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 **Wolverhampton**

An inspection led by HMI Probation

independent inspection of youth offending work

February 2016

Foreword

This inspection of youth offending work in Wolverhampton 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.

We chose to inspect in Wolverhampton Youth Offending Team (YOT) primarily because the annual plan was received very late. Further investigation gave cause for concern about the effectiveness of local governance and leadership arrangements given that the YOT Management Board had not met regularly.

The published reoffending rate for Wolverhampton was 33.8%. This was worse than the previous year but better than the England and Wales average of 37.9%[1].

Wolverhampton YOT and its partners had placed children and young people at the heart of their work. Planning for work to reduce reoffending was impressive. Interventions were delivered to a high standard by dedicated and skilful staff. Their knowledge about the children and young people with whom they were working was being used to change lives. Education, training and employment outcomes for children and young people known to the YOT required improvement. Overall, we found that Wolverhampton was performing very well; children and young people, and their parents/carers were appreciative of the service they were receiving. The YOT Management Board had overcome its recent difficulties and was now well-placed to consolidate its delivery of effective services.

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

Alan MacDonald

HM Assistant Chief Inspector of Probation

January 2016

1 Source: MoJ Proven Reoffending Statistics January 2013 – December 2013, published October 2015.

Reducing reoffending	
Protecting the public	
Protecting children and young people	
Ensuring that the sentence is served	
Governance and partnerships	
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Summary

Reducing reoffending

Overall work to reduce reoffending was good. Pre-sentence reports provided the necessary information to support sentencing recommendations. Assessments, plans and reviews were carried out when required. The variety of resources available to support desistance was good. Work delivered to reduce reoffending was largely effective. Restorative Justice interventions were delivered well.

Protecting the public

Overall work to protect the public and actual or potential victims was good. Multi-Agency Public Protection Arrangements to manage risk of harm were meaningful. The YOT police officer was well integrated into the public protection role but children and young people were not consistently highlighted on the police intelligence system. Planning of work to address risk of serious harm was good. A small number of risk of serious harm classifications were inaccurate.

Protecting children and young people

Overall work to protect children and young people and reduce their vulnerability was satisfactory. Assessments and reviews varied in quality. Planning of work to address safeguarding and vulnerability was done well. Joint work with social care was good. There was no Child and Adolescent Mental Health Services worker at the YOT. This had resulted in some emotional and well-being needs not being met. Interventions aimed at addressing safeguarding and vulnerability were delivered well. Management oversight was not consistently effective.

Ensuring that the sentence is served

Overall work to ensure that the sentence was served was good. The YOT and its partners worked effectively to achieve positive outcomes for children and young people. Compliance was managed extremely well. Children and young people, and their parents/carers praised the work of the YOT. Assessments and plans did not always fully take into account diversity needs. Health practitioners provided a good service. Education, training and employment provision for post-16 children and young people was limited.

Governance and partnerships

Overall, the effectiveness of governance and partnership arrangements was satisfactory. The YOT Board had not met for 11 months between 2014 and 2015. Three meetings had been scheduled but were cancelled due to apologies and unavailability across key personnel within the partnership. A well-attended Board met in June with a new Chair and on 2 subsequent occasions in 2015, and was now well-placed to oversee the delivery of quality services. The Board was engaged positively with local partners and there was evidence of collaborative working with both the public and voluntary sector. Children's and Adolescent Mental Health Services were not represented on the Board and there was a recognition that work on child sexual exploitation needed developing.

Interventions to reduce reoffending

Overall, the management and delivery of interventions to reduce reoffending was good. There was a good range of interventions available at the YOT. These had been delivered skilfully, purposively and enthusiastically. Outcomes had not been fully evaluated. Learning for children and young people was positively reinforced.

Recommendations

Post-inspection improvement work should focus particularly on achieving the following outcomes within 12 months following publication of this report:

1. education, training and employment outcomes for children and young people should be improved to ensure they are equipped with skills that contribute towards maximising their chances of employability (YOT Manager and Chair of the YOT Management Board)
2. leaders and managers should exercise their influence at all levels to secure an improved education and training offer that meets the behavioural and vocational needs of children and young people known to the YOT (Chair of the YOT Management Board)
3. the YOT Management Board should include a Child and Adolescent Mental Health Services representative (Chair of the YOT Management Board)
4. child sexual exploitation should be a standing item on the YOT Management Board agenda (Chair of the YOT Management Board)
5. outcomes from the delivery of interventions should be evaluated in order to ensure that their impact is understood (YOT Manager)
6. case file recording and planning for work to reduce offending should take full account of the barriers to engagement and the diversity needs of children and young people. (YOT Manager)

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

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Reducing reoffending

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Theme 1: Reducing 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

Overall 82% of work to reduce reoffending was done well enough.

Key Findings

1. The majority of pre-sentence reports (PSRs) produced for courts provided the necessary information to support sentencing recommendations.
2. Assessments, plans and reviews were carried out when required.
3. The variety of resources available to support desistance was good.
4. Work undertaken to reduce reoffending was effective and delivered well.
5. Education, training and employment (ETE) outcomes were not consistently achieved.
6. Restorative justice interventions were delivered well.

Explanation of findings

1. Overall, case managers had a good understanding of the reasons why children and young people had offended. We saw innovative examples of work to better understand these reasons. Examples included pictorial diagrams and children and young people being given a variety of opportunities to describe in their own words why they had offended. The quality of reports to the courts was generally good. Magistrates interviewed spoke positively about the offence analysis information contained in reports and pointed out that recommendations made by report writers were realistic in supporting desistance. We saw a small number of PSRs where there had been a lack of attention given to understanding the contribution of family relationships and the neighbourhood to a child or young person's offending.
2. Reviewing assessments throughout the sentence was carried out as required in the vast majority of cases. We were pleased to find that reviews had also been undertaken where there had been a significant change in circumstances. In a small number of reviews, vulnerability information had not been adequately incorporated. Planning for work in the community to reduce reoffending was done well. The targets set in plans were specific and achievable with realistic timescales. The revision of plans was not consistent across all the inspected cases. A small number of reviews did not contain all the relevant information which had resulted from work with the child or young person.
3. The variety of resources and materials available at the YOT for work to reduce reoffending were excellent. In case files, we saw numerous examples of activities which had helped children and young people to make better choices. In particular, case managers were skilled in affirming achievements that had led to periods of desistance. We saw examples of pictorial 'pathways' which showed the offending journey of children and young people. These images were then used appropriately as a means to determine the type of interventions that could bring about lasting change.

Example of notable practice

Jeremiah had made some poor choices which had led him to come to the attention of the YOT. He had not properly considered the consequences of his actions and had been belligerent in his attitude to working with his case manager. Through preparation and motivational work over a period of weeks the case manager had been able to maximise Jeremiah's engagement. They had already completed a leaning styles questionnaire with him that showed he had a short attention span and was a visual learner. This informed the method of intervention the case manager chose to use. Several bespoke paper exercises that had been used were seen in the case file. The exercises became more challenging and one which explored moral reasoning and values resulted in Jeremiah being asked to complete his own 'Ten Commandments' of what he should and should not do. The statements that were produced directly linked to his offending behaviour and the need to show respect to others and their property. Jeremiah had not reoffended for seven months.

4. ETE outcomes for children and young people known to the YOT required improvement. We found that the YOT had worked hard in the last few years to secure the education and training engagement of children and young people known to the service. As a consequence, children and young people had increased their engagement in ETE activity once they had come into contact with the YOT. However, the percentage of those engaged in education and/or training had not improved sufficiently in the last three years. Last year, and coinciding with staff shortages, the percentage of children and young people engaged in ETE fell dramatically to an all-time low level. In some cases, those who engaged well in ETE experienced an improvement in their behaviour and attitudes. Additionally, they developed their English and mathematics skills. Children and young people made good gains in education and training while serving a custodial sentence.

