HM Inspectorate of Probation
Arolygiaeth Prawf EM

Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

Full Joint Inspection of Youth Offending Work in **Islington**

An inspection led by HMI Probation

independent inspection of youth offending work

June 2014

Foreword

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

The majority of the Youth Offending Teams selected for these inspections are those whose performance – based on the three National Youth Justice Outcome Indicators 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 Islington YOS primarily because their performance showed that they had high reoffending rates coupled with the results of the last inspection in June 2011, when substantial improvement work was required to work on reoffending, risk of harm and safeguarding.

It was clear that since the last inspection substantial effort had been put in to try to improve the service delivered to children and young people. Unfortunately, this had not yet had sufficient impact. Improvement work had focused on assessment and planning but had concentrated on the introduction of processes when improvements to the quality of the work being undertaken were also required. Management oversight had not ensured consistent or effective practice.

There were very limited appropriate interventions available for case managers to address offending behaviour and for use on a one-to-one basis. Some good interventions had been provided externally but at the time of the inspection these were not being utilised by children and young people in the YOS. We saw that there were delays in accessing interventions delivered by partner agencies especially around health, but education inputs were good in the statutory school age range.

The YOS Management Board was clearly committed to the continuing need to improve services and had taken action to ensure that previous performance issues were being addressed. It had taken time to get the new infrastructure in place.

Work is now needed to ensure that the board and YOS managers focus on the quality of work being undertaken and that children and young people are able to access suitable interventions to address their offending behaviour. It is positive to note that there has been a reduction in the reoffending and custody rates recently, however these remain higher than the national average.

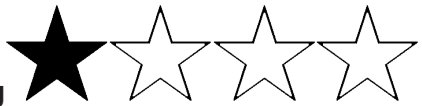
The recommendations made in this report are intended to assist Islington in its continuing improvement by focusing on specific key areas.

Paul McDowell

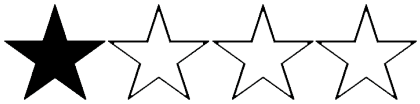
HM Chief Inspector of Probation

June 2014

Summary

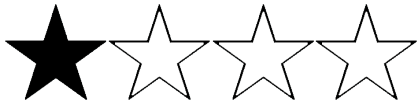
Reducing the likelihood of reoffending 

The work to reduce reoffending was poor. When a child or young person first came into contact with the YOS, time was taken to make an assessment of the factors that contributed to that individual's offending. However, the lack of regular reviews meant that both assessments and plans quickly became less relevant as children and young people's behaviour and lives changed. Case managers were overly reliant on the child or young person's perspective of their offending which did not always match all the accessible evidence. The range of interventions available was too limited and staff said that they had not had sufficient training in the delivery of interventions. We were pleased to see that case managers had developed good working relationships with children and young people and were committed to improving their lives but a lack of effective management oversight meant that staff were not always guided to do the right things at the right time.

Protecting the public 

Work to protect the public and actual or potential victims was poor. Identifying and responding to the risk of harm that some children and young people posed was considerably underdeveloped, and focused too narrowly on the current offence rather than also considering previous offending patterns and behaviours. Risk management plans often failed to plan for known risks. The recently developed risk and vulnerability management meetings were a positive development, well supported by partner agencies, but were not aided by sufficient relevant, current and consistent information to assist effective joint decision making.

There was some effective joint work to identify, monitor and manage those who were involved with gangs, and children and young people commented on how the victim awareness pack had helped them see crime from a different perspective.

Protecting children and young people 

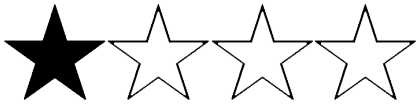
Overall work to protect children and young people and reduce their vulnerability was poor. Many of the children and young people in our case sample were vulnerable either from the actions of others or through their own behaviour. Identifying, assessing, and planning to reduce or manage these vulnerabilities was often not of a good enough quality. However, we were pleased to see that where children's social care were involved with an individual, there was good communication and effective action taken by social workers to keep the child or young person safe. Provision of health services was mixed. Staff found the new health referral process confusing and there were long delays in accessing some emotional and mental health services. Consideration of physical health, and how it impacted on the child or young person's well-being, was underdeveloped.

Ensuring the sentence is served 

Overall work to ensure that the sentence was served was satisfactory. This was the strongest area of practice we saw in Islington. Staff had developed good relationships with children and young people and with parents/carers. In many cases diversity issues were both understood and individual needs met in order to maximise the likelihood of positive outcomes. There was a fast response when children and young people breached or failed to comply with their orders, with positive attempts to re-engage children and young people.

Leadership, Management and Partnership 

Overall leadership management and partnership was poor. Board members were clearly committed to the need to improve the service, and although lots of positive activity had taken place, ably led by the chair, disappointingly this had not yet had a demonstrable impact on practice. It had taken time to get the new infrastructure in place, and there had been a focus on systems, but this had omitted improvement on the quality of work as well. Partnership arrangements were mixed with some positive joint work and other issues that still awaited conclusion.

Interventions 

Overall work to provide sufficient interventions to meet the needs of children and young people was poor. Staff were sometimes unaware of the interventions being delivered by partner agencies. Of the three main interventions used, two of these were written for adults and often not suitable for children. Case managers were very keen to deliver good quality interventions but were hampered by the limited options available and lack of training. As a consequence, we saw that work on offending behaviour drifted, that sentence plans lacked focus and that some offending behaviour needs were unmet. This was particularly evident to those children and young people who needed to work on their thinking and behaviour and attitudes towards offending.

Recommendations

Post-inspection improvement work should focus particularly on the following:

1. That the Management Board further develop their work to ensure a significant impact on delivery outcomes, not least that offending by children and young people in contact with the YOS is reduced. (Chair of the YOS Management Board)
2. That case managers make accurate and timely assessments, plan and review their work as required. (YOS Manager)
3. That suitable, sufficient and appropriate interventions, targeted to offending need, are available and used by trained staff. This should include interventions to target theft of vehicles, dangerous driving and robbery. (Chair of the YOS Management Board)
4. That children and young people's health needs are effectively assessed and met. (Chair of the YOS Management Board)
5. That management oversight of work ensures effective practice. (YOS Manager)
6. That plans are produced when needed which specify what actions need to be taken to manage the risk of harm to others that a child or young person may pose. (YOS Manager)
7. That assessments are effective in identifying the needs and vulnerabilities of children and young people who offend. (Chair of the Local Safeguarding Children Board and YOS Manager)
8. That vulnerability management plans are appropriately focused and keep the child safe. (YOS Manager)
9. That all workers in the YOS have a clear understanding of their role in safeguarding children and young people including making appropriate referrals to children's social care. (YOS Manager)

Please note – all names referred to in the practice examples have been amended to protect the individual's identity.

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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 35% of work to reduce reoffending was done well enough.

Key Findings

1. Assessments prepared for pre-sentence reports (PSRs) were good, using relevant and wide-ranging information to build up a picture of the child or young person's life and offending patterns. Once the individual was sentenced, and the case was allocated to the case management team, the quality of work was less effective.
2. Health issues were not always accurately assessed, particularly when they were directly linked to offending behaviour. This was noted in cases where children and young people had emotional or mental health needs and substance misuse issues.
3. Case managers were able to draw upon good assessments undertaken by children's social care.
4. Careful use of home visits enabled case managers to see for themselves the home situation and to witness family dynamics.
5. Reviews of work were not routinely undertaken, and there was a very limited range of suitable interventions to address offending behaviour.
6. Planning to support children and young people at the end of their orders needed to be strengthened to sustain non-offending behaviour.

Explanation of findings

1. Assessment

1.1. A sufficient assessment of the likelihood of reoffending had been completed in 22 of the 34 cases we assessed. These had been undertaken on time, and incorporated information from other agencies including children's social care, education and from information held about previous orders.

1.2. These initial assessments had led to the provision of good quality pre-sentence reports (PSRs) to assist with decision-making in court.

1.3. Assessments of offending patterns were often too accepting of the child or young person's version of events, and did not investigate anomalies with other information. For example, on occasions the police had intelligence about potential drug dealing, but because there had not been a conviction, case managers did not consider the possibility of the information being correct. As a result, it was hard to identify where effective challenge to children and young people might come from.

1.4. PSRs were mainly of good quality, made appropriate proposals and contained a good range of information that was helpful to the court. We saw some effective management oversight of PSRs. Reports prepared for the youth offender panel (for referral orders) were not as good.

1.5. At the time of the inspection, assessments did not fully identify the range of offending needs. Plans were often too general and in too many cases, offending behaviour work did not challenge attitudes and motivation to offending.

1.6. Once sentenced, assessments were rarely updated. Changes to the child or young person's life, their response to supervision and positive changes in attitude were not recorded in an appropriate manner. Consequently an increasing gap between the reality of the child or young person's life and their sentence plan emerged. Over time, the work we saw had little relevance to the work which actually needed to be done. This was disappointing, as often the case managers were aware of the changes.

