



Full Joint Inspection of Youth Offending Work in Warwickshire

An inspection led by HMI Probation



Foreword

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

The majority of the Youth Offending Teams selected for these inspections are those whose performance – based on the three youth justice outcome measures 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.

We chose to inspect in Warwickshire primarily because national indicators identified it as an area that was performing well.

In Warwickshire we found that staff were committed to providing good quality services and achieving positive outcomes. Staff were well trained and supported. They had access to sufficient resources to address the offending-related needs of children and young people. This included good quality interventions, both in house and through partnership arrangements. There was evidence of effective engagement with children and young people and with their parents/carers. We judged that the governance of Warwickshire Youth Justice Service was good. However, a key area of development centred on the need to improve the quality of assessments and plans to address the risk of harm to others posed by some children and young people, and the management oversight of that work.

The recommendations made in this report are intended to assist Warwickshire Youth Justice Service in its continuing improvement by focusing on specific key areas. We are confident that the recommendations contained in this report will be acted upon.

Liz Calderbank

HM Chief Inspector of Probation

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January 2013

Summary



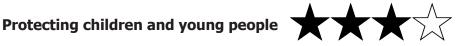
Overall, work to reduce reoffending was good. In the majority of cases, both the frequency and the seriousness of reoffending had reduced since the start of the sentence or release from custody. Most of the children and young people had made clear progress in addressing factors linked to their likelihood of reoffending. In the majority of cases progress was being made in respect of education, training and employment, substance misuse, thinking and behaviour and motivation to change. These were the factors that were most commonly linked to offending by the children and young people considered in our sample.

There were clear and thorough assessments of likelihood of reoffending at the initial assessment. We found timely and good quality planning to address reoffending issues. In the majority of cases planned interventions, aimed at helping to reduce the likelihood of reoffending, were delivered. Reviews of the assessments, plans and interventions were sound. More needed to be done to ensure that, for custodial cases, the sentence was being delivered as a single integrated sentence.



Overall, work to protect the public and both actual and potential victims was good. All reasonable steps had been taken to keep to a minimum the risk of harm to others in most cases. The delivered interventions, Multi-Agency Public Protection Arrangements (MAPPA) and other multi-agency arrangements had helped to effectively manage risk of harm to others issues in most cases.

Improvements were needed to the quality of initial assessments of risk of harm, and their reviews. Quality assurance arrangements, including management oversight, had not been effective in too many of the cases where a risk of harm to others was present.



Overall, work to protect children and young people and reduce their vulnerability was good. Youth justice staff had a clear understanding of their contribution to child protection plans and were committed to keeping children and young people safe. Planning regularly included work on emotional health; substance misuse; education, training and employment; and general care arrangements. However, the quality of plans for children and young people in custody was less strong.

Management oversight was effective, and staff demonstrated awareness of escalation processes for resolving professional disagreement, but we saw case examples where, despite concerns being raised by Warwickshire YJS staff, no changes were made to key decisions. The impact of joint work was reduced by the variable quality of engagement with some of the children's social work teams.

Ensuring that the sentence is served



Overall, work to ensure that the sentence was served was very good. Sufficient attention was being been paid to ensuring that young people engaged with the requirements of their sentences. Most had complied with these requirements and case managers worked to motivate those who had not met these commitments. This was successful in the majority of cases and case managers took appropriate enforcement action where children and young people consistently failed to meet the requirements of their sentences.

There was sufficient assessment of diversity factors and barriers to engagement. We were pleased to note the quality of the work undertaken by case managers and parenting workers to involve parents/carers in all aspects of the work. Practitioners had sufficient understanding of local policies to support engagement and to respond to non compliance by children and young people.

Governance arrangements



The governance arrangements of Warwickshire Youth Justice Service were good. Board members took responsibility for governance and scrutinised the work of the organisation through good performance data. Staff understood the organisation's objectives and how these fed into their work. However, there was a need for a systematic approach to monitoring and reviewing interventions and the outcomes delivered by partners. Greater attention needed to be paid to the quality of supervision and to quality assurance arrangements, to improve the quality of some key aspects of practice.

The co-location of criminal justice agencies, executive officers and staff at the Warwickshire Justice Centres enabled a strong working relationship between the partners. This contributed to broad strategic thinking on the role of Warwickshire Youth Justice Service. This went beyond criminal justice objectives and showed the interdependency between the partners. Appropriate attention was paid to sharing of resources between the partners across the area.

Recommendations

Post inspection improvement work should focus particularly on the following:

- 1. initial assessments, plans and their reviews, in relation to risk of harm issues, are completed to a sufficient quality and take account of the current circumstances in the case and relevant victims' issues (Warwickshire YJS Head of Service)
- 2. quality assurance arrangements, including management oversight, ensure that risk of harm assessments and plans, and their reviews, are adequate or better (Warwickshire YJS Head of Service)
- 3. Warwickshire YJS escalation processes ensure that where concerns are raised by YJS staff about the safety of a child or young person, and no changes are made to key decisions in other agencies, senior members of the relevant organisations review and make final decisions on actions (Chair of the Warwickshire YJS Management Board).

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Reducing the likelihood of reoffending

1

Theme 1: Reducing the likelihood of 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 74% of work to reduce reoffending was done well enough.

Key Findings

- 1. The frequency and seriousness of offending had reduced in the majority of cases.
- 2. Good progress was being made to address those factors that made children and young people more likely to reoffend.
- 3. Plans were in place for the progress to be sustained post-supervision in the majority of cases.
- 4. Initial assessments of the likelihood of reoffending were clear, thorough and of sufficient quality; these assessments were routinely reviewed.
- 5. In the vast majority of cases, plans were in place to undertake work to reduce reoffending; these plans were reviewed throughout the sentence.
- 6. Interventions to reduce reoffending were usually consistent with the assessment and plan of work in the case. They were generally delivered in accordance with effective practice principles. Sufficient attention was paid to reinforcing the learning from interventions.
- 7. In a number of custodial cases, the sentence had not been delivered as a single integrated sentence.
- 8. A wide range of interventions from a variety of sources were available to children and young people.
- 9. An appropriate balance was struck between achieving reductions in reoffending, managing risk of harm to others and addressing vulnerability in the delivery of interventions.
- 10. Staff reported being well trained and well supported in their work to address reoffending issues.

Explanation of findings

1. Assessment

- 1.1. The quality of the majority of initial assessments of the likelihood of reoffending examined during the inspection was generally satisfactory, but some required improvement. Most were prepared within an acceptable timescale but only two-thirds were of sufficient quality, mainly because they did not include factors linked either to the child or young person's offending or their vulnerability, or refer to assessments completed by others. We also found that a number of assessments were, in effect, copies of previous assessments and had not been updated to take account of the current circumstances in the case.
- 1.2. Other assessments for preferred learning styles, literacy and numeracy were undertaken swiftly to inform planning for those children and young people who had not accessed formal education for some time. Diagnostic testing such as dyslexia screening was arranged when necessary through the local authority's educational psychology service. Work to support children and young people with special educational needs was prioritised by education workers and placements sought that would best meet their needs.

Case illustration

Jack received a referral order for taking his parents' car without permission. He had been diagnosed with autism and was known to Warwickshire YJS for previous thefts. The initial assessment was thorough and made clear and relevant links between his autism, his previous behaviour, his cannabis use, his educational issues and his vulnerability. The initial sentence plan contained objectives which had been tailored to Jack's needs and focused on addressing his understanding of his behaviour to reduce reoffending. This included referrals to other agencies such as the Integrated Disability Service, substance misuse workers and others. In the course of the order, a new, more serious allegation was made against Jack. The assessment was reviewed and the risk of harm level was increased and a risk management plan put into place. The case was transferred to a new case manager, who had had specialist training, who initiated a commendably thorough and wide ranging multi-agency risk management process, and acted as the hub around which the investigation and handling of the case could progress.

- 1.3. Comprehensive physical health assessments for children and young people were conducted by the caseworkers who had received specific training in applying the general health screening tool. Once completed, assessments were sent to the health worker, who acted as a consultant. This helped to identify and signpost children and young people, via their case managers, into universal health services such as dentistry, sexual health and opticians.
- 1.4. Whilst Warwickshire YJS workers undertook some Tier 1 and 2 substance misuse work, there was, however, no specialist substance misuse service operating within Warwickshire YJS and COMPASS (the commissioned substance misuse service) was not routinely consulted when a child or young person was known to Warwickshire YJS. Early checks with COMPASS could help to identify if the children and young people had been known to community substance misuse provision, and if there were broader safeguarding concerns. The absence of specialist oversight of this work risked issues being left unidentified and inhibiting transition into community services.
- 1.5. Most pre-sentence reports (PSR) provided to the courts were of good quality. All were timely, concise and provided the court with an up to date assessment of the likelihood of reoffending, contained clear proposals and addressed custody where necessary.
- 1.6. Three-quarters of assessments had been sufficiently reviewed throughout the sentence.

2. Planning for interventions

- 2.1. In over three-quarters of plans, for both community and custody cases, sufficient planning had been undertaken to reduce reoffending. Attention was routinely given to addressing mental and emotional health issues. Similarly, education, training and employment (ETE), care arrangements and substance misuse also featured regularly in the plans. In over three-quarters of cases, the reviews of plans had been undertaken to a satisfactory standard.
- 2.2. In all nine cases in the sample where the child or young person had been in custody, a high level of joint work had been undertaken during the custodial period to address the child or young person's likelihood of reoffending. Case managers attended planning meetings in custody and communication between prison staff and case managers was good.

3. Delivery of interventions

3.1. We found many examples of creative interventions being delivered, by both Warwickshire YJS workers and by partnership agencies. An appropriate balance was achieved between addressing reoffending, managing the risk of harm to others and addressing vulnerability in the delivery

of interventions in two-thirds of the cases. In a clear majority of cases the interventions offered were of sufficient quality and were consistent with the assessment and plan of work. In over three-quarters of cases, the required interventions had been delivered and these had been reviewed appropriately.

