



Inspection of
Youth
Offending

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Arolygiad ar y Cyd Cyfiawnder Troseddol

Core Case Inspection of youth offending work in England and Wales

Report on youth offending
work in:

Wigan

ISBN: 978-1-84099-259-5

2009

Foreword

This Core Case Inspection of youth offending work in Wigan took place as part of the Inspection of Youth Offending programme. We have examined a representative sample of youth offending cases from the area, and have judged how often the Public Protection and the Safeguarding aspects of the work were done to a sufficiently high level of quality. Our findings will also feed into the wider annual Comprehensive Area Assessment process.

We judged that the Safeguarding aspects of the work were done well enough 69% of the time. With the Public Protection aspects, work to keep to a minimum each individual's *Risk of Harm to others* was done well enough 60% of the time, and the work to make each individual less likely to reoffend was done well enough 65% of the time. A more detailed analysis of our findings is provided in the main body of this report, and summarised in a table in Appendix 1.

The YOT had experienced significant changes over the last two years at both an operational and management level, owing to restructuring within the YOT and within children's social care services. The process of change had impacted negatively on the stability of the team and some staff lacked confidence in specific aspects of the work. The YOT had recognised the need for greater management oversight in order to drive up performance with more resources allocated to the role of quality assurance. This change had been operational since February 2009. In addition more staff training had been provided during March 2009. The continued attention to both training and quality assurance of the work will be crucial in ensuring the YOT can regain its stability and confidence in undertaking some of the key case management tasks.

Overall, we consider this a mixed set of findings, however, the YOT Management Board had recognised, through the self-assessment process, many of the areas for improvement and had begun to take steps to improve performance. We believe that if an improvement plan is produced and implemented to address the recommendations in this report there are good prospects for improvement.

Andrew Bridges
HM Chief Inspector of Probation

September 2009

Acknowledgements

We would like to thank all the staff from the YOT, members of the Management Board and partner organisations for their assistance in ensuring the smooth running of this inspection.

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Scoring – and Summary Table

This report provides percentage scores for each of the 'practice criteria' essentially indicating how often each aspect of work met the level of quality we were looking for. In these inspections we focus principally on the Public Protection and Safeguarding aspects of the work in each case sample.

Accordingly, we are able to provide a score that represents how often the *Public Protection* and *Safeguarding* aspects of the cases we assessed met the level of quality we were looking for, which we summarise here.

We also provide a headline 'Comment' by each score, to indicate whether we consider that this aspect of work now requires either **MINIMUM, MODERATE, SUBSTANTIAL** or **DRASTIC** improvement in the immediate future.

Safeguarding score:	
This score indicates the percentage of <i>Safeguarding</i> work that we judged to have met a sufficiently high level of quality. This score is significant in helping us to decide whether an early further inspection is needed.	
Score: 69%	Comment: MODERATE improvement required

Public Protection – Risk of Harm score:	
This score indicates the percentage of <i>Risk of Harm</i> work that we judged to have met a sufficiently high level of quality. This score is significant in helping us to decide whether an early further inspection is needed.	
Score: 60%	Comment: MODERATE improvement required

Public Protection - Likelihood of Reoffending score:	
This score indicates the percentage of <i>Likelihood of Reoffending</i> work that we judged to have met a sufficiently high level of quality.	
Score: 65%	Comment: MODERATE improvement required

We advise readers of reports not to attempt close comparisons of scores between individual areas. Such comparisons are not necessarily valid as the sizes of samples vary slightly, as does the profile of cases included in each area's sample. We believe the scoring is best seen as a headline summary of what we have found in an individual area, and providing a focus for future improvement work within that area.

Recommendations (primary responsibility is indicated in brackets)

Changes are necessary to ensure that, in a higher proportion of cases:

- (1) good quality Risk of Serious Harm assessments and risk management plans are produced in order to minimise the *Risk of Harm to others*. These should be communicated to all involved in the case (YOT Manager)
- (2) as a consequence of each assessment, the intervention plan is specific about what will be done in order to Safeguard the child or young person's well-being, to make him/ her less likely to reoffend, and to minimise any identified *Risk of Harm* (YOT Manager)
- (3) there is evidence in the file of regular quality assurance by management, especially of the quality of assessments, plans and reviews as appropriate to the specific case. The quality assurance process should have a clear benchmark that is consistently applied (YOT Manager)
- (4) the plan of work is regularly reviewed and correctly recorded in Asset with a frequency consistent with national standards for youth offending services. *Risk of Harm* is reviewed following significant change, with timely and appropriate action taken (YOT Manager)
- (5) the case manager clearly retains the active role of managing the case even when interventions are being provided by others (YOT Manager)
- (6) Asset is used to evidence change in offending related needs, *Risk of Harm* and vulnerability (YOT Manager)
- (7) enforcement practice is improved, including a more consistent application of the reasons for acceptable and unacceptable absences (YOT Manager).

Furthermore:

- (8) the YOT should comply with national statutory guidance relating to Multi-Agency Public Protection Arrangements (Chair of the Management Board).