5. The skills, needs and interests of children and young people known to the YOT were assessed promptly. For example, in the local college (Wolverhampton College) all children and young people undertook a diagnostic assessment of dyslexia and additional learning needs as soon as they joined. The schools and the YOT maintained a good focus on improving the children and young people's behaviour. Case workers involved children and young people well in producing a highly individualised contract on behaviours and attitudes, once the assessment of ETE needs had been completed.

6. As reflected in some case files, communications between case workers, managers and parents/carers were not consistent and the sequencing and actions taken to secure an ETE placement for the child or young person were not sufficiently prompt and clear. Some case managers did not include enough information about the child or young person when making a referral to Connexions[2]. This meant that the careers advisor had to dedicate some of their already limited time available to finding the necessary details to plan for the child or young person's needs appropriately. This caused delays to accessing services.

7. The YOT identified appropriately what was needed to support children and young people to make a successful transition from school into further education and training. However, the service did not gather sufficient information on whether all the children and young people remained engaged at the end of their order and what their ETE destinations were afterwards.

8. The delivery of work to reduce reoffending contained an impressive focus on restorative justice interventions.

2 An agency providing ETE advice, guidance and support services to children and young people.

Example of notable practice

Restorative justice work carried out in this case was exceptional. The restorative justice worker had met with the victim to explore the impact of the offence on them. A range of questions were asked in order to understand better the outcome that the victim desired. The worker agreed a time for the meeting to take place which was convenient for the victim. Considerable preparation work was done to explain the process. An equally thorough process was followed by the case manager with Anita (the young person) who had committed the assault. Anita was asked to give a full account of what had happened, who did she feel was affected by her actions and what was the outcome that she had hoped for. Again, the preparatory work carried out by the case manager for the restorative justice meeting was outstanding. A restorative meeting agreement was prepared and an evaluation carried out. The outcome of the meeting was that both the victim and Anita were able to share their perspectives. The relationship has now improved considerably and there has been no further offending.

9. We were pleased to find that in three-fifths of the inspected cases there had been a reduction in the frequency and seriousness of offending. We concluded that the work carried out by case managers was likely to reduce reoffending in at least half of the inspected cases. This figure could have been higher had focus been given to additional motivational work and preparation for interventions. In addition, while the assessment of emotional and mental heath needs showed a need for further attention, these needs were often left unmet.

10. Case managers demonstrated an appropriate level of understanding of work that was effective in reducing reoffending. Children and young people spoke positively about how the YOT had helped them to understand better their offending behaviour and the actions they needed to take in order to refrain from further offending. Additionally, parents/carers were able to report tangible evidence of how the YOT had had a positive effect on reducing further offending.

Quotes from children and young people

"*Well, if a situation happened before, I wouldn't think twice. I would be on auto pilot, I wouldn't be thinking. But after all the help I've received I'm now more aware when things are about to go wrong. There's a lot of times I could have been in trouble but I haven't been there because I'm thinking better now. The YOT's really helped me to focus on keeping out of trouble.*"

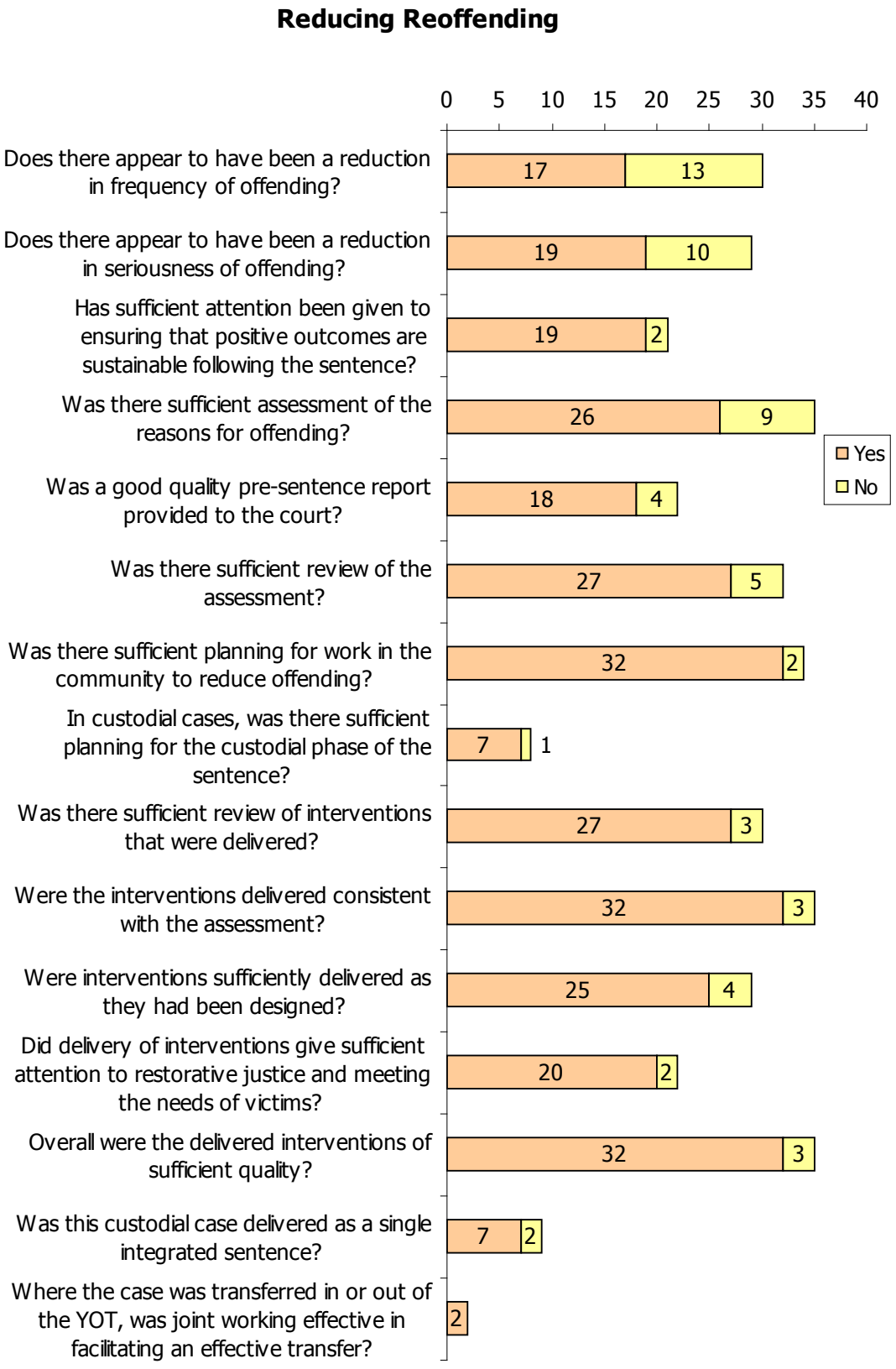
"*The YOT explained things to me in a way that I understood and now I haven't got into trouble with the police or nuffin for ages.*"

Quote from a parent/carer

"*The meetings have made him understand and he now actually stops and thinks about what he's doing because he's got anger problems. He is angry quite a lot. Talking to his case manager has helped him to understand why he gets angry in the first place and to think about what he needs to differently.*"

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 35 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

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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

Overall 81% of work to protect the public was done well enough.

