevant agencies, to promote the Safeguarding and well-being of the child or young person during the community phase of sentences was generally good. This particularly applied to ETE, substance misuse and emotional or mental health services. A number of examples were found where case managers had recognised potential physical health problems and worked jointly with the YOS nurse. In a significant proportion of cases there had also been effective joint working with other agencies who were not statutory partners of the YOS.

(5) Joint working during the custodial phase of sentences was similarly good. In one example the case manager and YOS education officer conducted a joint visit that developed the foundations for a positive relationship post release. This was the first occasion on which the child or young person had engaged with the YOS.

(6) In almost all relevant cases there was also effective joint work between the YOS and relevant agencies to ensure continuity of provision of mainstream services through the transition from custody to the community.

(7) Where specific interventions were required to promote safeguarding in the community these had been identified in the overwhelming majority of cases and delivered in most cases. A similar judgement applies to those interventions required during the custodial phase of sentences.

(8) Management oversight of Safeguarding and vulnerability needs during the delivery of interventions had been effective in most cases in custody and in three-quarters of cases in the community.

(9) Overall staff supported and promoted the well-being of the child or young person throughout the sentence in all except one custodial case and almost all cases in the community. We identified a continuing theme of active responses to crises in the lives of children and young people, alongside a determination to continue work to reduce LoR.

Areas for improvement:

(1) Necessary immediate action to protect any other affected child or young person had not been taken in one-third of relevant cases in the community.

(2) Specific interventions to promote Safeguarding in the community had not been reviewed regularly as required or following significant changes, in almost one-third of relevant cases.

(3) Inspectors observed that staff were not always clear about the thresholds for acceptance of referrals by children's social care services, and that on occasions case managers and managers had to advocate more than should have been necessary in order for referrals to be accepted and services provided.

OVERALL SCORE for quality of Delivery and Review of Interventions work: 87%

COMMENTARY on Delivery and Review of Interventions as a whole:

Leeds YOS had a dedicated programmes team to develop and deliver specialist programmes targeted at children and young people with medium or high LoR.

A broad range of specialist programmes were in place or under development. These included Think Smart (Junior Enhanced Thinking Skills), Knife Crime Prevention Programme (KCPP), Respect programme (for sexually inappropriate behaviour), two programmes to work with those involved in burglary and a programme targeted at those who dealt in drugs. A further range of programmes were available for children and young people undertaking less intensive sentences. These included work on anger management and weapons awareness.

The YOS specifically sought to develop a range of interventions that responded to local offending needs. The burglary programmes were examples of this.

A speech and language specialist worked across the YOS to advise case managers, to ensure that communication difficulties were recognised and addressed and to advise on programme materials.

Individual case managers also had access to a range of additional resources suitable for one-to-one work.

3. OUTCOMES

Our inspections include findings about initial outcomes, as set out in this section. In principle, this is the key section that specifies what supervision is achieving, but in practice this is by necessity just a snapshot of what has been achieved in only the first 6-9 months of supervision, and for which the evidence is sometimes only provisional.

3.1 Achievement of outcomes:	
General Criterion: *Outcomes are achieved in relation to RoH, LoR and Safeguarding.*	
Score: ***69%***	***Comment:*** ***MODERATE improvement required***

Strengths:

(1) Overall the *RoH* had been effectively managed in over three-quarters of cases.

(2) A robust but appropriate approach was taken to enforcement, where children and young people had not complied with the requirements of the sentence. Enforcement action had been taken sufficiently well in almost all cases where this was required. In one example of a Section 90/91 licence, recall was undertaken following the failure of the child or young person to settle in the community, without further offending, as a positive action to maintain stability whilst a more comprehensive licence plan was developed.

(3) Inspectors identified many cases where active engagement with families had resulted in substantial improvement in family and personal relationships, lifestyle and self esteem; leading to a reduction in LoR. This theme was echoed strongly in the responses from children and young people who had completed a questionnaire for the inspection.

(4) There were also many examples where work led by the YOS had resulted in children and young people successfully gaining college places. This theme was also echoed in questionnaires completed for the inspection.