Next steps

An improvement plan addressing the recommendations should be submitted to HM Inspectorate of Probation four weeks after the publication of this inspection report. Once finalised, the plan will be forwarded to the Youth Justice Board to monitor its implementation.

Service users' perspective

Children and young people

Eleven children and young people completed a questionnaire for the inspection.

- ◇ All but one of the children and young people knew why they had to attend the YOT. All felt well informed by the staff about what would happen when they attended.
- ◇ They all said YOT staff were interested in helping them, listened to and that the YOT took action to respond to their issues and needs.
- ◇ Just under three-quarters (73%) of children and young people said they had completed the self-assessment form *What do YOU think?*
- ◇ Most of the children and young people (82%) said they were less likely to reoffend and were completely satisfied with the work of the YOT.
- ◇ One child or young person said more community service work should be done. Another had been in contact with the YOT through a number of court orders and felt the staff had acted professionally and helpfully, providing on-going support with a range of problems.

Victims

Three questionnaires were completed by victims of offending by children and young people.

- ◇ The three respondents said the YOT fully explained the services available to them and that their needs were taken into account.
- ◇ All said they had a chance to discuss any anxieties or worries about contact with the YOT or the child or young person who had offended against them.
- ◇ All felt the YOT had given adequate attention to their safety, for example, preventing the child or young person from making contact with them.
- ◇ The three victims said they had benefited from the reparation work undertaken by the child or young person.
- ◇ Two victims stated they were satisfied and one completely satisfied with the service received.

Sharing good practice

Below are examples of good practice we found in the YOT.

Assessment and Sentence Planning

General Criterion: 1.2

Due to very low literacy and IQ levels of one young person, and to address their individual learning style, the case manager produced a timetable each week that showed each of the appointments and activities through a memorable picture. This helped the young person recall what each one meant.

Delivery and Review of Interventions

General Criterion: 2.2

Andy received a four month referral order for trespassing on a railway line. A sergeant with the British transport police attended the initial panel meeting to explain the distress experienced by train drivers who are involved in accidents caused by trespassers. Reparation involved Andy designing a poster warning other children and young people about the consequences of trespassing on a railway lines. In addition, the case manager arranged for an intervention from the British transport police about the dangers of trespassing on railway lines. There was a good joined up sequence of initiatives that continued to reinforce an important message.

Outcomes

General Criterion: 3.2

Aden received a 12 month supervision order for offences of harassment, including racist and homophobic behaviours. Aden and his family faced eviction from their home due to his ASB. The YOT put appropriate plans in place and Aden completed the ten session 'Dealing with Difference' course, followed by the 'Promoting Positive Community Cohesion' programme. He wrote a letter to one of the victims expressing his regret. The local authority housing department agreed not to evict the family as a consequence of his positive response to supervision and the fact that he was no longer involved in antisocial activities.

1. ASSESSMENT AND SENTENCE PLANNING

1.1 Risk of Harm to others:

General Criterion:

The assessment of RoH is comprehensive, accurate and timely, takes victims' issues into account and uses Asset and other relevant assessment tools. Plans are in place to manage RoH.

Score:

63%

Comment:

MODERATE improvement required

Strengths:

- (1) A RoSH screening was completed in 91% of cases and in 82% completed on time.
- (2) The RoSH screening indicated the need for a full analysis in 35 cases. A full analysis was completed in 81%.
- (3) The RoSH classification was clear in all but two cases and the classification was judged to be correct in 81% of cases.
- (4) Countersigning was evident in 89% of RMPs.

Areas for improvement:

- (1) The RoSH screening was accurate in 61% of cases. In those judged to be incorrect, the most common problem was the absence of previous convictions.
- (2) The RoSH analysis was completed on time in 66% of cases. It was of insufficient quality in 44%. In five of these cases, the risks to victims were not fully explored. In some other cases, details of current or previous behaviours had not been included. There was an over-reliance on current or previous convictions. RoSH assessments tended to provide facts of the current conviction and did not analyse previous or current information that would have an impact on the *RoH to others*.
- (3) Just under three-quarters (72%) of RoSH analyses drew adequately on available information, including MAPPA; other agencies'; or previous assessments and victim information.
- (4) The RoSH analysis was forwarded to the custodial establishment within 24

hours of sentence in 47% of relevant cases. In some cases, a previous RoSH was submitted to the institution.