Key Findings

1. The police officer was well integrated into the public protection role of the YOT.
2. Children and young people known to the YOT were not always highlighted on the police intelligence system.
3. Multi-Agency Public Protection Arrangements[3] (MAPPA) to manage risk of harm were well-established.
4. Information sharing with public protection partners was timely.
5. A small number of risk of serious harm classifications were inaccurate.
6. Restorative justice work was effective.
7. Planning for work to address risk of serious harm was generally good.
8. Health services had not consistently been considered in all risk of serious harm cases.

Explanation of findings

1. There was one full-time police officer who was co-located in the YOT. Such co-location had brought benefits, particularly in relation to intelligence sharing. The officer was focused on their core role and their duties were closely aligned to the national model. The officer undertook a number of additional relevant roles, for instance, supporting the out of court disposals and community resolutions panels. The officer also attended Child In Need[4] and safeguarding strategy meetings. We considered this to be good practice. The officer had undertaken specific training in relation to safeguarding and child sexual exploitation. However, the officer had not had MAPPA training.
2. There was a system in place for the police officer to identify when children and young people on the YOT caseload came to police attention. This was by way of a 'flag' on the police intelligence system. However, this was not systematically used and flags were not placed on all children and young people on the YOT caseload. Therefore, there were gaps in intelligence sharing, sometimes in critical areas for example child sexual exploitation. We found clear evidence of two-way intelligence sharing, with relevant police intelligence being recorded on the YOT case management system (YOIS). Likewise, information from YOT case managers was also found on the police intelligence system. However, information sharing was not always consistent. Sometimes information was passed on in an informal way and no record was made on YOIS. There were good links between the YOT and local neighbourhood policing teams, facilitated by the YOT police officer. This was especially the case in relation to those children and young people at higher risk of reoffending.
3. There was a strong partnership between the YOT and MAPPA. Responsibilities were well-understood and good information sharing took place between a wide range of partners.

3 Local public protection partnership arrangements to support the management of high risk children and young people.
4 Children under the age of 18 years old who are considered to need local authority services to achieve or maintain a reasonable standard of health or development.

Example of notable practice

One inspector observed a monthly risk/vulnerability meeting to discuss Gary (the young person) who met the MAPPA eligibility criteria. He had received a custodial sentence for robbery. This was the initial MAPPA/Risk and Vulnerability meeting for Gary since his release. The meeting was well-managed, participants were well-prepared and all contributed information to support public protection and decision-making. Actions were agreed in relation to supporting the parent/carer, offending behaviour work and access to ETE.

4. Integrated Offender Management[5] (IOM) was well-established and well run. There was a good range of partnership involvement and working relationships were constructive. A sharper and more obvious focus on the motivations for the offending behaviour would have improved the process further.
5. In public protection work it is crucial that case managers fully understand the risk of harm to others in every case and appropriately review assessments when circumstances change. We were pleased to find that this had been done well in three-quarters of inspected cases. Assessments and reviews had been undertaken when required and there was some evidence of work to keep actual and potential victims safe. In some cases, reviews were often reproduced from previous assessments and case managers had not taken account of dynamic factors. In one case, it was not clear whether the case manager fully understood risk of serious harm. The breakdown in a family relationship in this case had not prompted a review. We did not agree with a small number of risk of serious harm classifications, which we considered should have been higher.
6. Restorative justice work had a high profile in casework. Systems and processes were embedded and staff delivering theses services fully understood their role. The YOT had produced guidance information to support the preparation of letters of apology. The letters we saw were varied and personal to the children and young people. Most included a reflective element, recognition of the harm caused and virtually all commented on how they were beginning to turn their lives around. One case manager we spoke to demonstrated how they had systematically engaged in lengthy conversations with the young person about how the offence could have and had impacted on the victim. These discussions took place at a pace consistent with the learning needs of the young person. The case manager subsequently provided appropriate guidance to prepare a purposeful letter of apology.

Example of notable practice

Some strong restorative justice work had been completed with Kyber to address and manage his risk of serious harm. This began with work looking at his offence of possession of a knife and the impact and potential consequences of this. The initial meeting had been designed to start exploring with Kyber his thinking around carrying weapons. After a further preparatory meeting with Kyber about what to expect and what would be asked, he attended a restorative justice conference with a young person that he had fought with while being in possession of a knife. The restorative justice content was adapted from the standard format to reflect the fact that both participants were the victim and perpetrator. Through the process, Kyber was able to better understand the impact of his actions on the victim, consider how he could avoid a similar situation in the future and be clearer about resolving residual tensions that had been continuing. There had been no further offences of violence for over six months.

7. Initial planning of work in community cases to manage risk of harm to others was done well in most of the inspected cases. Diversity needs had been considered, plans flowed seamlessly from assessments and information sharing arrangements had been clearly identified. Victim awareness work had an impact on children and young people and there had been a decrease in the seriousness of the offending behaviour. However, in a small number of cases, victim issues had not been properly addressed and it was not clear what the planned response would be in a situation where risk increased. Management oversight in half of the inspected cases was not effective and deficits had not been consistently addressed.

5 A process of managing vulnerable and high risk of reoffending children and young people.

Quotes from children and young people

"*The victim awareness I did was useful because you can actually see like from the victim's point of view. Like what its put them through by you doing what you've done and it just makes you feel bad.*"

"*I hurt someone bad. I wasn't thinking straight. I was on weed. The YOT has helped me to think deep about what happened. I don't do that but they've been patient and now I can see that the victim must have been scared of me. I'm sorry I done that.*"

8. Plans were generally reviewed as required but the content did not always accurately reflect the changes that had taken place.