(5) There had been a reduction in the frequency of offending since the start of the sentence in just under two-thirds of cases, and a reduction in the seriousness of offending in over half of cases. In both instances this was better than the average performance of YOTs inspected to date.

(6) Overall, all reasonable action had been taken to keep the child or young person safe in almost all cases.

Areas for improvement:

(1) In those cases where, overall, the *RoH* had not been effectively managed, the main reason for this was that the assessment had been insufficient. In half of these cases the planning was also insufficient.

(2) There had been a reduction in the Asset score in less than half of cases.

3.2 Sustaining outcomes:	
General Criterion: *Outcomes are sustained in relation to RoH, LoR and Safeguarding.*	
Score: ***90%***	***Comment:*** ***MINIMUM improvement required***

Strengths:

(1) Full attention had been given to community reintegration during the custodial phase of the great majority of sentences.

(2) During community sentences and licence periods full attention had been given to community reintegration in almost all cases.

(3) Action had been taken, or plans put in place, to ensure that positive outcomes were sustainable during the custodial phase of well over three-quarters of sentences.

(4) In community sentences and licence periods the great majority of cases included appropriate actions or plans to ensure that positive outcomes were sustainable. Links were made with specialist youth facilities and Connexions often continued to be involved.

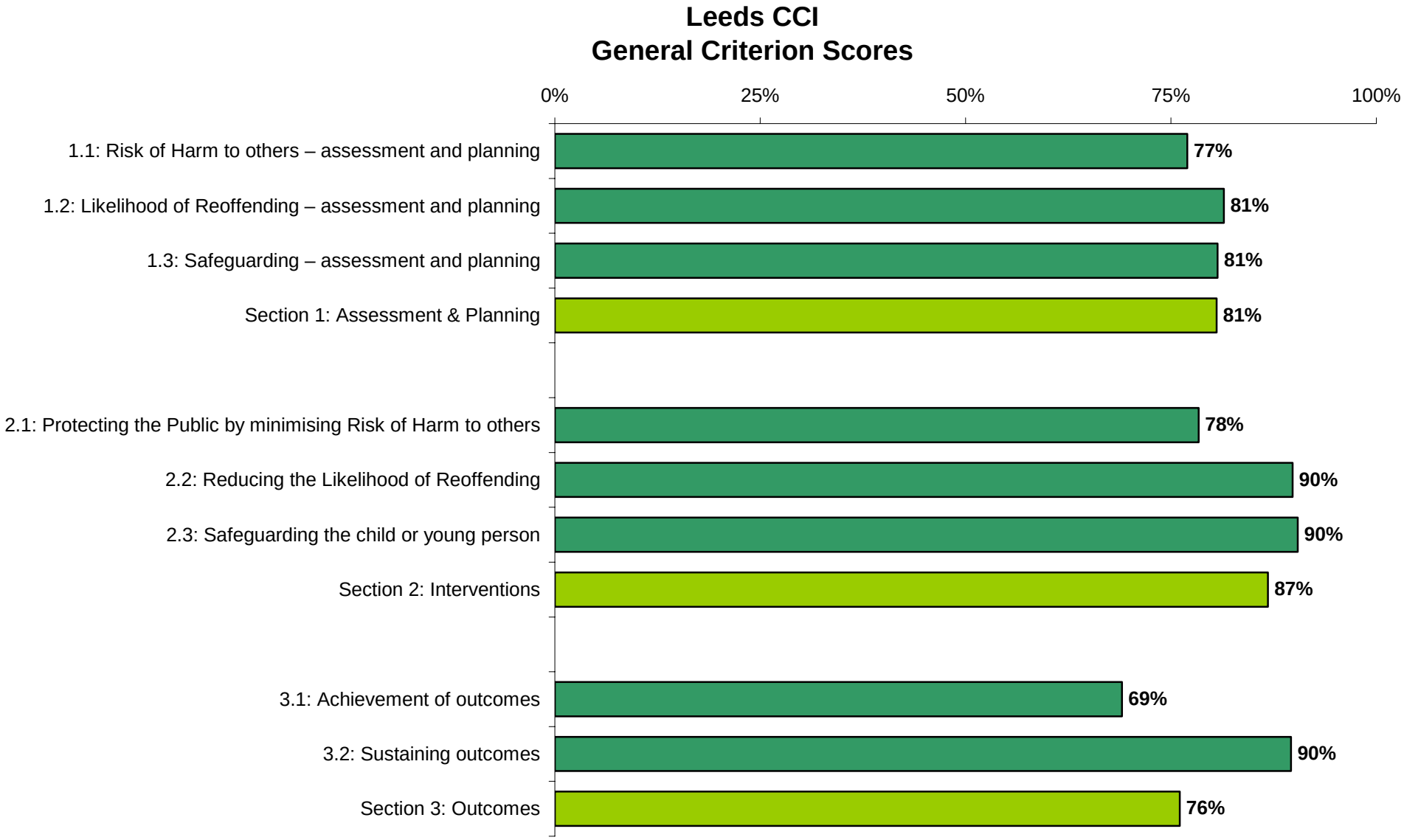
(5) A particular focus was noted on gaining the engagement of families to support progress that had been made, and on development of exit strategies for children and young people who were looked after. In another example the case manager gained the support of a child or young person to voluntarily engage with offending behaviour work after the end of the sentence, due to there being insufficient time to complete the work during the sentence.