- (5) A RMP was required in 23 cases classified as medium or high *RoH*. It was completed in 39%; completed on time in 23%; and of sufficient quality in only 18% of the cases. The main weaknesses in the quality of RMPs related to missing victim issues; unclear roles and responsibilities; and a lack of details about the planned responses. It was evident during some interviews that staff had identified steps to manage *RoH* but these had not been recorded in the plan. The plans did not provide active management of all the *RoH* factors presented by the child or young person.
- (6) A number of cases were incorrectly identified, on the YOIS database, as MAPPA cases, evidencing a misunderstanding in the YOT of MAPPA eligibility. Of the three cases that were eligible one had been allocated to the wrong category and level. In the three cases, there was no evidence of notification to MAPPA. The YOT Manager had recently clarified the eligibility criteria and referral process, but application in practice required careful oversight as some staff remained confused.
- (7) There was inadequate communication of the RoSH assessment and management plan to other staff in 57% of cases inspected. Processes for the sharing of this information with all other staff involved in the management of the case required further attention, this included partnership agencies.
- (8) Despite the countersigning of RMPs, there was a lack of effective management oversight in 78% of cases. Some countersigning was late and other assessments and plans, judged by the inspection team to be insufficient, had been approved. There was a need to develop consistency of management oversight to ensure that when necessary the assessment and plan were returned to the case manager for further improvement. Other forms of management oversight, such as discussion in supervision, needed to be recorded in YOIS and actions required following up to ensure completion.

1.2 Likelihood of Reoffending:	
<i>General Criterion:</i> <i>The assessment of the LoR is comprehensive, accurate and timely and uses Asset and other relevant assessment tools. Plans are in place to reduce LoR.</i>	
<i>Score:</i> 62%	<i>Comment:</i> <i>MODERATE improvement required</i>

Strengths:

- (1) An initial assessment of the LoR had been completed in 97% of cases. It was of sufficient quality in three-quarters of the cases inspected. Almost all assessments provided evidence of positive factors and diversity issues.
- (2) In 12 out of 16 cases sentenced to custody an updated initial assessment was forwarded to the custodial establishment within 24 hours.
- (3) There was evidence of active engagement with the child or young person to carry out the assessment in 68% of cases. In 85% of relevant cases there was active engagement in the assessment with parents/ carers.
- (4) Contact with or the use of information from the police and the ASB unit was adequately evidenced in 78% and 70% of cases respectively.
- (5) There was an intervention plan or referral order contract in all but one case. Three-quarters of plans focused on achievable change and 80% reflected national standards. The sentencing purpose was reflected in 74%.
- (6) Children and young people had been actively involved in the intervention planning process in three-quarters of cases. Parents/ carers had been actively involved in 76% of relevant cases.

Areas for improvement:

- (1) In 71% of cases, the case manager had not assessed the learning style of the child or young person at the earliest opportunity. A learning style questionnaire was available. Whilst there was evidence in some cases of it being used as part of the intervention programme it was not being used consistently to inform the initial assessment and plan.
- (2) The *What do YOU Think?* form had not informed the initial assessment in 90% of cases. It was not routinely used at the PSR stage. ISSP and the programmes team used it during the early stages of the work but this only involved a relatively small number of the children and young people. Its use by case managers was inconsistent.
- (3) Contact with or use of previous assessments by children's social care services was evident in only two-thirds of cases. ETE information had been used in 59% of cases. Adequate evidence of using substance misuse information was seen in 38% of cases. We speculated that this may have been a recording issue rather than a lack of information exchange.
- (4) Whilst the initial assessment was timely, reviews were less so. Less than two-thirds of cases had been reviewed at appropriate intervals.
- (5) Intervention plans had not sufficiently addressed all the offending related factors in 34% of cases. Whilst substance misuse was addressed in 86% of cases and thinking and behaviour in 76%, other relevant areas of need were sometimes missed, for example, lifestyle; perception of self and others; and emotional/ mental health.
- (6) RMPs were not fully integrated into the intervention plan in 74% of cases and 42% of the plans did not take Safeguarding needs into account. Positive factors were not included in 48% of cases and only 27% of the plans

incorporated the child or young person's learning style.

- (7) The plan gave a clear shape to the order in 61% of cases; and set relevant goals and had realistic timescales in 58%. Case managers were not routinely entering a timescale into the intervention, choosing instead to indicate urgent or none urgent goals.
- (8) More attention to sequencing and prioritisation was needed in the planning process. The plan prioritised *RoH* in 54% of cases; and was sequenced according to offending related needs in 52%. Almost half the plans (46%) failed to pay sufficient attention to diversity issues and 40% required a clearer focus on victims.

1.3 Safeguarding:	
General Criterion: <i>The assessment of Safeguarding needs is comprehensive, accurate and timely and uses Asset and other relevant assessment tools. Plans are in place to manage Safeguarding and reduce vulnerability.</i>	
Score: 62%	Comment: MODERATE improvement required

Strengths:

- (1) The Asset vulnerability screening was completed in 94% of cases and in 87% was completed on time.
- (2) The secure establishment was made aware of vulnerability issues prior to or immediately on sentence in all but one of the relevant cases. There was active liaison and information sharing with the secure establishment in 76% of cases.

Areas for improvement:

- (1) Whilst the vulnerability screening was completed on time it was not completed to a sufficient standard in 32% of cases. The assessment of Safeguarding needs was not reviewed at appropriate intervals in 41% of cases.
- (2) Thirty-two cases required a VMP but it was not completed in 56% of these. Timeliness and quality were generally not sufficient. Only 31% were on time and 28% were judged to be of a sufficient quality.
- (3) The VMP did not contribute to; and inform interventions and other plans, where applicable, in 70% and 79% of cases respectively.