Example of notable practice

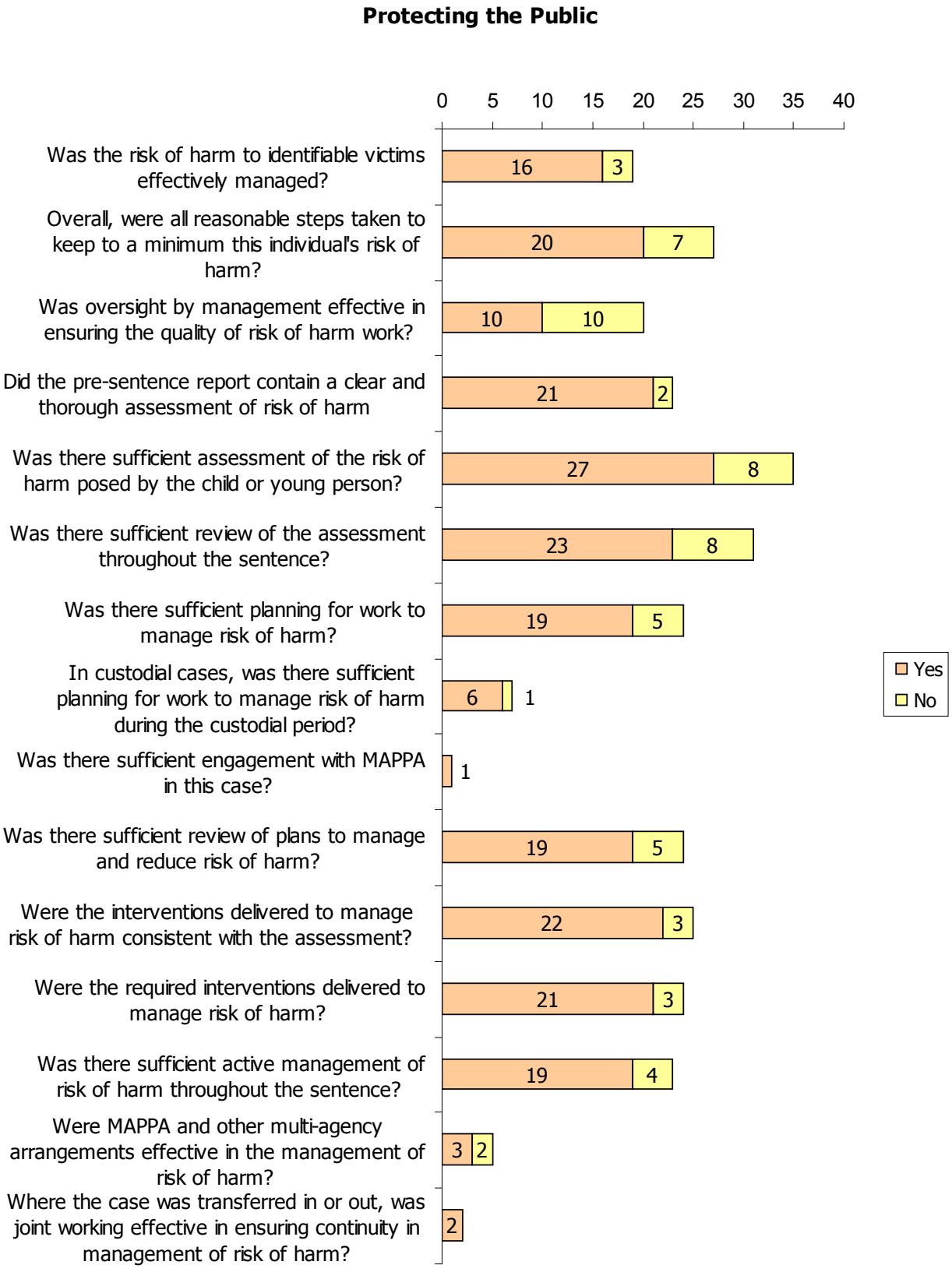
There had been significant changes in Judy's personal circumstances. Originally placed on a Youth Rehabilitation Order for a serious assault, she was asked to leave the family home due to violent outbursts. This resulted in her temporarily living in unsuitable accommodation with known older peers associated with group violence. As soon as this information came to the attention of the case manager they liaised with the YOT police officer, contacted Judy's mother and took immediate action to secure alternative accommodation. The case manager reviewed the plan and candidly explained to Judy that they would be increasing her risk level to not only keep others safe but also her. The plan was shared with Judy.

9. Interventions delivered to manage the risk of harm were properly informed by plans in most cases. Interventions delivered by health practitioners were of a good standard. Their recording was of a very high quality and we found no gaps around information sharing with case managers.

10. Health services had not always been well-considered in the assessment of risk of serious harm although good use had been made of existing external health reports such as psychological reports prepared as addendums for court. Both health practitioners had made meaningful contributions at MAPPA meetings on several occasions.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 35 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

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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

Overall 78% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. A number of assessments and reviews varied in quality.
2. Planning for work to address safeguarding and vulnerability was generally done well.
3. Joint working with children's social care was good.
4. There was no Child and Adolescent Mental Health Services (CAMHS) practitioner at the YOT. This had resulted in some emotional and well-being needs not being met.
5. The service provided by the YOT nurse was good.
6. Interventions aimed at addressing safeguarding and vulnerability were delivered well.
7. Management oversight in ensuring the quality of work to address safeguarding and vulnerability was not always effective.

Explanation of findings

1. We were not satisfied that assessments and reviews of safeguarding and vulnerability had been done well across all the inspected cases. Whilst we saw evidence of assessments and reviews that had been properly informed by behaviours, we were disappointed to find that, in just under one-third of the inspected cases, there were a number of deficits. Often, the quality of screenings was weak, the vulnerability classifications were inaccurate, some relevant behaviour had been overlooked and key information from other agencies had not been considered. As an illustration in one particular example where risk of harm had been identified, the young person's risk and vulnerability information had not been fully considered. He had a conviction for robbery, a pattern of aggressive behaviour and had been under pressure to commit further robberies with older peers. Potential for gang involvement had not been explored in any significant detail. He had been classified as low risk of serious harm and low vulnerability. He then committed a serious assault on a young person while on his court order. The case file also indicated issues of vulnerability around self-harm and weight loss due to anxiety. These behaviours exhibited by the young person and the deficits in the management of this case had not been picked up by the line manager.
2. Planning for work to manage safeguarding and vulnerability at the start of community orders and custodial sentences was good. Case managers had appropriately considered the information that was available to them from all sources and had produced realistic actions which would keep children and young people safe.

Example of notable practice

Abudallah was serving a custodial sentence for violent offences and had recently been diagnosed with type 1 diabetes[6] and Attention Deficit Hyperactivity[7] (ADHD). He had been struggling to come to terms with the diagnoses. Whilst in custody he had difficulties engaging with his peers and had been the victim of several assaults. The case manager spent time researching the physical and psychological effects of diabetes (lack of concentration, tiredness, mood swings and stunted growth). These issues were then taken account of in the sentence plan. The case manager used this information to maximise their engagement with Abudallah by visiting him in prison regularly. The case manager also responded well to frequent telephone calls to the office from Abudallah by organising a time slot for him to call on a weekly basis so that the case manager could give him their full attention. This resulted in some positive progress with Abudallah coming to terms with his medical diagnoses and engaging with the sentence plan. He reported that he now felt much safer.

3. YOT case managers appropriately sought advice from social care staff regarding possible referrals. Referrals to social care by the YOT were largely timely, clear and appropriate. Information back from social care regarding the outcome of the referral was timely and clear. Where social care took no further action they signposted the YOT to other referrers and alternative resources.
4. The reasons for the use of child sexual exploitation screening tools by YOT case managers, in some cases, were unclear. In one example, the reason given was 'concerns around the young person's associations within the setting and in the community'. Screening tools were not dated consistently. Some actions, for instance, relating to the YOT referral to Multi-Agency Sexual Exploitation meetings, were not followed through in a timely manner. The Children Missing Operational Group was well attended. There was some evidence of prompt liaison with child sexual exploitation coordinators in other areas.

Example of notable practice

There was good collaborative working with Zaci (the young person). A number of agencies were involved and they worked together effectively. They contributed to each other's plans and communicated with each other. Zaci received consistent messages from all of those working with her. There were indications of risk of child sexual exploitation and these were followed up appropriately. Liaison was appropriate and ensured that Zaci's needs were met.

5. In some instances, there was a lack of overlap with Child In Need plans and plans arising from vulnerability meetings concerning the same children and young people.
6. Joint working and home visiting to manage vulnerability by YOT case managers, social care staff and housing support workers was frequent and appropriate to each case. Children and young people were seen alone in almost all cases by social care and YOT staff. YOT staff were reliable in providing appropriate adults in order to ensure that children and young people fully understood their individual situations. YOT case managers had online access to the social care case management system. This was good practice. The Emergency Duty Team (out of hours) had access to both databases.
7. The YOT was involved at an early stage in child protection investigations. Case managers were properly engaged in strategic discussions and meetings. Their contributions were valued. YOT case managers attended child protection conferences and core groups where required. There was a gap in the provision of services addressing children and young people's emotional well-being.

6 Lifelong condition where the pancreas does not produce any insulin leading to high blood sugar levels.
7 A group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness.

