effective practice

Where we see our standards delivered well, in practice.

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AN HM INSPECTORATE OF PROBATION **EFFECTIVE PRACTICE GUIDE**

Effective practice guide
Case supervision – youth

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Contents

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Introduction

About this guide

Over the past two years, Her Majesty's Inspectorate of Probation has inspected over 2,250 individual cases against our standards for effective youth justice work. Based on that extensive dataset and individual feedback from our team of inspectors, we now have very good evidence of what the effective delivery of those quality standards looks like in practice, which we are keen to share with youth justice services.

This guide is designed for youth justice practitioners and those who support their development.

The capacity to be reflective, learn from experience and look for ways to improve are key qualities of good youth justice practitioners. This guide shares examples found by inspectors that illustrate what effective practice with court-ordered cases looks like against our standards and key questions. We want to show where inspectors observe work delivered well through engaging with children and families and supporting them to change their behaviour so that there is a reduced likelihood of children committing further crime. The practice examples for this effective practice guide have been drawn from a wide range of inspected cases to demonstrate how they apply across the whole youth justice caseload.

Our effective practice guides are designed for use within a wider framework of guidance, quality management, oversight and evaluation of services, practice and performance. We hope they will encourage a continuous process of evaluation and improvement to take place.

Justin Russell
HM Chief Inspector of Probation

Finding your way

Tools for practitioners

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Contact us

We would love to hear what you think of this guide. Please find current contact details via the HM Inspectorate of Probation Effective Practice page.

Background: About this guide

HM Inspectorate of Probation is committed to promoting effective practice across youth justice services so that work with children and families has as much impact as possible. We have collated examples of case supervision practice for this effective practice guide. We have illustrated these so that the reader is clear why they meet our researched-based inspection standards, and we have added a section to prompt the reader to apply the learning in each case.

We believe that identifying **effective practice** is crucial in developing and improving practitioners' understanding about what inspectors look for in youth justice practice.

Who is it for?

This handbook, accessible in short modules, for practitioners who manage post-court cases in the youth justice system. The modules describe the features of effective practice in assessment, planning, implementation and delivery of interventions, and reviewing.

How should it be used?

This handbook can be used for evidence-based self-assessment, practice development and quality assurance. It can also be used as part of a service's preparation for inspection, for action-planning after inspection or for general learning and training. Services can benchmark their own practice against inspection requirements using our published standards.

A note on inspections

HM Inspectorate Probation's youth standards for case supervision, which underpin this effective practice guide, were designed to provide a single, shared view of good-quality services. They apply equally across the whole Youth Offending Team (YOT) caseload, regardless of organisational structures.

Since the start of the current inspection programme, which began in the summer of 2018 to this publication in January 2021, HM Inspectorate of Probation has inspected over 2,250 YOT cases (1,900 of which had a practitioner present). We inspect a sample of cases that commenced their supervision six months previously. It is important to recognise that our inspection case examples focus on work undertaken within this six-month period only.

The four standards for inspection of case supervision follow the ASPIRE model, focusing on the quality of assessment, planning, implementation and review.

Within each standard, we assess the work to address desistance, to keep children safe and to keep other people safe. For the purpose of this practice guide, we have organised our findings and examples to demonstrate what good looks like for each of these areas of work.

HM Inspectorate of Probation ensures that inspectors inspect consistently. Inspectors assess the quality of YOT work by following our Probation inspection domain two Case Assessment Rules and Guidance ′(2019).

The rules and guidance are based on international and national youth justice practice and research, and are designed to set high standards to assess quality. We recognise that there is no 'one size fits all'. Practice needs to be tailored to the individual circumstances of the child and their family, relying on the local services and opportunities that are available.

Our key principle is that we inspect the quality of work overall. We do not require YOTs to use any specific assessment or planning tool, but instead judge the quality of case supervision as a whole.

This guide has been designed to support and encourage youth justice practitioners to develop their skills and enhance their effectiveness by providing case illustrations that demonstrate effective practice. The examples have been gathered from a range of inspection records from our YOT inspections during 2018-2020 (pre-Covid-19). They have been combined and presented in a way that will help practitioners to understand what effective practice looks like against our published standards and key questions.

What children tell us about their experience of youth justice practice

We consulted with a number of children who had previously been subject to YOT supervision. We wanted to seek and understand their perspective on effective practice. Here is some of what they told us.

On helping us to lead crime-free lives

"Sometimes YOT staff don't know how to work/communicate with young people – you need to want to work with children and to help them, and it needs to show."

"Working with different people is useful, you may make a connection with someone and not another – a mixture of different people will take a different approach to work."

"Mental health work is really important."

"If you want to understand us see us in our home environments."

"See what challenges we face."

"You should consider ex-service users as peers. We can help YOT staff as peers to young people on orders. Learned and lived experiences are important."

"Getting to know your worker is vital – take time to get to know us and understand us."

"Family – take time to get to know my family to get a better idea of what home is like."

"We don't like offices, it's easier to talk at home, it's more comfortable. You only see a small fraction of the child's life when working in an office."

"YOTs should spend more time out in the communities to help break down barriers."

"Help us find things to do – things we can enjoy."

"Help us get to move on to the next stage – like job and college interviews."

"Help us find alternatives to education – apprentices. Look for a future where we can get work."

"Involve us more in user engagement – we have a voice and we can influence this type of work."

On keeping us safe

"Please do more home visits – you will see how safe we are. Once a month is not enough."

"Improve work with other services – too many meetings, too many plans exist. Have one plan. The plan needs to have the young person at the centre."

"YOTs think education is always the answer – it's seen as a quick fix and an easy win – especially when the young person hasn't been in education for a while. Think about why we haven't been in school and understand we may not feel safe."

"Mental health and anxiety are big issues for us."

"Help us find places to go where can feel comfortable and safe."

On keeping others safe

"Restorative justice meetings are good and work."

"MAPPA needs to be more visible and include us – we don't know what is being said about us."

"Tags work for some and not others and there is a lack of flexibility."

"Tagged to a chaotic home is not good."

"Sometimes I feel set up to fail."

"Plans – might look good on paper but don't always work."

"Crimes with another person – children and young people need more supervision in their communities – encourage us to build positive relationships help us find good interesting things we like doing together."

"YOT to probation transition is not good enough."

The aim of the youth justice system and legislative framework

The legislative framework for youth justice covers:

- the prevention of offending by children and young people, for courts to consider the welfare of the child: Section 44 *Children and Young Persons Act (1933).*
- that all actions and measures must be taken to keep judicial proceedings to a minimum: Article 40 (3)9b0 *United Nations Convention on the Rights of the Child.*
- that the police and courts consider the welfare of the child at all times with the best interests of the child a primary consideration:
  - Section 11 *Children Act (2004).*
  - Section 44 *Children and Young Person Act* 1933 *Article 3(1).*
  - *United Nations Convention on the Rights of the Child (1989).*

Case supervision in context

The original YOT model was designed to offer a standard response to children who offend. Over the last 10 years, however, it has evolved to respond to local need and oversight arrangements. A range of models now operate across approximately 150 YOTs in England and Wales, ranging from distinct youth offending teams to YOT functions embedded within children's services and early help. While inspections do not favour one type of model over another, there are clear advantages to having access to children's services, especially for those with local authority looked after child status, and to early help in order to prevent children entering the youth justice system in the first place. However, the issues related to risk of harm and safety and wellbeing presented by these children need to remain a core part of their supervision.

The 'child first' approach to youth justice is reinforced by a desistance or strengths-based method of working with children. Rather than supervision that focuses on a child's deficits, or risks, youth justice practitioners promote a child's strengths, and therefore self-esteem, as a way of preventing future offending. There is some debate about the relative efficacy of the risk versus strengths-based models of delivery, with supporters siding with one or the other. In truth, both approaches have merit and a role to play.[1]

Youth justice services fully recognise the impact of early childhood trauma on children and the link it may have to offending.[2] Trauma-informed practice tends to form the bedrock of supervisory practice in youth justice services, as a result.

There is now more recognition of, and response to, the experiences of harm children face outside their families, in their local community and in their schools. Children are also exposed to harm online, which can feature violence and abuse. **Contextual safeguarding**, as it is now known, recognises that children are vulnerable to abuse beyond their front doors and this concept is becoming increasingly embedded in supervisory practice.[3]

Restorative justice practices are also well-embedded in approaches to youth justice. Referral orders have restorative justice at their core, providing the child who has offended and the victim of the crime with an opportunity to hear the other's perspective as a form of reparation.

Services are now configured to address the complexities and common conditions affecting children in the youth justice system, such as neurodiversity. Local partnerships are more familiar with the impacts of deprivation and neglect, the prevalence and overrepresentation of children who are looked after, and the continued racial disparity in the system.

Case supervision in YOTs is shared across the partnership and is not the sole responsibility of one single agency.

Each YOT is expected to manage each case by engaging the child, parents and carers, taking account of each child's diverse needs. They must establish a meaningful, trusting relationship, promote engagement with sentence requirements and work towards desistance

[1] Maruna, S. and Mann, R. (2019). 'Reconciling 'desistance' and 'what works''. *Academic Insights*, 2019/1. HM Inspectorate of Probation.

[2] McCarten, K.F. (2020). 'Trauma-informed practice'. *Academic Insights,* 2020/05. HM Inspectorate of Probation.

[3] Firmin, C. (2020). 'Contextual safeguarding'. *Academic Insights*, 2020/07. HM Inspectorate of Probation.

from crime. The children in the youth justice system are some of the most vulnerable in our society. They may have mental health issues, learning disabilities, and/or other presenting concerns. Many also have experience of the care system.

Case managers are required to work in partnership with the other statutory agencies to produce a plan from a comprehensive assessment. This should enable the child to adopt a pro-social identity and promote desistance from offending. It should also protect the child's safety and wellbeing, as well as the public. Case managers must review cases as required to reflect significant changes in the child's circumstances.

The case manager is required to coordinate interventions with all the relevant specialists and/or agencies and be clear about what is expected of them. They must also consider the child's broader vulnerabilities and/or safeguarding. They must recognise the impact of the public/social context on children's lives, and their safety. This contextual safeguarding approach identifies and responds to harm and abuse posed to children outside their home, either from adults or other children.

