Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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From:	Julie Fox, Assistant Chief Inspector
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Report of Short Quality Screening (SQS) of youth offending work in Wigan

This report outlines the findings of the recent SQS inspection, conducted during 18th-20th November 2013. We carried this out as part of our programme of inspection of youth offending work. This report will be published on the HMI Probation website. A copy will be provided to partner inspectorates to inform their inspections, and to the Youth Justice Board (YJB).

Context

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

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

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

Summary

Since the last inspection, over four years ago, improvements in the quality of work in Wigan YOT have been achieved. Overall, we found that the YOT was producing good quality pre-sentence reports (PSRs), assessments and plans. Staff were enthusiastic and committed to their work with children and young people and open to our feedback. There was scope for further improving the quality of work, mainly in relation to victim safety, responsiveness to significant changes in the child or young person's circumstances and behaviour and in taking a more proactive approach in plans to manage increased vulnerability or Risk of Serious Harm to others.

Commentary on the inspection in Wigan:

1. Reducing the likelihood of reoffending

1.1. In all but one case we found that good quality PSRs were provided to the court and had been through an effective quality assurance system, although in some cases it was difficult to evidence this. Reports gave sufficient attention to the impact of a custodial sentence on the child or young person and, where appropriate, offered intensive alternatives to it. One inspector noted that "*The case manager attended the Crown Court and addressed the court and answered questions. The judge commended the report and described the report as particularly helpful and detailed, providing him with the information he needed*". Another inspector commented "*The PSR is of a good quality and assesses the impact of a custodial sentence on the young person. The PSR also takes the diversity considerations of the young person into account in the assessment*".

1.2. All initial assessments of what was a factor in the child or young person's offending were on time and of a good enough quality. One inspector commented "*The initial assessment includes the key factors and is well evidenced*". Because children and young people's lives can change quickly, we expect to see regular reviews of the work being done. In almost two-thirds of cases we looked at this had been done well enough, but in three cases we felt a review should have be completed following a significant change in the child or young persons' circumstances.

1.3. Following on from assessment, we expect to see a plan of work to help reduce the likelihood of reoffending. The great majority of plans in the community and all four plans for the custodial phase of the sentence were of a sufficient standard. One inspector recorded "*The custodial sentence plan was refreshingly not limited to a custody specific regime and included offending behaviour work and a restorative justice intervention*". We thought it was good practice that plans were written in a child friendly way, for example 'I need to think about how decisions I make can affect my behaviour and increase the risk of me getting into trouble. I also need to identify what changes that I need to make and what steps I can take to make such changes'. However, sometimes the plans were too simplistic.

1.4. In nearly three-quarters of cases the plan to reduce the likelihood of reoffending had been appropriately reviewed. In three cases we felt that a review of the plan should have taken place.

2. Protecting the public

2.1. The majority of PSRs contained a clear and thorough assessment of risk of harm to others.

2.2. There was a sufficient assessment of risk of harm to others posed by the child or young person in all but four of the cases we inspected. In the four cases that we judged not good enough, insufficient account had been taken of actual victims and other relevant behaviour of the child or young person. We noted the good work delivered to victims by restorative solution workers. They were in regular contact with victims and kept them informed about the progress of the child or young person. The appropriate use of information gained by restorative solution workers would, in our view, improve the quality of assessments and plans.

2.3. The risk of harm a child or young person poses to others often changes; it can be reduced or heightened. There are certain significant changes that are associated with an increase in risk of harm, for example increased substance misuse or reoffending. We found that nearly three-quarters of the sampled Risk of Serious Harm to others cases in

Wigan were sufficient. However two reviews were not timely and another two were not undertaken following a significant change.

2.4. Where relevant, in eight out of nine community cases, and in three custody cases, plans to manage risk of harm to others were sufficient.

2.5. There were six cases where we judged a review of the plan to manage risk of harm to others was required. Four were sufficient, one review was not timely and one had not been completed.

2.6. In six out of nine cases where there was an identifiable or potential victim, we felt that the risk of harm to them had been effectively managed. In three cases this had not been managed well because the assessment and/or planning was insufficient.

2.7. There was effective management oversight of risk of harm to others in 5 out of 11 relevant cases. Management oversight was judged not effective mainly because there were deficiencies in assessments that had not been identified or addressed.

3. Protecting the child or young person

3.1. In seven out of nine PSRs there was a clear and thorough assessment of vulnerability and safeguarding needs. In the case sample overall, all but four had sufficiently assessed safeguarding and vulnerability needs of the children and young people. The factors that detracted from these four cases achieving the quality standard were a combination of not drawing adequately on information from other agencies and ignoring other relevant behaviour. This led to an inaccurate screening and classification. We felt that in some cases the threshold for identifying vulnerability as a significant issue was too high.