1.7. Management oversight was particularly poor. We noted cases where managers had instructed staff to undertake specific work, for example, update the sentence plan. In reality this had rarely occurred.

2. Planning for interventions

2.1. The planning of interventions to address offending behaviour was good enough in just one-third of cases. We considered these to be insufficient because of a number of factors; lack of understanding of the nature and type of offending; lack of suitable interventions known to case managers; and a lack of response to changes in the child or young person's life as they occurred.

2.2. There were no formal arrangements to consider the transition to adult probation services of young people aged 17 and a half who were approaching 18, except where there was a statutory order that required this. Prolific phone thieves or so called 'snatchers' (a local term for offenders who take mobile phones from their victims, usually using a pedal cycle or moped), were not routinely considered for inclusion on the Integrated Offender Manager cohort as a non-statutory offender. Consequently the support for young people could dramatically cease at 18. One young person had 93 offence entries on the Youth Offending Information System (YOIS), including many for stealing mobile phones; he was not referred to any adult support service to help him stop offending.

2.3. Intervention plans were often limited in scope and we saw lists of referrals rather than clear targets and objective setting.

2.4. Planning to develop the education, training and employability skills of children and young people known to the YOS, including intervention plans, lacked sufficient detail to give a full and comprehensive view of the individual's needs. For example, their education and training plans did not drive children and young peoples' progress.

2.5. Children and young people known to the YOS made good progress in alternative education provision and demonstrate particularly good skills. They had a clear view of their career aspirations. One individual spoken to was due to attend an interview for a vocational course. However, she had received insufficient support to help her understand the implications of her sentence on her career choices. She had no help with understanding any vetting and barring requirements or criminal record checks that may limit her opportunities. She had not been given advice about funding options and bursaries and there had been no reinforcement of what her sentence meant in plain terms that were understandable to her.

2.6. Children and young people felt that they had little input into the sentence plan at the outset. We found, in our sample of cases, that children and young people and their parents/carers were not sufficiently involved in the development of the sentence plan in three-quarters of the relevant cases. The views and priorities of parents/carers, and of children and young people had not been reflected in half of the plans.

Practice Example

One young person said that he had a long history of being bullied, which had led to his offending, it took six months for any work to be planned to address bullying and its impact.

3. Delivery of interventions

3.1. Planned interventions had been delivered in just over half of the cases (18), in nine of the other cases, planned interventions were not delivered and in four cases it was unclear exactly what had been delivered.

3.2. Case managers wanted to be able to do meaningful and relevant work but were hampered by the lack of interventions that they could use. Three main interventions were at their disposal, two of which were designed for adults. In several cases the work was clearly inappropriate for the child or young person.

3.3. As a result, some children and young people did not receive interventions around vehicle theft and dangerous driving, robbery, and thinking and behaviour which were appropriate to their offending. We also identified several gaps in the delivery of interventions to meet specific needs most notably in physical health, perception of self and others, family and personal relationships, and motivation to change.

3.4. Sometimes case managers did not know content of interventions to reduce drug use, making it difficult for them to support the child or young person during supervision.

Practice Example

One young person lacked confidence in a range of social situations; as a result he found it difficult to resist peer pressure and this had contributed to his offending. The case manager was trying to assess how confident he was, by using a set of statements to which he could rate how confident he would be. The focus of the work was right, however, the tool that the case manager used was based on an adult model, so it was difficult to see how this young person might relate to the statements such as *"how confident would you be giving a speech at your best friend's wedding"* or *"how confident are you in plumbing in a toilet"*. These examples seemed far removed from this young person's life experiences.

3.5. In 33 cases there should have been a review of the interventions. In 16 cases no review had taken place, in 6 cases the review was insufficient and was mainly a clone of the previous plan and in 3 cases the delivery of the intervention was not adapted to meet the needs of the child or young person.

3.6. Partner agencies often had interventions that could have supported the case manager in dealing with offending behaviour, but referrals to other agencies were inconsistent. Information provided by the YOS showed that 40% of cases open to the YOS were co-worked with other agencies. We saw good joint work with the Intensive Family Intervention Team (IFIT), which had resulted in parents/carers being supported to help manage their child or young person's behaviour in a more effective way.

3.7. There was strong emphasis on keeping children and young people in education, training or employment (ETE). Children and young people of statutory school age had access to a good range of provision and support to remain in school. New River College (pupil referral unit) had worked closely with YOS staff to identify children and young people who were at risk of exclusion and then to provide appropriate support packages to manage their behaviour.

3.8. We came across two specific interventions that would have been helpful for children and young people in contact with the YOS. One was a programme designed to look at the consequences of vehicle theft, which had been delivered by the targeted youth support team. No referrals had been made for YOS children and young people. We also visited a health provision where the sexual health needs of girls and young women could be met. This would have been a very useful service for the girls and young women in the YOS and for those who did not want to see a male worker. It was disappointing that no signposting or referrals had been made to this project.

4. Initial outcomes

4.1. In each of the 34 cases in the sample we make an assessment of what progress has been made. We consider factors that were linked to the individual's offending, and what could reasonably have been achieved during the course of the order. We found that the collated case data indicated that most progress had been made to improve living arrangements and to ETE.

User engagement

On behalf of HMI Probation, User Voice[1] conducted interviews with children and young people who attended Islington YOS. When asked about what work was being undertaken to address offending behaviour they found the following:

In terms of the work that the YOS had been doing with children and young people in order to reduce the likelihood of reoffending, there was a mixed picture. Some children and young people referred very specifically to the courses and the work they did with the YOS.

Interviewer: "Have you done offending work?"

Young person: "Anger management"

Interviewer: "And how did you find that?"

Young person: "it's alright"

Interviewer: "Do you think it was something that you needed?"

Young person: "It's some of the stuff I was arrested for so …"

Others noted that they had attended a drug prevention course.

One young person told us:

"The drugs prevention thing didn't help me but it made me understand the offence, what would happen, the law around it. When they spoke about the effects that didn't bother me, I know I don't smoke or drink but when he said if you get caught with this you will get 8 years and if you supply you get 14 years. He is teaching me and I am thinking I mustn't touch this."

Much of the work was done with individual children and young people on a one-to-one basis with their case manager. Children and young people were not always clear about how the sessions they attended linked to their sentence plans.

It was evident from the interviews conducted that it was the personal relationships between the young person and their case manager that enabled good work to be done. This was especially so when it came to the support and personal development offered by the case manager.

Young person: "she is trying to help with my future, she is honest and she is encouraging if she thinks you could do something better she will push you".

Interviewer: "she motivates and believes in you?"

Young person: "yes and she tells me to never give up, she is determined and I have faith in her".

1 User Voice is an independent organisation that is commissioned by HMI Probation to consult with children, young people and parents/carers about the work of the YOS.

4.2. Very little progress had been made in relation to neighbourhood issues, physical health, motivation to change, perception of self and others, and emotional and mental health. We saw 20 cases where there was a need for an intervention to address substance misuse - it was disappointing to see that in only four of those cases had progress been made.

4.3. In our view, the delivery of interventions made a sufficient contribution to reducing the likelihood of the child or young person reoffending in only 20% of the cases.

4.4. The number of Looked After Children who had offended was considerably lower than the national average. This had been achieved through effective targeting of services and support by the local authority for children and young people with challenging behaviour. Increasingly, this work had been coordinated with the YOS. There was also good liaison with other Youth Offending Teams where children and young people had been placed outside the local authority.

Comment from parents or carers

"I think they should still keep contact with him as he is not 18 but I don't know if they have the time."

"His time is coming to an end … I don't know what he is going to do then. He gets on so well with [the case manager] that it will … it would be good for him to stay in touch."

4.5. Consideration of strategies to support a child or young person when the order had finished were underdeveloped; this was an issue for some of the parents/carers. Similarly, children and young people felt that sometimes they would finish their order and then they would be pushed on with no ideas in place as to what to do next. This caused a lot of concern and could impact on the success of their continued desistance from offending. Two of the parents/carers made this point explicitly when they noted that contact should be continued, especially when the child or young person was still under the age of 18 years.

5. Leadership, management and partnership

5.1. Islington's reoffending rates were higher than the England and Wales average, but it was very pleasing to see welcome reductions in the last two time periods, in which reoffending data was available (January 2011 to December 2011 and April 2011 to March 2012).