When we inspect the work done in individual post-court youth cases, we apply our standards and look specifically at:

Assessment

Assessment is an integral part of case supervision. Theoretical models and research findings consistently highlight the importance of understanding the individual child's characteristics.

Assessment should pay attention to the child's wider familial and societal context and engage parents/carers and significant others as appropriate. It should identify factors linked to desistance, safety and wellbeing, and risks to others, as well as strengths and protective factors. Assessment should generate a holistic picture of the child and the interactions between all of these factors. It is important to ensure that a sufficiently comprehensive analysis of the different factors affecting the child's life is conducted.

The process of assessment is as important as the outcome. Practitioners should use a wide range of sources of information, including previous records and assessments and, in appropriate cases, information gained from other agencies or people who know the child. This information should include assessments and plans from early help or children's social care, emotional mental health and wellbeing providers, and education and health care services. This helps to build a rounded view of the child, capturing their full range of risks and needs.

Research has highlighted the importance of engagement, not passive involvement, with the child. Engaging the child in the process of assessment provides an opportunity for them to feel listened to, meaningfully involved and supported in working out what they want to achieve. Giving the child a voice and treating them with respect helps to build the one-to-one trusting personal relationships that can be a powerful vehicle for change.

We inspect cases to judge whether assessment is well-informed, analytical and personalised, actively involving the child and their parents/carers. See Standard 2.1 of the Standards for inspecting youth offending services.

Planning

There must be a strong connection between assessment and planning. The planning process should specify what is to be done about the needs and risks identified. The well-established principle of responsiveness requires that interventions and activities are delivered so that they are accessible to the individual child and optimise their ability to change, encouraging full participation. One-size-fits-all processes and interventions will not work.

Planning should be set in the wider familial and social context of the child, involving parents/carers and significant others as appropriate. Key practitioners working across different agencies should also be involved where necessary, making appropriate links to any other ongoing work within these agencies. Research further demonstrates the importance of services and interventions being multi-modal, holistic and sequenced, with strengths and protective factors being reinforced and developed.

Objectives in the plan should be specific and measurable so that progress can be monitored. They must also be achievable, realistic, and have clear timescales. Where necessary, the plan should be broken down into a smaller number of 'steps' with realistic, short-term objectives. The child may have multiple complex problems that cannot sensibly be tackled all at once, and they may disengage if the work plan is over-ambitious.

As with assessment, a plan that the child does not sufficiently understand or agree with is unlikely to be implemented. Practitioners should make efforts to engage the child as an active participant and help them to set goals. Research evidence suggests that when the child feels engaged, and the plan is drawn up collaboratively, they will be more likely to have a direct investment in achieving its outcomes. The language in the plan should be clear and easily understood by the child and their parents or carers. It should avoid phrases that label the child in a way that confirms an offending identity.

When we inspect a case, we judge whether the planning is well-informed, holistic and personalised, actively involving the child and their parents/carers. See Standard 2.2 of the Standards for inspecting youth offending services.

Implementation and delivery

The child should experience an integrated approach between different agencies and the YOT, with relationships, interventions and services combining holistically to address their individual risks and needs. Service delivery should reflect the child's wider familial and social context, and sufficient emphasis should be given to building on strengths and enhancing protective factors. Staff need to remain responsive to the child, so that trusting relationships continue to be built and delivery remains tailored to the individual. If the child receives consistent and integrated support, particularly at critical times, through an approach that is engaging, supportive and motivating, they are more likely to desist from offending.

The desistance literature promotes the importance of positive, non-judgemental and trusting relationships between practitioners and the child. Wherever possible, practitioners should reinforce desired behaviours and use natural opportunities to demonstrate and teach

thinking and behavioural skills. Practitioners must promote compliance, including helping the child to recognise the positive changes and benefits that result from a non-offending lifestyle. Any instances of non-compliance should be dealt with in a proportionate, fair and transparent manner.

When we inspect a case, we judge whether high-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child. See Standard 2.3 of the Standards for inspecting youth offending services.

Reviewing

Reviewing progress is another integral part of service delivery. It recognises that a child's risks, needs, protective factors and circumstances can change over time. The reviewing process should be used to: (i) analyse new information (including information from other practitioners and agencies); (ii) verify changes in a child's behaviour; (iii) adapt or change actions that are completed or no longer appropriate; and (iv) explore the full range of available resources. It is also a critical opportunity to recognise and record progress. YOTs will have local arrangements in place for reviewing cases, but we expect reviewing to be an ongoing process. Cases should be reviewed when a significant event occurs or within a six-month timeframe.

Changes in factors related to the child's safety and wellbeing and/or risk of harm to others should be emphasised. Practitioners also need to be alert to the possibility of changes in the child's life that could impact on their engagement. They should consider the views of parents/carers and significant others as appropriate. Work plans must be adapted to any change in the assessment. Any obstacles to compliance and engagement should be identified and discussed, with strategies developed to enable the child to fully engage.

As with planning, efforts should be made to engage the child as an active participant in the reviewing process, helping them to recognise and celebrate their achievements, to review and refresh their goals towards desistance and to take further charge of their own lives.

We inspect cases to judge whether reviewing of progress is well-informed, analytical and personalised, actively involving the child and their parents/carers. See Standard 2.4 of the Standards for inspecting youth offending services.

Desistance in case supervision

Evidence summary:

Desistance is the process of abstaining from crime by those with a previous pattern of offending. It is an ongoing process and often involves some false starts and stops. The collated evidence suggests that children are more likely to desist when they have:

- a stable home environment
- positive social interactions and friendship groups
- a commitment to education and training
- a pro-social identity, with a sense of purpose in their lives.

The term 'assisted desistance' has been used to describe the role that YOTs (and other agencies) can play, recognising that children can be supported to desist from crime but there are too many factors at play for an agency to 'cause' desistance.

The research literature highlights the importance of the following:

- **Adhering to risk, need and responsivity principles:** Interventions should match the likelihood of reoffending, and offending-related needs should be the focus of targeted interventions. They should be sufficiently tailored to individual learning styles, motivation and abilities. Opportunities to provide integrated services and pathways of delivery, particularly for children with multiple and complex needs, should be well developed. Interventions can be at the individual, family or community level. Actions at an individual and family level include peer mentoring, family-based interventions, and building life skills. Actions at a community level include providing trauma-informed services, working with substance misuse services, and linking with education, employment and housing.
- **Respecting individuality:** Since the process of giving up crime is different for each child, delivery needs to be properly individualised. The desistance process is influenced by a child's circumstances, the way they think, and what is important to them.
- **Recognising and developing children's strengths:** The supervision process should promote a range of protective factors, such as strong and supportive family relationships, and take a strengths-based approach, rather than focus solely on a child's deficits. There should be incentives and opportunities for the child to explore interests and develop skills. Protective factors can be categorised in a similar way to risk factors and grouped into individual, family, school and peer group, and community categories.
- **Building positive and trusting relationships:** Children are most influenced to change by those whose advice they respect and whose support they value. The relationship-based practice framework for youth justice highlights the value of establishing relationships that are non-blaming, optimistic and hopeful, open and honest, and empathetic. Genuine relationships demonstrate 'care' for the child, their desistance and their future. Children have highlighted the need for continuity of support. They benefit from the establishment of ongoing trusting relationships rather than having to repeat the same information to a succession of 'strangers'.
- **Working in collaboration**: Desistance is a process that can be assisted externally but it must be accomplished by the child themselves. Involving and motivating the child and their parents and carers is of paramount importance. This means real

collaboration and working with children rather than on them to establish goals and find solutions. Children have reported that they value being listened to and given a chance to 'tell their story', and the practitioner taking the time to recognise them as an individual, understanding their specific needs and expectations.

- **Providing structured supervision:** Approaches such as pro-social modelling, effective reinforcement, cognitive restructuring and problem-solving are found to be beneficial. Building and maintaining motivation are often vital. Practitioners should take account of any practical obstacles and engage parents/carers and significant others as appropriate.
- **Recognising the significance of social context:** Desistance is related to the external and social aspects of a child's life (for example the supportiveness of those around the child), as well as to internal and psychological factors (for example what the child believes in). Desistance can be supported by establishing both human and social capital. Giving up crime may require new networks of support and a focus on opportunities for longer-term community integration.

Reflecting this evidence, the '5C' characteristics of effective support are:

(i) constructive; (ii) co-created; (iii) customised; (iv) consistent; and (v) coordinated.[4]

What inspections tell us about desistance practice

When we inspect a case, we assess the quality of work delivered in relation to desistance, keeping children safe and keeping other people safe. In doing this, we do not focus on the quality of specific documents, work products or tools. Instead, we look at practice holistically.

Key strengths in desistance practice identified in inspection strengths

- Assessment of children's desistance is consistently good.
- A child's diverse needs are usually identified and understood throughout the assessment.
- Plans, interventions and delivery focus on a child's desistance and are delivered well in a high proportion of cases.
- There is strong evidence of YOT staff engaging children and their parents or carers and involving them throughout the assessment and reviewing processes.

Common failings and remaining challenges to achieving effective practice

- Management oversight does not always impact on the quality of the work delivered.
- Lack of partnership arrangements and resources, especially education, training and employment, and emotional, mental health and wellbeing provision will lead to negative outcomes for children.

[4] Youth Justice Board. (2018). *How to make resettlement constructive*. Available at: https://yjresourcehub.uk/custody-and-resettlement/item/610-how-to-make-resettlement-constructive-yjb-document.html

Assessing for desistance

This case example illustrates where assessment showed a good understanding of promoting a child's desistance. We expect to find that the assessment:

- is well-informed, analytical and personalised, actively involving the child and their parents/carers
- draws on relevant information held by all other agencies, including the child's education provider, children's social care, health services and the police
- sufficiently analyses how to support the child's desistance
- shows sufficient analysis of offending behaviour, including the child's attitude towards and motivation for their offending
- considers the diversity and wider familial and social context of the child
- focuses on the child's strengths and protective factors
- analyses the key structural barriers facing the child
- gives sufficient attention to understanding the child's levels of maturity, ability and motivation to change, and their likelihood of engaging with the court disposal
- gives sufficient attention to the needs and wishes of the victim/s, and opportunities for restorative justice
- meaningfully involves the child and their parents/carers and other significant adults in their lives (for example employers) in their assessment and considers their views.

