Inspection of Youth Offending Work
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From:	Julie Fox, HM Assistant Chief Inspector
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Report of Short Quality Screening (SQS) of youth offending work in the Isle of Wight

The Isle of Wight YOT was last inspected in 2011 as part of our inspection of youth offending work in Wessex. This report outlines the findings of the recent SQS inspection, conducted from 28th-30th April 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 14 cases supervised by the Isle of Wight 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 - www.justiceinspectorates.gov.uk/hmiprobation

Summary

Case managers were carrying high caseloads of a complex nature. We found they engaged well with children and young people, and their parents/carers, working creatively to identify and address their diverse needs and promote engagement and compliance with their sentences. There were gaps in the quality of work to protect the public, including victims, and in plans to safeguard the child or young person which could be improved through more careful management oversight.

Commentary on the inspection in the Isle of Wight:

1. Reducing the likelihood of reoffending

1.1. We look to see if the assessment of why a child or young person has offended is good enough. In the large majority of the cases we looked at, it was. There were very few aspects of offending related behaviour that had not been analysed sufficiently; mental

and emotional health, physical health and substance misuse are key examples. Where pre-sentence reports had been produced, these were all of good quality.

1.2. Assessments formed a sound basis on which to produce plans for work to reduce the likelihood that the child or young person would reoffend. We found that nearly three-quarters of initial plans were good enough and there was a good level of congruence between the objectives set and the issues identified in the assessment. Written plans did not always record the breadth of work that was going to be undertaken, for instance in relation to diversity, education, training and employment (ETE) and care arrangements.

1.3. We looked at four custody cases. Plans were good enough in three but in the fourth, there was no evidence of a custodial plan and the plan completed on release was far from adequate. Contracts (plans) for referral orders tended to focus on processes to be undertaken with the child or young person rather than on goals to be achieved and would have benefited from more detail and clarity.

1.4. Children and young people's lives can change often, with the subsequent need to review and update their assessments and plans. Most of the reviewed assessments we looked at had been completed well enough. We found that where there was a need to review plans, only three had not been reviewed sufficiently, two because they had not been updated to reflect changes or progress in the case.

2. Protecting the public

2.1. We expect to see that a clear, relevant and comprehensive assessment of the risk of harm a child or young person poses has been prepared at the time of their sentence. Of the 14 cases we looked at, we were satisfied in only three that this had been done. Many assessments focused on an analysis of the current offence and did not give enough attention to other relevant behaviours. Some provided too little information to identify the nature or level of risk the child or young person posed.

2.2. Having assessed the risks, the YOT should put plans in place to address any identified. We were concerned that of the ten cases where there was a need to manage risk of harm, there had been sufficient planning at the start of the sentence in only three, one of which was a custody case. Many risk management plans contained relevant information but were unstructured and difficult to follow. Some were missing completely and some had been completed too late. Case managers did not always understand that work outlined in these plans should link into the intervention plan (IP) with the consequence that important objectives to manage risk of harm were not always included in the IP.

2.3. Taking account of the needs of victims is crucial in helping to keep them safe. We found that the quality of work in this area was variable, with the risk of harm to victims being effectively managed in just over one half of the cases we looked at. In the others there were noticeable gaps in the quality of both the assessment of harm to actual or potential victims and planning to address and minimise this harm.

2.4. Risk of harm to others is dynamic in nature and needs to be continuously reviewed. Assessment and planning had improved considerably by the review stage. Although some assessments were duplicated and not updated sufficiently, overall we found more assessments and plans in place later in the case, and that these were of better quality.

2.5. All the case managers we interviewed had a sufficient understanding of local policies and procedures for the management of risk of harm and we were pleased to see the YOT using Multi-Agency Public Protection Arrangements (MAPPA) processes effectively.

2.6. There was little evidence of management oversight given to risk of harm. Overarching management comments were recorded on full risk of harm assessments but there was no evidence that case managers were being asked to improve their assessments and plans before they were countersigned. As a consequence, we judged that oversight by management was effective in ensuring the quality of risk of harm work in less than one-quarter of the cases we looked at.

3. Protecting the child or young person

3.1. In many cases, children and young people who offend will present issues relating to vulnerability and/or safeguarding which need to be properly assessed and planned for. We found that assessments of vulnerability and safeguarding had been completed well enough in almost three-quarters of the cases we looked at and pertinent issues had been identified in 13. We were pleased to see that case managers identified the need to refer for specialist evaluation where appropriate, and that mental health and substance misuse assessments were taking place. However, case managers were not always using all the information available to them when drawing up their own assessments and there were gaps in some, for example relating to care arrangements, health and wellbeing, and ETE. There were four cases where we judged the vulnerability classification to be inaccurate, with case managers tending to underestimate risk.