OVERALL SCORE for quality of Outcomes work: 76%

COMMENTARY on Outcomes as a whole:

Improvements have been made in Leeds over recent years across most YJB National Indicators. The YOS used analysis of outcomes data and feedback from users to inform decisions on the YOS structure and development of programmes.

Appendix 1: Summary



Appendix 2: Contextual information

Area

Leeds YOS was located in the Yorkshire & Humberside region of England.

The area had a population of 715,402 as measured in the Census 2001, 10.4% of which were aged 10 to 17 years old. This was the same as the average for England/Wales.

The population of Leeds was predominantly white British (91.8%). The population with a black and minority ethnic heritage (8.2%) was below the average for England/Wales of 8.7%.

Reported offences for which children and young people aged 10 to 17 years received a pre-court disposal or a court disposal in 2008/ 2009, at 56 per 1,000, were above the average for England/Wales of 46.

YOS

The YOS boundaries were within those of the West Yorkshire police and probation areas. The Leeds PCT covered the area.

The YOS was located within the Integrated Youth Support Service division of the Early Years and Integrated Youth Services Directorate of Leeds City Council. It was managed by the Head of Integrated Youth Support Services.

The Leeds YOS Partnership Board was chaired by the Chief Executive of Leeds City Council. All statutory partners attended regularly.

The YOS Headquarters was in a suburb of Leeds. The operational work of the YOS was based in offices covering the four quadrants of Leeds, each led by an operations manager. There was also a dedicated Programmes team and Leeds YOS managed its own ISSP provision. Other services such as restorative justice and court work were also organised as city-wide functions.

YJB National Indicator Performance Judgement

The YJB National Indicator Performance Judgement available at the time of the inspection was dated 10 June 2010.

There were five judgements on reoffending, first time entrants, use of custody, accommodation, employment, education and training.

On these dimensions, the YJB scored Leeds YOS 13 out of a maximum of 28 (for English YOTs); this score was judged by the YJB to be performing adequately.

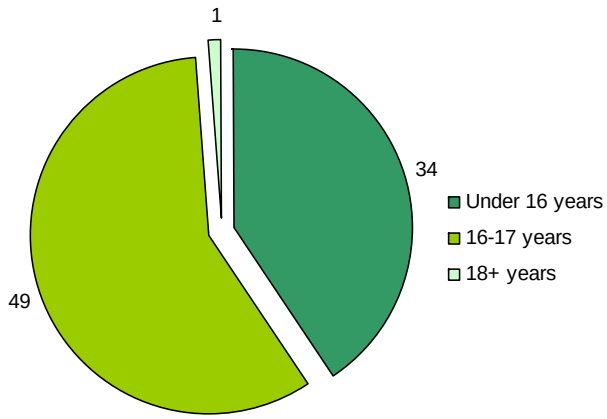
Leeds YOS's reoffending performance was judged by the YJB to be declining significantly and was significantly worse than similar *family group* YOTs.