Case summary

Tim is a 17-year-old male, sentenced to a referral order for an offence of robbery.

Tim lived with his mum, who had recently been diagnosed with cancer. He had no contact with his father. As an only child, he had found his mum's diagnosis difficult to cope with, and as an escape had spent more time with his friends drinking alcohol in the local park. The offence, which was his first, had occurred while he was with his friends and under the influence of alcohol. One of his friends had dared him to take a mobile phone from another child who was walking through the park.

From the start, the case manager took time to get to know Tim, and she recognised that he felt angry about what had happened to his mum and was afraid for the future. The family were not known to any other agencies. Since the offence, Tim had stopped associating with the group of friends who were involved in the offence, as he recognised the negative

influence, they had on him. Tim worked full-time as an apprentice car mechanic, and he had told his employer about the offence when he needed time off to attend court.

Throughout the assessment, the case manager took time to explain the criminal justice processes to Tim and what the impact would be on his future, especially in regard to disclosing his convictions. She made numerous home visits to speak to his mum and visited the garage where he worked. The case manager identified that Tim's mum was a positive factor in his life who helped, encouraged and supported him, and that he had a strong relationship with her. She assessed that further work was needed so that they could come to terms and cope with what his mum was going through and the impact it was having on both of them.

The case manager also included Tim's employer in the assessment and spent time speaking to both of them about the expectations of the order and the impact it would have on Tim and his employer's time. Through these visits, the employer developed a greater understanding of Tim and what his circumstances were and offered additional support to help him to complete his order. This included taking him to appointments and allowing him time off to complete interventions.

The assessment considered the impact of alcohol on Tim's offending and the case manager involved a specialist substance misuse worker to complete a screening tool, which formed part of the assessment. She concluded that, although alcohol had been a factor in the offence, Tim had now limited his intake and was not drinking outside on the streets anymore; therefore, this was no longer an issue.

The case record described Tim as having a positive outlook for his future and being motivated to learn from his supervision. When thinking about restorative justice, the case manager discussed with Tim what opportunities were available and they agreed that for his reparation hours he would work in a cancer charity shop near to his home. She knew that Tim would feel invested in this work due to his mother's experience.

The case manager gave the inspector a progress update on the order. She described the continued engagement of Tim's mother and employer, how she kept them updated with his progress and how they could further support Tim.

Inspector comments:

"This is a good example of a desistance-focused assessment. It identified that Tim's mother's cancer diagnosis had been a significant life event for Tim, which had led to him trying to escape the reality of it through drinking with his friends. The case manager gave a detailed explanation of Tim's negative emotional state at the time of the offence and how the situation he was in had led to him committing the offence.

"The case manager considered Tim's relationships with his mum and his employer and identified these as strengths in the assessment. She also analysed the impact that alcohol and negative peer influences had on him and his decision-making abilities at the time of the offence. By involving his mum and his employer, the case manager could use information from them to enhance the assessment. She identified his strengths and recognised his level of maturity in his ability to reflect on his behaviour at the time and make changes. The assessment capitalised on Tim's positive attitude and his motivation for an offending-free future."

Take away – applying the learning

For further information on desistance, see HM Inspectorate of Probation's Academic Insights publication by leading academics Shadd Maruna and Ruth Mann, *Reconciling 'Desistance' and 'What Works'.*

1. What stood out to you in this case illustration, and can you identify similar elements in your own approach to engaging the right people around the child to support your assessments?
2. How can you develop further your understanding of assessing for desistance?

This case summary is intended for training/learning purposes and includes a fictional name.

Planning for desistance

This case example illustrates where planning showed a good understanding of promoting a child's desistance. We expect to find that the assessment:

- the services most likely to support desistance, while considering available timescales and the need for sequencing
- diversity and the wider familial and social context of the child
- the child's strengths and protective factors, and to seek to reinforce or develop these as necessary
- the child's levels of maturity, ability and motivation to change
- the needs and wishes of the victim/s
- the involvement of the child and their parents/carers in the planning, taking their views into account.

Case summary

James is a 14-year-old male sentenced to a 10-month referral order for possession of a knife. The offence occurred in school.

James was a looked after child who lived with foster parents. He had no previous involvement with youth justice services and the incident of possession of a knife at school was the first time that any concerns about him had been identified. Due to the nature of the offence, James was at risk of exclusion unless he complied with a package of work to support him.

During the assessment process, James was reluctant to talk to the case manager and was very withdrawn. From conversations with the school, the case manager realised that unless James engaged with the assessment and subsequent plan there was a risk he would be excluded. There was a specific teacher who James liked and trusted. With James's

permission, the teacher joined the meetings and James started to open up about his circumstances. James said he was struggling at home and in school. He was having arguments with his foster parents and he was being bullied at school. The foster parents had set strict boundaries for James and he was not allowed out on school nights. This had led to him being called names on social media and he reported feeling threatened. It was for this reason that he had started carrying a knife. The case manager recognised that James did not have many friends and often felt frightened.

The case manager had worked hard to engage James and build a relationship with him and had included him and his foster parents in the planning process. She knew that he would be reluctant to meet other professionals and that he would need time to adapt to any changes. This was reflected in the plan, which appropriately sequenced the interventions that would be put in place and which professionals would be working with James. This included the teacher at school working with James on how to keep himself safe, and the YOT police officer doing sessions around the consequences of carrying knives. His social worker would do family therapy sessions with the family, and his foster parents would be offered parenting support. The case manager would provide interventions to improve James's self-esteem and teach him how to build positive friendships. As he enjoyed playing football, this would be used as a positive activity to keep him motivated and engaged.

The agencies agreed a single plan, which was jointly shared by the school, the social worker, the YOT police officer and the case manager. The case manager ensured that the plan was integrated with his looked after child plan, that agencies' roles were clear and that there was a timeline in place for discussing progress.

Inspector's comments

"Planning in this case was effective. There was a good record of why the professionals believed that planning the activities and sequencing the tasks would bring about good results. The case manager had successfully planned for positive relationships and constructive activities to support James's desistance and safely manage this referral order.

"The case manager saw that James did not have much trust in professionals, so she prioritised building a relationship with him first and then introduced a broader network of professionals to support the delivery of the plan in incremental stages. To develop the right plan, the case manager had to involve all the right specialist agencies that were also working with James and his family.

"The inspector saw evidence that the plan had been discussed with and understood by James and his foster parents. When the plan was complete, the case manager discussed it with James. He agreed that, with the right support, he could achieve what was expected. The case manager saw a shift in his motivation to a more positive outlook."

Important learning

- The case manager identified the protective factors in the child's network and focused on bringing these together.
- Joint working, information-sharing and planning with other professionals were good.
- The child was not excluded from school, which was a significant achievement given the nature of the index offence; the professionals worked hard to achieve this.

Take away – applying the learning

For further information on this subject, please see HM Inspectorate of Probation's Academic Insights publication by leading academics Shadd Maruna and Ruth Mann, *Reconciling 'Desistance' and 'What Works'.*

1. What stood out to you in this case illustration, and can you identify similar elements in your own approach when planning for desistance?
2. Will you make any changes to your practice when working with the child, and others in their network, to formulate and sequence a plan?
3. How can you develop further your understanding of planning for desistance?

This case summary is intended for training/learning purposes and includes a fictional name.

Implementation and Delivery for desistance

This case example illustrates where the implementation and delivery of services showed a good understanding of promoting a child's desistance. We expect implementation and delivery of services to:

- support the child's desistance
- deliver services that are most likely to support desistance, giving sufficient attention to sequencing and the available timescales
- reflect the diverse needs and wider familial and social context of the child, involving parents/carers or significant others
- build on the child's strengths and enhance protective factors
- develop and maintain an effective working relationship with the child and their parents/carers
- promote opportunities for community integration, including access to services post-supervision
- encourage and enable the child's compliance with the YOT's work.

Case summary

Kai is a 16-year-old male sentenced to a 24-month youth rehabilitation order with supervision, curfew and activity (reparation) for three counts of robbery.

Kai had one previous conviction for domestic burglary. He had been known to the YOT for a number of years and had been subject to prevention interventions and out-of-court disposals. He had received a previous referral

order for domestic burglary, which he had completed successfully. The robbery offences had all occurred in the same day and had involved Kai and others stealing from three local shops. One of the offences had included the use of a weapon and one of the victims had been an elderly shopkeeper. Intelligence from the police showed that Kai was on the periphery of a known gang in the local area and there were concerns that he was becoming more involved.

Kai's older brothers were known to the police and one of them was serving a sentence in prison for manslaughter. His parents had tried to keep Kai away from offending peers so that he did not go along the same path. However, over time, older peers from the local gang who were known to his brothers had encouraged Kai to spend time with them.

The case manager fully engaged Kai and parents in the assessment and planning processes. He wanted to understand Kai's motivation for the offences, Kai's relationship to the gang and their influence, and the use of a weapon. During the assessment process, Kai had revealed that he used cannabis and that he had lengthy periods when he felt very down and could not shake off dark thoughts. He told the case manager he was worried that he was destined to go down the same route as his brothers and that he had the capacity in himself to kill someone like his brother had.

The case manager recognised that, for Kai to stay away from the people he was associated with, he needed to keep him motivated and engaged in his order. The curfew had offered Kai an excuse to remain indoors every evening, but the case manager was also keen to understand what Kai enjoyed doing so that he could build foundations for a new structure to Kai's life. As the order was for two years, it was important that the interventions were tailored and tapered appropriately to keep Kai motivated.