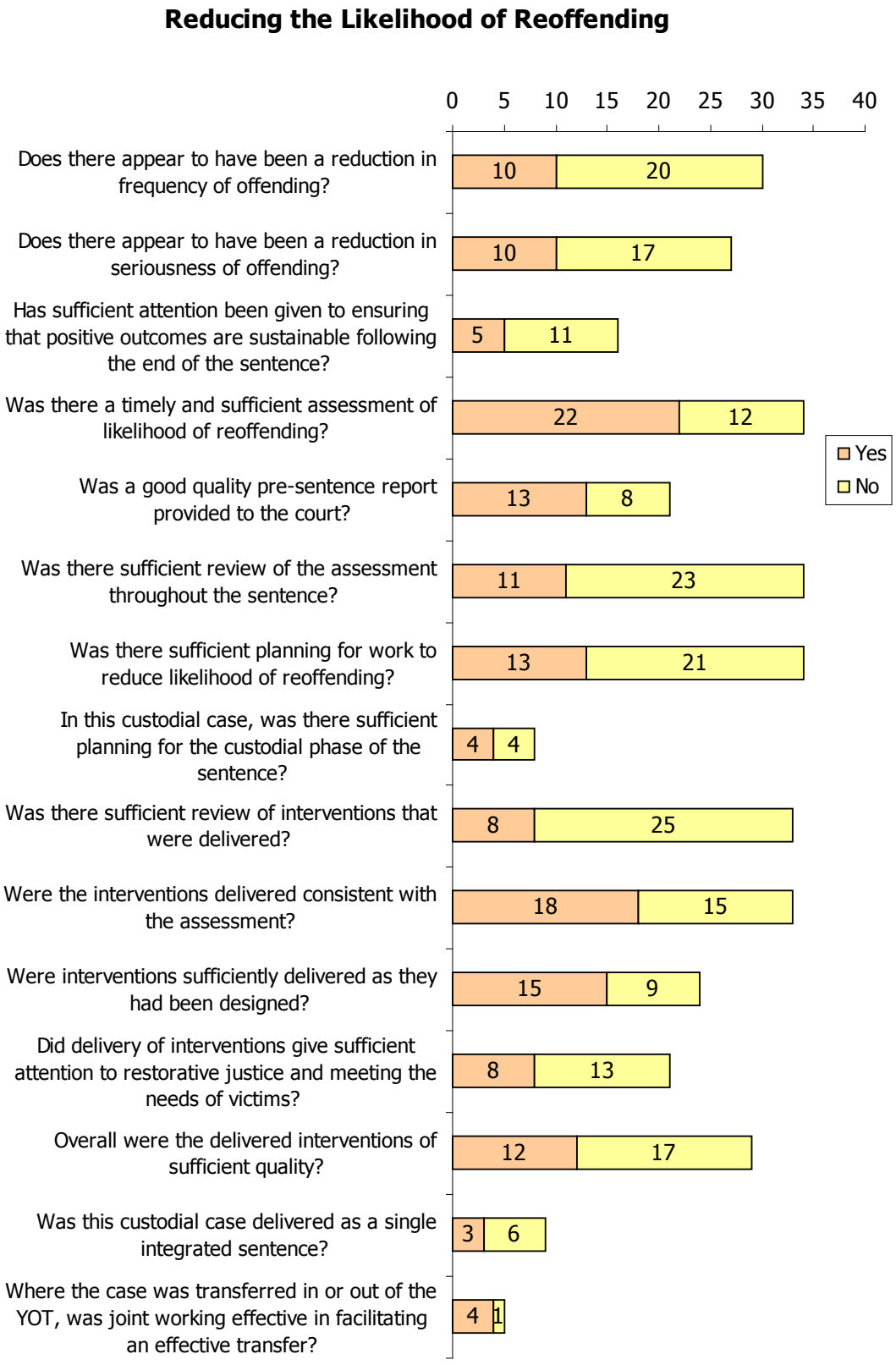
5.2. Since the last inspection in 2011, considerable work had been undertaken to address issues of poor practice. A new YOS Manager and an operational manager had been employed, and for the last 18 months they had been involved in a full and systematic review of services, service re-design and in dealing with staffing issues. It has taken time to develop procedures and protocols and recruit new staff including case managers and first-line managers. It was clear that the two managers have had the full support from their direct line manager and the Management Board.

Summary

The work to reduce reoffending was poor. When a child or young person first came into contact with the YOS, time was taken to make an assessment of the factors that contributed to that individual's offending. However, the lack of regular reviews meant that both assessments and plans quickly became less relevant as children and young people's behaviour and lives changed. Case managers were overly reliant on the child or young person's perspective of their offending which did not always match all the accessible evidence. The range of interventions available was too limited and staff said that they had not had sufficient training in the delivery of interventions. We were pleased to see that case managers had developed good working relationships with children and young people and were committed to improving their lives but a lack of effective management oversight meant that staff were not always guided to do the right things at the right time.

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

2

Theme 2: Protecting the Public

What we expect to see

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

Case assessment score

Within the case assessment, overall 34% of work to protect the public was done well enough.

Key Findings

1. Work to identify and respond to the risk of harm that some children and young people posed to others was underdeveloped and focused too narrowly on the current offence rather than considering previous behaviours.
2. Victims were rarely identified and risk management plans often failed to plan for known risks. There was little linkage between offending behaviour work and actions to manage the risk of harm.
3. Islington had focused attention on the reduction of serious youth violence which was understandable, but work with partner agencies to manage these risks was mixed. We saw some effective work to identify, monitor and work with individuals who were involved in gangs.
4. Other opportunities to support young people at the point of transition to adult services were missed, for example the lack of referrals to the Integrated Offender Management Unit who could offer ongoing support on both a statutory and non-statutory basis.
5. Appropriate interventions to manage risk of harm were not always available.

Explanation of findings

1. Assessment

1.1. In half the cases (17), there was a sufficient assessment of the risk of harm to others posed by the child or young person. In four cases no assessment had been undertaken, in six cases the screening had missed key issues (such as motivation for offending), in eight cases insufficient account was taken of potential victims, and in three cases relevant offences were ignored. Most worryingly, in ten cases previous relevant behaviour had been ignored. Case managers were too reliant on the child or young person's version of events and assessments lacked thorough analysis and consideration of all the available facts.

1.2. Where factors had been missed in initial assessments, it was highly unlikely that they would be picked up as part of a review, given that only one in five cases had been reviewed sufficiently. Case managers often knew about changes in the young persons' lives that had occurred, but had not used reviews in a purposeful way to consider the current situation and whether risk of harm to others had changed and what they might need to do in response.

1.3. A risk and vulnerability panel meeting had recently been initiated, chaired by the operational manager and attended by representatives from social care, the transitions team (managing 18-24 year old gang affiliated young people), the antisocial behaviour team and others. Whilst this meeting

had great potential it was let down by the lack of knowledge of staff presenting cases. When the operational manager tried to interrogate YOIS, case recordings were inconsistent and assessments failed to include all relevant information. One case was discussed with the intention of finding suitable supported accommodation. The risk assessment had failed to include the risk to female residents and staff posed by the individual, which would obviously impact on finding a suitable placement.

1.4. In nine of the cases, we found that staff had difficulty in fully understanding the impact of harmful behaviour and in analysing previous events as a way of predicting future behaviour. In some cases the risk of harm to others had been minimised.

Practice Example

Muhammad aged 14 was known to be linked to a gang. He had whipped a victim from a rival group with the buckle of a belt and had tried to bite the arresting police officer. He had then had been involved in a group fight where he had chased his victim with a knife. A subsequent stop and search resulted in an arrest for possessing a weapon, namely the knife. His risk of serious harm level was judged medium whereas in our assessment he should have been high.

1.5. The police officers within the YOS provided daily intelligence around arrests and overnight detentions. They passed this information on to case managers in order that risk of harm to others could be updated, classifications reconsidered and plans to prevent harm put in place. However, this valuable information was rarely incorporated into assessment and planning. We also saw that case managers had information that was relevant to reoffending which was not routinely passed on to the police.

2. Planning for interventions

2.1. There was an appropriate plan to manage risk of harm to others in only one-third of relevant cases. We found six cases where there should have been a plan but where one had not been produced. Plans tended to restate what the risks were but did not outline what action needed to be taken to manage these. Where there were concerns around violent behaviour we could not always see what work was needed to deal with this. There was effective risk management planning in half of the assessed cases of children and young people in custody.

2.2. The process for notifying and referring cases to Multi Agency Public Protection Arrangements (MAPPA) was not robust. Some case managers could not describe the process and were confused about what MAPPA meant. Given the involvement of some children and young people in serious youth violence, we were surprised that the MAPPA coordinator was unaware of any referrals being made from the YOS in the last 18 months.

2.3. Case managers had limited access to suitable interventions to address harmful behaviour. Within Islington the reduction of 'snatch theft' was a key priority. These offences tended to include the theft of mobile phones, sometimes using force. The nature of this offence was often underplayed and within the authority the term 'snatch theft' had become common. We were surprised that there was no specific intervention to address this type of offending.

3. Delivery of interventions

3.1. We saw delays in accessing the knife crime programme and little investigation from case managers, or first-line managers, to identify what caused the delays.

3.2. Delays were also noted in accessing support from Child and Adolescent Mental Health Services (CAMHS) to address anger management and emotional and mental health triggers to offending. The

delays in accessing the service resulted in one case not being referred, as the case manager felt the process would take too long. We were informed by case managers that in the majority of cases they had to be present at all appointments between CAMHS and the child or young person and not just the initial appointment. This would have had implications on their time, but may also have affected how open the child or young person might be and may, therefore, hinder the effectiveness of the intervention.

