HM Inspectorate of Probation
Arolygiaeth Prawf EM

Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

Full Joint Reinspection of Youth Offending Work in **Islington**

An inspection led by HMI Probation

independent inspection of youth offending work

January 2016

Foreword

This inspection of youth offending work in Islington is one of a small number of full joint inspections that we are undertaking annually with colleagues from the criminal justice, social care, health and learning and skills inspectorates.

We chose to reinspect in Islington as performance at the last inspection, 18 months ago, had shown that outcomes for children and young people were poor. The reoffending rate[1] for Islington was 52.1%, this had increased from the previous year and was significantly higher than the average for England and Wales of 37.4%.

Work to reduce reoffending in Islington is not without its challenges, including significant issues with gangs and serious youth violence. The Partnership Board has a clear idea of what work needs to be done to reduce reoffending, to protect the public and to keep children and young people safe. Since our last inspection there have been some improvements. However, the Partnership Board has not yet consistently ensured that services to children and young people are effective and, as a result, outcomes remain poor. Although the Youth Crime Strategy[2] sets out how the Partnership Board intends to tackle these problems, we found that the relationship between the local authority and the police, and the subsequent poor coordination of joint work, had resulted in a lack of focus on public protection and the management of the serious risks some children and young people posed to others.

The Board now needs to focus on improving the service delivered to children and young people who offend and on improving their outcomes. The recommendations made in this report are intended to assist Islington in its continuing improvement by focusing on specific key areas.

Paul Wilson CBE

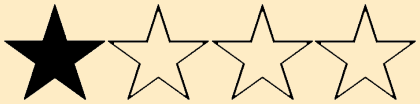
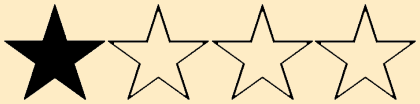
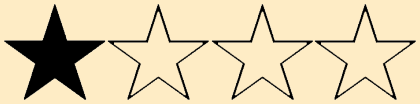
HM Chief Inspector of Probation

January 2016

1 Published July 2015 based on binary reoffending rates after 12 months for the October 2012 – September 2013 cohort. Source: Ministry of Justice.

2 The Islington 'Youth Crime Strategy' produced in July 2015 sets out how partners intend to reduce offending, protect the public and manage the vulnerability of those who offend.

Key judgements

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

Summary

Reducing reoffending

Overall work to reduce reoffending remained poor. The Partnership Board have not yet been able to translate work done into tangible improvements in the management of cases. The nature of the relationship between the local authority and the police has led to confusion of efforts, miscommunication and duplication of some work. Importantly, there are some key missed opportunities including information sharing and the provision of much needed offending behaviour interventions.

Protecting the public

Overall work to protect the public and actual or potential victims remained poor. This was the YOS's weakest area of practice. We found that assessment of the risk that some children and young people posed to others was often confused with their vulnerability. In addition, processes and systems to ensure that Multi-Agency Public Protection Arrangements were effective were not robust. Due to the nature of children and young people's involvement in gangs, which sometimes put their siblings and friends at risk of harm, this was not always considered or planned for.

Protecting children and young people

Overall work to protect children and young people and reduce their vulnerability remained poor. The YOS was able to identify issues that made children and young people vulnerable, but the response and support they received from children's services was variable, and there was a genuine confusion and lack of understanding of how to protect individuals who also posed a risk of harm to others due to gangs[3] or serious youth violence. The risks associated with gang activity, including the sexual exploitation of girls and threats to siblings and family, were either not understood or not always robustly considered. Some of the children and young people whose cases we assessed had not been fully protected.

Ensuring that the sentence is served

Overall work to ensure that the sentence was served remained satisfactory. The diverse range of needs that children and young people had was recognised and responded to. When necessary, breach and non-compliance were responded to appropriately.

Governance and partnerships

Overall, the effectiveness of governance and partnership arrangements was unsatisfactory. The Partnership Board has undertaken a range of work including strengthening the Partnership Board and recruiting a suitably skilled staff team. This was intended to provide the foundations for change. Board members now need to focus on a small number of key areas that will improve service delivery and outcomes for its children and young people.

Interventions to reduce reoffending

Overall, the effectiveness of interventions to reduce reoffending was unsatisfactory. Children and young people perceived some benefits in their relationships with case managers, but still lacked access to critical offending interventions including gang issues. This necessarily limited the impact of the YOS on children and young people. Access to education, training and employment opportunities had improved as had access to health care providers.