For a description of how the YJB's performance measures are defined, please refer to:

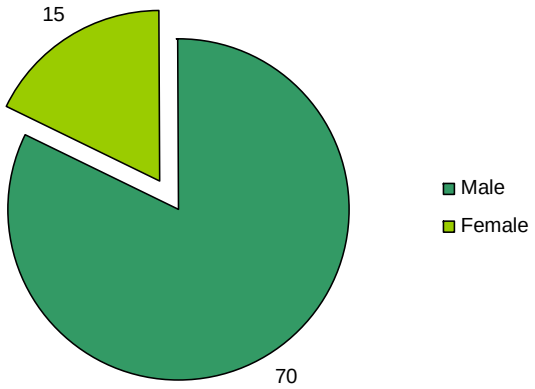
http://www.yjb.gov.uk/en-gb/practitioners/Monitoringperformance/Youthjusticeplanning/

Appendix 3a: Inspection data chart

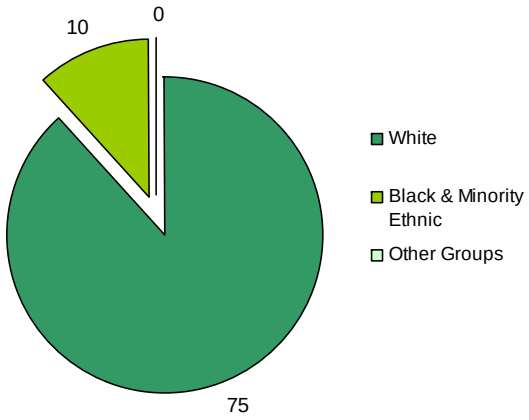
Case Sample: Age at start of Sentence



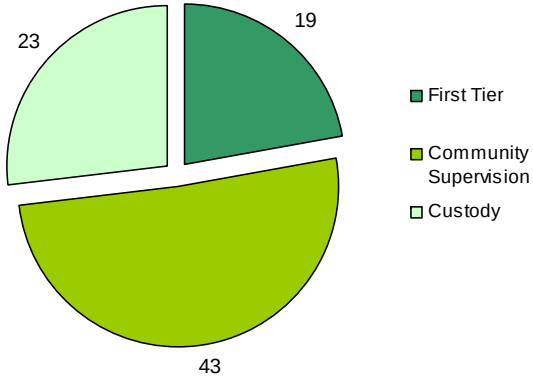
Case Sample: Gender



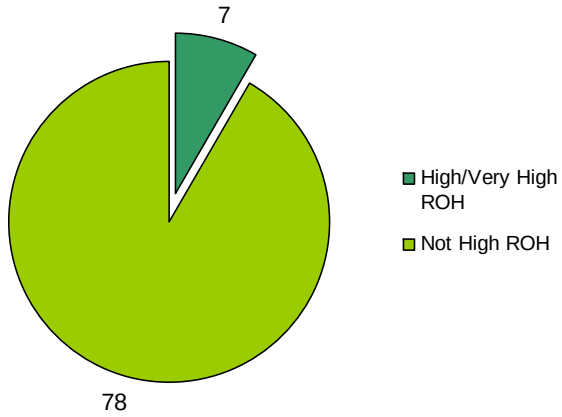
Case Sample: Ethnicity



Case Sample: Sentence Type



Case Sample: Risk of Harm



Appendix 3b: Inspection data

Fieldwork for this inspection was undertaken in September 2010

The inspection consisted of:

- examination of practice in a sample of cases, normally in conjunction with the case manager or other representative
- evidence in advance
- questionnaire responses from children and young people, and victims

We have also seen YJB performance data and assessments relating to this YOS.

