Inspection of Youth Offending Work
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From:	Julie Fox, HM Assistant Chief Inspector
Publication date:	2nd July 2014

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

This report outlines the findings of the recent SQS inspection, conducted from 9th-11th June 2014. We carried this out as part of our programme of inspection of youth offending work. This report will be published on the HMI Probation website. A copy will be provided to partner inspectorates to inform their inspections, and to the Youth Justice Board (YJB).

Context

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

Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. The purpose of this inspection was to assess the quality and effectiveness of recent casework with children and young people who had offended. In order to do this, we examined 20 cases supervised by Wiltshire Youth Offending Team (YOT). Wherever possible this was undertaken in conjunction with the allocated case manager, thereby increasing the effectiveness as a learning opportunity for staff.

We gather evidence against the SQS criteria, which are available on the HMI Probation website - http://www.justiceinspectorates.gov.uk/hmiprobation/.

Summary

We were pleased to see that many of the strengths we had identified in the work of the YOT in Wiltshire in our last inspection in 2010 had been maintained, and we saw improvement in the quality of risk of harm assessments and in the understanding of different learning styles. There had not been enough improvement in the timeliness of assessments and reviews, and in the quality of vulnerability assessments. Case managers had strong and positive working relationships with children and young people, and went to great lengths to meet with them in their local communities. Compliance with orders was very good. A key strength was the integration of victim work into casework. We found that staff were well trained and committed, and they told us they felt supported by their managers. Management oversight needed to be more robust, both to ensure that key assessments and plans were completed in appropriate timescales, and that all factors related to the likelihood of a child or young person reoffending or to their vulnerability were recognised and addressed.

Commentary on the inspection in Wiltshire:

1. Reducing the likelihood of reoffending

1.1. We saw eight cases where written reports were provided to courts. All were of good quality and made appropriate proposals, which were followed by the sentencers.

1.2. In just over half of the cases, we found an initial assessment by the case manager of factors that influence offending which was both sufficient and timely. In three cases, the assessment at the start of the order was done too late, and in two cases not all factors linked to offending had been identified.

1.3. Assessments need to be reviewed so that they remain relevant to the quickly changing circumstances of children and young people. This had been done well enough on over half of the occasions where it was needed. There were four cases where routine reviews had not been completed, and three where the review was later than it should have been.

1.4. Following on from the assessment, we expect to see a plan of work to order and coordinate the delivery of interventions, thus maximising the likelihood of reducing reoffending. This was in place, and of sufficient quality, in almost two-thirds of the cases where it was needed. Plans could be improved by ensuring that all relevant factors were recognised and included. The local template for intervention plans meant that objectives were not always written in ways that would have been clear and meaningful to the child or young person, and plans did not set out how any diversity factors relevant to the child or young person would be addressed.

1.5. We saw evidence of good quality victim work in many cases. The restorative justice (RJ) model was well embedded in the work of the team. Considerable effort was made to engage with all victims, including local businesses. Where a full RJ conference was not appropriate, a range of intermediate actions was used to ensure that the child or young person understood the impact of their offence on the victim. Victims were offered appropriate information about the progress of the child or young person and could also make representations about any reparation undertaken.

1.6. In one case an inspector noted *"Lindsay is a young woman with an attachment disorder who had committed a violent offence. The case manager used a restorative justice assessment to guide her motivation to engage in the RJ process and to improve her understanding of the impact of her behaviour on the victim".*

2. Protecting the public

2.1. We look for a detailed assessment of the risk of harm a child or young person poses to others. In three-quarters of cases, we found that this had been done well enough, and in all except one case we considered that the risk of serious harm classification was accurate.

2.2. The risk of harm to others can change over time and, therefore, needs to be kept under review. The assessment of risk of harm had been reviewed in almost three-quarters of the cases where it was needed. There were three cases where routine reviews had not been completed; one where the review was completed later than was needed; and one case was not reviewed following a significant change in circumstances.

2.3. Following an assessment of risk of harm, we expect the YOT to put in place plans to manage any behaviour likely to lead to harm being caused, and try to prevent it taking place. In almost three-quarters of cases, we found that the plans were clear and were put in place promptly. In two-thirds of the cases where these plans needed to be reviewed,

this had been done well enough. In three cases the review had not been completed when needed and in one it was not updated thoroughly.

2.4. We looked at one case where the young person was in custody and found that there was sufficient planning in place throughout the custodial period to manage the risk of harm to others.