As part of the intervention period, an assessment was completed by the restorative justice and victim worker to see if it was appropriate for Kai and the elderly shopkeeper to meet. Kai was reluctant to meet the victim, and the case manager knew that he was ashamed of his behaviour and found it difficult to think about seeing his victim face-to-face. Alongside this work, Kai was engaging with his Child and Adolescent Mental Health Service (CAMHS) worker, who was providing therapy to improve Kai's self-esteem and his belief in being able to determine his own future. Eventually the victim decided that he did not want to meet face-to-face but, as a result of his ongoing work with CAMHS, Kai felt comfortable being part of 'shuttle mediation' with the victim. The restorative justice and victim worker passed information, explanations, hopes and concerns between the victim and Kai. Both parties reported that this had a positive impact on them and enabled an understanding of each other's perspectives on the offence.

Due to the nature of his offence, Kai completed the knife crime and consequences programme and had some individual sessions with the YOT police officer about keeping himself safe in the community. This was supported by the case manager delivering a healthy relationships programme which looked at how Kai built friendships. The substance misuse worker also completed an awareness programme with him regarding his cannabis use. A range of different techniques, including apps, films, groupwork and one-to-one sessions, were used to deliver the interventions in order to keep Kai engaged, as initially he was seen twice a week.

For Kai to build a new structure to his leisure time, the intervention programme included things that he enjoyed, such as boxing, attending the gym and rugby. These also offered him the opportunity to develop new friendships. The case manager also used his interest in art to help him engage with the local graffiti project.

The case manager gathered Kai's parents' views and kept them informed of the progress he was making. There were good records of Kai's progress, which evidenced an improvement in his own perception of his wellbeing and his continued motivation to change his lifestyle.

Inspector comments:

"This case is an example of good work to promote desistance. The assessment, planning, service delivery and interventions are seamless and take a holistic view of the child rather than focusing solely on the offence. There was good recording in the 'explanation and conclusion' section in the AssetPlus assessment; it brought the case together well and there was good analysis of information.

"The interventions were appropriate. The case manager balanced the offence-focused work, such as knife crime and consequences, with emotional wellbeing, support and diversionary activities. There was a good approach to working with the family, sharing information and building trust.

"The services, activities and interventions underway in this case were the ones that are most likely to support the child's desistance. They were personalised to him and built on his strengths. The case records showed good attention to understanding engagement and participation and how the family could support desistance. The case manager made sure Kai's leisure activities were community-based so that he could continue to access universal services after his sentence finished.

"These constructive sports-based activities showed that the case manager understood and planned the delivery of the interventions to suit Kai's lifestyle, his physical health and development and self-identity being a priority."

Important learning:

- The case manager built on the child's strengths and continuously engaged his parents. This helped to minimise the risk of reoffending.
- The case manager identified Kai's motivation to change and selected a specific programme that promoted pro-social modelling and problem-solving techniques.
- The case manager involved other specialists in the wide range of interventions delivered.

Take away – applying the learning

For further information on this subject, please see HM Inspectorate of Probation's Academic Insights publication by leading academics Shadd Maruna and Ruth Mann, *Reconciling 'Desistance' and 'What Works'.*

See also:

- The Scottish Centre for Crime & Justice Research. (2009). *Towards effective practice in offender supervision.*
- HM Inspectorate of Probation. (2016). *Desistance and young people.*
- Youth Justice Board. (2014). *Desistance table: supporting guidance.*

1. What stood out to you in this case illustration, and can you identify similar approaches to delivering interventions in multi-faceted orders in your own practice?
2. Will you make any changes to your practice when considering structuring and delivering services and interventions in a complex order like this?
3. How can you develop further your understanding of interventions for desistance?

This case summary is intended for training/learning purposes and includes a fictional name.

Reviewing for desistance

This case example illustrates a good understanding of reviewing a child's desistance. We expect reviewing to:

- identify and respond to changes in factors linked to desistance
- build on the child's strengths and enhance their protective factors
- consider the child's motivation and engagement levels and any relevant barriers to engagement
- ensure that the child and their parents/carers are meaningfully involved in reviewing their progress and engagement, and that their views are considered
- lead to the necessary adjustments in the ongoing plan of work to support desistance.

Case summary

Theo is a 16-year-old male. He received a 12-month referral order for an offence of robbery.

Theo had no previous offences and lived at home with his parents and his younger siblings. He had just left school, having gained some good exam results, and the offence occurred in the summer before he was due to start sixth-form college. His closest friend had moved away, and Theo had met a new group of boys at his local gym. He had not known them long when, after drinking alcohol at one of their houses, he was pressured by the group to get more drink by stealing from the local shop. The owner of the shop, the victim of the offence, was known to him and his family.

The case manager had completed a good case assessment, which the plan built upon. The interventions included work on peer pressure and building healthy relationships, as well as an awareness programme regarding substance misuse. As the plan progressed and Theo received good feedback on his progress, the case manager recognised that Theo was ready to start the victim work. He met with Theo and his parents to discuss this, as he was aware that Theo was worried about this work because he felt anxiety and shame when he thought about the victim and the impact of his behaviour. However, part of his referral order contract required him to write an explanation and apology letter to the victim.

After discussing this with the case manager, Theo chose to write his letter in the form of a poem. He wrote a thoughtful and insightful account of his offence and the impact he thought this had on the victim. This was sent to the victim and he presented it at his three-monthly referral order panel review. The case manager and Theo then repeated this exercise at his six-monthly referral order panel review, when he produced a reflective poem on his experience of the YOT and the changes he had made, which was also shared with the victim. The case manager recognised that engaging Theo in his own reviews in such a positive way meant that he was able to share the progress he felt he had made, in a style he was comfortable with, and in his own words. There were comprehensive review records, which showed the progress that Theo was making and outlined what he still had to do. These were presented at the three-monthly referral order review panel meetings so that the panel members could monitor the progress being made.

Inspector comments:

"The reviews included the views of Theo's parents and updates from the other agencies involved. Most importantly, Theo was actively involved in the reviews, as the case manager encouraged him to express himself using a method that matched his skills and interests. He had been able to tell the panel about his progress using his own words. His achievements were recognised, and he was congratulated by the panel for the progress he had made."

Important learning:

- The case manager was creative in enabling the child to be actively involved in his own reviews by using his own words to describe his progress.
- This child received direct feedback from the panel about how well he was doing. This kept him engaged and motivated to produce further work for the panel to see.

Take away – applying the learning

For further information on this subject, please see HM Inspectorate Probation's Academic Insights publication by leading academics Shadd Maruna and Ruth Mann, *Reconciling 'Desistance' and 'What Works'.*

See also: The Scottish Centre for Crime & Justice Research. (2009). *Towards effective practice in offender supervision.*

1. What stood out to you in this case illustration, and can you identify similar approaches in your own practice in reviews?
2. Will you make any changes to your practice when reviewing achievement against the plan's objectives?
3. How can you develop further your understanding of reviewing for desistance?

This case summary is intended for training/learning purposes and includes a fictional name.

Keeping the child safe in case supervision

Evidence summary:

Our evidence of effective work to keep children on YOT caseloads safe overlaps with our findings relating to engagement and desistance. Where there were concerns regarding the child's safety and wellbeing, the following were found to be particularly important:

- **Trusting relationships**: Children with safeguarding needs require practitioners to be friendly, flexible, reliable and non-judgemental. They need stability, continuity and persistence. Frequent changes in practitioners can be unsettling. Children have said that they want: someone to notice that something is wrong; to be asked direct questions; for issues to be investigated sensitively but thoroughly; and to be kept informed about what is happening. They want to be heard and believed, and for their wishes to be taken into consideration. Clear communication and the establishment of trust can be the basis for disclosures that are essential for safeguarding, especially where the child is being criminally exploited and fears retribution.
- **Wider social support:** The importance of social support and supportive relationships that provide emotional, informational or instrumental aid is well established. It is critical to understand the child's context, relationships, any social capital and need for trusted relationships from agencies and friends and family. The 'team around the relationship' recognises that one partner may lead in building a trusting relationship, but it needs to be supported by others. Effective communication and timely and comprehensive information-sharing between agencies are critical.
- **Extra-familial contexts:** A contextual approach to safeguarding recognises that different forms of extra-familial harm present various welfare risks, and that plans to address these harms must take account of the context and associated environmental factors. Multi-pronged intervention plans work with children, parents and the extra-familial contexts.
- **Trauma-informed approaches:** There is a growing body of evidence on the prevalence and impact of trauma and adverse childhood experiences, and the need to adapt practice accordingly. Trauma-informed interventions have been found to be successful in treating traumatic stress, as they recognise the effects of traumatic experiences on children's psychological development and attachment and aim to support recovery rather than exacerbate vulnerabilities. They are based on creating safety and trust, promoting control, building resilience and empowerment, and prioritising self-empathy and self-care. The aim is to provide children with a sense of control and hope, and they should ideally involve all those working with the child, including parents/carers and wider family.
- **Key moments:** There are key moments in children's lives, such as exclusion, running away or moving between placements, when they may be particularly at risk. Anything that disrupts potentially supportive networks can be seen as a moment of extra risk. Practitioners need to be aware of these key moments and be proactive when required. A timely response can prevent a situation quickly deteriorating.

What inspections tell us about keeping the child safe in case supervision

When we inspect a case, we assess the quality of work delivered in relation to desistance, keeping children safe and keeping other people safe. In doing this, we do not focus on the quality of specific documents, work products or tools. Instead, we look at practice holistically.

Key strengths in keeping the child safe in practice

- YOT staff take time to get to know the child and their family and identify their individual needs.
- The views of the child and their parents or carers are considered when assessing a child's safety and wellbeing.
- Good multi-agency working, and appropriate information-sharing enable practitioners to monitor the child's safety and wellbeing effectively.

Common practice failings and remaining challenges to achieving good practice

- Insufficient integrated planning for safety and wellbeing with relevant agencies can lead to gaps and/or confusion in roles.
- Insufficient reviews to address a child's safety and wellbeing results in a limited range of, and/or changes to, approaches.
- Some practitioners do not escalate concerns, and some YOTs have poor or insufficiently responsive escalation processes.

Assessing to keep the child safe in case supervision

This case example illustrates where assessment showed a good understanding of keeping the child safe. We expect the assessment to:

clearly identify and analyse any risks to the child's safety and wellbeing

draw sufficiently on available sources of information, including other assessments, and involve other agencies where appropriate

analyse controls and interventions to promote the safety and wellbeing of the child.