Comment from a young person

"I have stopped drinking since going here. I used to drink every couple of days, sometimes two bottles of vodka."

- 3.2. During the inspection we identified factors that made the individual child or young person more likely to reoffend. In the majority of cases, interventions had been delivered to address the factors linked to offending. The following chart illustrates this finding (p10).
- 3.3. Interventions were being delivered in accordance with the principles of effective practice in over three-quarters of the cases. Following the delivery of interventions, we saw evidence that learning from the work undertaken with the young person had been reinforced by Warwickshire YJS staff in all but one of the cases. Sufficient attention was given to restorative justice, and meeting the needs of victims, in almost three-quarters of the appropriate cases.
- 3.4. The quality of practice to support children and young people to engage in education, learning and skills programmes and to make expected levels of progress was good. Strong and effective working relationships between the education specialists, case managers and social workers helped ensure that the majority of children and young people attended the interventions aimed at addressing their offending behaviour and achieve positive learning outcomes during their sentence and on exit. We saw much evidence of staff 'going the extra mile' to support children and young people to reach their potential.

Comment from a young person

When asked if he was involved in the planning of his work with Warwickshire YJS, one young person said that he felt he had been listened to throughout the order and that Warwickshire YJS had "helped me get back on my feet".

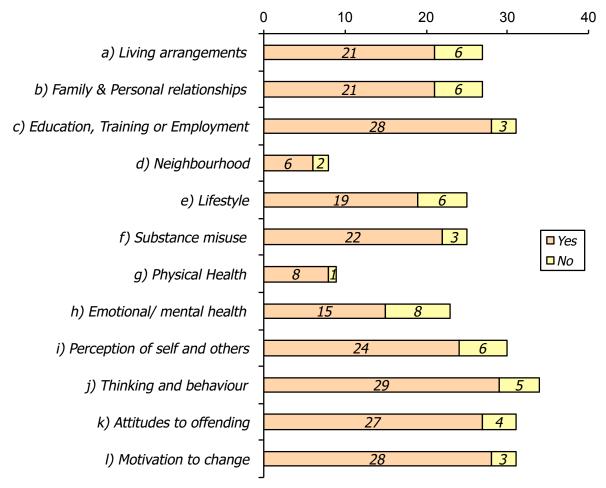
- 3.5. A good range of ETE interventions had been identified across the county, providing sufficient and appropriate placement opportunities for children and young people, particularly when main stream education was not appropriate. Access to alternative education provision had recently been enhanced for children of school age
- through the new Area Behaviour Partnerships. Much of the provision was tailored carefully and sensitively to ensure children and young people's learning needs were met and offending behaviour was addressed.
- 3.6. A number of innovative pathways had been developed with partner agencies to motivate children and young people to return to learning activities. Emphasis was placed on foundation learning programmes, and in developing employability and independent living skills, especially for young people who were over the school leaving age and who were accommodated by the local authority.
- 3.7. Three work clubs operating in partnership with Warwickshire YJS and a private careers
 - company had recently opened in Nuneaton, Leamington Spa and Rugby. These clubs helped children and young people to develop their employability skills, such as practising job interviewing skills, and searching for training and employment opportunities.

Comment from a young victim

One victim, when asked if she could suggest any improvements for Warwickshire YJS, said "No I don't think they need to make any improvements, they were wonderful and they are professional and empathetic".

Disappointingly, at the time of the inspection, referrals from Warwickshire YJS had been low, despite a positive publicity campaign across the three localities.

Were sufficient interventions delivered where required to address the following



- 3.8. Most of the hardest to engage children and young people could participate for short periods of time on programmes that focused on practical issues and were delivered as individually tailored packages. However, involvement was not always sustained long enough to ensure the children and young people could achieve meaningful outcomes from the work. The loss of two seconded Connexions advisers within Warwickshire YJS had significantly reduced the capacity for targeted work with post-16 young people. This had been identified by the service as a key area for development.
- 3.9. Intensive surveillance and supervision (ISS) programmes were delivered in-house and provided good challenges to children and young people on offending behaviour programmes, as well as improving their literacy and numeracy skills and attitudes to learning generally.
- 3.10. There was good use of patient and parental consent forms to enable children and young people to be clear about how their personal information would be used to inform the care and broader safeguarding issues.
- 3.11. The two Warwickshire YJS caseworkers with responsibility for the delivery of substance misuse Tier 1 and 2 provisions had access to a variety of educational resources to engage with children and young people. These included the 'drugs box' and 'beer goggles'. These complemented the six to eight week substance misuse sessions designed to address offending behaviour.
- 3.12. The sentence was delivered as a single integrated sentence, both during the custodial phase and on supervision in the community, in only five of the nine custodial cases examined. In three cases, the custodial plan did not address the whole sentence and there was insufficient linkage between work done in custody and that done in the community.

3.13. Warwickshire YJS children and young people had good and timely access to specialist health services such as family therapy, eating disorder specialists, psychiatrists, psychologists and neurodevelopment and Tier 4 services when required.

4. Initial outcomes

- 4.1. A key focus for Warwickshire YJS was to reduce both the frequency and seriousness of reoffending among the children and young people who were subject to supervision. In the majority of cases, since the start of the sentence or release from custody, it appeared that there had been a reduction in both of these areas.
- 4.2. In order to contribute to a reduction in reoffending it is important that children and young people, who are subject to supervision by Warwickshire YJS, make progress against those factors that are linked to their offending. We found that the work had addressed a range of such factors. The majority of children and young people made progress in their education, training and employment, substance misuse, thinking and behaviour and motivation to change. These factors were those that were most commonly linked to offending by the children and young people in our sample.
- 4.3. ETE outcomes for the children and young people known to Warwickshire YJS were satisfactory. The most recent performance data were very encouraging, particularly for those children of statutory school age. By the end of their supervision, 100% were placed in appropriate provision.
- 4.4. In general, the quality of practice to support children and young people to make expected levels of progress was good. Case managers could demonstrate how work helped children and young people attend ETE provision and the majority of children and young people were engaging well

Case illustration

Paul received an 18 month youth rehabilitation order (YRO) for burglary. He was well known to Warwickshire YJS and had previously failed to comply with the requirements of his supervision. Using a wide range of sources, his case manager developed a comprehensive initial assessment which addressed Paul's likelihood of reoffending, his risk of serious harm to others and preferred learning style. He then ensured that Paul had close links with specialist workers such as accommodation, employment and parenting officers and worked jointly with his substance misuse worker to reinforce progress. This led to a decline in Paul's use of cannabis and increased his level of engagement and compliance. The case manager attended the police tasking meetings, to inform them of Paul's progress and share intelligence, and liaised with the Warwickshire Victim and Witness Information Partnership to ensure that his victim received a letter of apology. The case manager also undertook a three way meeting with his probation officer when Paul turned 18 to ensure a smooth transition to adult services. Paul has not committed any further offences.

- and making good progress. Through this they were developing valuable personal and social skills, growing in self-confidence and building their emotional resilience. With strong support from the education specialists, most children and young people at the end of their interventions had clear pathways identified which reflected their needs and built on the learning and progress they had achieved while subject to supervision.
- 4.5. Outcomes for those young people aged 16 years and above were less good, reflecting some of the difficulties already identified in sustaining young people on programmes. It has, however, to be acknowledged that our concerns related to only a small number of young people ten, across the YJS caseload at the time of the inspection, all of whom had complex needs and a history of disengagement from services over several years. We saw several examples of

children and young people who continued on vocational courses or academic programmes to complete qualifications after orders had expired.

Case illustration

Tom had been out of education for several years. He had a chaotic family history and had experienced serious abuse in that context. He had been accommodated by the local authority and had several unsuccessful placements over a short period of time. More recently, the situation had stabilised and he was a care leaver living in semi-independent accommodation. He was attending 6th form school to complete his GCSEs and was planning to study A level Psychology.

- 4.6. The children and young people who had been assessed by the Child and Adolescent Mental Health Services (CAMHS) had individualised care plans, access to good interventions and achieved good outcomes related to reoffending. This data was captured through the completion of Strength and Difficulty Questionnaires (a mental health screening tool for adolescents). This was done at the assessment stage and followed up at the conclusion of the interventions.
- 4.7. In those cases that were near the end of supervision, we looked to see that steps had been taken to ensure that any positive progress made by the children and young people would be sustained following the end of the sentence. We assessed that this had been done in almost all of the cases inspected. This included developing exit plans, making referrals and signposting children and young people to services that would be available to them when they completed their order. However, it should be noted that feedback from some children and young people suggested that they were not aware of the plans that were in place to enable them access services once supervision had ended.

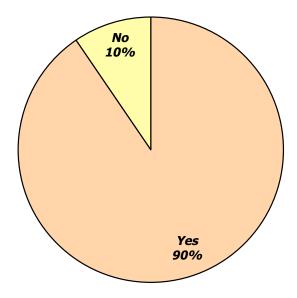
5. Management and Leadership

- 5.1. Case managers had access to sufficient resources to carry out work to reduce the likelihood of reoffending in all but two of the cases. Almost all of the practitioners had a sufficient grounding in the principles of effective practice.
- 5.2. Although there was no mandatory health training for Warwickshire YJS staff, council staff had access to training provided by Warwickshire County Council. Training was offered to Warwickshire YJS staff by partner agencies such as COMPASS. Health staff delivered training to the YJS in June 2011, in relation to understanding mental health concerns and the criteria for making referrals. The caseworkers with substance misuse responsibilities were qualified to provide Tier 1 and 2 interventions.
- 5.3. Health practitioners received regular individual and clinical supervision. The health team leader, and the health practitioner supplemented this with additional independent clinical supervision, necessary for them to meet the conditions of their registration and continue to practice.
- 5.4. Warwickshire YJS, in partnership with health (CAMHS), had good evaluation processes in place in relation to their health screening tool and the performance of CAMHS.
- 5.5. The matrix management structure presented some challenges for practitioners, even though outcomes for the education strand were improving well. The practice education leader managed the work stream across the county but did not manage the education specialists directly, and concern was expressed that the flow of information about ETE issues was inhibited by a lack of more regular, formal discussions between the relevant staff. Some performance management information was not forthcoming from training providers for the post-16 cohort. Attendance

figures for both school aged children and those aged 16 years and over were collected regularly by Warwickshire YJS. However, information about the achievement levels reached by those post-16 was not received centrally. Training providers would discuss individual's participation and performance with case managers but did not provide achievement data formally to Warwickshire YJS. Partnership arrangements however were good and the practice leader met regularly through locality and countywide post-16 ETE forums. In contrast both attendance and progress for school age children were regularly discussed with the providers through the Area Behaviour Partnerships and reported formally by education specialists.