3 The Metropolitan Police defines Gangs as a group of people who see themselves as a noticeable group, engage in a range of criminal activity and violence and Serious Youth Violence as any offence of most serious violence or weapon enabled crime where the victim is aged 1to 19. These definitions are widely accepted.

Recommendations

Within 12 months of the publication of this report, post-inspection improvement work should ensure that:

1. there is effective joint work between the local authority and the police to reduce offending, protect the public and keep children and young people safe, including co-location of the YOS police (Chief Executive Officer and the Metropolitan Police)
2. all staff have the relevant training, support and resources to mange the complex cases they hold (YOS Partnership Board and the YOS Manager)
3. risk of harm to others is identified and managed so that actual and potential victims are protected as far as possible. (All)

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

Contents

Reducing reoffending

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Theme 1: Reducing reoffending

What we expect to see

As the purpose of the youth justice system is to prevent offending by children and young people we expect youth justice partners to increase the likelihood of successful outcomes by undertaking good quality assessment and planning, delivering appropriate interventions and demonstrating both positive leadership and effective management.

Case assessment score

Within the case assessment, overall 44% of work to reduce reoffending was done well enough.

Key Findings

1. The relationship and joint working between the local authority and the police was not effective in reducing reoffending. Without better joint working, it is very difficult to see how the Youth Crime Strategy will be achieved.
2. Assessment had improved but planning remained weak. Planning often did not cover actions to address key offending behaviours, including gang membership and entrenched offending behaviour.
3. Targeted work had resulted in reduced reoffending rates for Looked After Children.
4. While there was good access to a range of interventions to support some of the wider welfare needs, there remained a lack of access to key interventions focusing directly on reducing reoffending.
5. Case managers were able to *tell* inspectors about the child or young person's involvement with gangs, and the effect of this. However, they rarely had sufficient timely information, support or training to assist them in *helping* individual children and young people who were affected by gang activities
6. Access to most health services had improved since the last inspection and we saw some good health outcomes.
7. The importance of education, training and employment (ETE) was recognised by the local authority and attention had successfully been paid to improving outcomes in this area.