Views of children and young people and parents/carers

User Voice's discussions with parents/carers, and children and young people, about victim work showed that good work around victim awareness had been done in these sessions. Much of this related to the case manager explaining the consequences of their actions and then taking children and young people through empathy and association exercises as these examples illustrate:

"My YOT worker showed me the truth and how lucky I was and the domino effect. And what if I had gotten away with her phone and she had loads of pictures that she can never get back. That kind of thing, I never thought of it like that, I only thought of it as money in my hand and me. They broke it down and now I understood what the actual effect is."

Interviewer: "Have you done any victim awareness work?"

Young person: "Yeah, yeah with [case manager]"

Interviewer: "What was that like?"

Young person: "She tells me how victims feel and she said you could be the victim and your sister could be the victim, they say like the victim of your crime and that you are a victim yourself."

Victim work designed to enable children and young people to understand the impact of their offending, was often drawn from their personal experiences of being a victim in order for them to understand the impact of what had happened.

"My offence happened on a main road and there were shop keepers there as well. We had to go into depth I even had to mention and I couldn't leave until I had mentioned all of them I even had to mention one like the shopkeeper's reputation. But the main one she was waiting for me to mention was myself – I kept talking about the victim and their family but I never mentioned myself."

In this instance it allowed the young person to come to terms with the extensive bullying that they had been subject to, and how this then related to their offending behaviour and the work they needed to do in order to understand the impact on their victim and to manage their own emotions more effectively.

One of the parents/carers noted that it was the relationship between the case manager and their child that had enabled them to make a change:

"Before, they would not have listened but [case manager] made them see what the victim would have felt. That's changed him … he knows now."

However, other parents/carers held a different view and felt that not enough was being done with their children or young people especially towards the end of the order "At the start there was do this, do that, work on this, work on that … but now? Nothing"

In terms of restorative practices only a few made any mention of any work being done. One in particular noted that their case manager had encouraged them to write a letter to their victim and that this had been the turning point for them in seeing the consequences of their actions and crime.

4. Initial outcomes

4.1. In 26 cases there was an identifiable victim or we identified a potential victim. In only six of these cases had the risk of harm been effectively managed. The reasons were the lack of effective assessment and planning, and in six cases the victim had not been identified.

4.2. We make an assessment about whether the YOS undertook actions to minimise the child or young person's risk of harm to others. In Islington we judged that sufficient work had been done in just 5 of the 31 cases needed.

Comment from a child or young person

"… my victims have been affected by it and I realise that now, at first when I got the order I didn't comply with – I didn't bother I didn't see the seriousness of it but then as time went and talking to [case manager] you think about the people on the other side you then feel like you should just come and do what you need to do and get done with it."

4.3. Management oversight had not ensured that the work to reduce the risk of harm was either effective or of sufficient quality. Case managers were sometimes unsure of how to assess, plan for, monitor and respond to risk of harm issues. In one case a member of staff did not know how to assess the risk of harm an individual posed. The young person had a recent conviction for possession of an offensive weapon, his behaviour was erratic and compounded by a learning difficulty. This should have been factored into his risk assessment but the case manager had recorded that they were unable to assess his risk due to his unpredictable behaviour.

4.4. Middle managers had not followed up on instructions given to them to improve the quality of risk management work, nor had they followed up actions they had requested staff to undertake.

5. Leadership, management and partnership

5.1. Partnership work had not yet ensured that the work of the YOS was integrated into all the relevant public protection arrangements. This was evident in the:

- lack of joint work with the Integrated Offender Management (IOM) team
- inconsistent knowledge of the MAPPA arrangements
- poor assessment and planning
- lack of delivery of relevant and timely interventions to reduce risk of harm to others and to reduce reoffending
- lack of effective management oversight of work to manage risk of harm.

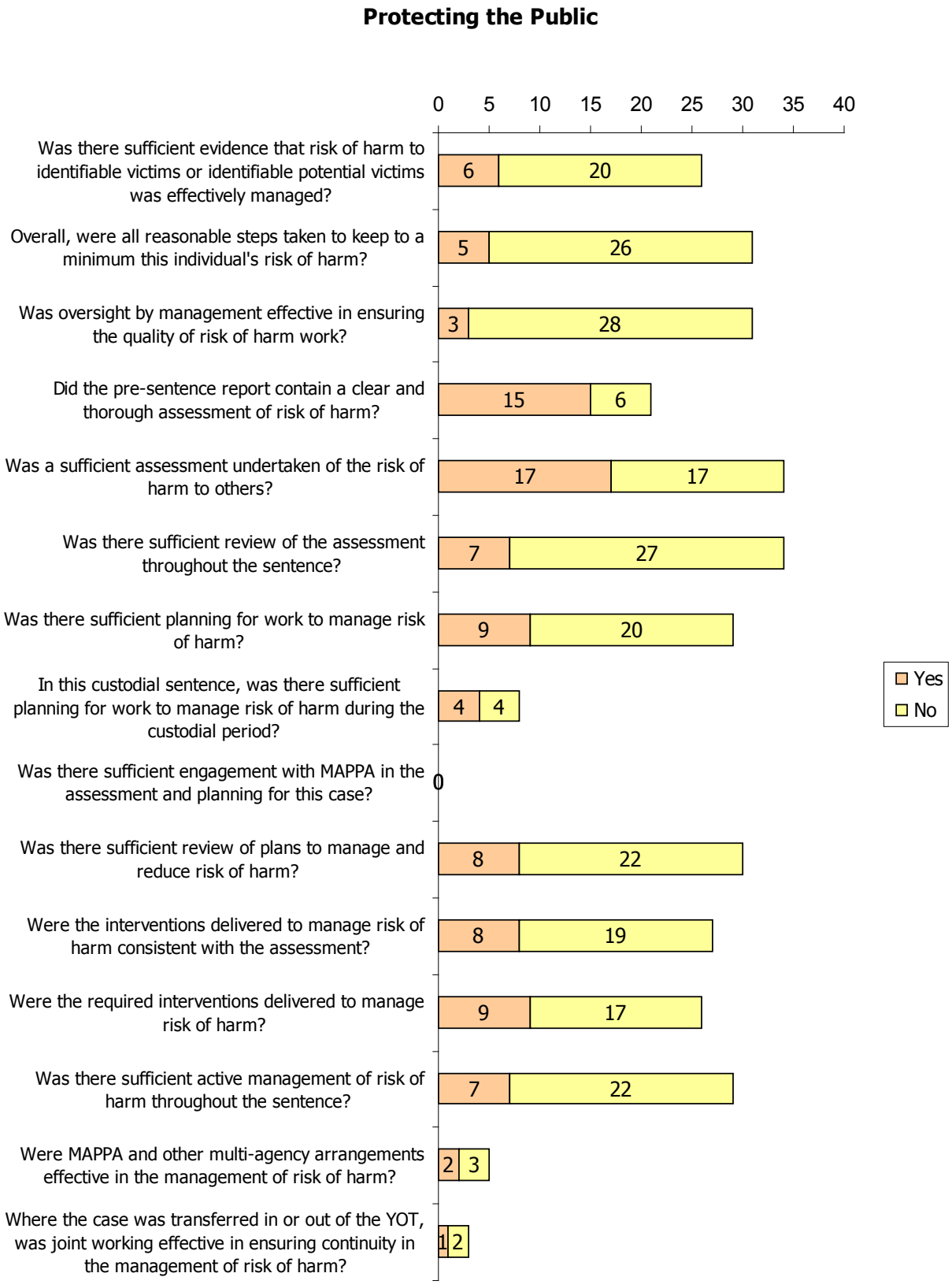
Summary

Work to protect the public and actual or potential victims was poor. Identifying and responding to the risk of harm that some children and young people posed was considerably underdeveloped, and focused too narrowly on the current offence rather than also considering previous offending patterns and behaviours. Risk management plans often failed to plan for known risks. The recently developed risk and vulnerability management meetings were a positive development, well supported by partner agencies, but were not aided by sufficient relevant, current and consistent information to assist effective joint decision making.

There was some effective joint work to identify, monitor and manage those who were involved with gangs, and children and young people commented on how the victim awareness pack had helped them see crime from a different perspective.

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

3

Theme 3: Protecting the child or young person

What we expect to see

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

Case assessment score

Within the case assessment, overall 44% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. We considered many of the children and young people who were under the supervision of the YOS to be vulnerable. Within the case sample no children were found to be at imminent risk of harm. However, action was not always timely, and management oversight and quality assurance methods had not improved the chances of vulnerabilities being identified and responded to appropriately.
2. Assessments varied in quality. In some cases the level of vulnerability was underestimated and plans were not specific enough to identify what actions needed to be taken to keep the child or young person safe.
3. There was good support from children's social care and from education for children and young people of statutory school age.
4. The specific skills of social workers employed in the YOS were not being fully utilised as their experience and knowledge was not yet having sufficient impact on the quality of case management.