8. There was no CAMHS practitioner at the YOT and this had led to some difficulties around triaging children and young people who may have been experiencing mental health challenges. The nurse at the YOT was highly trained in a number disciplines including Contraception and Sexual Health (CASH) and bereavement counselling. She was also able to fast track contraceptive appointments and had good links with the Looked after Children[8] and Pupil Referral Unit[9] nurses. With a significant number of children and young people being assessed as having mental health and well-being needs, there was sufficient evidence to suggest that having a CAMHS practitioner in-house dealing with referrals would have been appropriate.
9. Interventions specifically aimed at addressing safeguarding and reducing vulnerability had been delivered consistently well. This was true in both community and custodial cases. We were particularly pleased to find that case managers had adapted the materials available to them in order to ensure that the interventions met the assessed needs.
10. Management oversight to ensure the quality of work to address safeguarding and vulnerability was inconsistent. There were a number of inspected cases where deficiencies in assessments and plans had not been raised with case managers.
11. An establishment providing education for children and young people excluded from mainstream education. An establishment providing education for children and young people excluded from mainstream education.

Quotes from children and young people

"*The work I done with my youth justice worker was about my drinking alcohol and committing offences. I used to get paralytic because stuff was doing my head in. She talked to me about why I was drinking so much and what it was doing to me. I didn't want to end up in jail or dead. She used some questions to help me talk. I liked that. I understood them. Now I don't go partying or anything. I can't trust myself at the moment. I'm trying to not overstep the mark and doing stuff where I don't have to drink.*"

"*I needed some support with medical stuff and that. They came out to see me at my home because it was safer and I could talk privately. Yeah, they helped me. They answered all my questions.*"

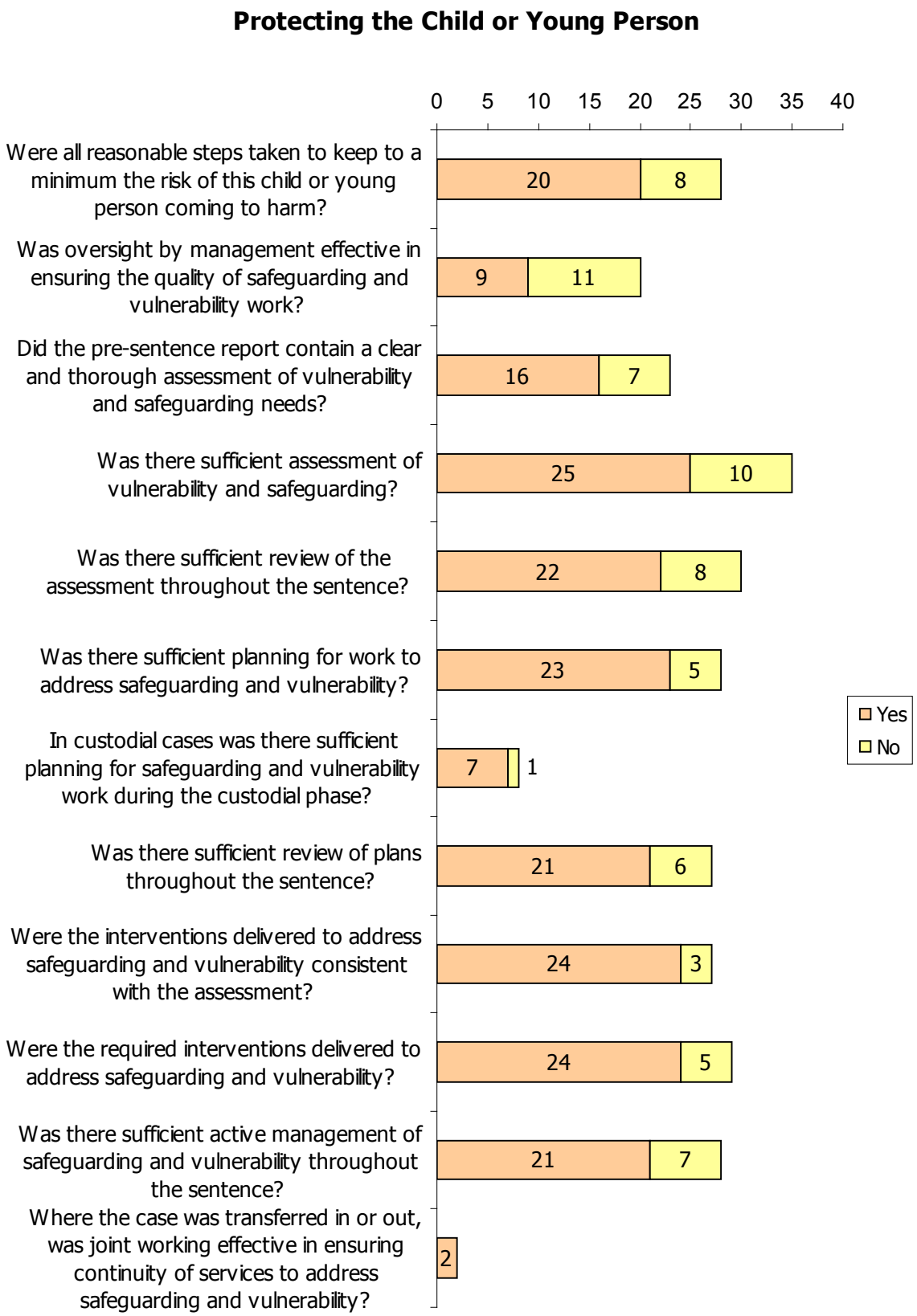
Quote from a parent/carer

"*When he (the young person) was taken into hospital from legal highs poisoning, the drugs worker gave him leaflets with all the ups and downs of it and everything else and all the toxic chemicals in them. It's opened his eyes a little bit more and luckily enough it's actually stopped three of his friends from taking legal highs as well. That's a good thing. He's stopped for now and is much better to live with.*"

8 Children and young people in the care of the Local Authority.
9 An establishment providing education for children and young people excluded from mainstream education.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 35 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 YOT will maximise the likelihood of successful outcomes by effective engagement with them and their families, responding to relevant diversity factors including paying attention to their health and well-being, and taking appropriate action if they do not comply.

Case assessment score

Overall 86% of work to ensure the sentence was served was done well enough.

Key Findings

1. The YOT and its partners worked effectively to achieve positive outcomes for children and young people.
2. Children and young people, and their parents/carers spoke positively about the work of the YOT.
3. Compliance was managed very well.
4. Assessments and plans did not consistently and fully take into account diversity needs.
5. Physical health practitioners in the YOT provided a good service.
6. ETE provision for post-16 children and young people was too narrow.

Explanation of findings

1. Ensuring the sentence was served was a particular strength in the YOT. Case managers were engaged proactively with children and young people and their parents/carers to ensure compliance. We repeatedly saw evidence of case managers working hard to strengthen their relationships with children and young people in order to affect lasting change. Home and office appointments were used appropriately and parents/carers were given space to contribute to assessments, plans and reviews. Children and young people were consistently held to account for non-compliance. This ensured that engagement levels were meaningful and children and young people were clear about their responsibilities.

Example of notable practice

The case manager had arranged a meeting with Sasha to specifically address a number of missed appointments. The case manager clarified whether Sasha understood the purpose of the meeting and then gave details of the missed appointments explaining the time and day of the meetings. Sasha responded to the first missed appointment by saying that he could not remember why he did not attend. To this, the case manager replied by saying that this was not an acceptable explanation. To the second missed appointment, Sasha said it was too far for him to travel and he had no means to attend. The case manager explained to him that this was not acceptable either. The case manager sensitively spoke to Sasha and said that he should have made contact to seek some advice from the case manager of the office. For these absences, enforcement action would be taken. While awaiting attendance at court Sasha's engagement had increased and there had been no further missed appointments.