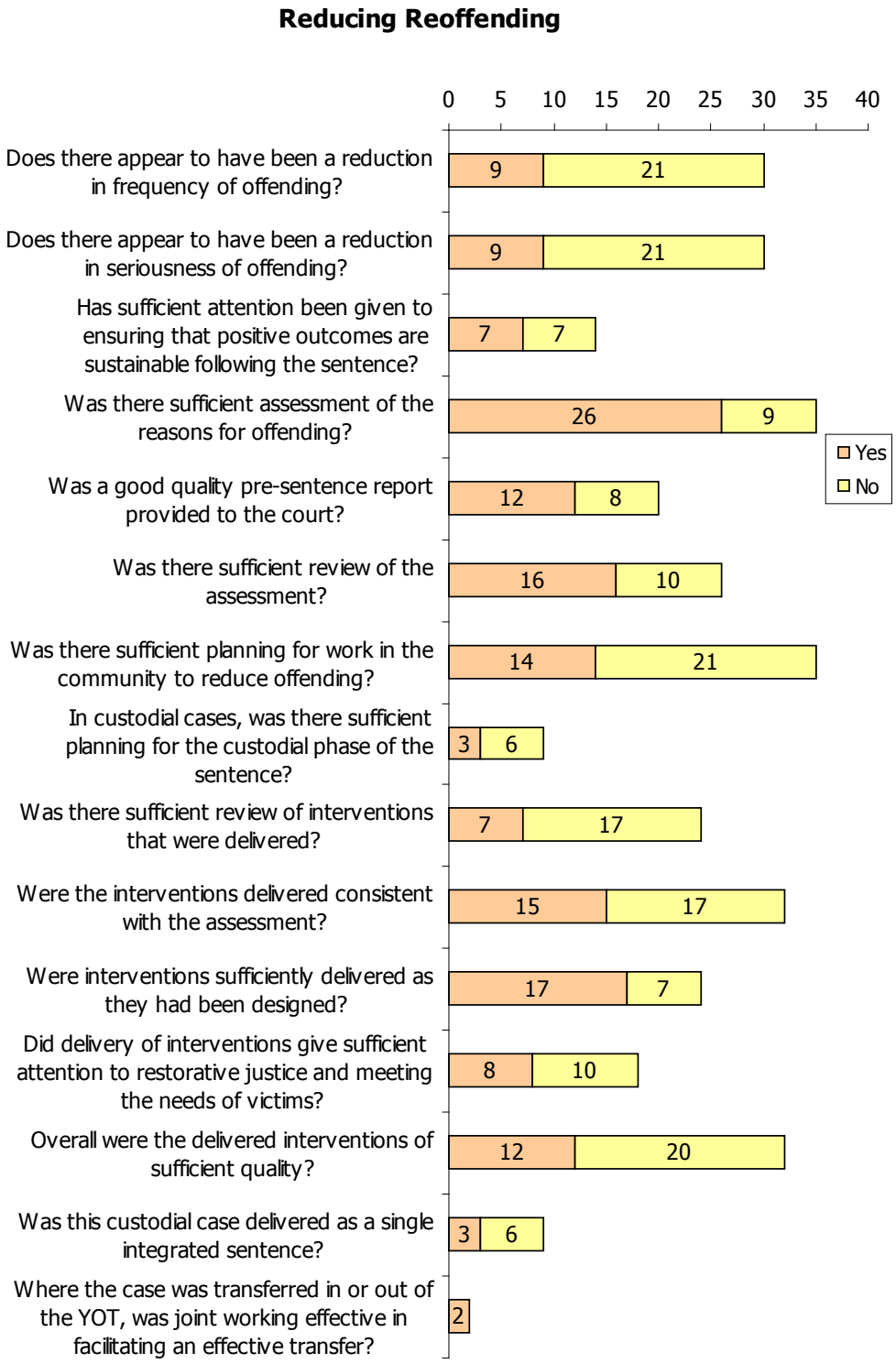
Explanation of findings

1. Inspectors were struck by the level of complexity of the cases held by the YOS, including the impact of gangs and serious youth violence. We knew that many of the children and young people and staff had been greatly affected by the tragic deaths of three young people in the area. Although the YOS had commissioned complex case training for all case managers, this had not been sufficient. Furthermore, we were disappointed that interventions to deal with emotional health, personal relationships, attitudes to offending and motivation to change, so critical to many of the children and young people, were not in place.
2. Sufficient efforts to assess why children and young people had offended had been made in three-quarters of all cases we assessed, with particularly good attention being paid to physical health issues, alcohol issues and living arrangements.
3. Planning to reduce reoffending was not strong. Although supporting factors were listed (especially ETE), the plans tended not to specify what direct action or work needed to be undertaken to reduce offending behaviour. Just under half of the children and young people in our case sample accessed key interventions that were consistent with their reasons for offending.

4. The reviews of offending behaviour work that had taken place had not enabled case managers, or children and young people, to refocus the work or support being provided. In only one-third of cases were the delivered interventions robustly reviewed and, therefore, case managers were not always told of any changes that they needed to know so that they could best manage the case. This included information from any police actions and updates from the involvement of children's social care.
5. When case managers became aware of positive changes they frequently supported children and young people to maintain these. This was usually achieved through one-to-one support. Case managers also paid particular attention to the many diverse needs of children and young people.
6. Given the nature of offending, which included ongoing issues with robbery, knife possession and crime, gang and serious youth violence; we were concerned about the nature of the joint work between the local authority and the police. Despite evidence of improved relationships, the lack of joint work was failing both children and young people and victims. The relationship between the two was simply not good enough.
7. Offending outcomes remain poor, one in ten of the YOS children and young people are in custody, and reoffending rates are higher than those of other similar YOSs. Case managers were concerned that, without the correct range of interventions targeted specifically at their cohort of children and young people, outcomes were unlikely to change. We share their concerns.
8. We identified more progress and impact on the lives of children and young people through the improved provision of ETE. Some very good provision was available with placements that were engaging and managed complex risks and vulnerabilities. Inspectors found that staff were tenacious in supporting children and young people's participation in ETE. Staff persisted with children and young people over time and tried different options for children and young people when their education broke down. The ETE worker in the YOS provided good leadership and intervened effectively in casework. We saw that due to the intervention of this worker, a child was returned to school after exclusion for an offence committed at the weekend and his education place was maintained.
9. Since the last inspection, assessment and access to health provision had improved. The health staff that we met during the inspection were motivated and dedicated to help improve health outcomes for children and young people. In general, they were well-regarded by their colleagues. It was evident that they used a variety of methods to engage children and young people, including seeing them in various locations and on home visits.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 35 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Protecting the public