5.6. ChildView data up until the end of July 2012 showed that approx 71% and 62% respectively were in suitable ETE. Most recent figures for the post-16 cohort were very strong at 100%.

Has the YOT given sufficient attention to ensuring that positive outcomes are sustainable following the end of the sentence



- 5.7. The value placed on the police role in Warwickshire YJS was reflected in the training provided to the Warwickshire YJS police officers. They received training in restorative justice, MAPPA, safeguarding and motivational training. Consequently they felt equipped to work directly with the children and young people.
- 5.8. Whilst there is an automated notification of all disposals of children and young people in custody, Warwickshire YJS was not systematically notified of all children and young people entering custody. Both Warwickshire YJS police officers had access to police custody records from their desks, but in their absence checks could not be done (one officer was off sick at the time of the inspection). An automated notification system would give an earlier and more systematic indicator of who was in custody, including those children and young people already subject to supervision and who may have reoffended.

Summary

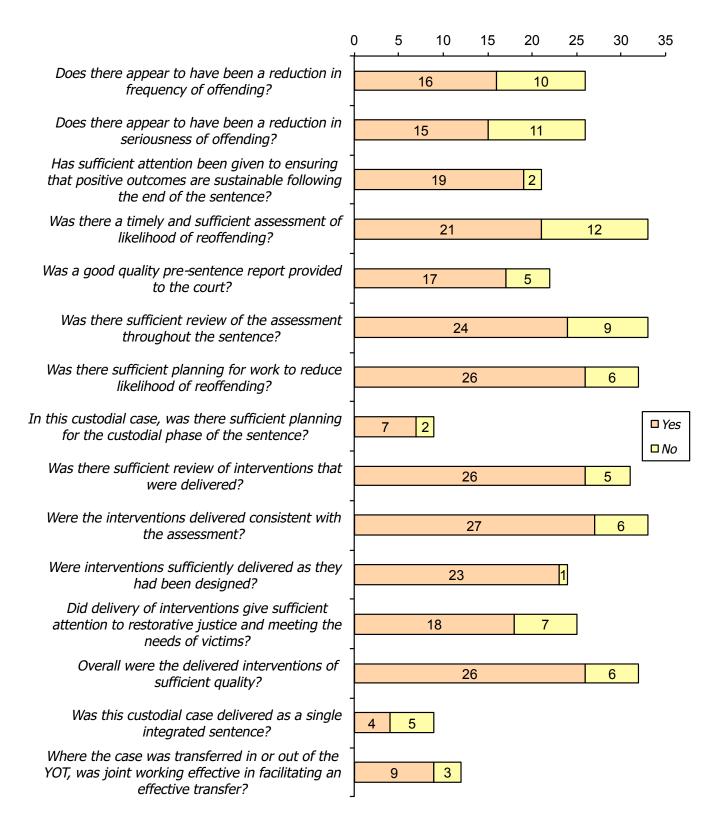
Overall work to reduce reoffending was good. In the majority of cases, both the frequency and the seriousness of reoffending had reduced since the start of the sentence or release from custody. Most of the children and young people had made clear progress in addressing factors linked to their likelihood of reoffending. In the majority of cases progress was being made in respect of ETE, substance misuse, thinking and behaviour and motivation to change. These were the factors that were most commonly linked to offending by the children and young considered in our sample.

There were clear and thorough assessments of likelihood of reoffending at the initial assessment. We found timely and good quality planning to address reoffending issues. In the majority of cases planned interventions, aimed at helping to reduce the likelihood of reoffending, were delivered. Reviews of the assessments, plans and interventions were sound. More needed to be done to ensure that, for custodial cases, the sentence was being delivered as a single integrated sentence.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case].

Reducing the Likelihood of Reoffending



Protecting the Public

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 69% of work to protect the public was done well enough.

Key Findings

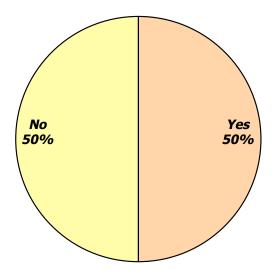
- 1. All reasonable steps had been taken to minimise the risk of harm to others in most cases. However, improvements were needed to the quality of these assessments and plans.
- 2. Initial assessment of the risk of harm posed by the child or young person was sufficient in only half of the cases inspected. Insufficient attention was paid to reviewing risk of harm assessments and plans.
- 3. Initial planning to manage the risk of harm to others was insufficient in too many cases. Plans had not been completed or were not timely. Some did not anticipate risk of harm issues or address victims' issues.
- 4. In most cases the interventions delivered helped to manage the risk of harm.
- 5. MAPPA and other multi-agency arrangements were effective in managing risk of harm in 11 of the 12 relevant cases.
- 6. Where there were concerns about the risk of harm, only half of the cases examined could show that management oversight, and other quality assurance arrangements, had contributed to the quality of assessment and planning in those cases.

Explanation of findings

1. Assessment

- 1.1. The majority of the PSRs we inspected contained a clear and thorough assessment of the child or young person's risk of harm to others. This was important in order to provide sentencers with the information they needed to deliver the most appropriate sentence to protect the public.
- 1.2. Overall, however, a sufficient assessment of the risk of harm posed by the child or young person had been undertaken at the start of the order in only half of the cases inspected. Having an accurate assessment of these issues, at an early stage, enables all staff to understand the level of risk of harm present, and what factors might increase or lower these risks.

Was there a sufficient assessment of the Risk of Harm to others posed by the child or young person?



- 1.3. In almost half of all cases, insufficient attention had been paid to reviewing the risk of harm throughout the sentence. This reflected deficiencies in the quality of the reviews, reviews being a copy of the previous assessment and not being updated to reflect the current circumstances. Some practitioners did not appear to understand risk of harm issues sufficiently well.
- 1.4. The multi-agency Risk and Vulnerability Panels provided a useful forum for consideration of complex and high risk/vulnerability cases, with advice provided to case managers by specialist workers and managers. However, there were occasions when there was little or no follow on agreed actions from these meetings, and subsequent management oversight of the cases did not lead to the required actions being taken.

Case illustration

Daniel was subject to detention and training order (DTO) supervision in the community and had been assessed as posing a medium risk of harm to others. There were indications that he was reoffending, his risk level was increased to high, and the assessments and plans updated accordingly. Daniel was arrested for further offending and again assessments and plans relating to managing the risk of harm were updated. The Warwickshire YJS police officer became involved and worked closely with the case manager in intelligence and information sharing, and in delivering direct work to Daniel. For example, work was done on knife crime, to help manage the risks in the case. Daniel was designated as a Prolific or Priority Offender and was overseen by the Integrated Offender Management team. The case manager maintained contact with the Integrated Offender Management police officer and this is resulted in positive management of the risks Daniel presented. The case manager supported Daniel's access to services necessary to safeguard his health and wellbeing. Daniel engaged well and this enabled the workers to effectively manage the risks he both posed and faced.

1.5. Some of the assessments did not make reference to all the available information. Some cases failed to contain information about issues identified in the risk management plan, for example concerning a young person who had presented sexually harmful behaviour that had not led to conviction. In this particular case the interventions offered only related to acquisitive offences and did not address the possibility of the young person being either a possible victim, and/or perpetrator, of sexual offences.

2. Planning for interventions

2.1. Where the child or young person had been in custody, we found a higher level of quality in respect of planning to address risk of harm during the custodial period. These were sufficient in over two-thirds of the custody cases. Of the three plans that were insufficient, two had not adequately addressed preparation for release.

Comment from an inspector

"The National Society for the Prevention of Cruelty to Children (NSPCC) had raised concern that a young person was unable to successfully engage in their programme whilst concerns surrounding his mental health remained unresolved. WYJS health practitioners worked with the young person, his General Practitioner (GP) and the NSPCC to address these concerns. Consequently, joint recommendations were presented to the court to alter the order in relation to the delivery of interventions. A course of cognitive behaviour therapy was delivered, alongside GP prescribed medication and monitoring by physical health. Following this, the required sexual offending intervention was recommenced."

- 2.2. Planning is important to ensure that everyone concerned understands the specific work to be undertaken, including the child or young person and their parent/carer. It also provides a mechanism to help judge progress on reducing the risk of harm to others and protecting the public. Initial planning to manage the risk of harm was sufficient in over half of the relevant cases. In the 14 cases where the planning was insufficient, the deficiencies we encountered were plans not being completed or timely and not anticipating risk of harm issues or addressing victims' issues. For example, in 5 out of the 14 relevant cases, we found that victims' issues had not been adequately addressed in the plans.
- 2.3. We were pleased to note good representation from health professionals at multi-agency meetings and risk management forums.
- 2.4. Only one case required planning in conjunction with the MAPPA processes. This had been done to a satisfactory standard.
- 2.5. The lack of priority, in relevant cases, being given to reviewing risk of harm assessments was mirrored in relation to reviews of plans for the work which were insufficient in just under half of the cases inspected. Reviews of plans provide an opportunity to reassess the progress and help to identify and address any changes in circumstances that may affect the level of risk of harm to others.
- 2.6. The role of the police officers in Warwickshire YJS had been tailored to ensure best use of their expertise in addressing the cases which presented the highest risks to the community. This was closely linked to the 'Harm Agenda', an approach adopted by the police and partners to focus work on issues of high concern. Police officers saw their primary role as facilitating close links between the WYJS and police, and ensuring effective two way communication of relevant information. An example of this was given by one of the officers, where he had helped to ensure that police resources from the West Midlands had responded to a vulnerable young woman, who had reported being the victim of a sexual assault.
- 2.7. We were pleased to note comments from police partners that there had been a positive shift in Warwickshire YJS, in recent years, towards a more balanced approach to addressing both child or young person vulnerability and risk of harm issues. Most Warwickshire YJS staff were seen to be giving higher priority to victims' concerns, and those of the wider community, than had previously been the case.