2. We saw several good examples of diversity needs being taken into account when assessments and plans were being produced. This was not consistent, however, across all the inspected cases. We found gaps in approximately a third of the cases. Often, diversity needs and barriers to engagement, which had been identified at the assessment stage, did not flow seamlessly into how case managers would take these needs into account when directly working with children and young people. One parent commented, "*sometimes my son doesn't get on with the one-to-one meetings. I don't think they fully get his communication difficulties and how they should respond. They should ask him and also me. I can get through to him sometimes. He's my son and I know what works with him*".
3. This illustrated a need to better engage children and young people and their parents/carers in determining how specific needs would be addressed in order to achieve successful outcomes. Engagement at the delivery end of interventions was markedly better.
4. Joint working was effective. We saw a number of examples where case managers maintained an appropriate exchange of information with others who were working with the same children and young people. This ensured that activities identified in plans were being delivered and any problems arising could be dealt with in a timely manner.

Example of notable practice

There were a number of workers involved in this complex case. Anton (the young person) had learnt to give different information to different workers. He would often say what he thought the workers wanted to hear rather than be truthful about his vulnerabilities, temptations to commit further crimes and pressure from his peers. Through exchanging information, both formal and informal, workers discussed the work together and where mismatches were discovered, joint meetings were arranged. Anton was challenged about these inconsistencies and encouraged to appreciate the need for openness with every worker. Gradually, he became more consistent with each of the workers and this led to the successful completion of a number of interventions.

5. Parents/carers were consistently engaged in the preparation of all court reports we inspected. This was good practice and endorsed their contribution in supporting case managers to better understanding the context of offending and past behaviours. It also demonstrated to children and young people the need for open and transparent conversations with family members.

Quote from a parent/carer

"*I was able to put my point of view across when she had her pre-sentence report interview. I was able to say how things were. I was happy with the content. It was fair and we were able to talk openly.*"

6. Case managers regularly took account of physical health needs in their supervision of children and young people in order to ensure that these did not act as barriers to successful outcomes being achieved.
7. Both health practitioners were excellent at engaging with parents/carers and made appropriate home visits. They took part in pre-release contact with secure establishments but agreed that the information received during and post-sentence was limited. This was not through the lack of trying on their part. There were exit plans presented at final meetings with children and young people and they were signposted to other services where necessary. These included informing General Practitioners of any significant changes e.g. a transfer to the National Probation Service or another secure setting.

8. Health practitioners in the YOT were skilled and trained to carry out their duties well and when called upon by case managers, they responded accordingly. They were not requested to do other non-specialist work and their time was protected. However, a few case managers failed to engage them when needed even if it was only for an initial assessment. There were no waiting lists for either service.
9. Some children and young people known to the YOT benefited from accessing vocational provision in school which kept them interested and motivated to learn while developing their independent life skills and their work attitude (Midpoint Pupil Referral Unit). The post-16 education and training provision did not meet the needs and interests of the children and young people well. The training provision for post-16 was too narrow, in particular, for those aged 16 to 17 years old.
10. There was inadequate provision available at foundation level to support children and young people to develop the necessary skills and attitudes to allow them to access further training and education in the community. Timetables of activities over the summer and for those under Intensive Surveillance and Supervision were good.
11. The majority of children and young people known to the YOT presented complex and challenging behaviours that often acted as barriers to their engagement with ETE activities. The YOT made good use of the Educational Psychology team to support children and young people. Their work with schools was effective. They amended children's educational needs plans in a prompt manner to reflect any changes that would impact on quality of learning while attending school. It was less clear, however, how the specific behavioural and educational needs of children and young people attending training were being met.
12. Children and young people, and their parents/carers consistently spoke positively about the way in which they were treated by YOT staff. They felt that they had been listened to and there was a genuine desire to support desistance.

Quote from a young person

"*My worker doesn't judge me. She understands. She gives me the chance to say what I want to say. When we talk about my crimes it's like we've gone behind the offence and she's worked out what kind of person I am. Sometime we end up talking for hours because we get too carried away in conversation. She's a really good YOT worker.*"

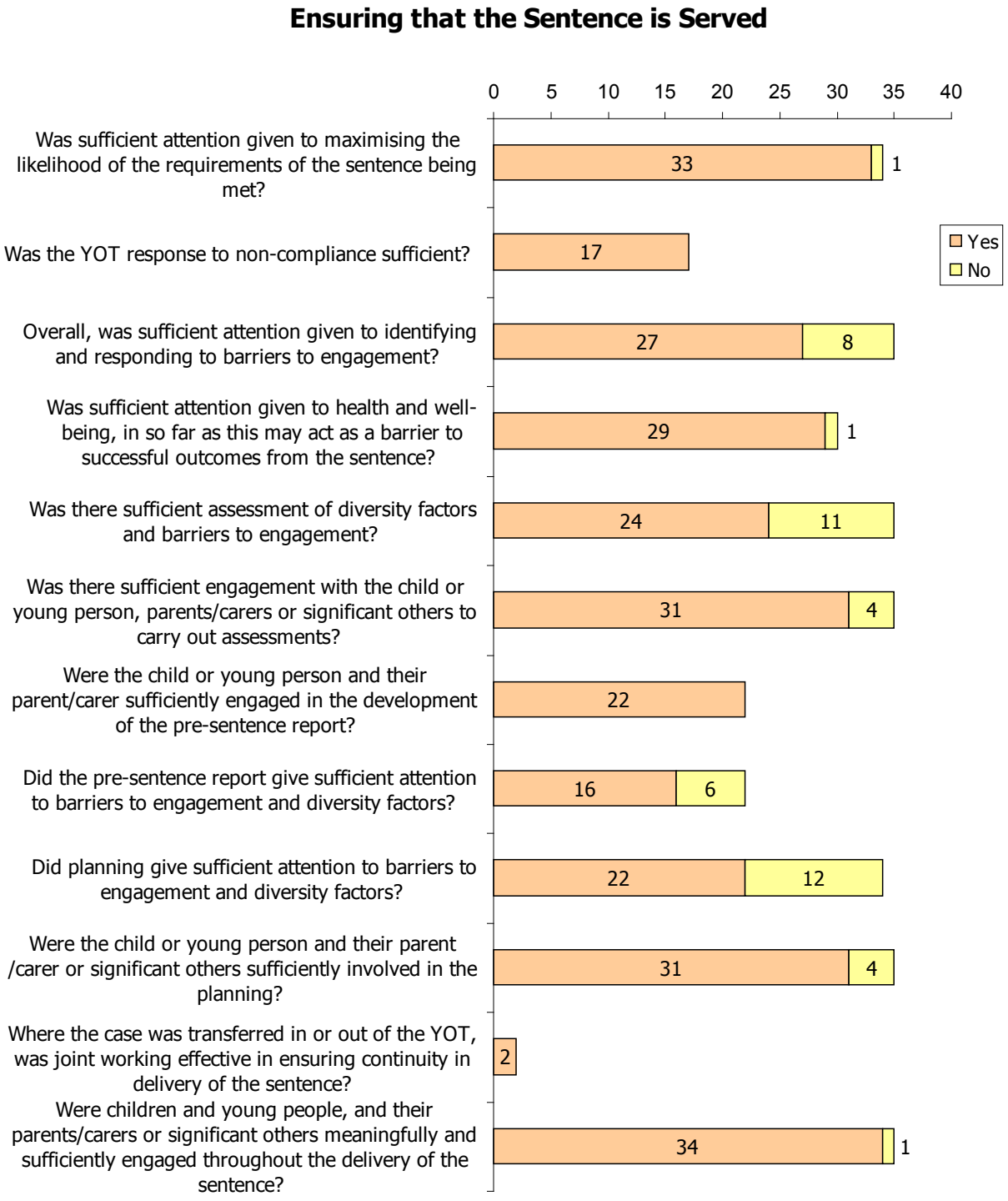
Quotes from parents/carers about YOT workers

"*He is being supported because he's listened to and he talks about whatever he has going on. He will talk to him about it and he really likes that. He will open up to him and they talk about all sorts of stuff. Must be working because my lad's not as bad as he used to be. He's getting through his court order.*"

"*I think she is brilliant with him, I can't ask for more to be honest.*"

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 35 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. These enable the YOT to meet national and local criminal justice and related objectives, and to deliver and maintain good quality services.