3.2. Assessments were always reviewed when appropriate. However, this was not always to a good enough standard. A small number were copies of the original and there were two cases that had not been reviewed after a significant change in circumstances.

3.3. Despite care being taken to assess needs, this was not being translated, in enough cases, into good quality plans. There were considerable gaps relating to care arrangements such as living and parenting, and a lack of evidenced linkage between care plans and YOT intervention plans. There was also a need to give more consideration to objectives relating to substance misuse, emotional or mental health and ETE. In six cases that merited it, there was no YOT plan to manage the child or young person's vulnerability. We saw an improvement at review stage but in four cases there was either no review or there had been a delay in completing this.

3.4. Case managers understood local policies and procedures for the management of safeguarding. In many instances, they were making good use of their links with specialist colleagues, such as the police, mental health nurse and substance misuse worker to provide an holistic approach to protecting children and young people. An inspector noted the following positive example of good work: *"In view of the many issues around the vulnerability of this young man, the YOT worked hard to persuade children's social care services to take action to protect him. This initially led to a 'child in need' registration, and later resulted in the local authority taking responsibility for the young person's care, so that a leaving care worker could help to support him once he became 18 years of age".*

3.5. There was evidence of effective management oversight of safeguarding work in only four cases. Where there was a vulnerability management plan, most of these had been countersigned but this did not necessarily guarantee the quality of the plan.

4. Ensuring that the sentence is served

4.1. Case managers at the Isle of Wight YOT were working hard to understand, and respect the values of, the children and young people with whom they worked. Despite high and complex caseloads, they were focused on making a difference to their lives in order to reduce the likelihood that they would offend again.

4.2. In custody cases, YOT workers travelled to the mainland, sometimes as far as Kent, to ensure they maintained relationships with children and young people placed there. In one example, the case manager ensured an education provider was able to stay involved with a young person by taking the tutor to the institution and acting as a conduit for homework. This also helped to secure an educational assessment for the young person. In the community, home visits were used appropriately to help build constructive relationships with children and young people and their parents/carers.

4.3. Case managers nearly always took account of the health and well-being outcomes that could impact on how well a child or young person would progress through their sentence. Generally, they had a thorough understanding of the diversity needs in their cases and potential barriers to engagement. However, this was not always evidently reflected in the planning process or recorded sufficiently on file.

4.4. Where the child or young person had not complied with their sentence, the YOT responded appropriately in all but one case.

4.5. In one positive example we found that: *"the YOT had made some commendable attempts to try to engage a difficult and transient young male. They agreed with him an individual compliance contract, and arranged for him to have consistent afternoon appointments aided by text reminders and assisted travel arrangements. Additionally, they facilitated one-to-one work with him through electronic means in response to his individual learning needs".*

Operational management

Case managers had a good understanding of the principles of effective practice with children and young people who have offended. Overall, they felt their manager was skilled and knowledgeable and appreciated the range of groups, such as the pre-court and practice groups, that helped to guide and provide management oversight of their work. There was some acknowledgement, however, that there could be more proactive management oversight, and this was confirmed by our inspection findings, especially in relation to safeguarding and risk of harm. We judged that staff supervision and other quality assurance arrangements made a positive difference to less than one half of the cases we looked at which leaves considerable room for improvement. We were pleased to see that action had been taken, recently, to increase the YOT's management and supervisory capacity.

Key strengths

- Pre-sentence reports were concise and relevant and provided good quality information.
- Assessments of the likelihood that a child or young person would reoffend were well informed and analytical, and contained a relevant mix of historical and current information.
- Case managers had effective links with specialist staff in the YOT to assess and manage vulnerability and safeguarding needs.
- Case managers took an investigative, creative and sometimes determined approach throughout the sentence to build effective relationships with children and young people and help them comply with their orders.

Areas requiring improvement

- There should be a clear record of oversight to ensure assessments and plans are completed and reflect the needs of each case.
- Assessments of risk of harm should provide sufficient information to identify the nature and level of risk posed by children and young people.

- Plans to manage risk of harm and vulnerability should be completed in a timely fashion, and structured so as to make it clear what work needs to be completed, whether by the YOT or other agencies.
- Case managers should improve their recording of needs and plans relating to family and caring factors to ensure these are given appropriate priority by all those involved in a case.
- Referral order contracts should be outcome focused, clearly framed and meaningful to children and young people and their parents/carers.
- More account should be taken of the needs of victims in order to ensure that appropriate action can be taken to manage the risk of harm to them.

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 Vivienne Clarke. She can be contacted at Vivienne.Clarke@hmiprobation.gsi.gov.uk or on 07872 485611.

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