3. Delivery of interventions

- 3.1. It is important that interventions are delivered to help manage risk of harm and that the services delivered are consistent with the assessment and plan of work in the case. In almost three-quarters of the cases we inspected, the interventions that had been delivered were in line with both the assessment and the planning for the individual young person. We were pleased to see, in a similar number of cases, interventions being delivered to help manage risk of harm issues. In addition, almost three-quarters of cases showed active management of the risk of harm throughout the delivery of interventions.
- 3.2. Warwickshire YJS children and young people had good access to mental health services. The estimated waiting times were five days for acute mental health, and 15 days for non-acute.

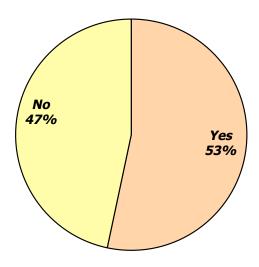
4. Initial outcomes

- 4.1. In two-thirds of the cases with an identifiable or potential victim, we found that the risk of harm posed to those victims had been effectively managed. Ten cases required improvement in this aspect of work.
- 4.2. In almost three-quarters of cases all reasonable steps had been taken to keep to a minimum the risk of harm posed by individual children and young people under the supervision of Warwickshire YJS. In those cases where risk of harm had not been kept to a minimum, the key areas for improvement were the quality of assessments and plans, and the delivery of required work by Warwickshire YJS.
- 4.3. MAPPA and other multi-agency arrangements were effective in managing the risk of harm in 11 of the 12 relevant cases.

5. Management and Leadership

- 5.1. Case managers had access to sufficient resources to carry out work to manage the risk of harm posed to others in all of the relevant cases. We also found that all but one of the practitioners we interviewed had sufficient understanding of local policies and practice for this work.
- 5.2. But, in only half of the cases, management oversight was effective where the child or young person posed a risk of harm to others. There were a variety of reasons for this, including oversight not taking place in a timely fashion. Warwickshire YJS accepted that their 'last line of defence', i.e. management oversight, had not provided assurance in a number of cases, as issues had been missed or actions not undertaken as instructed. In too many of the cases that were reviewed in supervision, or been considered at the Risk and Vulnerability Panel meetings, agreed actions had not been implemented. The quality of management oversight, in respect of improving the quality of risk of harm practice, was an area that required improvement.
- 5.3. During the inspection we interviewed 13 case managers (over the 34 cases). We discussed their understanding of Warwickshire YJS's policies and procedures. Following this we felt that almost all had sufficient understanding of the principles of effective practice and local policies and procedures for the management of risk of harm to others, however not all had operated to these standards in all cases.
- 5.4. Warwickshire YJS was seen as being committed to MAPPA. For example, their attendance at MAPPA meetings for individuals under 18 years of age was 100%. Partners viewed Warwickshire YJS involvement in MAPPA as working well.

Was oversight by management effective in ensuring the quality of Risk of Harm work in this case?

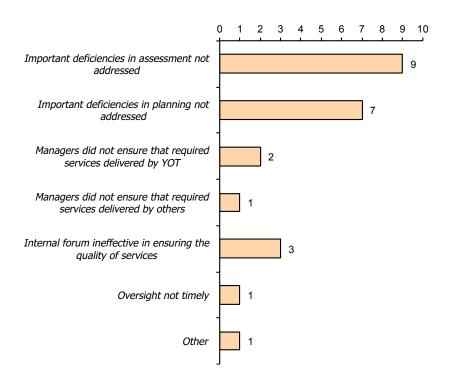


Summary

Overall, work to protect the public and both actual and potential victims was good. Reasonable steps had been taken to keep to a minimum the risk of harm to others in most cases. The delivered interventions, MAPPA and other multi-agency arrangements had helped to effectively manage risk of harm to others issues in most cases.

Improvements were needed to the quality of initial assessments of risk of harm, and their reviews. Quality assurance arrangements, including management oversight, had not been effective in too many of the cases where a risk of harm to others was present.

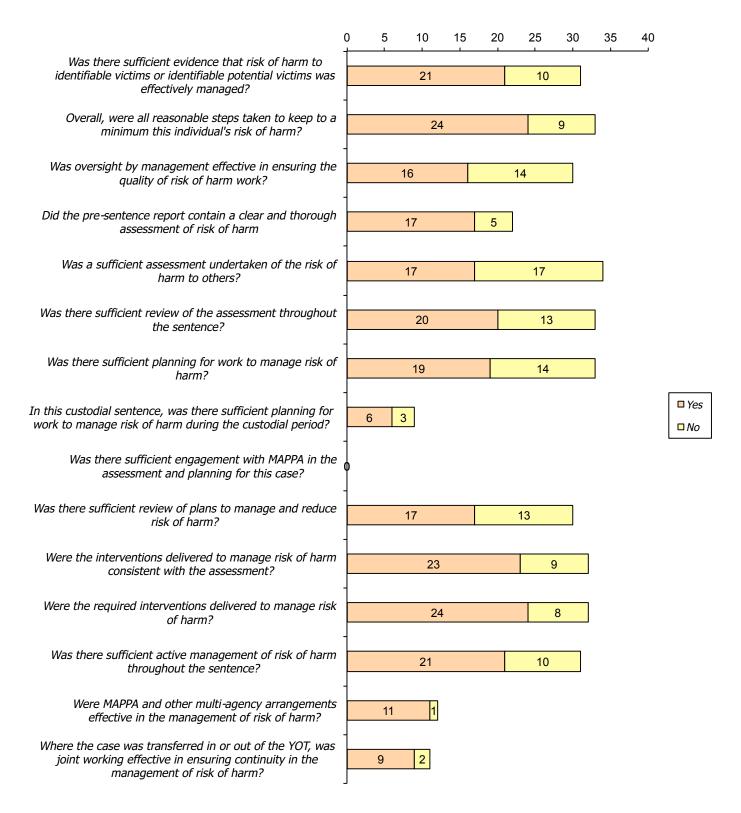
Management oversight of Risk of Harm work was not effective because



Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 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



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 through positive leadership and management, including an effective contribution to multi-agency child protection arrangements.

Case assessment score

Within the case assessment, overall 80% of the work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

- 1. The Warwickshire YJS team was committed to keeping children and young people safe and had supported many children and young people in order to reduce their levels of vulnerability.
- 2. Work undertaken by Warwickshire YJS, in partnership with their colleagues from Children's Services, had led to positive outcomes being achieved and sustained in most cases.
- 3. Assessments of vulnerability and safeguarding were sufficient to meet the needs of the particular case and priority was being given to reviewing assessments. Sufficient planning was in place and regularly included work to address emotional health; substance misuse; ETE and general care arrangements.
- 4. The quality of plans for young people in custody was less strong in relation to their safeguarding and vulnerability. However, interventions were routinely being delivered to address these issues.
- 5. Management oversight was effective in ensuring the quality of work done by Warwickshire YJS staff to keep children and young people safe. Staff had a clear understanding of their role and the significance of their contributions to child protection plans. In addition, staff demonstrated awareness of escalation processes for resolving professional disagreement. However, inspectors saw case examples where, despite concerns being raised by Warwickshire YJS staff, no changes were made to key decisions.
- 6. The impact of joint work was reduced by the variable levels of communication from some of the children's social work teams and their perceived inconsistent approach to thresholds.

Explanation of findings

1. Assessment

1.1. PSRs were generally of a good quality and over three-quarters provided a clear and thorough assessment of the vulnerability and safeguarding needs of the relevant children and young people.

Comment from a carer

When asked if her views were taken into account when the YJS was preparing a PSR, one carer said "They [Warwickshire YJS] always ask regularly, they ask my opinion. Without them I don't think I would be doing the remand scheme".

- 1.2. In all but 6 of the 34 cases inspected, assessments of vulnerability and safeguarding were good enough to meet the needs of the particular case. This included quality as well as timeliness, and recording the correct level of vulnerability.
- 1.3. Priority was being given to reviewing these assessments. More than three-quarters of cases

were reviewed sufficiently throughout the sentence. In the few cases where this did not happen, the concerns centred on case managers copying previous assessments and not taking into account new information.

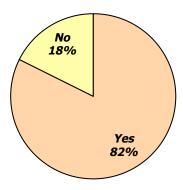
Comment from an inspector

"The initial assessment by Warwickshire YJS was extremely thorough and well thought out, giving a clear link, where appropriate, to issues such as the young person's autism, his previous behaviour, his cannabis use, his educational issues and his vulnerability. His risk cZ\Ufa level was low, but his vulnerability from behaviour such as previous self harming incidents was medium" High Ugaddressed with a robust vulnerability management plan."

2. Planning for interventions

2.1. In the majority of cases, sufficient planning was in place for work to address the safeguarding and vulnerability needs of the children and young people. This regularly included work to address emotional health; substance misuse; ETE and general care arrangements.

Was there a sufficient assessment of vulnerability and Safeguarding?



2.2. The quality of most plans was adequate and we saw some good examples where health, substance misuse and ETE issues were routinely identifiable. In some plans there was too little emphasis on identifying the outcomes to be achieved and that added to difficulties in tracking the effectiveness of the work.

Case illustration

Arl was aged 14 when he received a lengthy custodial sentence for an offence of robbery. This had been his first time before a court although concerns had previously been raised about his gang associations and the potential for offending. In custody Karl had cut the links with his gang and was potentially vulnerable to attack as a result. He was placed in Warwickshire, as part of a package to manage the risk of harm he both posed and faced. The police tasking meeting brought together a range of organisations to assess and plan for managing the various risk issues in this case. A comprehensive and well coordinated package was put in place. Unfortunately, Karl was spotted and accosted in the street by a former gang member. Anxiety about his personal safely led to him leaving the accommodation and failing to maintain contact with Warwickshire YJS. He was subsequently returned to court for non-compliance and was resentenced. The work to protect him and to address his offending continues.