- (4) A contribution had been made, through the CAF to other assessments and plans designed to safeguard the child or young person in six out of 16 cases. Copies of other plans (care pathway, protection) were found in only two of the relevant case files.
- (5) There was evidence on the YOIS database of effective management oversight of the vulnerability assessment in just under half of the cases (47%). More attention was needed to ensure management oversight was consistently applied and clearly evidenced on the YOIS database.

OVERALL SCORE for quality of Assessment and Sentence Planning work: 62%

COMMENTARY on Assessment and Sentence Planning as a whole:

Clear guidance and support was needed for staff in identifying the need for RMPs and VMPs and in developing good quality intervention plans to help embed these important aspects of effective case management in the day-to-day practice of the YOT. The extent and quality of management oversight required significant attention. Management oversight and how this was recorded on the YOIS database required significant attention. The benchmark being applied by those overseeing the work needed to be more consistently applied. This was a priority for the YOT and a Deputy YOT Manager had been appointed, as well as two additional senior practitioners. The new structures had only been fully operational since February 2009.

2. DELIVERY AND REVIEW OF INTERVENTIONS

2.1 Protecting the public by minimising Risk of Harm to others:

General Criterion:

All reasonable actions have been taken to protect the public by keeping to a minimum the child or young person's RoH to others.

Score:

60%

Comment:

MODERATE improvement required

Strengths:

- (1) In 94% of cases appropriate resources had been allocated throughout the sentence according to the assessed *RoH*.
- (2) Specific interventions to manage the *RoH to others* were identified in 80% of community orders.
- (3) Case managers and other relevant staff contributed effectively to multi-agency meetings on *RoH* in 94% of custody cases and 73% of community orders.
- (4) Purposeful home visits were undertaken throughout the sentence to manage *RoH* and Safeguarding issues in 83% of cases.

Areas for improvement:

- (1) Specific interventions to manage the *RoH to others* were identified in 50% of custodial sentences. Attention to the management of *RoH* while the child or young person was in custody was not sufficient. Structural changes within Hindley YOI had negatively impacted on the quality of communication throughout the year.
- (2) A review of the *RoH to others* was not being undertaken as often as it should have been. It had been undertaken within three months of the start of the sentence in half of the community cases. In those cases that had reached the six month stage 40% had been reviewed. It had not been reviewed following a significant change in 65% of community cases. A review was completed at appropriate points in the custodial phase of the sentence in 44% of relevant cases.
- (3) Changes in factors linked to *RoH to others* were anticipated where feasible in

27% of cases. They were identified swiftly in 52% but acted on appropriately only one-third of the time. Case managers were not always alert to *RoH* changes posed by the child or young person being supervised.

- (4) RMPs prepared on community cases incorporated specific interventions to manage *RoH* in 58% of cases. This was evident in only one-quarter of custody cases. The custodial phase of the sentence was not being managed as an integral part of the wider sentence in terms of *RoH*.
- (5) Specific interventions to manage *RoH to others* were delivered as planned in 61% of community orders and 20% of cases in custody. The interventions were reviewed every three months or following a significant change in 28% of community orders and 50% of custodial sentences. There was a lack of attention to reviewing, evidenced by too many plans being 'cloned' from a previous plan.
- (6) Confusion about MAPPA, the categories, levels and the referral processes contributed to the inadequate use of the arrangements in the small number of eligible cases.
- (7) A full assessment of victim safety was evidenced in 49% of relevant cases and full attention had been given to their safety in 63%. The YOT had recently allocated more resources to victim work and this had the potential of improving the focus on this important area.

2.2 Reducing the Likelihood of Reoffending:	
<p>General Criterion:</p> <p><i>The case manager coordinates and facilitates the structured delivery of all elements of the intervention plan.</i></p>	
<p>Score:</p> <p>73%</p>	<p>Comment:</p> <p>MODERATE improvement required</p>

Strengths:

- (1) Interventions delivered in the community were designed to reduce the LoR in 81% of cases; were of good quality in 72%; and incorporated all diversity issues in 71%.
- (2) YOT staff attended sentence plan review meetings during the custodial phase of the order in 89% of cases.
- (3) In 88% of cases appropriate resources had been allocated to the assessed LoR throughout the sentence.
- (4) In 94% of cases appropriate resources had been allocated to the assessed *RoH* throughout the sentence.

- (5) The YOT worker was judged to have actively motivated and supported the child or young person in 82% of community and 89% of custody cases. The case managers reinforced positive behaviour in 83% of custody cases and in 84% of community orders. Where appropriate the worker had actively engaged the parents/ carers in all of the custody cases and in 85% of community orders.

Areas for improvement:

- (1) Interventions delivered in the community were implemented in line with the plan in 66% of cases and in 63% were appropriate to the learning style of the child or young person.
- (2) Appropriate sequencing of the delivery of interventions in the community was evident in 57% of cases and reviewed in only just over one-third of cases.
- (3) The delivery of interventions in the community reflected the PPO status of the child or young person in two out of six relevant cases. There was a lack of evidence of an enhanced level of contact in the other four cases.
- (4) In a small number of cases there were insufficient resources used to address LoR in relation to thinking, behaviour and attitudes to offending.

