Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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

This report outlines the findings of the recent SQS inspection, conducted during 13th-15th May 2013. We carried this out as part of our programme of inspection of youth offending work. This report will be published on the HMI Probation website. A copy will be provided to partner inspectorates to inform their inspections, and to the Youth Justice Board (YJB).

Context

As an independent inspectorate, HMI Probation provides assurance to Ministers and the public on the effectiveness of work with those who have offended or are likely to offend, promotes continuous improvement by the organisations that we inspect and contributes to the effectiveness of the criminal justice system.

Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. The purpose of the SQS inspection is to assess the quality and effectiveness of casework with children and young people who have offended, at the start of a sample of 20 recent cases supervised by the Wandsworth Youth Offending Team. Wherever possible this is undertaken in conjunction with the allocated case manager, thereby increasing the effectiveness as a learning opportunity for staff.

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

Summary

Wandsworth YOT has made substantial progress in many aspects of its work since our previous inspection in 2011, although significant challenges remain. Progress had been driven through a post-inspection improvement plan that was delivered with ambition. In particular, management oversight of cases and work to protect the public have both developed significantly. We found much evidence of management involvement and some good practice, although further improvement is required. However, work to reduce the vulnerability of children and young people has made less progress.

Commentary on the inspection in Wandsworth:

1. Reducing the likelihood of reoffending

1.1. The sentencing court made use of a new pre-sentence report (PSR) in three-quarters of the cases. All except three were of sufficient quality, providing the court with valuable information about the circumstances of the child or young person to inform the sentence. In one case we found a comment from a Crown Court judge indicating how useful the PSR had been to them. However, there were some cases where the case record was unclear on what advice had been provided to the sentencing court.

1.2. The quality of initial assessments of likelihood of reoffending was variable. Some were of a high standard. One case manager helpfully summarised the theory that applied and the questions that had been asked in order to support the assessment. When assessments were not sufficient, this was primarily because evidence was unclear or was otherwise insufficient to ensure that the assessment was robust. Where reviews of the initial assessment were necessary, two-thirds met the needs of the case, although more attention was sometimes required to ensure that the need for a review was recognised following a significant change.

1.3. Planning for work to reduce likelihood of reoffending was good enough in half of the cases. In general, case managers recognised and were able to articulate how they planned to address the needs of the child or young person. This was often unclear from the recorded plans, and in some plans more attention needed to be given to victims. In order to be effective tools that support joint working and case management, plans need to detail the objectives of each intervention, and how they are to be delivered, with the link to the specific offending-related factor clearly apparent.

1.4. For those children and young people placed in young offender institutions (YOIs), planning during the custodial phase of the sentence is a joint responsibility between the YOT and the YOI, with the sentence plan agreed at a planning meeting held in the secure establishment. More attention needs to be given to ensuring that engagement with the YOI is effective in ensuring that the sentence plan, agreed with them and the child or young person, reflects the whole sentence and addresses offending behaviour; rather than focusing primarily on behaviour and services in the YOI.

2. Protecting the public

2.1. The initial assessment of risk of harm to others was sufficient in almost three-quarters of cases. While there is still room for improvement, this shows significant progress since the last inspection. Wandsworth YOT has a policy of requiring a full assessment of risk of serious harm in all cases where violence features in the offending behaviour. This is a robust and appropriate way to support consideration of harm related behaviour in order to inform planning. Care was needed to ensure that all assessments are timely and sometimes more account needed to be taken of actual or potential victims. In some assessments we found good use of intelligence or other relevant information to inform the assessment. One case manager, having identified the characteristics of harmful behaviour, then helpfully preceded each paragraph of the analysis with a heading referencing the relevant characteristics, thereby making the link between each section much clearer.

2.2. Unusually, every case that we inspected in Wandsworth required specific planning to manage the risk of harm to others. The planning was sufficient in just over half these cases which, whilst still not good enough, was a significant improvement since our inspection in 2011. The biggest area for improvement was the need to give more

consistent and explicit consideration in plans to the safety of known victims. In addition, the timeliness of the planning sometimes needed to be better. In general, as with plans to address likelihood of reoffending, case managers were able to clearly articulate their thinking about planning, but the written plans often needed to be more precise.

2.3. Reviews of assessments and plans to manage risk of harm to others were inconsistent. In some cases there were timely and effective reviews, in particular in response to significant changes in circumstances. Failure to respond sufficiently to such changes and to ensure that reviews were timely were also the primary reasons why we assessed that reviews were insufficient in almost half the cases where they were required.

2.4. It was encouraging that case managers had a good understanding of the potential of Multi-Agency Public Protection Arrangements (MAPPA) to contribute to the management of cases and the protection of the public, particularly for cases under MAPPA Category 3 (other dangerous offenders that may require multi-agency management). There was evidence of appropriate consideration of engagement with MAPPA in a number of cases, although in one case, where referral was undertaken, the process had become confused.