2.3. For the children and young people who were subject to the community part of a custodial sentence, good work was undertaken by the education specialist and case managers, in negotiation with the child or young person. This helped to ensure that resettlement was well planned, suitable accommodation was identified and ETE interventions were available on release.

Comment from an inspector

"Staff within the WYJS strove to work effectively with other agencies to protect the child or young person and reduce their vulnerability. There were a number of examples of effective work in this area, including the collaboration with Barnardos to provide specialist foster placements for young people at risk of custody, the use of qualified social workers on cases with known child protection elements and the effective partnerships around individual pieces of work that have achieved positive outcomes."

- 2.4. The quality of plans for children and young people in custody was less strong in relation to their safeguarding and vulnerability. Only four of the seven relevant cases had plans that sufficiently included work to address their identified vulnerability needs.
- 2.5. Satisfactory reviews of plans to address safeguarding and vulnerability needs were found in almost three-quarters of the cases.

Case illustration

David was given an 18 month YRO, a curfew and a period of unpaid work for two burglary offences. He was a looked after child, who had been passed between accommodation in Warwickshire and Coventry on many occasions. A strong relationship had been built with his substance misuse worker based in Coventry. David also remained committed to completing his education at Coventry College. In order to ensure that the cross-border communication continued, the case manager in Warwickshire YJS initiated monthly 'Multi-agency professionals meetings'. These were held at Coventry College to ensure that David, representatives from Children's Services, Warwickshire YJS, the college, Barnardos, accommodation workers, his foster carer and the substance misuse professionals were all able to attend and coordinate their efforts.

3. Delivery of interventions

- 3.1. In all but 2 out of the 27 relevant cases, interventions were delivered to address safeguarding and vulnerability needs. We also found in over three-quarters of these the interventions provided were consistent with the assessment and plan of work in the case.
- 3.2. Issues around safeguarding and vulnerability were actively and effectively addressed throughout the delivery of interventions in over three-quarters of cases. In three cases joint work with children's social care services had not been effective.
- 3.3. Good substance misuse harm reduction work had been developed by the substance misuse worker. This was delivered with the assistance of the speech and language therapist and Warwickshire YJS case managers.
- 3.4. For 8 out of the 12 relevant transfer cases, work had been done to ensure a smooth transition and continuity of service delivery.
- 3.5. Warwickshire YJS staff worked hard with other agencies to protect the children and young people and reduce their vulnerability. There were a number of examples of effective work in this area. These included collaboration with Barnardos on providing specialist foster placements for children and young people at risk of custody, the use of qualified social workers on cases with known child protection elements and effective partnership work that had led to positive outcomes.

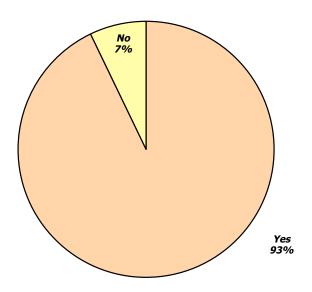
4. Initial outcomes

- 4.1. The Warwickshire YJS team was committed to keeping children and young people safe. In almost all of the relevant cases we found that all reasonable steps had been taken to keep to a minimum the risk of the individual child or young person coming to harm, either from themselves or from others.
- 4.2. Work undertaken by Warwickshire YJS, in partnership with their colleagues from Children's Services, had led to positive outcomes being achieved and sustained in most cases. Examples included making appropriate referrals to Children's Services in relation to child protection matters, providing intensive support along with colleagues in order to secure settled housing for the child or young person and sharing information appropriately through regular multi-agency meetings.
- 4.3. Work was being undertaken with both parents/carers and children and young people to address substance misuse, housing, behaviour and family problems. Children and young people had been supported to reduce levels of vulnerability and to keep to a minimum the risk of the individual child or young person coming to harm.
- 4.4. In a small number of cases, outcomes had not been achieved despite appropriate referrals being made by Warwickshire YJS to Children's Services and where the internal escalation processes within the WYJS had been exhausted. Examples of this included ineffective action to protect a young person where there were indicators of sexual exploitation.

5. Management and Leadership

- 5.1. Overall, Warwickshire YJS management oversight was effective in ensuring the quality of work to address safeguarding and vulnerability in over three-quarters of the relevant cases. Management oversight for this aspect of practice included regular supervision with the case workers and attendance at the weekly Risk and Vulnerability Panels. Case managers had access to sufficient resources to carry out work to improve safeguarding and reduce vulnerability in over three-quarters of the relevant cases.
- 5.2. Warwickshire YJS staff had a clear understanding of their role and the significance of their contributions to child protection plans. All of the practitioners interviewed had sufficient understanding of local policies and practice to support the management of safeguarding.

Overall, has the YOT done enough to keep this child or young person safe, either from themselves or from others?



Staff demonstrated a clear knowledge and understanding of child protection procedures and how to refer cases and undertake joint work with other professionals. We found a number of examples in the cases we examined which illustrated how positive

Comment from an inspector

"The Risk and Vulnerability Panels held at the Leamington office are open to all staff. This allows different perspectives to be gained from a multidisciplinary approach."

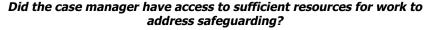
relationships and understanding of core business by staff in both Warwickshire YJS and Children's Services supported effective practice in this area.

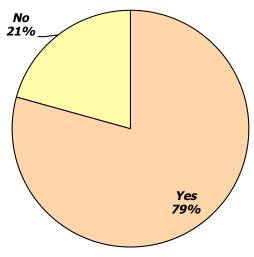
- 5.3. All health professionals received good and regular safeguarding training in line with Local Safeguarding Children Board (LSCB) guidance. This was complemented by a nominated child and mental health lead for Coventry and Warwickshire Partnership Trust. Health staff had, in the past, escalated concerns through their named nurse. However, an example was seen where agencies had shared concerns regarding the safety of a child or young person, but the risks had not been sufficiently addressed, nor had health staff passed the issue onto their safeguarding health leads.
- 5.4. All external ETE providers met safeguarding requirements and undertook relevant checks to ensure staff working with children and young people were suitably qualified.
- 5.5. The impact of joint work was reduced however by the variable levels of communication from some of the children's social work teams and the perceived inconsistencies in their approaches to thresholds. We heard from several sources of variations in the quality of service and decision making within the different children's services 'duty' teams, and it was unclear, at the time of the inspection, what action had been taken to address that issue.
- 5.6. Staff were aware of escalation processes for resolving professional disagreement and we saw some cases where Warwickshire YJS staff had appropriately challenged the decisions made
 - by Children's Services. However, we also found case examples where, despite concerns being raised by Warwickshire YJS staff, and internal escalation processes being used, no changes had been made to key decisions made by other organisations. We were told that responses from Children's Services

Comment from a victim

The mother of a victim, when talking about the quality of engagement with Warwickshire YJS said, "I could not fault them, I was let down by the police and social services which created extra problems".

- could be variable, and that there were often communication issues about initial decision making on referrals. Some cases seen by inspectors illustrated these difficulties.
- 5.7. In relation to the specific issue of sexual exploitation, insufficient attention had been paid to this complex area of work both by the LSCB and by operational managers. The LSCB had not followed statutory guidance Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children 2010 in developing policy or procedures for professionals in this area of work. Consequently, the actions taken in relation to two children and young people had not been effective or timely. This exposed them, and potentially others in the community, to significant harm. Warwickshire YJS staff had identified relevant concerns and had made referrals to Children's Services in this respect. However, despite the internal Warwickshire YJS escalation processes being used, the issues had still not been adequately addressed.





Summary

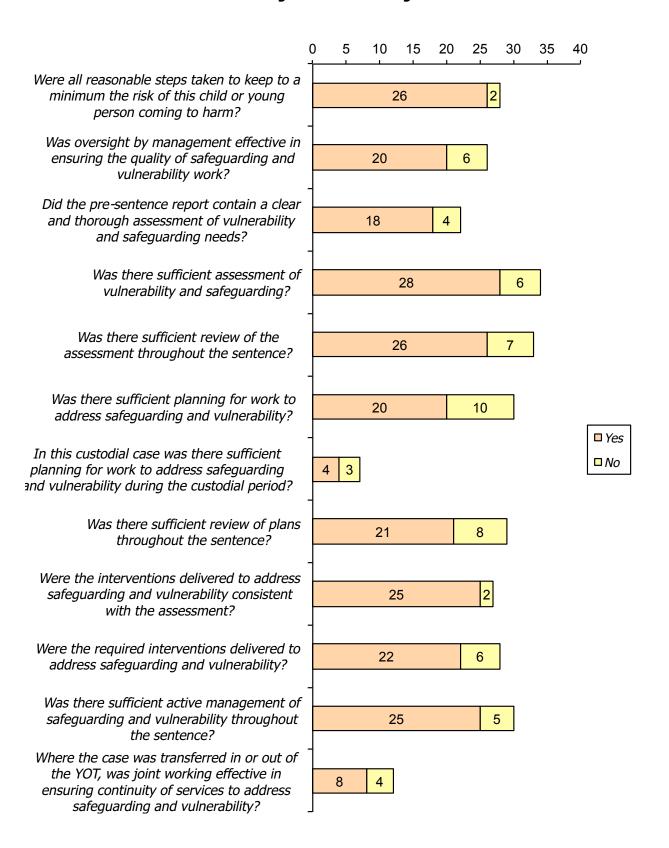
Overall, work to protect children and young people and reduce their vulnerability was good. Youth justice staff had a clear understanding of their contribution to child protection plans and were committed to keeping children and young people safe. Planning regularly included work on emotional health; substance misuse; ETE; and general care arrangements. However, the quality of plans for children and young people in custody was less strong.