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Theme 2: Protecting the Public

What we expect to see

Victims, and potential victims, of crime have the right to expect that everything reasonable is done to manage the risk of harm posed by children and young people who have offended. We expect to see good quality assessment and planning with the delivery of appropriate interventions, and positive leadership, effective management and partnership work which reduces the risk of harm to others.

Case assessment score

Within the case assessment, overall 38% of work to protect the public was done well enough.

Key Findings

1. There had been little improvement since the last inspection in work to manage risk of harm to others and to protect the public.
2. A lack of effective communication between the YOS and the police hampered the case manager's ability to respond to changing risks.
3. There was confusion as to how to manage an individual's risk of harm to others and their vulnerability at the same time.
4. Management oversight of work to manage risk of harm to others and public protection was not sufficient.
5. Wider public protection arrangements were not always used as they should be.

Explanation of findings

1. In just over half of the cases that we inspected there was an accurate assessment of all relevant risk factors. In those that were not good enough this was because the nature and level of risk was unclear, we judged that in six cases the risk classification was too low, and that in seven cases there was insufficient assessment of potential victims and other harm related behaviour.

Example of notable practice

In one case the nature of the young person's history of offending (persistence in carrying imitation firearms and bladed weapons and his previous convictions of supplying class A drugs) was simply not reflected in the assessment of his risk of serious harm to others.

2. Case managers' ability to respond to and adapt to changes was significantly hampered by a lack of real-time and direct information from the police. When we spoke to case managers about how they knew of any police intelligence for those children and young people who were in a gang, they told us about a weekly intelligence meeting. We observed this meeting and found that police information had been distilled into a report providing a summary of information from the previous week. YOS managers attended this meeting, but the YOS police officers did not. This system of information sharing was ineffective, actions were unclear and, critically, case managers did not have direct and quick access to the police officers to explore the information and its implications.

Example of notable practice

During a weekly intelligence sharing meeting between community safety and the YOS, the case of a 14 year old boy was discussed. He had been reported missing by his carer who was concerned that he was: "*trafficking*". There was no discussion of this or any pattern of behaviour or what steps needed to be taken to find him. In fact there was no clarification about the exact nature of the trafficking, and it was not clear whether or not it was this young person who was being trafficked. The meeting could be effective if it was clear what actions would be taken as a result of the information.

3. Multi-Agency Public Protection Arrangements (MAPPA) were not robust. There were a number of issues that came to light in two of the cases that we inspected. Firstly, there was a problem in the identification of cases that met the MAPPA criteria and secondly, there was a lack of joint work with the police.

Example of notable practice

A 17 year old had repeatedly used violence to enable him to dominate and control others. He made credible threats to kill others and he was assessed as being capable of this. The case manager knew that the risks needed multi-agency management and put forward a request that he be considered by MAPPA. This was the correct judgement, but his request did not reach MAPPA as it was discussed at an internal risk review meeting. At this meeting the case was incorrectly graded as not being eligible. The case was eventually referred to MAPPA, who accepted the case at the highest risk management level (3) just days before his release; not leaving much time to put arrangements in place. Separately, and unknown to the case manager or the YOS, the police had already referred the case to MAPPA and had implemented a range of measures to manage the risk he posed to others and the risk to himself.

4. Planning to manage risk of harm to others was sufficient in just over half of the cases assessed. There was no plan in six cases where there should have been one, and in eight cases there was insufficient contingency planning, including that with other agencies.
5. We saw that some individual work was being delivered by case managers to help children and young people understand and reduce the risk that they posed to others, including work around anger management.
6. We judged that the YOS had done enough to keep risk of harm to a minimum in just 11 of the 32 assessed cases where it was required.

Quotes from a member of staff

Staff were aware that the assessment and management of risk needed to be improved. One member of staff told us:

"*It's not that they are risk averse it's that they are risk unaware.*"
Another said: "We need someone who understands risk and the risks here in Islington."