5 . Management oversight was insufficient in ensuring effective work to identify, plan and manage the vulnerability of children and young people.

Explanation of findings

1. Assessment

1.1. Many of the children and young people known to Islington YOS were involved in offending that placed them at risk of being harmed. This included theft of motorised vehicles, serious youth violence, drug taking and dealing. A number of them were also affected by deprivation and poverty. We expect the YOS to respond to vulnerability factors so that case managers are able to minimise these. From the 34 cases in the sample, in our assessment, 4 were of a low vulnerability level, 20 were medium vulnerability and 10 were high vulnerability. This meant that we considered the vast majority of children and young people in our sample were at risk of being harmed, predominantly through their own, often offending, behaviour.

1.2. We found that in only one-third of cases was the assessment of safeguarding and vulnerability robust and detailed enough. In eight cases no review had been undertaken, and in a further eight the reviews had not taken into consideration new risks to the child or young person. Often we found that the assessment of vulnerability had been copied from a previous one, rather than brought up to date.

Practice Example

One case involved Jek, a 16-year-old who had stolen a moped, been involved in a collision and was seriously injured. His friend had died in a similar incident. Jek continued to steal mopeds and place himself and others at risk. He was assessed by the YOS as being of low vulnerability.

1.3. In a number of the cases, we saw there were some clear health needs either related to substance misuse, emotional and mental health, sexual health or physical health. Assessments rarely covered the link between health issues and offending, and physical health was usually not explored despite there being cases where deprivation and poverty were issues.

1.4. However, whilst assessments of health needs were developing there was a complex referral process which seemed to build in unnecessary delays. Case managers were unclear about the process and we saw cases where there had been significant delays in accessing services.

1.5. One case manager told us that *"The referral process changes frequently. Referrals get bounced back and it feels quite obstructive"*. This may have contributed to the low numbers of cases currently open to the CAMHS worker. At the time of our inspection, this was seven children and young people, which given the usual prevalence of the need in this vulnerable group and the size of the YOS, appeared to be low.

1.6. Funding had been made available for a nurse to meet physical health needs but for a variety of reasons this had not yet resulted in an effective service to children and young people.

1.7. Islington had a range of good quality services to meet the health needs of children and young people. One of these was visited as part of the inspection but no children or young people from the YOS had been referred or supported to attend.

1.8. Protocols were in place to clarify the role of both children's social care and YOS staff in safeguarding children and young people, and Looked After Children. Where children and young people were involved with children's social care, YOS and social care communicated appropriately and in a timely manner so that plans were in place, and work undertaken, to ensure that children were properly protected. However, the roles and responsibilities of YOS workers were not sufficiently well coordinated so that the contribution of the YOS was appropriately focused on the safeguarding needs of the child or young person, as well as reducing their risk of reoffending.

1.9. Systems to refer children and young people for additional support outside the YOS either during their statutory involvement or on completion of their order, were not sufficiently robust to ensure that their needs were met on a consistent basis.

2. Planning for interventions

2.1. There were sufficient plans in place to protect children and young people in 12 out of 30 relevant cases. It was of concern to note that there were nine cases where a vulnerability management plan was required but had not been completed. There were also six cases where a plan had been produced but the response was insufficient. Areas that were often missed on plans included emotional or mental health, and substance misuse.

2.2. As we noted earlier in this report, likelihood of reoffending and risk of harm work reviews did not take place when needed. This included times where new information came to light that would have increased the child or young person's vulnerability. A sufficient review of plans to keep children and young people safe had been undertaken in just under half of the cases where it was needed.

2.3. There was enough planning in place to address safeguarding and vulnerability in 40% of the relevant cases. Planning to address care arrangements and ETE was sufficient in half of the cases. For emotional or mental health, physical health and substance misuse this sufficiency reduced to one-third of cases. Planning to keep children and young people safe in custody was better and was effective in 75% of the cases we assessed.

3. Delivery of interventions

3.1. Systems were in place in the cases we saw, to ensure that referrals were made by the YOS to the Islington Family Intervention Team (which utilised troubled families resources) so that families received targeted support to address entrenched problems. This included issues that had contributed to their child or young person's behaviour, such as targeted parenting skills or budgetary support.

3.2. There was an appropriate balance between the reduction of reoffending, managing risk of harm, and addressing vulnerability in just over one-quarter of cases. Cases often had long periods when nothing seemed to happen and where interventions were allowed to drift.

3.3. Some specialist partner workers felt that a lack of access to the case management system (YOIS) got in the way of effective communication. For case managers this meant that they had to access a range of documents to get a full picture of what was happening. Direct access to YOIS would mean all of the intervention information could be stored in one place and would be more easily accessible to all.

3.4. There was sufficient and active management of safeguarding throughout the delivery of interventions in one-third of cases. There were 15 cases where an intervention was required to reduce or manage vulnerability, that had not been delivered. These included cases where emotional and mental health needs were left unaddressed, where sexual health was not responded to, and most notably when it was hard to see what substance misuse work had been undertaken. In one example, the case manager was unable to say what work was being undertaken and whether the child or young person was receiving general substance misuse awareness or whether he was having targeted sessions aimed preventing him from dealing drugs again in the future.

4. Initial outcomes

4.1. Overall, the YOS had done enough to keep the child or young person safe from themselves or from other people in only one-third of relevant cases. Where not enough had been done, this was mainly because assessments failed to recognise vulnerability, plans were too narrow in focus and work was not undertaken by the YOS or by other agencies.

4.2. We considered that management oversight was effective in ensuring the quality of work to address safeguarding vulnerability needs in just 4 of the relevant 30 cases. First-line managers had not rectified deficiencies in assessments or planning and had not followed up to ensure that interventions had been delivered.

4.3. Sufficient attention to health and well-being outcomes was given in half of the relevant cases.

5. Leadership, management and partnership

5.1. The YOS was represented on the Local Safeguarding Children Board (LSCB) by the Director of Specialist and Targeted Children's Services who was the line manager of the YOS Manager. She disseminated information to the YOS and there had been helpful reporting on specific issues, for example, children and young people held overnight in custody. It is also positive to note that the YOS was represented on the sexual exploitation sub group.

5.2. We considered that it would be beneficial to have a direct link from the YOS to the LSCB. The

guidance provided in Working Together[1] lists YOT's as statutory partners. Section 3.70 states:

> *'The LSCB should include representatives of the local authority and its board partners, the statutory organisations which are required to co-operate with the local authority in the establishment and operation of the board and have shared responsibility for the effective discharge of its functions. These are the Board partners set out in section 13 (3) of the Children Act (2004)'*
>
> This section specifically states *'the Youth Offending Team for an area any part of which falls within the area of the local authority'.*

5.3. We did not see evidence of routine robust challenge from the YOS to the police over the use of police custody. For example, in one custody record seen, custody officers requested secure accommodation after charge at 1am when they should have been requesting 'suitable' accommodation. This could not be found and the young person remained in custody to appear at court the next morning.

5.4. Despite resources being available, the health needs of children and young people were not being met, at the time of inspection. However, we were aware that this was being addressed.

5.5. We were concerned that learning from serious case reviews had not yet impacted on the quality of work. In each of the four serious case reviews undertaken in Islington YOS, action points were raised about the quality of management oversight. Throughout this report we have raised concerns around the lack of effective management oversight seen in all areas of YOS work.