2.3 Safeguarding the child or young person:	
General Criterion:	
<i>All reasonable actions have been taken to safeguard and reduce the vulnerability of the child or young person.</i>	
Score: 76%	Comment: MINIMUM improvement required

Strengths:

- (1) In all custody cases where Safeguarding issues had been identified appropriate steps had been taken to protect the child or young person or other children and young people. In addition, all necessary referrals had been made to other relevant agencies in all of the custody cases and in 86% of the community orders.
- (2) In the majority of cases other YOT workers and relevant agencies worked together to promote the Safeguarding and well-being of children and young people in custody and in the community. The links with secure establishments were particularly strong in relation to Safeguarding.
- (3) There was good attention given to working together to ensure the continuity of services when the child or young person moved from custody to the

community. This was strong in relation to children's social care services. However, there was less evidence in relation to the continuity of substance misuse, ETE and accommodation services.

- (4) Specific interventions to promote Safeguarding in the community were identified in 91% of community orders and all of the seven relevant custody cases. For community cases 92% of interventions incorporated those identified in the VMP. This was evident in half of the relevant custody cases.
- (5) Interventions to promote Safeguarding were delivered in 84% of community cases and all of the relevant cases in custody. Staff supported and promoted the well-being of the child or young person throughout the sentence in 88% of community cases and in all but one custody case.

Areas for improvement:

- (1) All necessary steps had been taken to Safeguard the child or young person in the community in 57% of relevant cases. Steps had been taken to Safeguard and protect other children and young people in 46% of all community order cases.
- (2) More attention was needed to be given to reviewing interventions aimed at promoting Safeguarding as this was undertaken in only 32% of community and 67% of custody cases.
- (3) As with earlier findings, there was a lack of evidence of effective management oversight of Safeguarding and vulnerability needs in both custodial (60%) and community cases (52%).

OVERALL SCORE for quality of Delivery and Review of Interventions work: 69%

COMMENTARY on Delivery and Review of Interventions as a whole:

Case managers were not always responsive enough to changes in the *RoH to others* in order to provide active management and an adequate level of public protection. They needed to ensure that every step was taken to keep to a minimum the *RoH to others*. Reviews were not always being undertaken and there was an over-reliance on further convictions to evidence a change in risk levels rather than a conscientious review of all the information available.

The YOT had a useful portfolio of offending behaviour work and were looking to develop more evidence based programmes. The separation of programme delivery staff and case managers had benefits and disadvantages. One benefit was the clarity of role. Disadvantages included the added complexity of ensuring efficient and effective communication between the two parts of the organisation. In addition, there was a need to be clear about who was responsible for the overall management of the case. The YOT was reviewing the level of offending behaviour work delivered through ISSP as the provision was over-reliant on social and leisure activities and in many cases lacked clear and intensive offence-focused work.

3. OUTCOMES

3.1 Achievement of outcomes:

General Criterion:

Outcomes are achieved in relation to RoH, LoR and Safeguarding.

Score:

54%

Comment:

SUBSTANTIAL improvement required

Strengths:

- (1) The *RoH to others* had been effectively managed and every reasonable step taken to minimise the risks in 72% of cases.
- (2) In cases where there had been a reduction in factors linked to offending these most frequently related to lifestyle (80%); family and personal relationships (75%); attitudes (71%); and thinking and behaviour (68%).
- (3) Inspectors judged that all reasonable action had been taken to keep the child or young person safe in 81% of cases.

Areas for improvement:

- (1) There was evidence of a reduction in factors linked to offending in 44% of cases. The lack of good quality reviews of Asset and plans missed the opportunity to evidence further change.
- (2) The child or young person had not complied with the requirements of the sentence in 26 cases out of 62. Where the child or young person had not complied enforcement action had been taken sufficiently well in ten (38%) cases.
- (3) There had been no reduction in the frequency of offending and seriousness of offending in 50% and 63% of cases respectively.
- (4) There was an identified risk factor linked to Safeguarding in 35 cases. This had been reduced in 57% of the cases.

3.2 Sustaining outcomes:

General Criterion:

Outcomes are sustained in relation to RoH, LoR and Safeguarding.

Score:

75%

Comment:

MINIMUM improvement required

Strength:

- (1) There was adequate attention to community reintegration issues in 79% of community orders. In 75% of relevant cases adequate attention was given to ensuring that positive outcomes were sustainable.

Area for improvement:

- (1) Community reintegration issues were sufficiently addressed in 64% of cases. This reflected the need to improve the management of the custodial phase by the YOT. In 71% of these cases adequate attention had been given to ensure that positive outcomes were sustainable.