Data Summary

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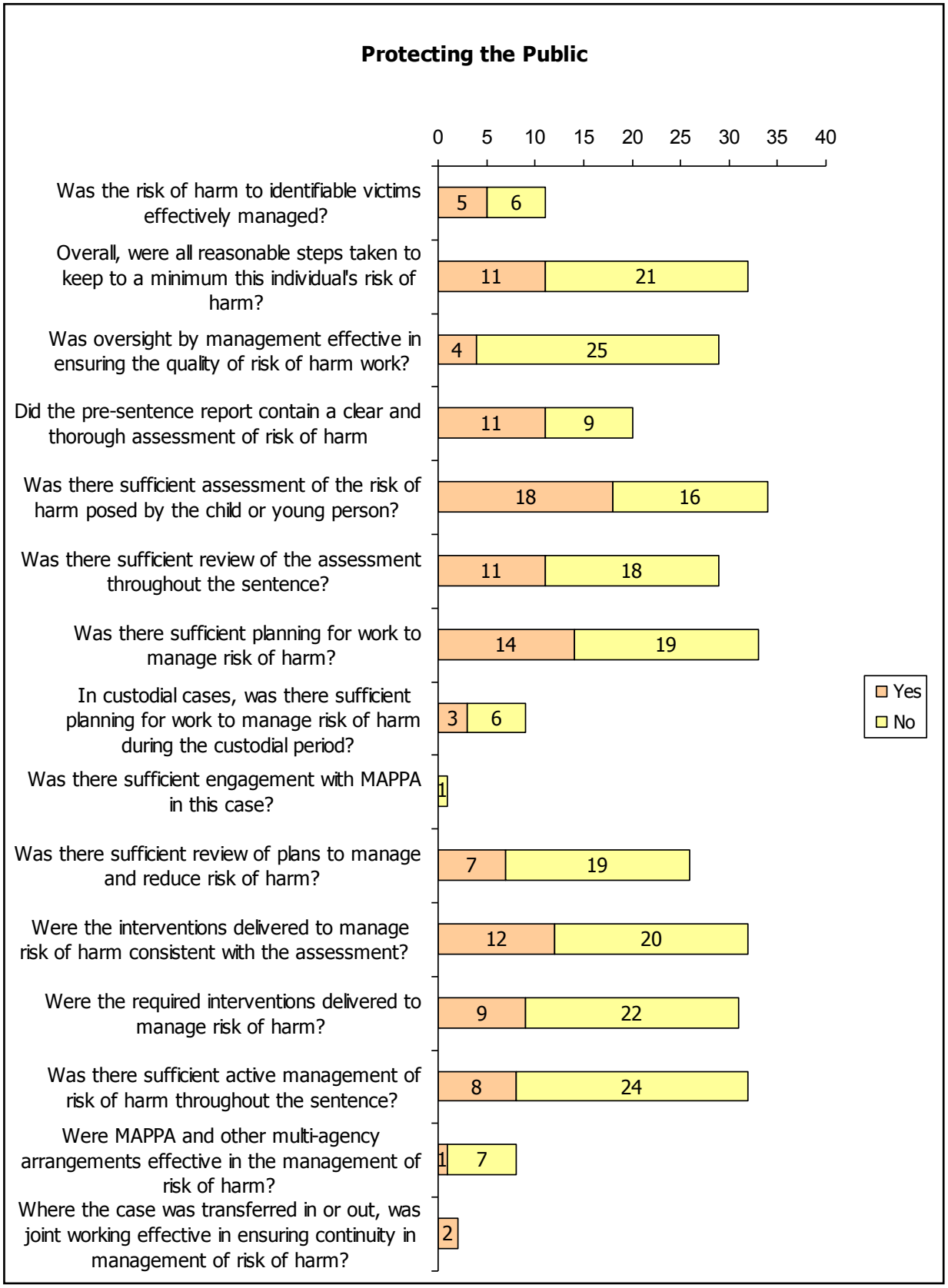

Protecting the child or young person

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Theme 3: Protecting the child or young person

What we expect to see

Whether the vulnerability of children and young people is a consequence of their own behaviour or the behaviour of others, we expect to see that they are kept safe and their vulnerability is reduced. This should be through good quality assessment and planning with the delivery of appropriate interventions, positive leadership and management, and an effective contribution to multi-agency Child Protection arrangements.