Management oversight was effective, and staff demonstrated awareness of escalation processes for resolving professional disagreement, but we saw case examples where, despite concerns being raised by Warwickshire YJS staff, no changes were made to key decisions. The impact of joint work was reduced by the variable quality of engagement with some of the children's social work teams.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 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



Ensuring 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 sentence as the court intends. We expect that the YOT 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 88% of work to ensure the sentence was served was done well enough.

Key Findings

- 1. Sufficient attention was paid to ensuring that children and young people engaged with the requirements of their sentences. Most had complied and case managers worked to motivate those who had not met these commitments. This was successful in the majority of cases and case managers took appropriate enforcement action where young people consistently failed to meet the requirements of their sentences.
- 2. Diversity factors and barriers to engagement were sufficiently assessed, and we were pleased to note the quality of the work undertaken by case managers and parenting workers to involve parents/carers in all aspects of the work with their children.

Explanation of findings

1. Assessment

- 1.1. The assessment of diversity factors and barriers to engagement was sufficient in over three-quarters of the cases.
- 1.2. We were pleased to note the quality of the work undertaken by case managers and parenting workers to involve parents/carers in all aspects of Warwickshire YJS work with their children. As a result, in a clear majority of cases inspected, there was significant engagement with children and young people, parents/carers or significant others to carry out assessments. Parents/carers can provide vital information relating to

Comment from a young person

When asked how well Warwickshire YJS had worked to engage the young person in supervision he said: "They are easy to approach and talk to". He indicated that it took him some time engage in the work as it was "his choice when he started to listen to what had been advised". Since he had decided to engage in the work he said "it's been fun". He added that he enjoyed his reparation placement making bird boxes and being able to use the Bloxham Youth Justice Centre to wash his clothes in the machine when he was living at the Bed & Breakfast.

the child or young person's behaviour and changes in attitude. The involvement of the child or young person provides them with the opportunity to own the assessment and is likely to elicit greater commitment to the order.

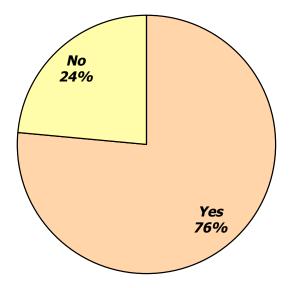
- 1.3. We also found high levels of engagement with children and young people and their parents/ carers in the development of the PSR. Most parents interviewed told us that their views had been sought by the Warwickshire YJS worker writing the report and that their views had been expressed within the report.
- 1.4. PSRs gave sufficient attention to diversity factors and barriers to engagement in all but one of the reports inspected.

Case illustration

Darren was released from 12 months in custody into a new area to live with his mother for the first time in a number of years. The WYJS staff liaised well with his home area YOT and went to the final two DTO reviews in order to formulate an effective plan for his release. They visited separately to start building a relationship with him, and put in place a good quality plan to meet his needs. This involved constructive activities that allowed Darren to use his spare time well, but also to get to know the local area.

Darren attended a project at a local youth club which had the dual result of enabling him to consider his substance misuse as well as widening his social network and accessing universal youth services. Warwickshire YJS provided him with education sessions and he gained a place on a college course as a result. Warwickshire YJS staff put in place parenting support for Darren's mother, as they had anticipated that there might be some difficulties in adjusting to living together as a family again. The case manager worked with Darren directly on work around his thinking and behaviour in a very facilitative way, enabling him to engage and to build a positive relationship with professionals for the first time. The result was that Darren engaged well with community supervision and began to make some positive steps towards a stable and productive future.

Was there sufficient assessment of diversity factors and barriers to engagement?



2. Planning for interventions

- 2.1. In over three-quarters of all cases inspected, initial planning had included sufficient attention being paid to barriers to engagement.
- 2.2. There was a high level of involvement in the work by parents/carers, as well as children and young people under the supervision of Warwickshire YJS. This included their involvement in the planning processes.

3. Delivery of interventions

3.1. For 10 of the 12 relevant transfer cases, work had been done to ensure a smooth transition and effective delivery of the sentence.

Comment from an inspector

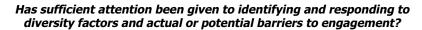
"The children young people interviewed as part of the inspection reported that Warwickshire YJS used a variety of creative methods in their work and supported young people to develop life skills in the process. They were aware that there were good partnerships that worked to establish good interventions. Some commented specifically on the services offered by the Fire and Rescue Service and with Network Rail. The children and young people saw these as being examples of innovative work that had helped them to complete their sentences successfully."

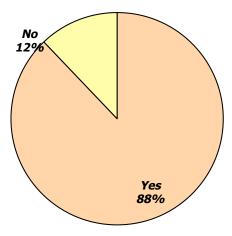
- 3.2. In all but four cases inspected, children and young people, their parents/carers (or significant others) were meaningfully and sufficiently engaged throughout the delivery of the sentence.
- 3.3. Partnership working with health and the agencies delivering aspects of the sentence plan was good. This was illustrated through health practitioners working with the NSPCC in relation to a young person's sexual offending.
- 3.4. The commitment and hard work of the small specialist team had ensured that work with statutory school aged children had improved most recently, and the range of provision offered to all young people had been sustained. They responded to the diverse and complex needs of the Warwickshire YJS cohort. Innovative work had been developed with the early help and prevention service, within Children's Services, to develop preventative work and build capacity within communities to help to reduce offending behaviour among children and young people and families.
- 3.5. Limitations in the extent to which some staff were aware of the importance of addressing the speech, language and communication needs of children and young people were noted. This was evident in one case where the psychologist report stated, the young person had "some speech and language difficulties with pronunciation difficult to understand". We could not see evidence of these being addressed in the work.
- 3.6. Health practitioners had good engagement and retention with the children and young people who accessed their service, with accessible and sustainable interventions. Telephone and texting communication was utilised so that the children and young people could communicate with their health worker at a time that suited them. They accommodated diverse needs by providing interventions within homes, community facilities (such as college/school premises and health clinics) and custody visits. They did this, where appropriate, to maintain continuity of care. They adopted flexible working practices, staggering their shifts and including evening work, whilst still delivering a range of therapies targeting risk taking and offending behaviour.
- 3.7. Children and young people had good access to Tier 3 substance misuse services via COMPASS, when those needs had been identified correctly by Warwickshire YJS. COMPASS offered good access to community provision and pharmaceutical services via the Recovery Partnership.

4. Initial outcomes

4.1. In all cases, sufficient attention was paid to ensuring the child or young person engaged with Warwickshire YJS and the requirements of their sentence. This involved case managers and other Warwickshire YJS workers ensuring that the individual child or young person, and their parent/carer, were clear about what was expected of them and involved them throughout the order. It also included responding to the child or young person's needs and motivating them.

4.2. Almost three-quarters of the children and young people complied with the requirements of their sentence. Many required work by case managers to motivate them to meet their commitments under the sentence and this was successful in the majority of those cases. Case managers took appropriate action, including returning cases to court, where children and young people failed to meet the requirements of their sentence.





- 4.3. In 88% of cases we found that barriers, or potential barriers, to engagement had been identified and addressed. Such barriers, if not addressed, can make the child or young person
 - frustrated and can lead to a lack of commitment and compliance and can contribute to further offending. In all but two cases, sufficient attention had been given to the health and well-being of the child or young person in so far as it could act as a barrier to successful outcomes being achieved.

Comment from a victim

One victim stated that "The WYJS are very professional and have clear guidelines and training". The victim felt safer after the work done by Warwickshire YJS and said he was once again able to visit the local supermarket, where the offence had taken place.

- 4.4. Managers and education staff regularly reviewed cases through formal supervision arrangements, and worked diligently to ensure children and young people received appropriate and sustained ETE placements. Action was taken swiftly to address issues as they arose and, in some instances, placements were changed to ensure disruption to learning was kept to a minimum.
- 4.5. Health practitioners had successfully acted as advocates for children and young people under their care. Strong evidence was provided by practitioners, illustrating how they had voiced the children and young people's concerns at multi-agency forums. In doing so they had challenged other professional's and resolved the concerns, in particular the appropriateness of some care placements.

5. Management and Leadership

- 5.1. We found that all of the practitioners interviewed had sufficient understanding of local policies to support engagement and responding to non-compliance.
- 5.2. Partnerships were strong between the range of service providers including schools, the virtual

school, colleges and independent training providers. Specialist education staff attended key strategic meetings to advocate on behalf of Warwickshire YJS, such as Access 2 Education, to ensure good ETE interventions were available.

Summary

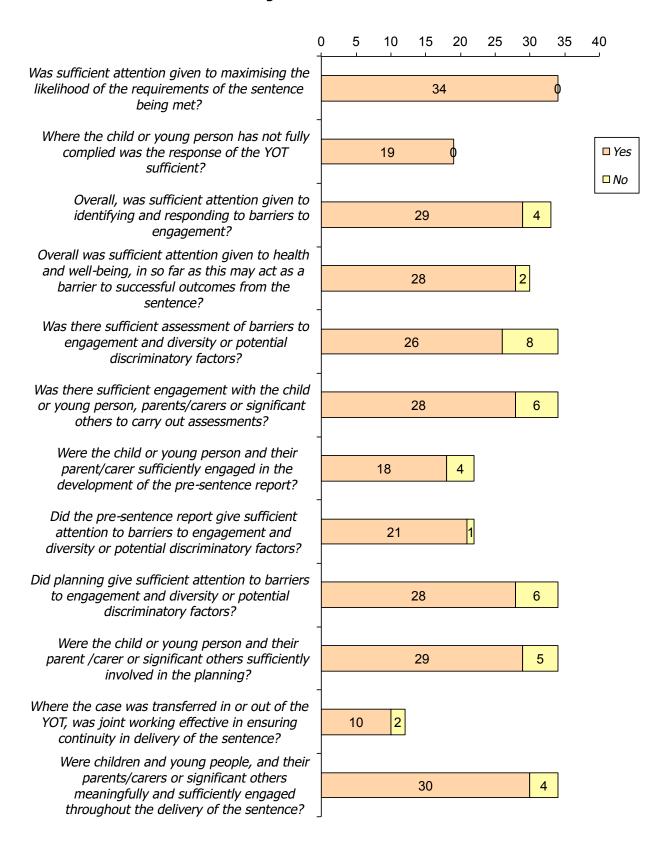
Overall work to ensure that the sentence was served was very good. Sufficient attention was being been paid to ensuring that young people engaged with the requirements of their sentences. Most had complied with these requirements and case managers worked to motivate those who had not. This was successful in the majority of cases and case managers took appropriate enforcement action where children and young people consistently failed to meet the requirements of their sentences.