2.5. Management oversight of work to manage risk of harm to others was sufficient and effective in almost two-thirds of cases. Whilst improvement is still required, this also shows significant progress since the last inspection. We found substantial evidence of management involvement in cases, and often apposite comments about the quality of work and improvements that were required. However, this was not consistent. While managers would rightly not countersign work until they judged that it was good enough, sufficient attention was not always given to ensuring that required actions (for example, an instruction to complete a risk management plan) were undertaken in a timely manner. The conclusion in assessments of risk of serious harm to others was often followed by a detailed comment from a manager explaining why they agreed with the judgement of the case manager. This was good practice contributing to the robustness of the oversight and assessment, and the confidence of the case manager about their conclusions.

3. Protecting the child or young person

3.1. We were pleased to find that staff, and YOT policies, took a holistic approach to understanding vulnerability, including in PSRs. Just over half of the assessments of vulnerability met the needs of the case. In those cases where the assessment was not good enough, the most common reason was that the opportunity had not been taken to pull together all relevant behaviour into the assessment. Sometimes this also led to inaccurate classification of the level of vulnerability.

3.2. Planning to address the vulnerability of the child or young person was sufficient in half of the cases where this was required. Where assessments were insufficient this had an immediate impact on whether a vulnerability management plan was produced, and in some cases this was not timely. The YOT needed to be more effective in ensuring, through its contribution to planning during the custodial period of sentences, that the required plans were in place to address safeguarding and reduce vulnerability. Earlier comments on the need for plans to manage risk of harm to others to be more precise equally apply to plans to reduce vulnerability.

3.3. There were some cases where we found a timely and appropriate response to changes in vulnerability factors, including in complex circumstances. In general, engagement with, and communication between, case managers and staff in children's social care services was good. There was sufficient review of vulnerability assessments and plans in, respectively, just over two-thirds and just over half of relevant cases. With both aspects

the main area for improvement was recognising the need for a timely review following a significant change, such as a move to a different location.

3.4. Oversight by managers was sufficient and effective in half of the relevant cases. The main area for improvement was the need to ensure that deficiencies in assessment or planning were addressed.

4. Ensuring that the sentence is served

4.1. Consideration of diversity was central to Wandsworth's approach and, in general, assessment of diversity factors was good. Case managers often clearly articulated their understanding of the breadth of diversity factors in individual cases, and their plans to address them. However, we rarely found these plans clearly written within the case record. It would be helpful if the YOT considered a standard approach to recording diversity factors, their impact and specific plans to address them so that they are consistently accessible to all involved in the case.

4.2. Children and young people and their parents/carers were normally sufficiently engaged in assessment and planning. Children and young people were not always seen alone before the initial assessment was completed, which is an essential step towards ensuring that their voice is heard. In some cases there was insufficient evidence that the YOT had ensured that PSRs were fully understood by children and young people before the court hearing.

4.3. Most plans were not written in language that was meaningful to children and young people, and made clear to them the changes that were required, how they were to be achieved and their part in achieving that.

4.4. Children and young people fully or largely complied with the requirements of the sentence in three-quarters of cases. Where the child or young person did not comply fully, the response of the YOT was sufficient in all except two cases. When considered in conjunction with a reduction in the number of children and young people who have received custodial sentences following non-compliance, this is testament to the quality of engagement between case managers and children and young people that was evident during the inspection.

Operational management

Staff had a good understanding of what was expected from them and of the key policies and procedures that applied to their work. They had not received sufficient training to enable them to recognise and respond effectively to speech, language and communication needs; otherwise, they spoke positively about the training that was available to them. They also spoke positively about the supervision and support they received, characterising managers as adopting an open door policy. They understood the outcomes from the previous inspection, and their role in delivering improvements. They were supportive of the improvements that had been required and were committed to driving up the quality of their practice.

Key strengths

The best aspects of work that we found in Wandsworth included:

- The substantial improvement in some aspects of practice since the previous inspection.
- A robust approach now being taken to management oversight that was recorded well and led to management involvement in a high proportion of cases, albeit with the need for further improvement.

- A staff group who understood the expectations on them, were committed to their work and wished to improve their practice.
- PSRs that provided the court with valuable information to inform sentencing decisions.
- Consideration of diversity factors was central to how the YOT operated.

Areas requiring improvement

The most significant areas for improvement were:

i. More consideration should be given to the needs and safety of victims in assessment and planning.

ii. Assessment of vulnerability needs to pull together all relevant aspects of vulnerability into a good quality assessment that then leads to appropriate plans to address those needs in relevant cases.

iii. Plans for the delivery of interventions, protection of the public and reduction in vulnerability need to be clear and precise, written in language that is outcome-focused and fully understandable by those who access them. In addition, plans that should be owned by children and young people must be written in language that is meaningful to them.

iv. Management oversight should be effective across all aspects of work; specifically it should ensure that required actions are addressed in a timely manner.

v. Case managers should review assessments and plans as required following significant changes in circumstances.

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

We are grateful for the support that we received from staff in the YOT to facilitate and engage with this inspection. Please pass on our thanks, and ensure that they are made fully aware of these inspection findings.

If you have any further questions about the inspection please contact the lead inspector, who was Ian Menary. He can be contacted on 07917 183197 or by email at ian.menary@hmiprobation.gsi.gov.uk.

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