Case summary

Sophie is a 15-year-old female. She received a six-month referral order after pleading guilty to possession of a knife and assault of a police constable.

This was Sophie's second offence for possession of a knife within a two-month period. She had previous court disposals for public order and common assault offences. Sophie lived at home with her parents and was known to children's social care as a child in need. Recently she had started going missing from school and had been picked up by the police in houses where known adult offenders were present. Her father worked away a lot and so it was mainly Sophie and her mum at home. Her mum struggled to set boundaries for her and had reported that she suspected Sophie was taking drugs.

The case records were comprehensive, and the assessment had used information from social care and the school. Sophie was assessed as high risk across all three domains of reoffending, safety and wellbeing, and risk of harm to others (this illustration addresses safety and wellbeing only).

The case manager introduced a Signs of Safety[5] model assessment to assist her with this difficult case. This additional assessment helped her to address the indicators of danger/harm alongside the indicators of safety and strengths. This helped her make an overall judgment using a safety scale.

She was keen to protect Sophie's safety by using the strengths and resources that the family had to offer. These strengths could, in time, become protective factors in support of Sophie. This assessment was dynamic and so continued to evolve while the case manager worked on the other elements of the order.

The case manager identified that twice weekly was an appropriate level of contact to monitor and address the concerns about Sophie's safety and wellbeing. She formed a good relationship with Sophie and, as a result, Sophie disclosed that she was subject to long-term bullying. The case manager spoke with her parents, form teacher and the head of year about the extent of the bullying and the measures that had been taken at home and in school to address it. The case manager continued to assess Sophie's resilience to the bullying and discussed with her parents and the school what additional action was required to keep her safe. Sophie also presented a risk of harm to others because of her escalating poor behaviour, so the case manager was simultaneously assessing how to keep others safe. The case manager was concerned that Sophie had been found in possession of a knife on two occasions and made every effort to understand her reasons for committing these offences.

Through the ongoing work that the case manager and support worker were doing, Sophie felt comfortable in telling them that she struggled to get along with her mother and therefore she was unhappy at home as well as at school. This led to Sophie revealing she suffered with low self-esteem and had previously taken an overdose. Overall, these issues were affecting Sophie's health and wellbeing and were clear factors in her pattern of offending. The case manager reacted quickly and appropriately to this information and made an urgent referral for an additional assessment from CAMHS.

Although this was a short community order and so offered limited time, the case manager completed a good-quality assessment, put in place a supportive plan involving other

[5] The Signs of Safety model is intended to help practitioners with safety planning in child protection cases. It aims to enable practitioners across different disciplines to work in partnership with families and children. The tools are designed to help conduct risk assessments and produce action plans to reduce risk and danger by identifying areas that need to change while focusing on strengths, resources and networks that the family has. The use of common language helps to avoid assumptions and misunderstandings and ensures that all agencies are clear about the risks posed and the work that needs to be carried out.

agencies, and began the interventions to minimise Sophie's risk of harm to both herself and to others.

The case records showed good evidence that the case manager worked effectively with the support worker and a range of agencies to address Sophie's complex needs. Sophie made good progress throughout this court order and there was a reduction of risk recorded across all domains and specifically her perception of her own safety and wellbeing.

Inspector's comments

"This was a good assessment. It considered all the risks to Sophie's safety and wellbeing and clearly stated what the risk was, why it was present, and its likelihood and imminence. It was very detailed and included good information on Sophie's insight into her own behaviour and her volatile relationship with her mother.

"The case manager used Sophie's self-assessment very well. Use of the Signs of Safety assessment also helped the case manager work with Sophie and her family to create protective factors, starting at home. The case manager recorded Sophie's comments, thoughts and feelings and used them appropriately in the assessment process. There was substantial evidence to support the assessment of a high level of risk to Sophie's safety and wellbeing, as the case manager documented her recent overdose and threats to self-harm, her absconding, being a victim of bullying and her low mood.

"Conversations with the case manager during the inspection also highlighted how treating Sophie with respect and listening to her enabled Sophie to discuss her feelings and disclose the extent of the bullying. Practical arrangements also helped, as the case manager and support worker had organised the appointments at the same time on the same days each week and sent a text message as a reminder.

"The assessment considered the impact that Sophie's behaviour had on her own safety and wellbeing. This included concerns about her mental health and her risk-taking behaviour. The case manager included information from other agencies, including children's social care, mental health services and the police. She also included information about the immediate interventions that were put in place to support Sophie's safety and wellbeing."

Important learning

- Case managers in the youth justice system identify safety and wellbeing as the most significant factor affecting children (88 per cent of cases[6]).
- The case manager identified correctly that there were increasing concerns for this child with the frequency and increasing gravity of her offending. She explored the child's relationship with others and her emotional wellbeing as early as possible in the assessment.

[6] The Youth Justice Board for England and Wales. (June 2020). Assessing the needs of sentenced children in the Youth Justice System 2018/19. Available at: https://www.gov.uk/government/statistics/assessing-the-needs-of-sentenced-children-in-the-youth-justice-system

Take away – applying the learning

1. Did you benefit from the case illustration and will you make any changes to your assessment practice?
2. How can you develop further your understanding of techniques to improve your assessment of safety and wellbeing practice?

This case summary is intended for training/learning purposes and includes a fictional name.

Planning to keep the child safe in case supervision

This case example illustrates a good understanding of planning to keep the child safe. We expect the plan to:

- involve other agencies where appropriate, and align sufficiently with other plans concerning the child, such as child protection or care plans
- set out the necessary controls and interventions to promote the child's safety and wellbeing
- set out the necessary and effective contingency arrangements to manage the risks that have been identified.

Case summary

Tomasz is a 17-year-old male convicted of burglary. He received an 18-month youth rehabilitation order with 180 days of intensive supervision and support (ISS), a six-month curfew and a criminal behaviour order.

Tomasz had been known to statutory services for a number of years, including children's social care, the Troubled Families team, mental health services and the police. He had 18 previous sanctions for offences relating to anti-social behaviour, breaches and thefts. He first experienced custody in 2019, when he received a significant sentence that included him being recalled to prison for not complying with his licence conditions. His life had been complex. He did not engage well with school and had limited support from his parents. From an early age he had been unsupervised both at home and in the community, and regularly went missing from home and school. There were concerns that he was vulnerable to the influence of older, more criminally sophisticated, peers and was being exploited by them. Agencies felt that Tomasz had emotional and mental health issues, but these remained undiagnosed due to his family's lack of engagement with statutory services.

From the start, the case manager worked alongside the other agencies who knew Tomasz and his family history to plan together how they could engage and support him. The case manager drew on the available information to develop a good understanding of Tomasz's individual needs and recognised that his history of poor compliance and breach of orders was linked to his childhood experiences. He put a plan in place quickly, which focused on

engaging Tomasz by using regular appointments, and he explained to him how the different agencies would be working together and sharing information. When the case manager liaised with other professionals, including the electronic monitoring agency, he kept Tomasz updated with the information he was receiving from them. This resulted in Tomasz feeling included in his plan and understanding the roles of the different people who were supporting and monitoring him. As he was aware that agencies were working together and sharing information, he was motivated to engage and comply with all services.

Getting the ISSP plan right in this order was key to its success. An ISSP is the most rigorous non-custodial intervention available for children. It combines high levels of community-based supervision with a focus on tackling the factors that contribute to the child's offending. Tomasz's plan set out his hours of curfew, which ran from 7pm to 7am daily; electronic monitoring to support him in complying with the curfew; and a requirement to attend the YOT for offence-focused programmes, starting with 20 hours' attendance for the first three to six months of the order. The appropriate combination of interventions was discussed at a multi-disciplinary meeting. A risk assessment that measured individual safety and wellbeing was carried out for Tomasz and the other children attending interventions to make sure they could mix safely.

As his supervision plan was being developed, Tomasz felt his views were being taken into consideration and that he was being listened to by all workers. His plan included elements that interested him, for example mending bicycles and attending the gym, as well as attending appointments with his CAMHS worker. He complied with all appointments and fully engaged with the service.

The case manager recognised that Tomasz required high intensity management. The plan had a clear structure. It initially focused on ensuring that Tomasz kept appointments so that the case manager could help him to understand the requirements of the plan and the repercussions if he did not comply. He engaged Tomasz by explaining how the plan would be tapered over time and if he progressed well and complied it would become less restrictive.

The criminal behaviour order plan was incorporated into the supervision plan and focused on Tomasz's compliance with the community restrictions to minimise his anti-social behaviour.

Inspector's comments

"This case is a good example of planning to keep a child safe. The planning involved Tomasz from the start and identified activities, services and interventions that would engage him and protect others. It was closely aligned with other agencies' plans, and there was good evidence that the YOT case manager was taking a lead role in coordinating the planning and prioritising the actions, ensuring all agencies were focused on his safety and wellbeing. This included working alongside children's social care, health and mental health services, the police, the Troubled Families team and voluntary organisations.

"The inspector was impressed by the leadership displayed by the case manager, who was very clear during the discussion on which agency should lead on each activity and why. He liaised and communicated between workers and agencies regarding progress and ensured there was a focus on maintaining Tomasz's engagement. The case manager showed that planning in this case was cohesive with the work of the other agencies involved and that there were contingency plans in place to manage and reduce the risks to Tomasz."

Important learning

- This case was impressive in managing a complex community order within a context of poor compliance, emotional and mental health concerns, and persistent offending patterns.
- The case manager coordinated a high-risk, complex order to promote the child's safety and wellbeing, and to minimise his risk of harm from other people while considering the risk he posed to others. He agreed with all relevant agencies that, by prioritising Tomasz's engagement and promoting his safety and wellbeing, they would increase his prospects for desistance from further offending.

Take away – applying the learning

1. What stood out to you in this case illustration, and can you identify similar elements in your own approach to planning? What, if anything, will you change?
2. When formulating and sequencing a plan in a complex high-risk case, will you take the lead role as coordinator? What support will you need to do this?
3. How can you develop your practice in planning for safety and wellbeing?

This case summary is intended for training/learning purposes and includes a fictional name.