Key Findings

1. The YOT Management Board had not met between July 2014 and May 2015.
2. The Board had been re-established in June 2015 and was now well-placed to ensure the delivery of high quality youth justice services.
3. The Board was currently well engaged with local partnerships.
4. There was evidence of good collaborative working with both statutory and voluntary partners.
5. CAMHS were not represented on the Board.
6. The Board was aware that ETE outcomes for children and young people were not good.
7. The YOT Board was engaged with key strategic Boards and partnerships including Safer Wolverhampton Partnership and Children's Safeguarding Boards.
8. Key elected members in the local authority had a clear understanding of the work of the YOT.
9. The Board had identified the need to develop its work on child sexual exploitation.

Explanation of findings

1. Leadership and governance – offending is reduced and other criminal justice and related objectives are met

1.1. The Board had not met for 11 months until it was refreshed with a new Chair in June 2015. Three meetings had been scheduled but were cancelled due to apologies and unavailability across members in the partnership. Most of the key agencies were now represented on the Board and members described the Board as providing appropriate accountability and challenge. At the time of the inspection, three meetings of the new Board had been held as well as a development event designed to help Board members understand their role and expectations placed on them. The Board was now well-placed to oversee the delivery of high quality services.

Example of notable practice

The YOT Management Board had held a development event, facilitated by the Youth Justice Board (YJB), with its key partners to agree the needs of the community, children and young people and victims. This had informed some critical decisions around education, substance misuse and health outcomes. The Board was building on the learning from this event and the conversations had improved how each partner on the Board could contribute to achieving better outcomes for children and young people.

1.2. The Board had a representative group of health members, at the right seniority, who were aware of the work being carried out in the YOT.

1.3. CAMHS were not currently represented on the Board and there was no children's mental health specialist within the YOT.

1.4. Adult probation services (National Probation Service) expressed a willingness to participate but had so far been unable to attend due to external changes in probation services. There was evidence of some strategic liaison at an informal level.

1.5. Reoffending rates were low and the Board had a good understanding of reoffending data. The Board had commissioned further analysis of reoffending information in order to reduce the time lag in data becoming available.

1.6. Police analysis of crime data was not presented to the Board to enable the group to understand offending patterns and emerging trends and respond accordingly.

1.7. Leaders and managers were clear about the importance of children and young people engaging in ETE and its contribution to reducing reoffending. They were committed, experienced and knowledgeable about ETE and had already identified the appropriate areas for improvement. However, managers had not analysed data sufficiently to evaluate the effectiveness of ETE provision and to inform managerial decisions. The principal measure of success focused on full-time attendance and ETE activities. Information analysis needed to be widened to ensure that children and young people experienced high quality education and training outcomes.

1.8. The YOT had developed a good collaborative approach with key partners such as Connexions and the Educational Psychologist team to support children and young people's access to ETE provision. Access to a careers advisor was not available every day of the week. Partners spoke highly of the responsive approach that staff at the YOT displayed when dealing with issues affecting children and young people. The YOT held, with limited success, several and frequent review meetings focusing on improving the percentage of children and young people engaged in ETE activities. However, the action plan to improve this outcome was insufficiently robust to bring about further rapid improvement.

1.9. Local authority elected members were familiar with the work of the YOT and had met many of the frontline staff. They expressed support for the work that took place to reduce reoffending.

1.10. A detailed performance report had been provided to the Board at each of the last three meetings. The report provided both data and analysis and a particular strength was the analysis of the overrepresentation of black and minority ethnic children and young people in the youth justice system.

2. Partnerships – effective partnerships make a positive difference

2.1. The YOT was well integrated into local partnerships including the Children's Safeguarding Board and the Safer Wolverhampton Partnership. The YOT also appeared to be closely involved in many service developments across the city including work around gangs and a number of children's services innovations.

2.2. Scrutiny of further child sexual exploitation in the YOT context (e.g. through case studies) was identified as an area for future activity. Child sexual exploitation did not appear as an agenda item on Board meetings. We were, however, pleased to find that the YOT risk and vulnerability strategy had been a key discussion at the June Board meeting, part of which included an important section in relation to child sexual exploitation.

2.3. Data suggested that there had been an increase in the number of First Time Entrants into the youth justice system. Whilst the Board appeared to have been aware of this increase, it had not taken action to analyse the causes of this change.

2.4. The YOT had effective working relationships with local voluntary sector organisations and was able to access services for children and young people affected by a range of issues including domestic violence, gang membership and child sexual exploitation. The YOT worked effectively with Catch 22[10] and was a member of the DETER[11] group. There was good voluntary sector representation on the Board.

2.5. The Chair of the local youth court panel was a member of the Board and expressed a high degree of confidence in the work of the service.

2.6. The national protocol for transferring cases to adult probation services had not been adopted.

2.7. The YOT was well integrated into the local authority children's services while, at the same time, maintained its distinct identity and effectiveness as a component of the criminal justice system.

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

3.1. The YOT had a relatively stable workforce and most staff were skilled and knowledgeable practitioners. The service had made a distinction between supervision which focused on ensuring compliance with processes and reflective supervision, which focused on understanding what was happening in the lives of children and young people. This distinction had supported desistance.

3.2. The YOT seconded police officer was a valued member of the team. Their role included intelligence sharing, however, not all of the available relevant intelligence was captured on the YOT case management system.

3.3. Overall, there was good operational oversight of the work of the health workers in the YOT. They felt supported and well positioned to carry out the necessary work.

4. Learning organisation – learning and improvement leads to positive outcomes

4.1. The YOT had a Youth Justice Action Plan which contained a number of learning related actions. While a corporate training plan was evident, there was no specific training plan for the YOT.

4.2. Training records were maintained. These demonstrated that YOT staff were well-trained for the role they undertook. Training was increasingly through e-learning but a significant investment had been made in face-to-face training to ensure staff were equipped to work with high risk sex offenders.

4.3. Case managers spoke positively about their managers. They reported that they received regular supervision and were able to share openly any concerns they had.

4.4. The YOT had an extensive set of quality assurance systems in place which were used well to inform developments. We saw evidence of sampling, reviews and all staff in the YOT were committed to achieving positive outcomes for the children and young people with whom they were working.

10 Catch 22 - a registered charity providing mentoring and interventions to reduce the risk of reoffending for those aged between 10 and 25 years old.

11 Multi-agency group monitoring and supporting the management of high risk of reoffending children and young people.

Interventions to reduce reoffending

6

Theme 6: Interventions to reduce reoffending

What we expect to see

This module focuses specifically on interventions intended to reduce reoffending. We expect to see a broad range of quality interventions delivered well, coupled with appropriate assessments and plans 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

Overall 85% of work using interventions to reduce reoffending was done well enough.