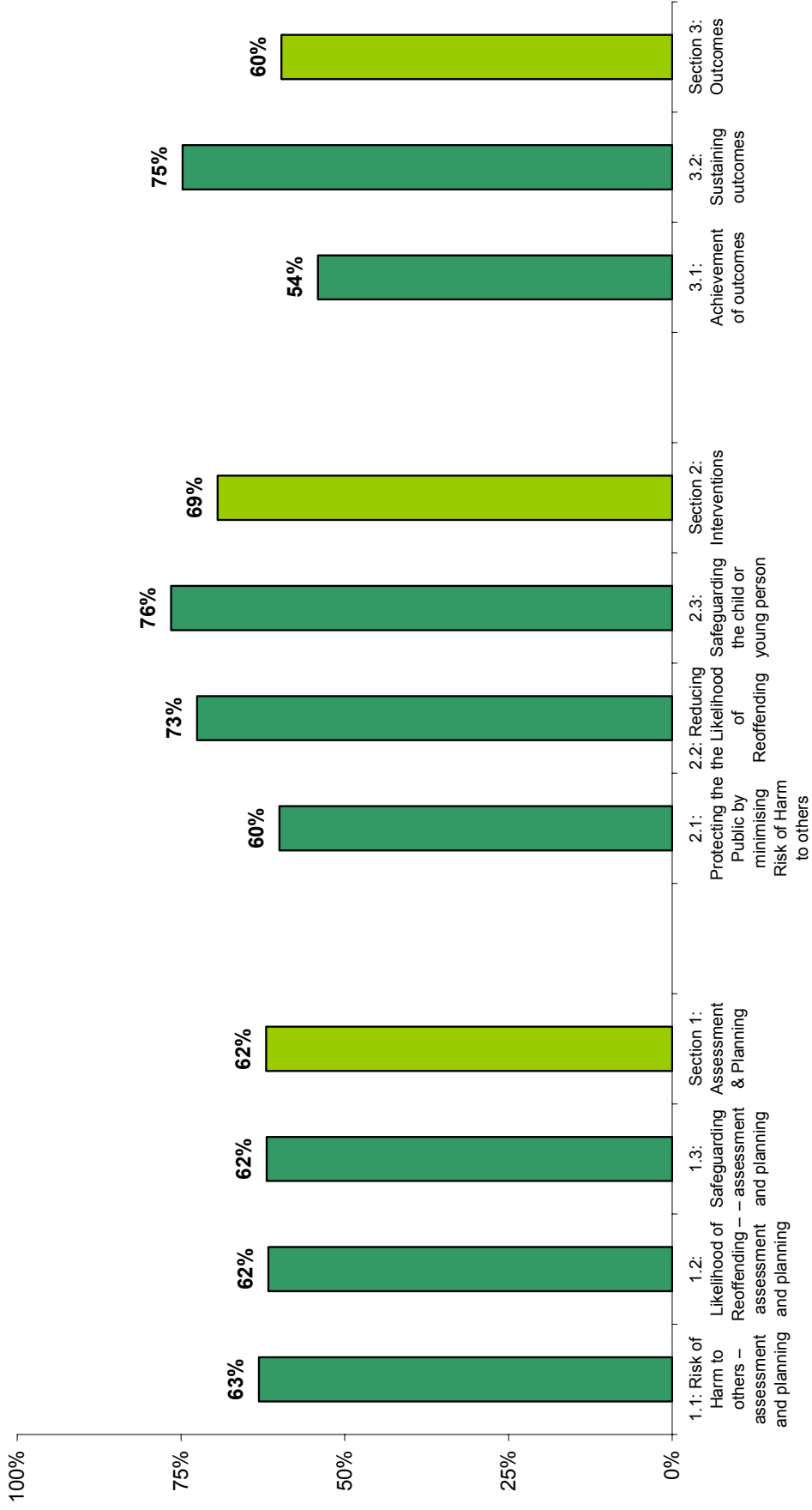
OVERALL SCORE for quality of Outcomes work: 60%

COMMENTARY on Outcomes as a whole:

Evidence of change was not as strong as it could have been due to weaknesses in the reviews of Asset, RoH, vulnerability and intervention plans. Opportunities to evidence change were missed. YOT staff were not seeing the use of Asset in terms of evidencing change. The YOT had introduced new quality assurance processes that could contribute to an improvement in this area.

Appendix 1: Summary

Wigan CCI June 2009 General Criterion Scores



Appendix 2: Contextual information

Area

Wigan YOT was located in the North-West region of England.

The area had a population of 301,415 as measured in the Census 2001, 10.7% of which were aged ten to 17 years old. This was slightly higher than the average for England/ Wales, which was 10.4%.

The population of Wigan was predominantly white British (98.7%). The population with a black and minority ethnic heritage (1.3%) was below the average for England/ Wales of 8.7%.

Reported offences for which for children and young people aged ten to 17 years old received a pre-court disposed of or a court disposal in 2008/ 2009, at 48 per 1,000, were above the average for England/ Wales of 46.

YOT

The YOT boundaries were within those of the Greater Manchester police and probation areas. The YOT was covered by the Ashton, Wigan and Leigh PCT.

The YOT was located within Integrated Support within the Children and Young People Services. It was managed by the Head of Service for Integrated Support.

The YOT Management Board was chaired by the Director of Children and Young People's Services.