Appendix 4: Role of HMI Probation and Code of Practice

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

http://www.justice.gov.uk/inspectorates/hmi-probation

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:

HM Chief Inspector of Probation
2nd Floor, Ashley House
2 Monck Street
London, SW1P 2BQ

Appendix 5: Glossary

APIS	Assessment, Planning, Intervention and Supervision
ASB/ASBO	Antisocial behaviour/Antisocial Behaviour Order
Asset	A structured assessment tool based on research and developed by the Youth Justice Board looking at the young person's offence, personal circumstances, attitudes and beliefs which have contributed to their offending behaviour
CAF	Common Assessment Framework: a standardised assessment of a child or young person's needs and of how those needs can be met. It is undertaken by the lead professional in a case, with contributions from all others involved with that individual
CAMHS	Child and Adolescent Mental Health Services: part of the National Health Service, providing specialist mental health and behavioural services to children and young people up to at least 16 years of age
Careworks	One of the two electronic case management systems for youth offending work currently in use in England and Wales. See also YOIS+
CRB	Criminal Records Bureau
DTO	Detention and Training Order: a custodial sentence for the young
Estyn	HM Inspectorate for Education and Training in Wales
ETE	Education, Training and Employment: work to improve an individual's learning, and to increase their employment prospects
Family Group	Used by the YJB for comparative performance reporting, this is a group of YOTs identified as having similar characteristics
FTE	Full-time equivalent
HM	Her Majesty's
HMIC	HM Inspectorate of Constabulary
HMI Prisons	HM Inspectorate of Prisons
HMI Probation	HM Inspectorate of Probation
Interventions; *constructive* and *restrictive* interventions	Work with an individual that is designed to change their offending behaviour and/or to support public protection. A *constructive* intervention is where the primary purpose is to reduce Likelihood of Reoffending. A *restrictive* intervention is where the primary purpose is to keep to a minimum the individual's *Risk of Harm to others*. Example: with a sex offender, a *constructive intervention* might be to put them through an accredited sex offender programme; a *restrictive intervention* (to minimise their *Risk of Harm*) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case. NB. Both types of intervention are important
ISSP	Intensive Supervision and Surveillance Programme: this intervention is attached to the start of some orders and licences and provides initially at least 25 hours programme contact including a substantial proportion of employment, training and education
LoR	Likelihood of Reoffending. See also *constructive* Interventions
LSC	Learning and Skills Council

LSCB	Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality.
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher *Risk of Harm to others*
Ofsted	Office for Standards in Education, Children's Services and Skills: the Inspectorate for those services in England (not Wales, for which see Estyn)
PCT	Primary Care Trust
PPO	Prolific and other Priority Offender: designated offenders, adult or young, who receive extra attention from the Criminal Justice System agencies
Pre-CAF	This is a simple 'Request for Service' in those instances when a Common Assessment Framework may not be required. It can be used for requesting one or two additional services, e.g. health, social care or educational
PSR	Pre-sentence report: for a court
RMP	Risk management plan: a plan to minimise the individual's *Risk of Harm*
RoH	*Risk of Harm to others.* See also *restrictive* Interventions
'RoH work', or 'Risk of Harm work'	This is the term generally used by HMI Probation to describe work to protect the public, primarily using *restrictive interventions,* to keep to a minimum the individual's opportunity to behave in a way that is a *Risk of Harm to others*
RoSH	Risk of Serious Harm: a term used in Asset. HMI Probation prefers not to use this term as it does not help to clarify the distinction between the *probability* of an event occurring and the *impact/severity* of the event. The term *Risk of Serious Harm* only incorporates 'serious' impact, whereas using '*Risk of Harm'* enables the necessary attention to be given to those offenders for whom lower *impact/severity* harmful behaviour is *probable*
Safeguarding	The ability to demonstrate that all reasonable action has been taken to keep to a minimum the risk of a child or young person coming to harm.
SIFA	Screening Interview for Adolescents: Youth Justice Board approved mental health screening tool for specialist workers
SQIFA	Screening Questionnaire Interview for Adolescents: Youth Justice Board approved mental health screening tool for YOT workers
VMP	Vulnerability management plan: a plan to safeguard the well-being of the individual under supervision
YJB	Youth Justice Board for England and Wales
YOI	Young Offenders Institution: a Prison Service institution for young people remanded in custody or sentenced to custody
YOIS+	Youth Offending Information System: one of the two electronic case management systems for youth offending work currently in use in England and Wales. See also Careworks
YOS/T	Youth Offending Service/Team