Implementing and delivering to keep the child safe in case supervision

This case example illustrates where the service delivery showed a good understanding of keeping the child safe. We expect implementation and delivery of services to:

promote the child's safety and wellbeing

involve, and coordinate well with, other organisations in keeping the child safe.

Case summary

Daniel is a 17-year-old male subject to a seven-month youth rehabilitation order with a supervision requirement for violent offences. He assaulted a member of the care staff and a nurse at school.

Daniel was a looked after child and had been on a full care order since he was two years old. He was brought into care because of severe neglect that left him with brain damage and a range of physical, emotional and mental health needs. The victims of his offences were professionals who had worked with him and included social workers and medical staff.

Daniel presented with many complex issues and challenges and initially behaved aggressively towards his case manager. With the support of her line manager and guidance from the YOT health care team, the case manager took steps to build a relationship with Daniel. Adequate time was built into the planning process so that she could take account of

how to work with his disability while addressing his persistent offending behaviour. She recognised that she would have to gain Daniel's trust and be flexible and understanding of his chaotic lifestyle.

One of her challenges had been to identify the complexities around Daniel's emotional, mental health and wellbeing issues. She took account of his traumatic childhood experiences and, with the help of health colleagues, understood how his neurodisabilities could affect his learning needs. With the help of his GP and the YOT healthcare team, the case manager identified specialist communication tools and techniques to use with Daniel. She shared these with Daniel's new social worker so that he was equipped to communicate with Daniel and understand his needs.

The case manager tailored a programme of work by gradually introducing Daniel to interventions, using activities that she knew he enjoyed and focusing on his strengths and what he could achieve. She included computer design and artwork that she knew Daniel liked, and made sure that she asked him for feedback on the interventions and the tools that they were using. This improved Daniels's level of trust, his attitude and motivation, and his engagement with the sentence as it progressed.

The case manager took a strengths-based approach to the programme. The aim of this was to achieve greater stability for Daniel and reduce the level risk he posed to himself. It also aimed to increase Daniel's wellbeing and resilience in his residential home. The approach encouraged Daniel, and the staff, to get involved in decision-making so that he was more in control of the support he received and thereby his everyday life. The programme included a good mix of leisure and learning opportunities, and home- and community-based activities. The case manager helped Daniel and his carers to challenge each other constructively to create change, by identifying ways to deal with conflict and build confidence. She took care not to undermine staff in their role but to build Daniel's resilience. This was really successful, and Daniel and his carers looked forward to the sessions. They all said he was happier, responded better at home and managed to communicate with fewer outbursts, with a generally improved mood.

Towards the end of the order, the case manager enlisted the services of a mentor who was helping Daniel to master basic tasks, such as washing and attending to personal hygiene, to improve his self-esteem and develop his resilience.

Inspector's comments

"This was identified as effective practice because the case manager delivered services with the assistance of specialist health advisers. She considered Daniel's complex needs and was allowed the time to create the bespoke interventions, like managing specific conflicts with people and tasks at home, that were needed to engage him. Daniel was not managing self-care or meeting the general expectations of the home, like sharing domestic tasks such as loading the dishwasher and hoovering his room. Due to his highly complex needs, relationship-building was key for the interventions to promote his safety and wellbeing and reduce his risk of reoffending. The case manager focused on interventions that were sensitive to his disabilities and built on his strengths. She was aware of the traumatic effect that adverse childhood experiences, for example child neglect, can have on child development.

"As Daniel was a looked after child, the case manager engaged with his social worker. The YOT interventions were delivered alongside the work of the social worker and there was good communication regarding roles and responsibilities. The inspector commended the case manager for establishing and maintaining regular meetings between Daniel and his social worker. This helped cement their relationship, as the social worker had recently been allocated

Daniel's case. This work was well coordinated, with joint working, good information-sharing and a clear record of each agency's role, all of which helped the case manager to deliver the work to support Daniel's safety and wellbeing.

"The inspector was impressed that the case manager regularly sought feedback about how Daniel was engaging with children's social care and worked well with all other agencies to manage and promote his safety and wellbeing."

Important learning

- Looked after children and children with neuro-disabilities are over-represented in the criminal justice system.
- A focus on strengths and wellbeing and interventions from the right agencies helped to improve the child's wellbeing and ensured that he complied well with the order.

Take away – applying the learning

For further information on this subject and managing looked after children, please see:

Department for Education. (2018). *National protocol on reducing unnecessary criminalisation of looked after children and care leavers.*

Academy for Social Justice Commissioning. (2018). *Understanding and use of trauma-informed practice* (see slide pack at bottom of the page).

Kate Aubrey-Johnson, S. L. (2019). *Youth Justice Law and Practice. Legal Action Group Education and Service Trust Ltd. Chapter 3.*

1. Will you make any changes to your practice when structuring and delivering services and interventions for a child with a disability?
2. Is your practice influenced by the emerging research in child and adolescent brain development and the criminal justice system?
3. Is your practice grounded in an understanding of, and responsiveness to, the impact of trauma? Does it emphasise the importance of physical, psychological, and emotional safety for everyone?

This case summary is intended for training/learning purposes and includes a fictional name.

Reviewing to keep the child safe in case supervision

This case sample illustrates where case reviews showed a good understanding of keeping the child safe. We expect reviewing to:

identify and respond to changes in factors related to safety and wellbeing

be informed by the necessary input from other agencies involved in promoting the child's safety and wellbeing

lead to the necessary adjustments in the ongoing plan of work to promote the child's safety and wellbeing.

Case summary

Mason is an 18-year-old male sentenced to a nine-month referral order for an assault on a police officer. Mason was in college and living at home with his family, and this was his first offence.

At first, Mason engaged well with his order. He was attending college and had stopped seeing the friends he had been with when the offence happened. After a couple of months, however, he started to miss appointments and his case manager struggled to get in touch with him. The case manager sent the first warning letter and Mason attended the appointment. He looked visibly upset and disclosed to the case manager that he needed help. He had suffered recent bereavements, was not getting along with his family and was worried that people were "after" him. She recognised that he was experiencing a mental health crisis and immediately spoke to the YOT mental health worker, who instigated a rapid review. Within 24 hours the YOT mental health worker, a specialist CAMHS worker and the case manager visited Mason and his family at home. A referral was made to Mason's GP for further assessments and the family were helped to manage the deterioration in Mason's mental health.

Over time, the case manager and mental health worker developed a good relationship with the family, which helped them to monitor Mason's mental health. The case manager understood Mason's specific needs and did some effective, proportionate work around offending behaviour, taking account of his mental health issues. She worked hard to sustain Mason and his family's engagement with the order. She involved them in the frequent reviewing process, which included reflecting their needs and wishes for the future.

As Mason turned 18 years old, the case manager carefully considered what adult services were available and how Mason and his family could access them. Discussions about transition to the probation service were ongoing, as Mason remained vulnerable and there was only a limited time left on his order. The YOT mental health worker led the transition to adult mental health services and, alongside the case manager, kept both Mason and his family updated.

Inspector's comments

"The case manager developed a good relationship with Mason and his family, which enabled them to discuss and monitor his mental health. The case manager constantly reviewed Mason's circumstances, what was happening for him and what measures were in place to keep him safe. She adapted the interventions accordingly as more information became available regarding his mental health, recent bereavements, associations and family relationships.

"The AssetPlus reviews were in-depth and contained relevant, up-to-date information regarding Mason's safety and wellbeing. The case reviews identified that Mason's family was a positive pro-social factor, whereas his relationships with his peers were negative. The reviews included the views of other professionals and work carried out by the mental health worker and the GP, without compromising confidentiality and with Mason's knowledge.

"Reviewing in this case was particularly good because the case manager identified how well Mason responded to the interventions and how his responses impacted on his safety and wellbeing. It included feedback from partner agencies, and from Mason and his family. The

case manager explained the changes in risk and how the level of risk was being determined and made clear how risk would be monitored."

Important learning

- Mental health issues, including depression, are very common among children in the criminal justice system.[7]
- Case managers in the youth justice system identified safety and wellbeing, specifically mental health, as significant in 71 per cent of assessed cases.[8]
- It is important to enlist the professional support of CAMHS via the primary care route. These specialist health professionals should be engaged in the review of progress throughout the order.

Take away – applying the learning

For further information on this subject, please see:

Centre for Mental Health. (2018). *Briefing 53: Social media, young people and mental health.*

Kate Aubrey-Johnson, S. L. (2019). *Youth Justice Law and Practice. Legal Action Group Education and Service Trust Ltd. Chapter 3.*

1. Will you make any changes to your practice, such as involving specialist services when reviewing whether the objectives in your plan have been achieved?
2. How can you develop further your understanding of reviewing for safety and wellbeing? Do you undertake reflective learning with other agencies?

This case summary is intended for training/learning purposes and includes a fictional name.

[7] Kate Aubrey-Johnson, S. L. (2019). *Youth Justice Law and Practice.* Legal Action Group Education and Service Trust Ltd. Chapter 3.

[8] The Youth Justice Board for England and Wales. (June 2020). *Assessing the needs of sentenced children in the Youth Justice System 2018/19*. Available at: https://www.gov.uk/government/statistics/assessing-the-needs-of-sentenced-children-in-the-youth-justice-system

Keeping other people safe in case supervision

Evidence summary:

The evidence on keeping other people safe overlaps with the findings relating to desistance and keeping the child safe. For those children who pose significant risks to others, the following have been found to be particularly important:

- **Effective communication** and timely and comprehensive information-sharing between statutory and non-statutory agencies helps to reduce the risk of harm a child poses to other people. There is evidence that, through sharing information and resources and managing cases holistically, partnership work and inter-agency collaboration can contribute to better risk management and reduced reoffending. Risks are most effectively managed when agencies use their skills and knowledge in a complementary way. This includes providing better access to services when required and enabling practitioners to respond quickly to escalating risk or deteriorating behaviour. Interventions may be required at the individual, family and community level.
- **Defensible decision-making** at every level, from practitioner to senior leadership, is crucial to public protection. Defensibility is only possible where evidence-based practice and effective supervision skills have been deployed. Agencies working with children who pose a high risk of harm to others must also ensure that their staff have access to validated assessment tools.
- **A positive and trusting relationship** between the individual practitioner and child can be very motivating for the child and influence them to change. The relationship should be supportive but challenging when necessary, with appropriate disclosure.