3.2. Reviews of safeguarding and vulnerability throughout the sentence were of a similar standard to the initial assessments. In four cases, reviews were either not timely or not completed after a significant change.

3.3. In 11 out of 16 cases there was an appropriate level of planning to address safeguarding and vulnerability. When this was lacking, it was either because a plan had not been completed or if completed the contingency plan was insufficient in the event of an increase in the vulnerability of the child or young person. Contingency plans were not specific to the circumstances of the individual child or young person. Actions tended to be general and passive, such as reviewing, monitoring and sharing concerns.

3.4. In the custodial cases we inspected, three out of four were judged to have sufficient planning in place throughout the sentence to address safeguarding and vulnerability.

3.5. In four-fifths of the relevant cases we examined, there were sufficient reviews throughout the sentence of plans to address safeguarding and vulnerability.

3.6. Overall, management oversight of safeguarding and vulnerability made a difference in 12 out of 16 relevant cases. Where there were deficiencies, these were related to problems with assessment and planning.

4. Ensuring that the sentence is served

4.1. High quality assessments of diversity factors and barriers to engagement were undertaken in all cases except one.

4.2. We were pleased to see that in all cases there was sufficient engagement of the child or young person and their parents/carers to carry out the assessment and in the development of the PSR.

4.3. In over three-quarters of initial plans, sufficient attention had been given to engagement and other diversity factors. We were pleased to see diversity factors listed in the intervention plan but it was not always clear if different methods to deliver interventions would need to be considered. We did see evidence that different methods had been used in several cases. One inspector noted "*The case manager completed a Learning Styles Questionnaire with the young person. This indicated that their preferred learning style was visual. Consequently the case manager undertook a "cartooning" exercise using pictures to discuss and explore the offence. The young person was able to see the consequences of their behaviour and identify how they would prevent a similar situation reoccurring in the future"*.

4.4. In 15 out of 19 cases the child or young person and their parents/carers were sufficiently involved in the planning process. The attendance of children or young people and parents/carers at Case Planning Forums was a positive way to involve them in the preparation of the intervention plan.

4.5. In all relevant cases we reviewed sufficient attention had been given to the health and well-being of the child or young person.

4.6. Thirteen of the children and young people had complied with the requirements of their sentence. For those children and young people who had not cooperated with the requirements of their sentence, even after steps had been taken to address this, the response of the YOT was good enough in all except one case.

Operational management

We found that staff supervision and quality assurance processes had made a positive contribution in over half of the cases. It was good to see evidence of monthly case discussions in supervision recorded on YOIS, however sometimes there were no timescales for actions to be concluded or confirmation that they had been completed or reviewed. All case managers thought that countersigning/management oversight of risk of harm and safeguarding was an effective process although as outlined above we found this was not always the case.

Just over half the case managers we interviewed agreed that their manager actively helped them improve the quality of their work. But all case managers felt that their managers had the skills and knowledge to assess the quality of their work. The majority thought that they were provided with effective and appropriate supervision and were supported. One case manager commented, "*My manager chaired the Case Planning Forums for a complex case I was managing and has been very supportive*".

Most of the case managers interviewed thought their training and skills needs were met to undertake their current job and deliver interventions but less so in relation to their future development. All case managers felt they had received sufficient training to respond to speech and communication needs and recognise diversity factors for children and young people. Over half of the case managers thought that the organisation positively promoted learning and development, while others thought it was a mixed picture. The majority felt that they sufficiently understood the priorities of the organisation in relation to their role.

The majority of staff had sufficient understanding of the local policies and procedures for the management of safeguarding and risk of harm, and the application of the principles of effective practice in their work with children and young people. All staff were aware of the local policies and procedures for supporting effective engagement and responding to non-compliance.

Key strengths

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

- the quality of initial assessments of the likelihood of reoffending

- the overall quality of PSRs provided to the court
- the involvement of children and young people and parents/carers with the assessment, the PSR and the intervention plan.

Areas requiring improvement

The most significant areas for improvement were:

i. assessments and plans for the management of risk of harm to others should address the safety of any identified or potential victims

ii. reviews of assessments and plans should take place after a significant change or event

iii. plans should contain case specific actions for the case manager and others in the event of an increase in vulnerability or Risk of Serious Harm to others.

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

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

If you have any further questions about the inspection please contact the lead inspector, who was Nigel Scarff. He can be contacted on 07766 422290 or by email at nigel.scarff@hmiprobation.gsi.gov.uk.

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