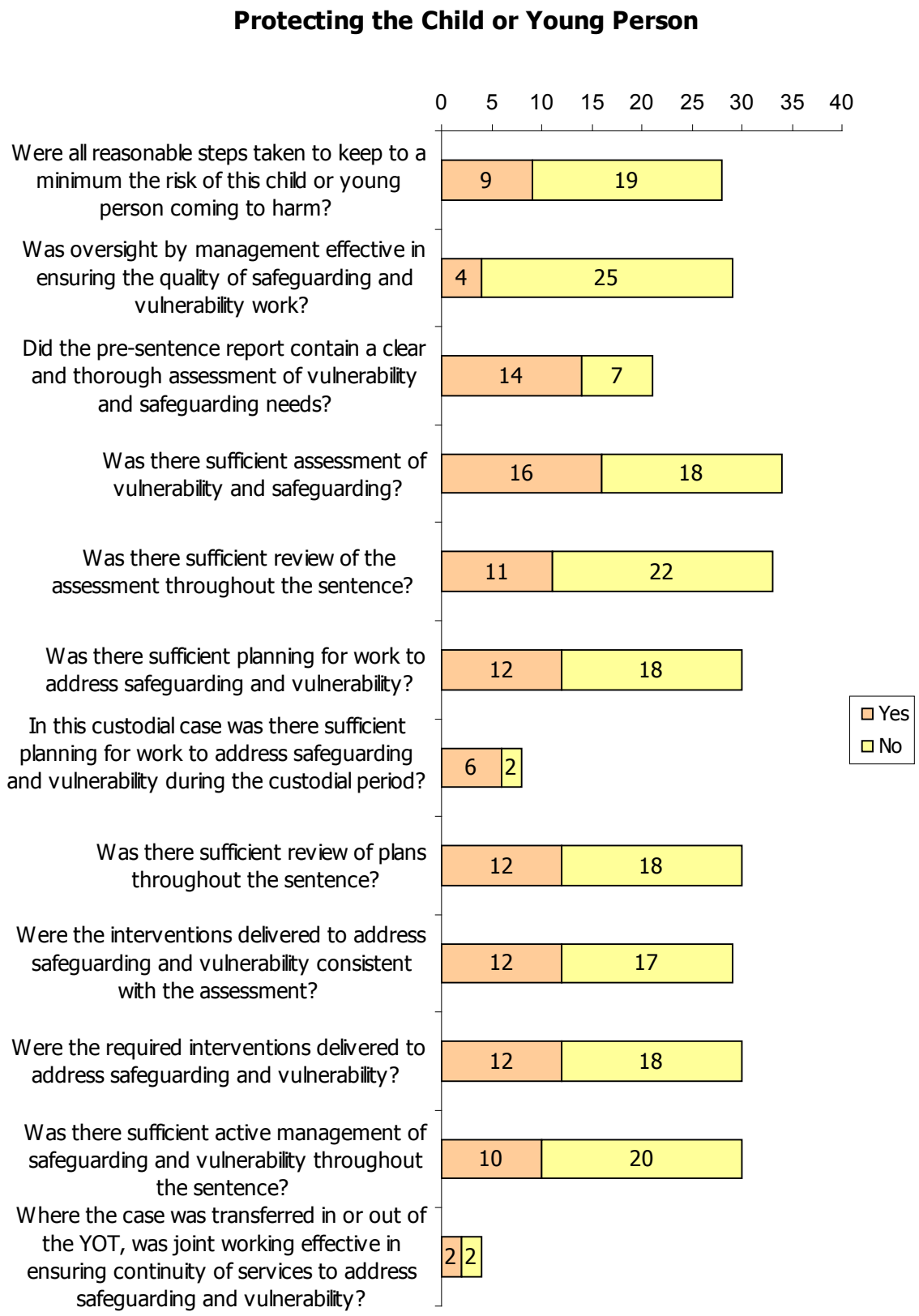
Summary

Overall work to protect children and young people and reduce their vulnerability was poor. Many of the children and young people in our case sample were vulnerable either from the actions of others or through their own behaviour. Identifying, assessing, and planning to reduce or manage these vulnerabilities was often not of a good enough quality. However, we were pleased to see that where children's social care were involved with an individual, there was good communication and effective action taken by social workers to keep the child or young person safe. Provision of health services was mixed. Staff found the new health referral process confusing and there were long delays in accessing some emotional and mental health services. Consideration of physical health and how it impacted on the child or young person's well-being, was underdeveloped.

1 *Working Together* to Safeguard Children: March 2013. A guide to inter-agency working to safeguard and promote the welfare of children.

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

4

Theme 4: Ensuring that the sentence is served

What we expect to see

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

Case assessment score

Within the case assessment, overall 70% of work to ensure the sentence was served was done well enough.

Findings

1. This is the strongest area of practice within the YOS; we saw good attention to diversity needs and the development of some strong and effective relationships between children and young people.
2. There was a very clear process and practice in place to implement breach proceedings when a child or young person did not comply with the terms of the order.
3. Diversity needs were known, understood and responded to in most cases.
4. In every case we inspected, we noticed changes in case managers. Children and young people and parents/carers also commented that this could be disruptive. Whilst the need for change was sometimes accepted by service users, a timely introduction to the new worker and a period of time to get to know them prior to transfer is suggested.

Explanation of findings

1. Assessment

1.1. The assessment in preparation for the PSR identified diversity factors and barriers in every case, and in all but six cases this was sufficient. 86% of PSRs gave sufficient information to sentencers about diversity and barriers to engagement.

1.2. There was good engagement with children and young people and their parents/carers at the initial assessment stage in over three-quarters of cases.

1.3. Some young people were confused by the language used within the criminal justice system.

1.4. Where IFIT were involved in cases, we saw evidence that parents/carers had been involved in supporting the work of the YOS and in some cases where they were better able to manage their child or young person's behaviour.

Comment from a young person

One young person said "everyone is using big complicated words that you don't understand".

1.5. Where the first language of a child or young person was not English, there was a good service provided by the Community Interpreting Translation and Access Service, which provided fast and reliable translation either face-to-face, over the phone or by letter.

Practice Example

In one case a young person used English as his first language and Turkish as a second language. He was unable to fully express himself in Turkish which was his mum's first language. The case manager allotted some of the session time, with the translator, to facilitate open conversation between mother and son so that they understood each other better.

1.6. There had been dedicated provision of a speech and language therapist within the YOS since October 2013. Considerable capacity building work had been undertaken. For example, training for staff and parents/carers, adaption of materials, direct work and consultation. This was an encouraging start and followed good practice guidelines. It was intended that the awareness raising would lead to an increase in referrals.

2. Planing for interventions

2.1. Staff took the time to explain the requirements of the sentence to children and young people and their parents/carers. Comments showed that generally processes and stages of the order were explained to them in language they understood.

2.2. We saw numerous examples where staff had tried to motivate children and young people to comply with their sentence. This was not always effective sometimes due to the case manager's partial awareness of the child or young person's motivation to offend.

2.3. Service users did not feel that they had an opportunity to contribute to the sentence plan. We found that there had been sufficient involvement in planning in only 13 of the 33 relevant cases.

2.4. Barriers to engagement had been factored into half of the initial sentence plans.

3. Delivery of interventions

3.1. In three-quarters of cases, attention has been given to ensure that the child or young person had engaged with the YOS and that the requirements of the sentence were met.

3.2. Overall, diversity factors and barriers to engagement had been responded to in over 60% of all cases. An area for improvement would be the consideration of how children and young people with a learning disability are enabled to access suitable and adapted interventions.

3.3. In our case sample, almost half the children and young people complied with the requirements of the sentence. Where they failed to comply, action was taken either to re-engage or to breach them. Nearly all of these children and young people went on to either comply with the order (11) or the order was returned to court (10).

4. Leadership, management and partnership

4.1. In only three cases had staff supervision or other quality assurance arrangements made a positive difference to the quality of work. The lack of good case management input or subsequent managerial oversight meant that whilst cases started off well at the PSR stage, they deteriorated once the order had started. Most significantly there had been no effective follow-up to ensure cases had been reviewed or that the required work was undertaken.

4.2. We found that case managers had a good understanding of the principles of effective practice but did not have sufficient resources or support to apply these principles well enough in a criminal justice setting.

4.3. Only one-third of staff felt that their training and skills development had been sufficient to do their current job and only one-quarter thought they had had sufficient training in terms of delivery of interventions. This is supported by our case sample findings.

4.4. Half of the staff interviewed felt that there was a culture of learning and development within the organisation although in our view the evidence to support this is limited.