The YOT Headquarters was in the Greater Manchester town of Wigan. The operational work of the YOT was based in Wigan. ISSP was provided by a Greater Manchester West consortium of Wigan, Bolton, Trafford, Salford and Bury.

YJB Performance Data

The YJB summary of national indicators available at the time of the inspection was for the period April 2008 to March 2009.

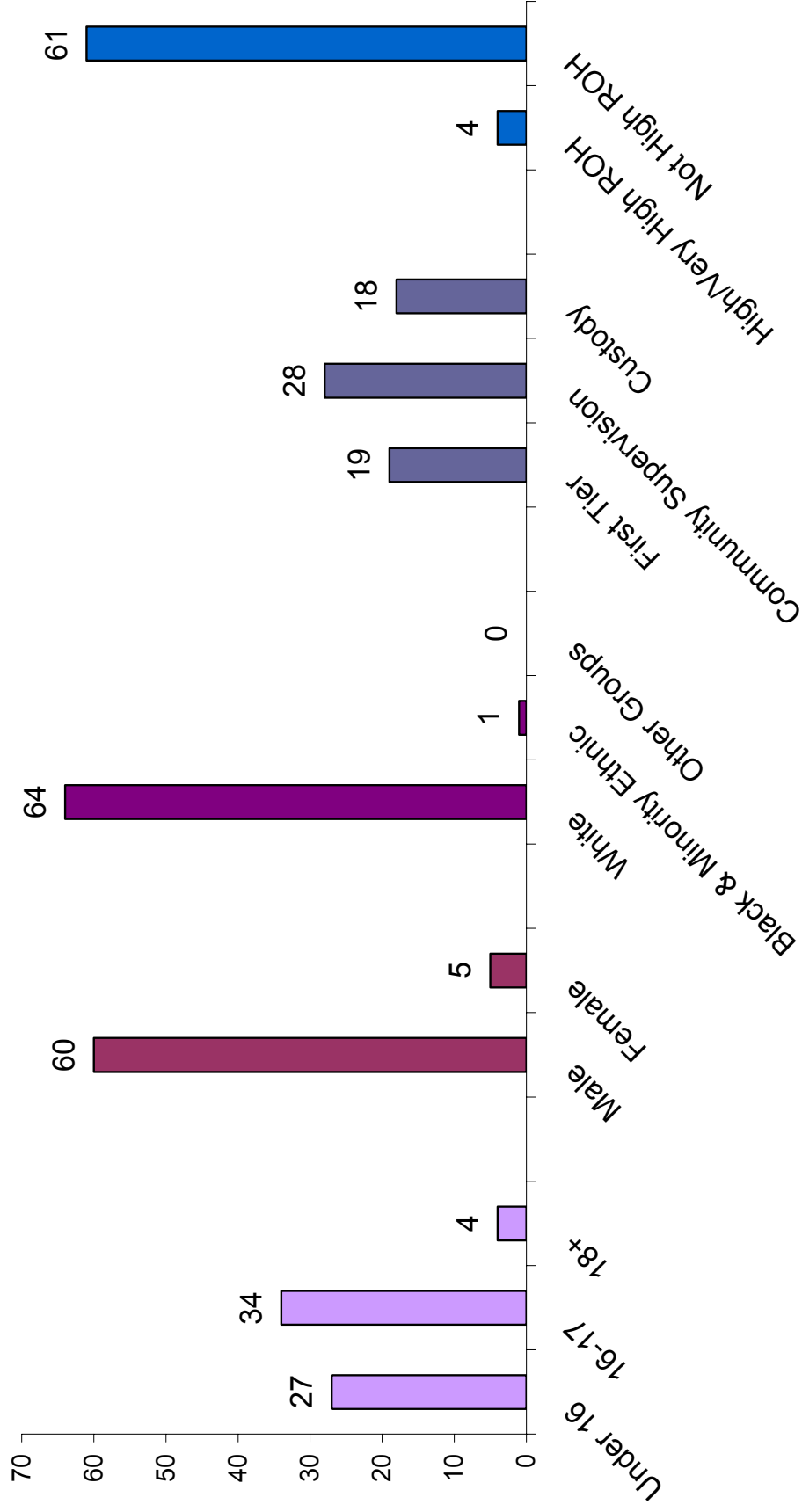
Wigan's performance on ensuring children and young people known to the YOT were in suitable education, training or employment was 53.6%. This was worse than the previous year, and below the England average of 72.4%.

Performance on ensuring suitable accommodation by the end of the sentence was 92.4%. This was an improvement on the previous year but worse than the England average of 95.3%.

The "Reoffending rate after nine months" was 86%, worse than the England average of 85% (See Glossary).

Appendix 3a: Inspection data chart

Case sample information: Wigan



Appendix 3b: Inspection data

Fieldwork for this inspection was undertaken in late June and early July 2009

The inspection consisted of:

- ◇ examination of practice in a sample of cases, normally in conjunction with the case manager or other representative
- ◇ evidence in advance
- ◇ questionnaire responses from children and young people, and victims

We have also seen YJB performance data and assessments relating to this YOT.