2.5. In a case where the young person had committed a serious offence, the inspector noted "*There was a stringent package to address his thinking and behaviour, a high level of contact from police and mental health staff as well as the YOT worker, and after initial resistance there was good engagement from the young person".*

2.6. Inspectors found eleven cases requiring management oversight to ensure the quality of work to protect the public, and that oversight was effective in six. Managers need to ensure that they identify shortcomings in the original assessments of children and young people, and then make sure that any plans arising covered all of the relevant factors that had been identified. They also need to check that when they identify improvements that are needed, this is followed up and all actions are completed.

3. Protecting the child or young person

3.1. In many cases, children and young people who have offended are also vulnerable themselves, and we expect to see that this has been taken into account in the work done with them. We found that the initial assessment of vulnerability and safeguarding issues was done well enough in almost two-thirds of cases. Case managers did not always record the raised vulnerability of children and young people who were looked after by the local authority, or who were making themselves vulnerable through substance misuse, for example.

3.2. We expect to see a regular review of vulnerability issues, because children and young people's lives can change very quickly. In just over half of the relevant cases, we found that this was done when needed. In four cases, no review had been completed. Two cases were not reviewed following a significant change in the child or young person's circumstances, such as leaving care. In two cases the review did not fully update the previous assessment.

3.3. Where there were written plans to address vulnerability and safeguarding issues, these were good enough in almost two-thirds of cases. In two cases, plans had not been completed and should have been. The quality of plans would be improved if more attention was paid to the impact of care arrangements, health issues and substance misuse on children and young people. In just over half of the relevant cases, plans to address vulnerability and safeguarding issues had been reviewed well enough when needed. In four cases there had been no review, and another four had not been reviewed well enough.

3.4. All but one of the staff interviewed appeared to fully understand local safeguarding children policies. In several cases we saw evidence of very good joint work with children's social care, where children or young people were looked after by the local authority.

3.5. In one case, an inspector noted *"Kieran is a young man who is in the care of the local authority. He had committed violent offences against family members, police officers and staff and other residents in his care home. The plans for work with him took into account his unwillingness to engage with mental health services. There was good multi-agency work with his social worker, care home staff and parent. Information sharing was good and support a coordinated approach to manage his behaviour".*

3.6. Management oversight of vulnerability and safeguarding issues was effective in just over half of the cases where it was needed. Where it was not effective, as above, the reasons were that shortcomings in assessments and plans were not identified or followed up.

4. Ensuring that the sentence is served

4.1. Performance in this area was strong. In almost all cases, the child or young person complied with the requirements of their order. There was just one case where formal breach action had been necessary. In that case we felt the initial response to failed appointments had been inadequate, but this was swiftly remedied by a new case manager.

4.2. In most cases, we saw good work to engage with children and young people and their parents/carers, including staff in residential settings. There were five cases where we felt this could have been done better.

4.3. When we spoke to case managers, we found that they recognised and addressed a range of diversity issues in the way they worked with children and young people, but this was not always fully recorded in the assessments or plans.

4.4. We found two cases where there had been a lack of clarity about how the YOT would ensure the delivery of unpaid work requirements, and little or no work had been completed by the children or young people. Under the new arrangements, the YOT will now provide this requirement itself so these issues should not arise.

Operational management

We interviewed six case managers and found that they all felt supported and said that their line managers had the skills and knowledge to help them to improve the quality of their work. Almost all of the case managers were aware of local policies and procedures that related to compliance, vulnerability and risk of harm and how the principles of effective practice applied in their work with children and young people.

We found a mixed picture of management oversight of the work of the YOT. There were clear policies for thorough oversight of all risk management plans and vulnerability management plans. However, we found that managers did not always identify factors that had been missed in the original assessments. We did not see any evidence of processes to ensure that assessments and plans were completed within the timescales that were needed, and to make sure that remedial action identified by managers was completed. Inspectors found that oversight by managers had made a positive difference in just seven of the cases we looked at.

Key strengths

- Case managers built strong working relationships with children and young people and this resulted in a high level of compliance with their orders.
- Assessments of risk of harm to others were accurate and identified the relevant factors for children and young people.
- Contact with victims was comprehensive and supported work with the children and young people.

Areas requiring improvement

- Intervention plans should include objectives that are easy for the child or young person to understand and should explain how any diversity factors will be addressed.
- Case managers should ensure that assessments and plans are completed and reviewed on time in all cases.

- Management oversight should ensure timely completion of assessments and reviews, that identify and plan for all relevant factors for the child or young person.
- Assessments and plans should be reviewed when required, particularly in response to significant changes in circumstances.

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

If you have any further questions about the inspection please contact the lead inspector, who was Liz Smith. She can be contacted at liz.smith@hmiprobation.gsi.gov.uk or on 07827 663397.

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