Case assessment score

Within the case assessment, overall 47% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. When a child or young person was vulnerable to gang issues, these were not always recognised or responded to in a consistent way by children's social care, who had been overly focused on matters unrelated to gangs.
2. There was some desensitisation to the vulnerabilities that children and young people faced and, as a result, there were high referral thresholds for strategy meetings.
3. Planning and the delivery of interventions to help keep children and young people safe was not always effective.
4. The role of the police in protecting children and young people was not clear; including to children and young people themselves.

Explanation of findings

1. There was a sufficient understanding of vulnerability in 69% of inspected cases. The case managers' understanding was often better than that recorded, and we judged that all but one child or young person in the case sample was vulnerable and should have had a plan to keep them safe.
2. Planning to keep children and young people safe tended to lack specific actions with only 40% of vulnerability management plans judged as sufficient. We observed a risk and vulnerability panel where there was discussion about an individual who was missing from home. The action to the case manager from the meeting was: "*to find him*" but there was no support from the line manager or from other agencies about how this might be achieved. It was difficult to see how this meeting contributed to keeping this young person safe.
3. Case managers had made appropriate referrals to children's services when they had concerns, but had not always received the support they needed to keep the individual safe. This was particularly the case when vulnerability was linked to the child or young person's own behaviour or to gang issues. In one case we saw, a young person arrived at the YOS with a large burn to his neck and his explanation did not fit with his injury. He was known to be linked to a gang and had previously been assaulted by a parent. He was deemed to be a child in need, yet when neither he nor the parent would discuss the injury, no further action was taken.
4. There is a coordinated multi-agency response to child sexual exploitation which includes the YOS, and an equally effective system to track and review children and young people who go missing from home, care and education.

5. Many children and young people with complex needs had a Child in Need social worker as well as a YOS worker, and meetings had been held to share information and review progress. However, these did not always consider the right information and key knowledge which had previously been known, subsequently got 'lost'. Assessments and interventions did not always take account of all the known risks surrounding the children and young people, or give sufficient weight to critical offending information and intelligence. As a result, there was not a clear picture of what life was like for some children and young people, what the impact was on their families, or the 'push' and 'pull' factors at play, particularly in relation to gangs. Some interventions lacked specificity and timescales, making it difficult to review progress. Senior managers had acknowledged that the awareness of gang-related issues across the Child in Need Service requires improvement.
6. There has been insufficient understanding in the Child in Need Service that the harm experienced by a child or young person should be regarded as a safeguarding matter. Risks to siblings had not been routinely considered. The recent audit of YOS referrals to the Children's Services Contact Team, which was initiated as a consequence of this inspection, highlighted the need for staff within the Child in Need and Children's Services Contact Teams to revisit their understanding of what constituted a safeguarding issue. Clear advice has been provided to staff in these services that a strategy discussion or meeting should be considered when a child or young person has been stabbed, and that risk of harm to siblings should be considered.
7. There was not a clear understanding across the children's social care workforce of what constitutes a safeguarding issue with respect to children and young people affected by gang-related issues. Child in Need staff were not aware of the full range of risk indicators related to gang-related activity.

Example of notable practice

During a session provided by the Targeted Youth Support Service, we spoke to a 14 year old young person who was known to the YOS. He told us that he was having problems getting to education as it was not in a safe area for him. This young person felt so at risk, having been stabbed on three previous occasions, that he chose to wear a stab vest.

8. Senior managers were unable to assure themselves that all staff in the YOS had a sufficient understanding of safeguarding issues. There was no current up to date picture of the training and competence of all staff. While training was available, it was not clear how that has been matched to needs. This was particularly important as the service had many staff who had joined relatively recently, and there was a lack of social workers with recent experience of Child Protection work within the service.
9. The vast majority of children and young people interviewed did not know that there were YOS police officers. One young person, who had difficulty reaching the YOS due to an intimidating gang presence at Finsbury Park, said that they would have liked to take advice from the YOS police regarding the nerve-racking walk to the YOS, had the young person been aware of them. He said: "*I found out there was one copper here when there was a kick off in reception*."
10. The YOS police officers had limited knowledge of child sexual exploitation, MAPPA referral criteria, or the radicalisation of children and young people. Police officers within the gangs unit were aware of the radicalisation of one young person managed by the YOS but the YOS police officer was not aware.