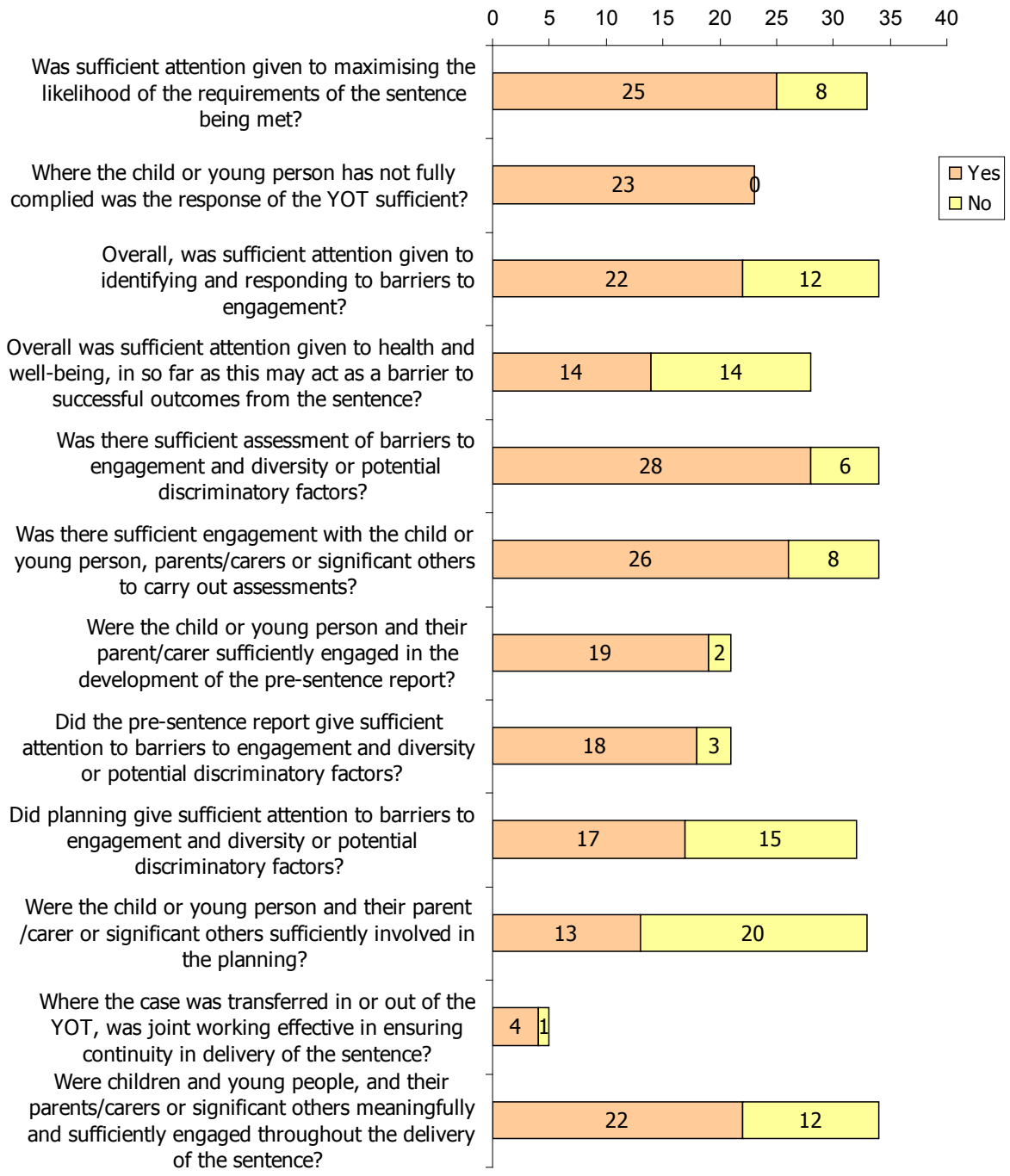
4.5. Most of the staff interviewed felt that their line managers had the necessary skills and experience to support them in their work to improve the quality of work and to assess their work. Two-thirds of staff felt that they had been provided with effective and appropriate supervision. However we found that the supervision provided had not improved the quality of work or the service to children and young people.

Summary

Overall work to ensure that the sentence was served was satisfactory. This was the strongest area of practice we saw in Islington. Staff had developed good relationships with children and young people and with parents/carers. In many cases diversity issues were both understood and individual needs met in order to maximise the likelihood of positive outcomes. There was a fast response when children and young people breached or failed to comply with their orders, with positive attempts to re-engage 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]



Governance and Partnerships

5

Theme 5: Governance and partnerships

What we expect to see

Effective governance, partnership and management arrangements are in place. In particular the YOS partnership and Management Board provide effective governance to ensure that national and local criminal justice objectives are met, and positive outcomes are achieved for children and young people who offend or who are likely to offend, their victims and the local community. Equality of opportunity and wider diversity factors are prioritised throughout. Partnerships are in place working together well to ensure effective outcomes. Workforce management arrangements are in place within the YOS that enable staff to deliver quality engagement and achieve effective outcomes. The YOS is a learning organisation that continually reviews and evaluates the quality and effectiveness of its services in order to improve and sustain positive outcomes.

Key Findings

1. The board had recognised, and acted upon, the findings of the last inspection, and had taken significant action to improve management arrangements of direct work and to improve partnership support to the YOS.
2. The new YOS Operational Management Team were in place, along with a large number of new staff. Opportunities for substantial improvements in practice continued to be difficult due to some ongoing staffing issues and a lack of focus on the quality of practice and outcomes for children and young people.
3. Performance management was not effectively helping the board identify what interventions were working or where there were gaps in work to address offending behaviour.
4. The work undertaken so far was moving in the right direction but it had yet to improve outcomes for children and young people. This related to reducing reoffending, addressing those factors that contribute to them – such as education and health outcomes, and also identifying and managing the risk of harm to others and vulnerability.

Explanation of findings

1. Leadership and governance – criminal justice and related objectives are met

1.1. Although demonstrating a pleasing reduction, reoffending by children and young people in Islington remains above that of the England and Wales national average. Other measures of performance showed that the use of custody was coming down, although still higher than the national average. The number of first time entrants remains high at 815 against the national average of 464 and a London average of 491 (Oct 12 – Sep 13, YJB Indicator Data).

1.2. The YOS Management Board was fully aware of poor performance issues highlighted in the last inspection in 2011. As a result, they had undertaken a wide range of actions to improve the quality of work and outcomes for children and young people. In the last two years this had included a review of the previous practice and action to rectify the deficits. A new operational management team and new staff members were appointed and the management team had, by necessity, focused on ensuring that key tasks were being undertaken, including assessment and planning. Our inspection showed that there was need to focus on the quality of work as well as ensuring that the right work was being done.

Practice Example

HMI Probation observed a risk and vulnerability management panel. It was positive to see good attendance by children's social care, adult social care, police and the antisocial behaviour team. The purpose of the meeting was to take a multi-disciplinary view of the vulnerabilities of a particular child or young person and work together to provide a package of appropriate support so that risk of harm and vulnerabilities can be better managed. In a number of the cases brought to the panel, it was not possible to see a clear view of what the case manager thought the risks were for the child or young person. In one case, the partners did not have a copy of a risk management plan that should have been produced by the YOS on which to base their decisions around support. In another case there were differing records of the level of risk of harm the child posed and in another case significant information regarding a child's sexually inappropriate behaviour was not provided to the panel when they were trying to identify a suitable supported accommodation placement. The manager trying to chair this meeting had real difficulties in providing partners with accurate and relevant information.

1.3. A Youth Justice Plan was in place as required and served as a vehicle for change. However, it did not effectively cover how positive outcomes for children and young people would be achieved. Nor did it detail information about local offending behaviour patterns, how relevant interventions might address them and how progress might be monitored.

1.4. There was a lack of understanding by elected members and senior managers in partnership agencies about the distinct role of the YOS in improving the life chances for children and young people who offend. As a result, they were unable to articulate the 'value added' by the youth justice partnership and how the current improvement was impacting on outcomes.

2. Partnerships – effective partnerships make a positive difference

2.1. There was good representation from health on the YOS Management Board, at the right level, from both providers and commissioners. Evidence showed that health was discussed at meetings and that action had been taken when needed. This had included a review of the health services in place, an assessment of the needs of children and young people and use of this for commissioning appropriate services.

2.2. During the inspection, it emerged that the YOS Management Board were unaware that there were a considerable number of children and young people who were waiting for physical health screenings. A new form had been developed to help capture key health information. This will be introduced from April 2014 and help ensure that the board receive important information. This is in a format which is easier to understand as it was acknowledged that the existing format was not clear. Representatives on the YOS board recognised that changes were occurring at a slower pace than desired.

2.3. The planning and oversight of the post-16 education, training and employment options for children and young people known to the YOS lacked coordination or effective management. There was no clear view of outcomes for these learners, including their achievements in post-16 programmes. For this group, achievements were not disaggregated from mainstream young people aged 16 to 18 years and as such it was difficult to measure their progress and achievement. The further education and skills providers within the borough were less successful than schools with only 63% graded good or better.

2.4. Support and challenge to post-16 education, training and employment providers to ensure effective provision met the needs of children and young people known to the YOS and avoided duplication of services, was insufficient. The borough's current arrangements to oversee options for all young people between the ages of 16 and 19 years, and which used data to show the performance of different groups of young people within the borough, did not include those young people who are completing ETE programmes with the YOS.

2.5. Planning to develop the education, training and employability skills of children and young people known to the YOS, including intervention plans, lacked sufficient detail to give a full and comprehensive view of the young peoples' needs. For example, their education and training plans did not contain targets that were specific, measurable, achievable, realistic or time-bound and as such, they did not drive young peoples' progress.

3. Workforce management – effective workforce management supports quality service delivery

3.1. Although there were a number of social workers within the YOS, their role was not sufficiently clear. Their professional skills were not always used to ensure that their distinct skills provided a high quality service to children and young people. Further development of the role was needed to ensure that their skills were known and utilised to the best effect for children and young people.

3.2. The three police officers assigned to the YOS had been in post since December 2013. For one officer this was their second posting to the YOS and this person was acting as a mentor to colleagues. Police staff felt well supported by the YOS managers and the Metropolitan Police Force.

3.3. There was good management oversight of health staff within the YOS. Staff reported that supervision occurred on a regular basis and all stated that they received clinical supervision from the retrospective agencies.

3.4. First-line managers informed us that support and direction given to case managers was recorded in supervision notes. However, we were unable to confirm this as requested supervision notes were not provided to the Inspectorate. This was important as a number of staff were concerned that they did not receive adequate supervision to help improve their practice or notes of the supervision sessions.