Key Findings

1. There was a good range of interventions available at the YOT.
2. Assessments to determine the suitability and eligibility of interventions were carried out well.
3. Barriers to positive engagement were not always identified.
4. Outcomes from interventions had not been fully evaluated and measured.
5. Interventions to improve parenting skills were delivered well.
6. Case managers delivering interventions were enthusiastic and skilled.
7. Learning for children and young people was reinforced well.

Explanation of findings

1. We observed 12 interventions which included a combination of one-to-one and group work sessions, a referral order panel and a risk and a planning meeting. Interventions were delivered consistently well.
2. There was a good range of interventions available at the YOT to support desistance.

Quotes from children and young people

"*I've done a lot of behaviour courses about making the right decisions and joint enterprise. I've done thinking skills and how to avoid situations and what's the best thing to do in situations.*"

"*My case worker helped me write a letter to my victim. I wasn't sorry at first but talking made me realise that I overreacted and should have kept my gob shut.*"

"*I did a restorative meeting. It was hard sitting there listening to how my crime had affected the woman. I needed to hear it though. It isn't right what I did.*"

"*I did my community service in an allotment. It was hard but when my worker wrote me a report and said how well I had done it made me feel well good.*"

"*We done stuff about how my offending had hurt someone. It was a worksheet. I said I didn't get the questions so my youth worker put the worksheet away and we just talked. I liked that and we had a really good chat. I've stopped getting into trouble now.*"

3. Assessments to determine the suitability of interventions that would lead to reducing reoffending were very good. They were completed within appropriate timescales, were clear and contained good analysis. Equally encouraging was the assessment of eligibility. Case managers had a good grasp of the interventions that were available at the YOT.

Example of notable practice

The suitability of interventions was assessed very well in this case. Engagement and responsivity were particular strengths in working with Blyth (the young person). He had a complex set of needs and was young. The case manager had worked hard to ensure that work was delivered in a way that would reduce the likelihood of further offending. The case manager drew up a separate intervention plan with Blyth so that it was in a more child friendly format. The case manager took time to consider all the information that was available to them and involved Blyth in all their judgements. As a result, the intervention was delivered at Blyth's pace and his relationship with the case manager developed to ensure a successful outcome.

4. Initial planning to determine what interventions would be provided and how they would be delivered was done well in the vast majority of cases. There were some examples where case managers had effectively identified and addressed individual needs and barriers to engagement. This was not consistent across all the inspected cases.
5. Interventions to enhance parenting skills were delivered well as illustrated below.

Example of notable practice

An inspector observed the first of six 'Let's get cooking' sessions. The purpose of this intervention was to provide Fraser (the young person) with an opportunity to build his relationship with his mother through cooking activities. There had been evidence to suggest that family relationships had been poor and Fraser's mother had struggled to communicate effectively with him.

The baking session demonstrated to the parent that the child could follow instructions, behave appropriately, observe boundaries and make wise decisions, safely. The case manager had clear objectives and structure for the session. The mother was given the opportunity to observe her child's positive behaviour, bond with him and give positive feedback. A youth centre was used for this session. The mother and Fraser were enthusiastic and became involved in the process; all parties had opportunities to comment and ask questions. A record of this positive activity was kept in the form of photographs. The case manager encouraged both Fraser and his mother to talk and laugh together whilst baking and were encouraged to attempt similar activities at home. Positive messages were reinforced, 'well done; that was excellent; you are really good at that; laughing together is great for building relationships; mum has he done a good job?'

6. Case managers delivering interventions were enthusiastic and well-prepared for sessions. They had clear plans of what they wanted to achieve and were able to adapt the content and delivery of the material. They were skilled in keeping children and young people focused on the aims and objectives of the sessions.
7. Feedback from children and young people was systematically gathered at the review stage. However, it was not clear what impact the interventions had had on embedding change. There were no mechanisms or systems in place to monitor and evaluate the effectiveness of all the interventions delivered.

8. Case managers were able to appropriately challenge the views of children and young people to help them reflect on previous behaviour, the progress they had made and develop sustainable plans for the future. They affirmed good choices and positive decisions made by children and young people.
9. Children and young people were actively engaged in all the sessions observed. One of the observed group work interventions was particularly challenging. In this situation facilitators were able to take a break, regain focus and complete the aims and objectives as intended. They showed tremendous skill in responding to the difficult situation that had arisen.

Example of notable practice

An inspector observed a challenging group session with 4 children and young people aged 15 and 16 years old. All had committed offences with others. The aim of the session was to ensure that the group understood the law in relation to joint enterprise. The facilitators had prepared well for the session, adapting materials from the Home Office booklet 'Raising awareness of the law on joint enterprise'. Regrettably, the facilitators encountered technical difficulties, which meant that they were unable to show the short video clip that was intended for the session. There were no planned contingencies. As a result, the facilitators skilfully adapted the session using very little material to meet the intended aims and objectives. The volatile situation was tackled effectively by the facilitators who reminded the group about ground rules. They took a short break and resumed the session. The aims and objectives of the session were achieved. The children and young people in the group summarised what joint enterprise was and how the law could be applied to them.

10. Parents/carers were meaningfully engaged in the preparation for interventions and were seen as crucial to achieving successful outcomes for children and young people.
11. The nurse used a range of tools to deliver interventions to children and young people. She had access to work sheets, both pictorial and written, in addition to mood cushions and models.

Example of notable practice

The YOT had a dedicated health room with Body Mass Index scales, height measure, pregnancy and Chlamydia tests and c-card distribution (condoms). Every child and young person who came into contact with the nurse received advice and specific sessions depending on what the identified need was in the initial assessment.

12. Interventions that were delivered to address accommodation needs, alcohol misuse and physical health achieved favourable outcomes. Overall we found that the delivery of interventions had contributed to reducing reoffending.

Appendices

Appendix 1 - Background to the inspection

Inspection arrangements

The Full Joint Inspection (FJI) programme inspects youth offending work, predominantly in statutory community and custodial cases, in a small number of local authority areas each year.

The majority of the YOTs selected for these inspections are those whose performance – based on reoffending rates, National Youth Justice Outcome Indicators and 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.

The primary purpose of the youth justice system is to reduce offending. This is the main theme of the inspection. The other core themes are protecting the public, protecting the child or young person, ensuring the sentence is served and governance and partnerships.

Criteria

A copy of the inspection criteria is available on the HMI Probation website:

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

Methodology

YOTs are informed approximately 11 working days prior to the inspection taking place.

Fieldwork for this inspection was undertaken on the weeks commencing:

09 November 2015 and 23 November 2015

In the first fieldwork week we looked at a representative sample of 35 individual cases up to 12 months old, some current, others terminated. The sample 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. Cases were assessed by a team of inspection staff. They examined these wherever possible with case managers, who were invited to discuss their work in depth, explain their thinking and identify supporting evidence in the record.

We also received copies of relevant local documents.

During the week in between, the data from the case inspections was collated and a picture about the quality of the work of the YOT developed.

The second fieldwork week is the joint element of the inspection. HMI Probation was joined by colleague inspectors from police, health, social care and education. We explored the lines of enquiry which emerged from the case inspections. The leadership, management and partnership elements of the inspection were assessed, with a particular focus on reducing offending.

We also gathered the views of others, including strategic managers, staff and service users, children and young people, parents/carers and victims, and observed work taking place.

At the end of the second fieldwork week we presented our findings to local strategic managers, the YOT Management Team, YOT staff and other interested parties.

Scoring Approach

Details of how our inspection judgements are made 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/

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/

Role of HMI Probation and Code of Practice

Information on the role of HMI Probation and our 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:

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Appendix 2 - Acknowledgements

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Assistant Chief Inspector (Youth Justice)	Alan MacDonald, *HMI Probation*

Criminal Justice Joint Inspection

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