Appendix 4: Role of HMI Probation and Code of Practice

Information on the Role of HMI Probation and Code of Practice can be found on our website:

<http://www.justice.gov.uk/inspection/hmi-probation/>

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

*HM Chief Inspector of Probation
2nd Floor, Ashley House
2 Monck Street
London, SW1P 2BQ*

Appendix 5: Glossary

ASB/ ASBO	Antisocial behaviour/ Antisocial Behaviour Order
Asset	A structured assessment tool based on research and developed by the Youth Justice Board looking at the young person's offence, personal circumstances, attitudes and beliefs which have contributed to their offending behaviour
CAF	Common Assessment Framework: A standardised assessment of a child or young person's needs, and of how those needs can be met. It is undertaken by the lead professional in a case, with contributions from all others involved with that individual
CAMHS	Child and Adolescent Mental Health Services: part of the National Health Service, providing specialist mental health and behavioural services to children and young people up to at least 16 years of age
Careworks	One of the two electronic case management systems for youth offending work currently in use in England and Wales. See also YOIS+
CRB	Criminal Records Bureau
DTO	Detention and Training Order, a custodial sentence for the young
Estyn	HM Inspectorate for Education and Training in Wales
ETE	Employment, training and education. Work to improve an individual's learning, and to increase their employment prospects
FTE	Full-time equivalent
HM	Her Majesty's
HMIC	HM Inspectorate of Constabulary
HMI Prisons	HM Inspectorate of Prisons
HMI Probation	HM Inspectorate of Probation
Interventions; <i>constructive</i> and <i>restrictive</i> interventions	<p>Work with an individual that is designed to change their offending behaviour and/ or to support public protection.</p> <p>A <i>constructive</i> intervention is where the primary purpose is to reduce Likelihood of Reoffending.</p> <p>A <i>restrictive</i> intervention is where the primary purpose is to keep to a minimum the individual's <i>Risk of Harm to others</i>.</p> <p>Example: with a sex offender, a <i>constructive intervention</i> might be to put them through an accredited sex offender programme; a <i>restrictive intervention</i> (to minimise their <i>Risk of Harm</i>) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case.</p> <p>NB. Both types of intervention are important</p>
ISSP	Intensive Supervision and Surveillance Programme – this intervention is attached to the start of some orders and licences and provides initially at least 25 hours programme contact including a substantial proportion of employment, training and education
LoR	Likelihood of Reoffending. See also <i>constructive</i> Interventions
LSC	Learning and Skills Council
LSCB	Local Safeguarding Children Board – set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality.

MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher <i>Risk of Harm to others</i> .
Ofsted	Office for Standards in Education, Children's Services and Skills – the Inspectorate for those services in England (not Wales, for which see Estyn)
PCT	Primary Care Trust
PPO	'Prolific and other Priority Offender' – designated offenders, adult or young, who receive extra attention from the Criminal Justice System agencies
Pre-CAF	This is a simple 'Request for Service' in those instances when a Common Assessment Framework may not be required. It can be used for requesting one or two additional services, e.g. health, social care or educational
PSR	Pre-sentence report – for a court
"Reoffending rate after 9 months"	A measure used by the Youth Justice Board. It indicates how many further offences are recorded as having been committed in a 9-month period by individuals under current supervision of the relevant YOT, and it can be either more or less than 100%. "110%" would therefore mean that exactly 110 further offences have been counted as having been committed 'per 100 individuals under supervision' in that period. The quoted national average rate for England in early 2009 was 85%
RMP	Risk management plan. A plan to minimise the individual's <i>Risk of Harm</i>
RoH	<i>Risk of Harm to others</i> . See also <i>restrictive Interventions</i>
'RoH work', or 'Risk of Harm work'	This is the term generally used by HMI Probation to describe work to protect the public, primarily using <i>restrictive interventions</i> , to keep to a minimum the individual's opportunity to behave in a way that is a <i>Risk of Harm to others</i>
RoSH	'Risk of Serious Harm', a term used in Asset. HMI Probation prefers not to use this term as it does not help to clarify the distinction between the <i>probability</i> of an event occurring and the <i>impact/ severity</i> of the event. The term <i>Risk of Serious Harm</i> only incorporates 'serious' impact, whereas using 'Risk of Harm' enables the necessary attention to be given to those offenders for whom lower <i>impact/ severity</i> harmful behaviour is <i>probable</i>
SIFA	Screening Interview for Adolescents (Youth Justice Board approved mental health screening tool for specialist workers)
SQIFA	Screening Questionnaire Interview for Adolescents (Youth Justice Board approved mental health screening tool for YOT workers)
VMP	Vulnerability management plan. A plan to safeguard the well-being of the individual under supervision
YJB	Youth Justice Board for England and Wales
YOI	Young Offenders Institution. A Prison Service institution for young people remanded in custody or sentenced to custody
YOIS+	Youth Offending Information System: One of the two electronic case management systems for youth offending work currently in use in England and Wales. See also Careworks.
YOS/ T	Youth Offending Service/ Team