4. Learning organisation – learning and improvement increases the likelihood that positive outcomes are achieved sustained

4.1. Protocols were in place to clarify the role of both children's social care and YOS staff in safeguarding children and young people, and Looked After Children. Where children and young people were involved with children's social care, YOS and social care staff communicated appropriately and in a timely manner so that plans were in place, and work undertaken, to ensure that children were properly protected. However, the roles and responsibilities of YOS workers were not sufficiently well coordinated so that the contribution of the YOS was sufficiently focused on the needs of the child and young person and reducing their risk of reoffending.

4.2. Systems to refer children and young people for additional support outside the YOS either during their statutory involvement with the YOS or on completion of their order, were not sufficiently robust to ensure that their needs were met on a consistent basis.

Summary

Overall leadership management and partnership was poor. Board members were clearly committed to the need to improve the service, and although lots of positive activity had taken place, ably led by the chair, disappointingly this had not yet had a demonstrable impact on practice. It had taken time to get the new infrastructure in place, and there had been a focus on systems, but this had omitted improvement on the quality of work as well. Partnership arrangements were mixed with some positive joint work and other issues that still awaited conclusion.

Interventions

6

Theme 6: Interventions

What we expect to see

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

Case assessment score

Within the case assessment overall, 40% of intervention work was done well enough.

Key Findings

1. We found a limited range of interventions to address offending need with gaps in the availability of focused interventions to address thinking and behaviour, violent and aggressive behaviour, and specific local offending such as robbery and vehicle theft.
2. Access to appropriate health interventions was mixed.
3. We were not made aware of any plans to review and improve the range of interventions available to children and young people.

1. Overview of findings

1.1. The YOS had a menu of interventions which identified limited internal resources but a more comprehensive suite of external and internal providers. There were no programmes concerning current offending behaviour patterns. Although there were a variety of community resources available, we saw little evidence of the systematic use of these.

1.2. We saw no evidence of internal development activity concerning interventions. Staff used old material such as Targets for Change and a victims pack from adult probation. It was left to individual case managers to adapt these interventions to the needs of children and young people.

1.3. There was no mechanism in place to quality assure interventions being delivered and therefore, it was difficult to see whether the interventions were having an impact on the child or young person.

1.4. There was little understanding of what worked to produce appropriate outcomes, interventions were largely ad hoc and the service received by young people was variable.

1.5. Intervention plans were not specific or individualised to the needs of the child or young person. In ten relevant cases there was insufficient focus on substance misuse issues and in nine relevant cases a lack of attention to mental health. Objectives were often not linked to need and seemed to stand alone from earlier assessments.

1.6. The interventions delivered were judged to be of sufficient quality and delivered in line with the principles of effective practice in just under half of the relevant cases. In seven cases there was no clear basis for the intervention selected and no clear structure for delivery. There was a lack of clarity of what intervention had been delivered and in six cases the use of inappropriate resources. This included a girls programme being used for a young male with learning disabilities.

1.7. There was a lack of understanding concerning what positive outcomes would look like for the children and young people being supervised. Objectives were often process focused and clear outcomes were not identified in plans.

1.8. In only 5 of 16 relevant cases, had sufficient attention been given to ensure that any progress made could be continued after the sentence is completed. Often, we noted that there was no clear plan to support the child or young person when the involvement of the YOS had finished.

1.9. The provision of good support for Looked After Children was seen in cases and this had contributed to a reduction in reoffending for this group of children and young people.

1.10. Children and young people of statutory school age were well supported to maintain their education.

Summary

Overall work to provide sufficient interventions to meet the needs of children and young people was poor. Staff were sometimes unaware of the interventions being delivered by partner agencies. Of the three main interventions used, two of these were written for adults and often not suitable for children. Case managers were very keen to deliver good quality interventions but were hampered by the limited options available and lack of training. As a consequence, we saw that work on offending behaviour drifted, that sentence plans lacked focus and that some offending behaviour needs were unmet. This was particularly evident to those children and young people who needed to work on their thinking and behaviour and attitudes towards offending.

Appendices

Appendix 1
Contextual information about the area inspected

Islington had a population of 206,125 as measured in the Census 2011. The youth population (those aged between 10 and 17 years old) accounted for 7.0% of the population. This was lower than the average for England and Wales as a whole, which was 9.5%.

The percentage of the youth population with a black and minority ethnic heritage was 52.8 % (Census 2011). This was higher than the average for England and Wales, which was 18.3%.

Reported offences for which children and young people aged 10 to 17 years received a pre-court disposal or a court disposal in 2012/2013, at 30.8 per 1,000, were higher than the average for England and Wales of 18.5 (Youth Justice Board 2012-2013).

The proportion of young people in Islington aged 16 to 18 who were not in education, training or employment is estimated at 8.8%. This is higher than the average for England which is estimated at 5.7% (Department for Education 2013).

Youth Justice Board indicators

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

Reoffending measures:

(i) Of those children and 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 Islington was 42.4 %, worse than the 35.5% for England and Wales as a whole.

(ii) Of those children and 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 children and young people. For Islington there were 1.22 offences per child or young person who reoffends, worse than the 1.02 for England and Wales as a whole.

(Data based on April 2011 to March 2012 cohort)

First time entrants measure:

The number of children and 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 Islington is 815, compared to 464 for England and Wales as a whole.

(Data based on October 2012 to September 2013 cohort)

Use of Custody measure:

The number of children and young people receiving a conviction in court who are sentenced to custody in a 12 month period, as a proportion per 1,000 10-17 year olds in the general local population. The figure for Islington is 1.57, compared to 0.52 for England and Wales as a whole.

(Data based on January 2013 to December 2014 cohort)

Appendix 2
Contextual information about the inspected case sample

In the first fieldwork week we looked at a representative sample of 34 individual cases up to 12 months old, some current, others terminated. These were 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 sought to reflect the make up of the whole caseload and included a number of those who are a high risk of harm to others, are particularly vulnerable, are young women, or are black and minority ethnic children and young people.

Appendix 3
Acknowledgements

Lead Inspector	Yvonne McGuckian, *HMI Probation*
Deputy Lead Inspector	Jon Nason, *HMI Probation*
Inspection Team	Lisa Clarke, *HMI Probation* Beverley Reid, *HMI Probation* Paul Eveleigh, *HMI Constabulary* Rosy Belton, *Ofsted* Karen McKeown, *Ofsted* Cat Raycraft, *CQC* Chris Dossett, *User Voice* Rebecca Page, *User Voice* Jenny Daly, *Local Assessor*
HMI Probation Support Services	Jane Regan, *Support Services Officer* Rob Turner, *Support Services Manager* Oliver Kenton, *Assistant Research Officer* Alex Pentecost, *Publications Manager* Adam Harvey, *Proof Reader*
Assistant Chief Inspector	Julie Fox, *HMI Probation*

Appendix 4
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

Fieldwork for this inspection was undertaken on the weeks commencing:

10 March 2014 and 24 March 2014

YOTs are informed 11 working days prior to the inspection taking place. The primary focus is the quality of work undertaken with children and young people who have offended, whoever is delivering it. Cases are assessed by a team of inspection staff with local assessors (peer assessors from another YOT). 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 YOT 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, insofar 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.

At the end of the second fieldwork week we present our findings to local strategic managers, the YOT Management Team, YOT staff 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 YJB. Copies are made available to the press and placed on our website.

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

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

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

Appendix 5
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% +	Good	
65% - 79%	Satisfactory	
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 the child or young person suffering or inflicting harm that leaves 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.

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

Appendix 6
Criteria

The aspects of youth offending work that are 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 website at the following address:

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

Separate criteria are published for each additional module inspected, which are available from the same address.

Appendix 7
Glossary

ASB/ASBO	Antisocial behaviour/antisocial behaviour order
Asset	A structured assessment tool based on research and developed by the Youth Justice Board looking at the 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
HM	Her Majesty's
HMI Probation	HM Inspectorate of Probation
Interventions; constructive and restrictive interventions	Work with an individual that is designed to change their offending behaviour and/or to support public protection. A *constructive* intervention is where the primary purpose is to reduce the likelihood of reoffending. A *restrictive* intervention is where the primary purpose is to keep to a minimum the individual's risk of harm to others. Example: with a sex offender, a *constructive intervention* might be to put them through an accredited sex offender programme; a *restrictive intervention* (to minimise their risk of harm) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case. NB. Both types of intervention are important
IFIT	Intensive Family Integration Team
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
Ofsted	Office for Standards in Education, Children's Services and Skills: the inspectorate for those services in England (not Wales, for which see Estyn)
PCT	Primary Care Trust
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

Appendix 8
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.justiceinspectorates.gov.uk/hmiprobation

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

HM Chief Inspector of Probation
1st Floor, Manchester Civil Justice Centre
1 Bridge Street West
Manchester
M3 3FX

Criminal Justice Joint Inspection

Arolygiad ar y Cyd Cyfiawnder Troseddol

HM Inspectorate of Probation
Civil Justice Centre
1 Bridge Street West
Manchester
M3 3FX

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