There was sufficient assessment of diversity factors and barriers to engagement. We were pleased to note the quality of the work undertaken by case managers and parenting workers to involve parents/carers in all aspects of the work. Practitioners had sufficient understanding of local policies to support engagement and to respond to non compliance by children and young people.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 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



Governance

5

Theme 5: Governance

What we expect to see

The YOT Management Board partnership provides sufficient governance to meet national and local criminal justice objectives, and delivers effective outcomes for children and young people who offend or who are likely to offend and the local community. Equality of opportunity and wider diversity issues are prioritised throughout.

Key Findings

- Warwickshire YJS Management Board members took responsibility for the overall governance of Warwickshire YJS and the scrutiny of its work. They had developed strong and productive relationships.
- 2. There was good performance data available to senior managers and the Warwickshire YJS Management Board. The Warwickshire YJS performed well against the YJB national indicators.
- 3. There was a cohesive system which ensured that staff were both clear about Warwickshire YJS objectives, and how the objectives fed into their work. It also ensured that they received appropriate training.
- 4. The co-location of the majority of the criminal justice agencies executive officers (and staff) at the Leamington Spa Justice Centre, illustrated the commitment to enable a strong working relationship between Warwickshire YJS and its partners. This led to broad strategic thinking which was went beyond criminal justice objectives and demonstrated a powerful interdependency between all partners. Appropriate attention was paid to sharing resources between Warwickshire YJS and partners across the area.
- 5. The quality of supervision, and quality assurance arrangements, required further development in order to improve the quality of some key aspects of practice.

Explanation of findings

1. Leadership

- 1.1. The Chief Executive of the Warwickshire Probation Trust chaired the Warwickshire YJS Chief Officer's Board (the local name for the YOT Management Board) and was a strong advocate for Warwickshire YJS. The board received regular performance data. Warwickshire YJS had, for a number of years, performed well, with performance improving against the national indicators (reducing the number of first time entrants to the criminal justice system, reducing the use of custody and reducing reoffending rates) as well as a number of local indicators to ensure that local services were commissioned appropriately.
- 1.2. Warwickshire YJS had management structures in place to facilitate the achievement of local and national objectives. The Management Board had representatives from all statutory partners, and was appropriately aware of the day-to-day working of Warwickshire YJS. Meetings were held quarterly, and members contributed effectively to the work of the Board. There was an acceptance that individual Board members should see their role as including the responsibility to appropriately challenge each other, as well as representing their own organisation.
- 1.3. Board members were positive about the partnership's ability to meet both Warwickshire YJS's objectives and to assist with meeting relevant partner's objectives. They cited a strong 'interdependency' between the different agencies. In this sense the 'value' of the work of

Warwickshire YJS was recognised across many agencies. In particular, the specific opportunities provided by Warwickshire YJS by occupying a pivotal role between criminal justice and wider social policy, particularly in respect of issues relating to the care and management of a complex group of children and young people and their families.

1.4. Warwickshire YJS prepared an annual plan that focused on the national and local objectives for the coming year, as well as reviewing progress against the previous year's plan. The plan was sufficient to meet the needs of Warwickshire YJS and provided evidence of progress.

Comment from an inspector

"The management of the WYJS were always keen to challenge and hold other organisations to account". This was seen as a healthy position.

1.5. The Warwickshire Youth Justice Partnership Group, a sub-group of the Chief Officer's Board staffed by service and operations managers, also provided a useful forum for discussions and problem solving amongst representatives of the partnership agencies. The substance misuse provider, COMPASS, was not represented on the Partnership Group and hence they were unable to respond to any operational needs of Warwickshire YJS. The strategic responsibility for substance misuse commissioning lay with the Strategic Director of Communities on the Chief Officers' Board.

Comment from an inspector

"Partners communicated well outside the formal meetings, resolving issues where the need arose such as when Warwickshire YJS practitioners reported difficulties in children and young people accessing sexual health and smoking cessation services. This was raised by the Warwickshire YJS Manager with the Director of Public Health. He fed the issues into the Joint Strategic Needs Assessment for Warwickshire and provided training to Warwickshire YJS staff to enable them to deliver sex and relationship awareness including condom distribution and smoking cessation work."

- 1.6. Youth justice plans were integrated into other relevant plans for children and young people. For example, the local Health and Well-being Board was considering how issues relating to youth offending fed into its strategy and how they should monitor the outcomes. Warwickshire YJS also contributed to other plans such as; the Children and Young People's Plan; the Safeguarding Children's Board Plan; the Community Safety agreement; the Drug Implementation Plan; the Alcohol Strategy; the MAPPA Business Plan; the Anti-Social Behaviour Action Plan; and the Integrated Offender Management Plan.
- 1.7. The Warwickshire YJS Management Board paid attention to diversity factors in its work. They addressed issues for services users and staff by ensuring that interventions took account of diversity and that staff received training in this area.

2. Partnerships

- 2.1. The close working relationship between Warwickshire YJS and its partners was a key strength. They focused on criminal justice areas and also local indicators such as health, living arrangements and user engagement. This aided the delivery of services across the various organisations. Warwickshire YJS had a number of services delivered with and by partners
- 2.2. There was a mixed picture with regard to monitoring the effectiveness of some of the services provided. For example, the monitoring of substance misuse commissioned services was good. However, Warwickshire JYS did not receive achievement and progress data centrally about the post-16 cohort from the range of training providers, even though numbers were comparatively small and the sentences ranged from short community orders to longer-term DTO licenses.

- 2.3. Warwickshire YJS shared resources with statutory and other partners, including the co-location of staff in the new Justice Centres at Leamington Spa and Nuneaton. Service delivery was assisted by the co-location of Warwickshire YJS staff with other partners, for example, police, probation and victims' services. This helped to ensure smooth sharing, between the agencies, of information regarding individual children and young people. Warwickshire YJS was seen by partners as a leading player in the development of initiatives to improve the safety and well-being of children and young people, and was always willing to share resources effectively and work positively with others.
- 2.4. Inspectors identified an area of concern regarding the effectiveness of LSCB arrangements. No evidence was seen of policies or procedures developed by the LSCB for staff to follow in cases where sexual exploitation issues had been identified, despite clear national guidance being issued in 2010. Despite referrals by Warwickshire YJS staff in relation to these issues, we found a there had not been a coherent overarching consideration of such issues, using the information available from cases.

3. Workforce management

- 3.1. A reduction in the number of education specialists within Warwickshire YJS, and the loss of two Connexions advisers, had increased the workload for the two education specialist workers. This exposed a gap in advice and guidance provision for those post-16 young people who were more difficult to engage.
- 3.2. Warwickshire YJS's commitment to the organisation and delivery of training for staff was a key strength. There had been joint training between Warwickshire YJS and partners, for example, on motivational interviewing, which was provided to Warwickshire YJS staff and the co-located police officers. Warwickshire YJS had a coordinated approach to the identification and delivery of training, through the identification of service development needs. These were based on national drivers or strategic priorities. It also had a Development Matrix, where managers could assess any individual in a particular role, to help identify the training they needed for their role. There were good opportunities for education staff to access training within the WYJS, children's services, and externally.
- 3.3. The appraisal system fed directly into the Development Matrix, ensuring that expressed training needs were identified and, if appropriate, met. Staff interviewed commendably demonstrated their understanding of the services, policies and procedures relating to all areas of their work and Warwickshire YJS's vision and their role in achieving that vision. Specialist workers had a good experience of supervision and appraisals.
- 3.4. We noted Warwickshire YJS's learning culture, which supported and valued continual training and development. Other evidence included staff's clarity on the availability of ongoing professional development and manager's citation of other developments such as joint work with Warwick University on the effect of brain damage on behaviour.
- 3.5. Three-quarters of the case managers believed that their training and skills development needs were being met. We asked case managers if they had received sufficient training to recognise and respond to speech, language or communication needs, and other diversity or potential diversity factors. Almost half said they needed more training to recognise and respond to these issues.
- 3.6. Managers had the necessary skills, but had faced challenges in finding sufficient time, to assess and improve the quality of practice. Although managers regularly reviewed cases, we found this had not led to improvements in the quality of assessments and plans, in particular for issues of risk of harm. Assessments and plans were being countersigned when they were of insufficient quality.

4. Review and evaluation

4.1. The quality of case work recordings reviewed with regard to ETE interventions was generally clear, comprehensive and timely. Education specialists retained much informal knowledge about individual children

Comment from an inspector

"Health practitioners received good and regular individual case supervision and clinical supervision. In addition they also had open case safeguarding meetings where practitioners could bring cases for collective discussion to refine practice."

and young people's placement and progress. Attendance information about all children and young people was regularly received and reviewed. Achievements of the post-16 cohort overall however were less easy to ascertain other than through updated individual case files.

- 4.2. Detailed quarterly performance data was available to managers and the partnership board. The Warwickshire YJS annual plan also provided some excellent performance information. We found evidence of partners reviewing performance information to ensure that they were contributing to improving outcomes for children and young people.
- 4.3. Performance management systems ensured data were collected annually from providers regarding the level of ETE engagement for those young people aged 16 years. However, while the quality and effectiveness of alternative provision for school aged children was monitored robustly through the Area Behaviour Partnerships, there was no similar requirement or expectation on commissioned independent training provision to supply to Warwickshire YJS regular performance management information, such as attendance details and achieved learning outcomes, for post-16 placements.
- 4.4. Good performance reports detailing outcome measures were regularly submitted by COMPASS to the Criminal Justice Partnership Board and the Warwickshire Drugs and Alcohol Management Group¹.
- 4.5. This was complemented by good internal monitoring of substance misuse ASSET classifications by the Warwickshire YJS Performance and Planning Officer to identify trends.