An integrated approach that balances control with rehabilitation is called 'blended public protection'. A protection strategy that aims to protect through control of risks and a rehabilitative strategy that aims to reduce risk and protect through rehabilitation should not be seen as conflicting and can be combined.

What inspections tell us about keeping other people safe in case supervision

When we inspect a case, we assess the quality of work delivered in relation to desistance, keeping children safe and keeping other people safe. In doing this, we do not focus on the quality of specific documents, work products or tools. Instead, we look at practice holistically. We have found:

Key strengths in keeping others safe in practice
• Most YOT areas have a risk management panel in place. These are effective when there is multi-agency representation.

- In the main, YOT staff know of the Multi-Agency Public Protection Arrangements (MAPPA) in the local area.

Common practice failings and remaining challenges to achieving good practice

- Assessments of a child's risk of harm to others do not always address past behaviour and include information from other agencies.
- Greater account needs to be taken of the needs, wishes and safety of victims.
- Work with other agencies to manage a child's risk of harm to others in some areas is not well coordinated.
- Contingency planning does not consistently address the needs of individual cases.

Assessing to keep other people safe in case supervision

This case example illustrates where assessment showed a good understanding of a child's risk of harm to others. We expect assessment to:

clearly identify and analyse any risk of harm to others posed by the child, including identifying who is at risk and the nature of that risk

draw sufficiently on available sources of information, including past behaviour and convictions, and involve other agencies where appropriate

analyse the controls and interventions used to manage and minimise the risk of harm presented by the child.

Case summary

Farooq is a 16-year-old male who was given an eight-month referral order for two offences of robbery committed with another child.

Farooq and his co-defendant targeted children on their way to school to rob them of their mobile phones. Neither the phones nor the weapons, thought to be knives, were recovered. This was the first time Farooq had been involved in the youth justice system and the case manager was aware that these were serious offences that included threats to the victims and the use of weapons.

The case manager recognised Farooq's lack of confidence and his inexperience of the youth justice system and spent time with him explaining the court and assessment processes. He sought to engage Farooq in the assessment by asking him to undertake a safety and wellbeing questionnaire and this helped Farooq to feel more involved in the process. This is a self-assessment and is part of the general health screening. It also enabled the case manager to develop a good understanding of Farooq and assess his involvement in, and motivation for, committing the offences. Although Farooq had stability at home and a supportive family, the case manager was concerned about his emotional development and that he could have been susceptible to peer influence or criminal exploitation.

A parenting assessment had also been completed and this helped the case manager to broaden his understanding of the wider context of Farooq's life, and to assess any further safety, wellbeing and protective factors in his home and his social settings. The case manager then embarked on a comprehensive risk of harm assessment to ascertain the nature and gravity of any prevailing risks to others. He analysed the different aspects of Farooq's life in terms of his family, his community and his relationship with his peers. He considered the impact on the victims of the robberies and any potential victims in the future. Through the assessment, the case manager understood that Farooq had been influenced by his peers. He regretted his involvement in the offences and realised the impact his behaviour had on the victims and his family.

During the inspection interview, the case manager explained how the assessment had resulted in Farooq being correctly assessed as presenting a medium risk of further serious harm to others.[9] The case manager explained how he then factored this into his plan for Farooq. He detailed the frequency of contact and how he wanted any interventions to function, including restorative justice work, if it was appropriate, with the victims of the robbery offences.

Inspector's comments

"The case manager completed a thorough assessment that considered who was at risk from Farooq, the nature of that risk, and the impact and imminence of the risk. This was identified as a good practice case because the case manager included all harmful behaviours that Farooq was displaying and not just those that related to the robberies. The case manager explored with Farooq his motivation for committing the offences and did a lot of work to understand whether he specifically identified and targeted the victims.

"The case manager recognised the importance of collating information from other agencies, including police intelligence, which helped to inform the level of assessed risk of harm Farooq presented to others. All agencies involved considered the controls that were in place for Farooq. These included the supervision he had at home, where clear boundaries were being set, as well as his attitude to committing the offences and offending in general.

"The inspector noted that the case manager, through the assessment process, also explored and considered Farooq's capacity and capability to comply with any restorative activity. This was then included in the planning process. The outcome was a positive experience for both Farooq and the victims involved."

Important learning

A combination of assessment methods and approaches are critical in preparing a suitable and sufficient plan to deliver services, where necessary, to keep people safe. These include:

- addressing the interaction between different aspects of the child's life
- taking account of their broader context, such as family and peers, and situations where the child could be exploited

[9] Medium risk using the AssetPlus assessment is applied when some risk is identified but the offender *is unlikely to cause serious harm* unless circumstances change.

- gaining the child's own perspective on their behaviour and the risk that they may present to others.

Take away – applying the learning

1. Did you benefit from the case illustration and will you make any changes to your assessment practice?
2. How can you develop further your understanding of assessing risk of harm to others?

This case summary is intended for training/learning purposes and includes a fictional name.

Planning to keep other people safe in case supervision

This case example illustrates where planning showed a good understanding of a child's risk of harm to others. We expect planning to:

- promote the safety of other people and sufficiently address risk of harm factors
- involve other agencies where appropriate
- address any specific concerns and risks related to actual and potential victims
- set out the necessary controls and interventions to promote the safety of other people
- set out necessary and effective contingency arrangements to manage those risks that have been identified.

Case summary

Wayne is an 18-year-old male who received a two-year youth rehabilitation order for distributing and possessing extreme pornographic images. In addition, the court imposed a sexual harm prevention order.[10]

Wayne was 17 years old at the time of the offence. He distributed extreme pornographic images of a number of different children through a messaging app on his mobile phone. He was in post-16 education with special educational needs and/or disabilities (SEND) provision. He had very few friends of his own age and was struggling socially at school. He lived at home with his mother and spent most of his time online in chat rooms. He was interacting with young children online at the time of the offence. A parent of one of the children had seen the images and contacted the police.

[10] To impose a sexual harm prevention order the court must be satisfied that the offender presents a risk of sexual harm to the public (or particular members of the public) and that an order is necessary to protect against this risk. See Schedule 5 to the *Sexual Offences Act (2003).*

When Wayne was first arrested and taken to the police station, he received a mental health screening. This screening recognised that Wayne needed a further assessment and the case manager proactively fast-tracked the assessment to ensure that it was completed in time for it to be included in the court report. The assessment eventually led to a formal diagnosis of autism spectrum disorder (ASD). This informed the court report, and the sentencing options and decisions.

The case manager liaised extensively with relevant professionals to address all of Wayne's needs throughout the subsequent assessment and management of this case. Alongside the mental health assessment, a pre-sentence report and an AIM2[11] assessment were completed. These provided a comprehensive analysis of Wayne's needs, strengths and required level of supervision.

In terms of needs, Wayne required support with:

- finding ways of coping when frustrated (like not hitting others)
- learning to accept personal responsibility for actions (good and bad)
- understanding when he should be directed away from a negative situation to a positive one.

He had strengths in maths and logic, including seeing and understanding patterns in nature and in numbers, and solving puzzles or word problems. In addition, he liked taking things apart and figuring out how they work.

The AIM2 assessment identified the following actions for Wayne:

- safety planning to reduce the risk he posed to himself and others
- engagement that took into account his minimisation of his behaviour
- sex and relationships education, including consent, boundaries and social and moral consideration
- how to make good choices to keep himself and others safe sexually
- emotional and self-regulation
- understanding of his harmful sexual behaviour.

The subsequent report outlined a plan to address the level of need and risk during the community sentence. It included an AIM2 intervention programme that recognised Wayne's ASD and used tools that suited his learning style. The case manager also involved health colleagues in working with Wayne regarding healthy relationships, as well as his social worker, who supported Wayne and his family in understanding how to live with his diagnosis.

In addition to Wayne's welfare needs, the case manager also addressed the risk of harm he could pose to others. There was evidence of extensive planning to manage his risk of harm, which included working with the police and the probation service, MAPPA, sex offender registration and managing the sexual harm prevention order.

[11] The AIM2 framework is risk tool used by youth justice professionals to assess risk in sexually harmful behaviour. The assessment model uses an evidence-based tool to determine the level of supervision that is required for children and their therapeutic needs.

This specified that Wayne should not:

- possess any device capable of storing digital images, such as a USB stick or external hard drive, unless he made it available on request for inspection by a police officer
- install any encryption or wiping software on any device other than that which was intrinsic to the operation of the device.

Inspector's comments

"The inspector identified this as effective practice because the planning addressed all of the relevant risk of harm factors and took a multi-agency approach. The case manager coordinated the plan and made clear which agency was leading on each activity. It was reassuring to see that all agencies kept each other informed of Wayne's compliance and engagement with the plan.

"The planning specified in detail the range of controls and interventions required to minimise the risk of harm to others, and who was responsible for delivering them. The case manager outlined that the specialist work on the offending behaviour needed to take account of needs related to Wayne's ASD. He recognised, as part of the planning, that Wayne could get anxious about unfamiliar situations, could take longer to understand information and was likely to do or think the same things over and over.

"The case manager had clear contingency planning in place, which included the actions to be taken by all agencies if the risk of harm either increased or decreased. He ensured that the overall sentence plan included managing the risk Wayne posed to himself and others, as well as monitoring his compliance, parental support, setting realistic goals and continuing to encourage him to engage with the interventions."

Important learning

This case highlights:

- the need to engage health professionals at the earliest opportunity
- the importance of the YOT partnership, specifically at the police station when the services of health professionals were first sought
- the importance of comprehensive specialist assessments like AIM2 to support the pre-sentence report, which enabled the case manager to create an early outline of a plan to supervise the child in the community.

Take away – applying the learning

For further information on this subject, please see:

National Autistic Society. *Criminal Justice – a guide for police officers and professionals.*

1. What stood out to you in this case illustration and can you identify similar elements in your own approach to planning when you are managing a case where the child has complex needs and presents a risk of serious harm?

2. Will you make any changes to your practice when considering collaborating with other specialists and agencies to formulate a plan where a child poses a high risk of harm to others?
3. How can you develop further your understanding of planning for keeping people safe?

This case summary is intended for training/learning purposes and includes a fictional name.

Implementing and delivering to keep other people safe in case supervision

This case example illustrates where the interventions and services delivered showed a good understanding of a child's risk of harm to others. We expect interventions and services delivered to:


be sufficient to manage and minimise the risk of harm


ensure that sufficient attention is given to protecting actual and potential victims


ensure the involvement of other agencies in managing the risk of harm is sufficiently well coordinated.

Case summary

Phoebe is a 15-year-old female and a looked after child. She has emotional and mental health needs. She received a nine-month referral order for serious assaults against residential staff and criminal damage.

During her childhood, Phoebe suffered physical abuse and neglect and was subject to a child protection plan before becoming a looked after child. She was living in a residential home where all her offending had taken place.

At the start of the order, Phoebe was very unhappy. She had not been out of her residential placement for some time and had a mistrust of adults. When the case manager first met Phoebe, she would not come out of her bedroom or engage with her in any way. The case manager slowly built up a relationship with her and continued to see her at home and speak to her through the bedroom door. She recognised that, because of her childhood experiences, Phoebe was withdrawing from the world around her in order to keep safe. The case manager spoke to Phoebe about her feelings towards the residential staff who were the victims of the assaults. She recognised that Phoebe was confused about her feelings towards the members of staff. She thought they had not understood her and should have tried to help her by recognising that some of her behaviour was a cry for help. She acknowledged, however, the seriousness of her actions and that the workers would have been scared and that some had been physically hurt.

The case manager had planned the delivery and implementation of this order primarily to minimise the risk of harm Phoebe presented to others. She then planned to work with

Phoebe to improve her sense of self and minimise the likelihood of continued isolation and feelings of hopelessness. Finally, the plan focused on the support required from primary care and mental health services. The case manager referred Phoebe to specialist CAMHS services. A cognitive behaviour programme was identified to help Phoebe improve her impulse control and reduce her aggressive and violent behaviour. However, there was a three-month wait for this.

In the meantime, the case manager prioritised the relationship between Phoebe and the residential staff as an immediate action, and worked through a range of restorative approaches with the staff team in order to manage any risk of harm to others. This included one-to-one meetings with some staff members and shuttle mediation with others. There were some early signs of repair in Phoebe's relationships with others in her home; she was spending more time in communal areas and was less isolated. The case manager and Phoebe's social worker spent time with the residential staff looking at ways they could interact with and support Phoebe, as well as de-escalate situations.

During the assessment and planning stages, Phoebe had identified boxing as an interest she would like to explore. The case manager was keen to engage her in things she enjoyed doing, particularly activities that would get her out of the residential home to meet other children and make some friends. In addition, any activity that would coach her to control and manage aggression would help reduce the risk of harm she presented to others. At first Phoebe was anxious and reluctant to go. The case manager suggested she drive her to the venue, and they attend together. Phoebe, however, struggled to leave the residential home and so the case manager encouraged her to manage this in stages, starting with looking at her car from the window of her room. Gradually, over time, Phoebe was able to sit in the case manager's car and then eventually the case manager could drive her to the boxing club. This was a staged approach to building up trust and making progress at a pace she was comfortable with before she physically entered the club. The case manager accompanied her on a couple of occasions and she now attends boxing independently.

Throughout the interventions, the case manager engaged Phoebe in exploring all the options available to her to minimise her social isolation and maximise her opportunity to learn something new, get out to a club and meet others, and enjoy learning a new sport.

Inspector's comments

"The inspector identified this as an example of effective practice as, from the beginning, the case manager recognised her overarching responsibility for public protection and worked closely with staff at the residential home to ensure that the risk of harm Phoebe posed to other people was minimised. As staff were the identified victims, restorative justice work was completed to help build relationships to increase everyone's safety. The inspector recorded that focusing on an activity that Phoebe wanted to do helped to develop trust among staff at the residential home, Phoebe and the case manager. The case manager understood that it was important to work at the child's pace and sought feedback from her, and from other agencies, in order to promote the safety of other people."

Important learning

- The key highlight in this case for managing risk to others was to help the child identify opportunities to explore things to do and enjoy, as well as focusing on the control factors needed to minimise risk of harm to others.

- The case manager factored in the experiences of early life trauma in her case supervision and oversight of this order. She took a trauma-informed approach and worked at the child's pace while ensuring that restorative practices were in place to reduce the risk of harm to the residential staff.

Take away – applying the learning

For further information on this subject, please see:

Department for Education. (2018). *National protocol on reducing criminalisation of looked-after children.*

Crown Prosecution Service. (2020). *The decision to prosecute: the 10-point checklist for offences in children's homes.*

1. Will you make any changes to your practice when considering delivering services and interventions that are creative and constructive and that minimise risk of harm?
2. How can you develop further your understanding of creative approaches to minimise risk of harm using restorative techniques?

This case summary is intended for training/learning purposes and includes a fictional name.

Reviewing to keep other people safe in case supervision

This case example illustrates where effective reviewing of a case showed a good understanding of keeping other people safe. We expect reviewing to:

identify and respond to changes in factors related to risk of harm

be informed by the necessary input from other agencies involved in managing the risk of harm

meaningfully involve the child and their parents/carers in their risk of harm, and consider the views of others

lead to the necessary adjustments in the ongoing plan of work to manage and minimise the risk of harm.

Case summary

Sam is a 17-year-old male, and a looked after child, sentenced to a two-year youth rehabilitation order following a serious sexual assault. A sexual harm prevention order was considered but not imposed.[12]

This was Sam's first offence and the victim was a female friend who he had known for a couple of years. He was living in a residential children's home out of the local area and away from the victim.

[12] The court [has the power to impose this, but] must be satisfied that the offender presents a risk of sexual harm to the public (or particular members of the public) and that an order is necessary to protect against this risk. See Schedule 5 to the Sexual Offences Act 2003.

Although Sam was 17 years old, because of the nature of the offence, the case manager contacted his previous school. He was informed that there had been concerns about Sam's inappropriate sexualised language and behaviour, especially around female teachers. At the time, a referral to children's social care was made and an early help worker was identified to work with Sam's family. Sam also had complex speech and language difficulties and appointments were offered for him to see a speech, language and communication therapist. Unfortunately, the family did not engage with the early help provision offered and did not take Sam to see therapist.

The YOT where Sam had lived with his family, and where he had committed the offence, had completed the pre-sentence report and an AIM2[13] assessment and intervention plan. During the initial assessment there had been good liaison by the case manager with children's social care, Sam's previous school, residential care staff and the YOT where Sam was now residing.

The case manager recognised that, due to his speech and language difficulties, Sam often got upset when he encountered unfamiliar people and environments. As the area where he was now living was not too far away, it was agreed that the case manager from his home YOT would remain involved and provide interventions alongside a member of staff from the YOT where he now lived. Sam had clearly benefited from the continuity in the relationship. He was responding well to the interventions being delivered and was positively engaging with the speech and language specialist.

Initially, staff at the residential placement worked on an individual basis with Sam and he was not allowed to be unsupervised due to the risk he could present to others. As part of his regular looked after child reviews, which included feedback from all the agencies involved, his level of supervision was discussed. Over time, as he responded well to the interventions delivered and his risk of harm to others reduced, he was eventually allowed limited unsupervised time in the community where he lived.

The case was reviewed every three months by the case manager. These were in depth, reflected Sam's changing circumstances, and incorporated the discussions from other agencies' meetings. At the first review meeting, the case manager had asked the speech and language therapist to advise on how best the professionals involved could improve their communication with Sam – by using simple language, using shorter, clearer sentences and speaking clearly.

Sam's intervention plan was changed as different priorities emerged. The changes built on Sam's strengths and the positive developments he was making as he progressed through his order.

Inspector's comments

"Coordinating the right stakeholders and accountable agencies at the right time is often a challenge when a child lives out of area. All case reviews were shared with the other agencies involved, who, in turn, kept the case manager updated about any developments in their interventions with Sam and his family. The case manager continually updated and reviewed the assessments with relevant information as it emerged and provided these to Sam and his

[13] The AIM2 framework is risk tool used by youth justice professionals to assess risk in sexually harmful behaviour. The assessment model used an evidence-based tool that can be used to determine the level of supervision that is required for young people and their therapeutic needs.

family. In this case, there was also a good rationale recorded for proposals to change the assessed level of risk of harm to others.

"The case manager coordinated the involvement of the other agencies and included Sam and his family in the reviews. As a result, they were able to identify and anticipate any situations that might increase his risk and work together to negate these immediately."

Important learning

- The case manager recognised the complexity of the case, the child's needs and the degree of risk. This was balanced with the need for continuity for this child due to his speech and language difficulties.
- The case manager continued to assess the child throughout the order, recognising that his risk of harm to others was not a static factor. The case reviewing stages were used to revisit the assessment and continue to commission the support of specialist services. This was a challenge when the child was living away from home.

Take away – applying the learning

For further information on this subject, please see:

National Autistic Society. *Criminal Justice – a guide for police officers and professionals.*

Youth Justice Board. (2015). *Practice advice: speech, language and communication needs in the youth justice system.*

1. What stood out to you in this case illustration and can you identify similar approaches to carrying out reviews in your own practice?
2. Will you make any changes to your practice, including working with a range of other agencies, where there is a requirement to manage ongoing risk of harm to others when a child lives away from home?
3. How will you develop further your practice in reviewing cases when managing a child's risk of harm to others?
4. Recent data indicates that up to 71 per cent of children in the youth justice system have speech, language and communication difficulties.[14] How can you develop further your case reviewing stages to minimise any risk of harm being realised where there are complex learning and developmental issues, and speech, language and communication difficulties?

This case summary is intended for training/learning purposes and includes a fictional name.

[14] The Youth Justice Board for England and Wales (2020). *Assessing the needs of sentenced children in the Youth Justice System 2018/19*. Available at: https://www.gov.uk/government/statistics/assessing-the-needs-of-sentenced-children-in-the-youth-justice-system