5. Leadership supports front line delivery of services

- 5.1. Supervision and other quality assurance arrangements had made a positive difference to the quality of key aspects of practice in only half of the cases inspected. Quality assurance processes should identify practice that is not of sufficient quality and rectify any deficiencies. Warwickshire YJS accepted that their 'last line of defence', i.e. management oversight, had not provided this assurance in a number of cases.
- 5.2. During the inspection we interviewed 13 case managers and discussed the inspected cases with them. We also discussed their understanding of Warwickshire YJS's policies and procedures. Almost all case managers interviewed had sufficient understanding of the principles of effective practice and local policies and procedures for the management of risk of harm to others. However, these standards had not been applied in all cases.
- 5.3. Case managers had sufficient understanding of local policies and procedures for the management of safeguarding and what was required to ensure effective engagement and compliance.
- 5.4. The case managers agreed that their line managers had the skills to: assess the quality of their work, support them with their work; and provide effective and appropriate supervision. All case managers also believed that their managers actively helped them improve their work.
- 5.5. Almost all of the case managers interviewed told us that the culture of the organisation positively promoted learning and development.

A partnership between NHS Warwickshire and complementary agencies, and responsible for monitoring Warwickshire alcohol implementation plan 2010-2012. This plan sits beneath the overarching Warwickshire Alcohol Harm Reduction Strategy.

Summary

The governance arrangements of Warwickshire YJS were good. Board members took responsibility for governance and scrutinised the work of the organisation through good performance data. Staff understood the organisation's objectives and how these fed into their work. However, there was a need for a systematic approach to monitoring and reviewing interventions and the outcomes delivered by partners. Greater attention needed to be paid to the quality of supervision and to quality assurance arrangements, to improve the quality of some key aspects of practice.

The co-location of criminal justice agencies executive officers and staff at the Leamington Spa Justice Centre enabled a strong working relationship between the partners. This contributed to broad strategic thinking on the role of Warwickshire YJS. This went beyond criminal justice objectives and showed the interdependency between the partners. Appropriate attention was paid to sharing of resources between the partners across the area.

Appendices

Contextual information about the area inspected

Warwickshire had a population of 543,800 as measured in the Census 2011. The youth population (those aged between 10 and 17 years old) accounted for 9.6% of the population. This was about the same as the average for England/Wales as a whole, which was 9.4%.

The percentage of the youth population with a black and minority ethnic heritage was 9% (ONS, mid year estimate 10-17 black and minority ethnic 2009). This was lower than the average for England/Wales, which was 14%.

Reported offences for which children and young people aged 10 to 17 years received a pre-court disposal or a court disposal in 2010/2011, at 23 per 1,000, were lower than the average for England/Wales of 33 (Youth Justice Board 2010-2011).

The proportion of young people in Warwickshire aged 16 to 18 who are not in education, training or employment is estimated at 4.5%. This is lower than the average for England which is estimated at 6.1%. (Department for Education 2012)

Youth Justice Outcome Measures

The Youth Justice Board indicators are national measures of YOT work and performance:

Reoffending measures:

- (i) Of those young people who received a reprimand, final warning, court conviction or who were released from custody or tested positive for a class A drug on arrest, the proportion who reoffend within a 12 month reporting period. This reoffending proportion for Warwickshire was 29.9%, somewhat better than the 34.1% for England/Wales as a whole.
- (ii) Of those young people who received a reprimand, final warning, court conviction or who were released from custody or tested positive for a class A drug on arrest, the average number of reoffences within 12 months, per 100 such young people. For Warwickshire, there were 0.70 offences per young person who reoffends, better than the 0.96 for England/Wales as a whole.

(Data based on April 2009 to March 2010 cohort)

First time entrants measure:

The number of young people who received their first reprimand, final warning or court conviction (and thus entered the youth justice system) in a 12 month period, as a proportion per 100,000 10-17 year olds in the general local population. The figure for Warwickshire is 576, compared to 747 for England/Wales as a whole.

Use of custody:

This number of custodial sentences per 1,000 10-17 year olds in the general local population. The figure for Warwickshire is 0.21, compared to 0.8 for England/Wales as a whole.

Contextual information about the inspected case sample

In the first fieldwork week we look at a representative sample of between 23 and 84 (depending on the size of the YOT throughput of cases) individual cases up to 12 months old, some current, others terminated. These are made up of first tier cases (referral orders and reparation orders), youth rehabilitation orders (mainly those with supervision requirements), detention and training orders and other custodial sentences.

The sample seeks to reflect the make up of the whole caseload and will include a number of those who are a high risk of harm to others, are particularly vulnerable, are young women or are black & minority ethnic children & young people.

Appendix 3

Acknowledgements

Lead Inspector	Joseph Simpson, HMI Probation
Deputy Lead Inspector	Caroline Nicklin, HMI Probation
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	Stella Butler, Ofsted
	Paul Eveleigh, HMI Constabulary
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	,
Assistant Chief Inspector	Christopher Reeves, <i>Proof Reader</i>

Inspection arrangements

The Full Joint Inspection (FJI) programme inspects youth offending work in a small number of local authority areas each year. It focuses predominantly on the quality of work in statutory community and custodial cases during the sentence up to the date of inspection. Its objective is to seek assurance that work is being done well enough to achieve the right outcomes. The four core themes for this inspection are:

- Reducing the likelihood of reoffending
- Protecting the public
- Protecting the child or young person
- Ensuring the sentence is served

Methodology

YOTs are informed 11 working days prior to the inspection taking place. Fieldwork is undertaken over two weeks with a week in between. The primary focus is the quality of work undertaken with children and young people who offend, whoever is delivering it. Cases are assessed by a team of inspection staff with local assessors (peer assessors from another Youth Offending Team). They examine these with case managers who are invited to discuss their work in depth, are asked to explain their thinking and to identify supporting evidence in the record.

Prior to or during this first week, we receive copies of relevant local documents. During the week in between, the data from the case assessments are collated and a picture about the quality of the work of the youth offending team emerges.

The second fieldwork week is the joint element of the inspection – HMI Probation are joined by colleague inspectors from the police, health, social care and education to explore in greater detail the themes which have emerged from the case assessments. In particular, the leadership, management and partnership elements of the inspection are explored, in so far as they contribute, or otherwise, to the quality of the work delivered.

During this week we also gather the views of others including strategic managers, staff and service users – children and young people, parents/carers and victims, and where possible observe work taking place. From April 2013 we will also gather the views of children and young people through a questionnaire.

At the end of the second fieldwork week we present our findings to local strategic managers, the YOT management team and other interested parties.

Publication arrangements

A draft report is sent to the YOT 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 Youth Justice Board. 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'.

Scoring approach

This describes the methodology for assigning scores to each of the core themes:

- Reducing the likelihood of reoffending
- Protecting the public
- Protecting the child or young person
- Ensuring that the sentence is served

Inspection staff examine how well the work was done across the case - from assessment and planning to interventions and outcomes, focusing on how often each aspect of the work was done well enough. This brings together performance on related elements of practice from all inspected cases.

Each scoring question in the inspection tool contributes to the score for the relevant section in the report. In this way the core themes focus on the key outcomes.

This approach enables us to say how often each aspect of work was done well enough, and provides the inspected YOT with a clear focus for their improvement activities. Each core theme is assigned a percentage (quantitative) score, which along with a descriptor is then given a provisional star rating.

Case assessment score	Descriptor	Star rating
80% +	Very good	***
65% - 79%	Good	***
50-64%	Unsatisfactory	***
< 50%	Poor	

Each of these themes contains elements of leadership, management and partnership which cannot be evidenced through the scoring system for individual cases, and which are a particular focus of the work of partner inspectorates. A moderation process then takes account of these elements to determine the final descriptor.

Additional modules are scored on a similar basis.

If there are serious and unaddressed shortcomings, in individual cases, relating to the risk of suffering harm either to or from the child or young person, that have left someone at risk, then this may constitute a limiting factor to the star rating.

Further details of this process can be found on our website:

Inspection of Youth Offending Work

Criteria

The aspects of work youth offending work that were covered in the core themes in this inspection are defined in the Inspection Criteria for Full Joint Inspection. A copy of the inspection criteria is available on the HMI Probation web-site at the following address:

http://www.justice.gov.uk/about/hmi-probation/inspection-programmes-youth/full-joint-inspection-fji-of-youth-offending-work

SEPARATE CRITERIA ARE PUBLISHED FOR EACH ADDITIONAL MODULE INSPECTED, WHICH ARE AVAILABLE FROM THE SAME ADDRESS.

Appendix 7

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:

www.justice.gov.uk/about/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 6th Floor, Trafford House Chester Road Manchester M32 0RS

Glossary

ASB/ASBO Antisocial behaviour/antisocial behaviour order

A structured assessment tool based on research and developed by the Youth Justice Board **Asset**

looking at the child or 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

CJS Criminal justice system. Involves any or all of the agencies involved in upholding and

implementing the law - police, courts, Youth Offending Teams, probation and prisons

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

FTE Full-time equivalent

НМ Her Majesty's

HMI Probation HM Inspectorate of Probation

Interventions; Work with an individual that is designed to change their offending behaviour and/or to

support public protection. constructive

and restrictive A constructive intervention is where the primary purpose is to reduce the likelihood of interventions

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

ISS Intensive Surveillance and Supervision: 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

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

Offsted 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

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, for example 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

Risk of harm to others See also restrictive Interventions

'Risk of harm to others 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

Scaled Approach The means by which Youth Offending Teams determine the frequency of contact with a

child or young person, based on their RoSH and likelihood of reoffending

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 Youth Offending Team 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 children and 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

YOS/YOT/YJS Youth Offending Service/Youth Offending Team/Youth Justice Service. These are common

titles for the bodies commonly referred to as YOTs

YRO The youth rehabilitation order is a generic community sentence used with children and

young people who offend



Arolygiad ar y Cyd Cyfiawnder Troseddol

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