Data Summary

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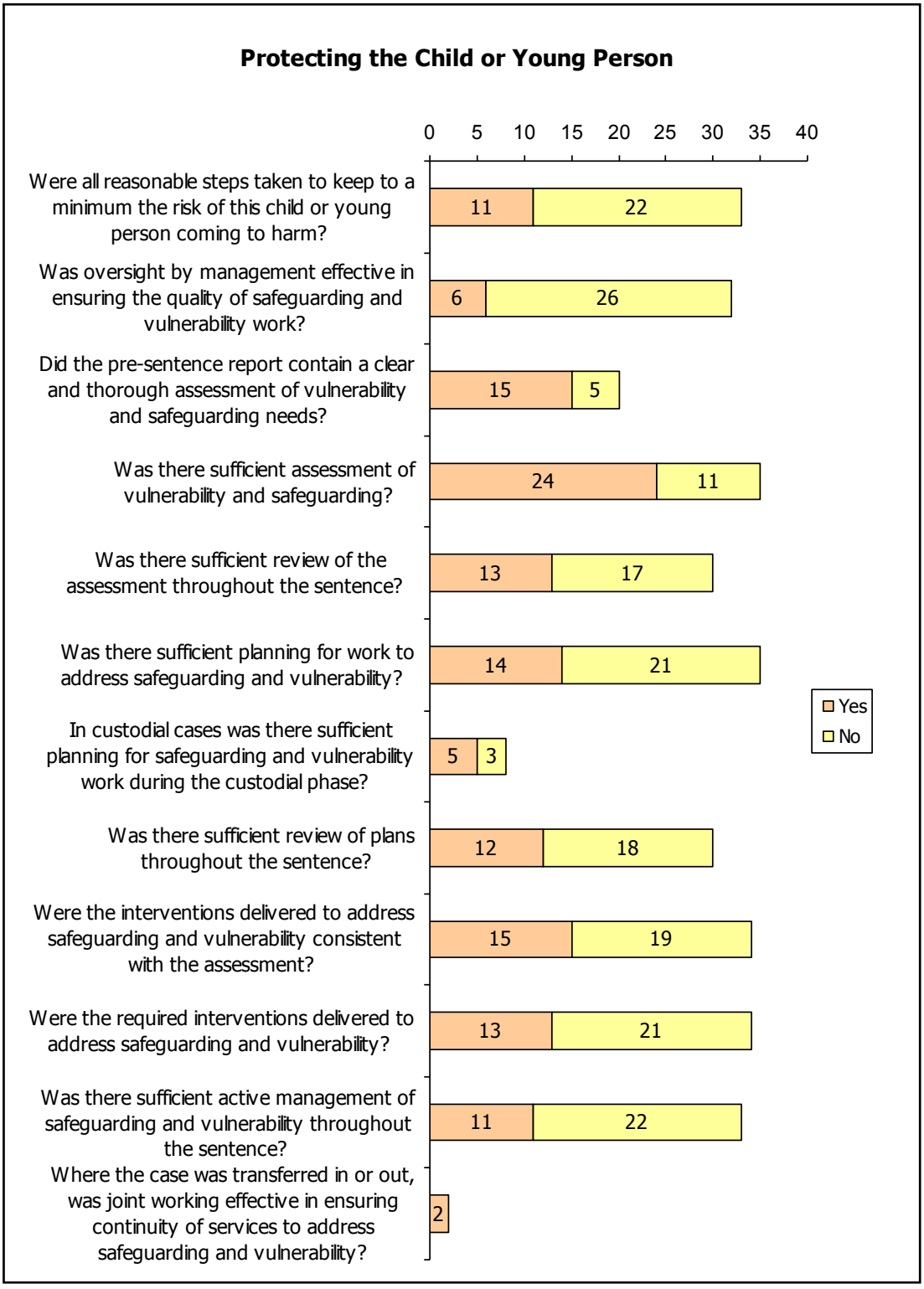

Ensuring that the sentence is served

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Theme 4: Ensuring that the sentence is served

What we expect to see

Children and young people should serve their sentences as the court intends. We expect that the YOS will maximise the likelihood of successful outcomes by effective engagement with them and their families, responding to relevant diversity factors including paying attention to their health and well-being, and taking appropriate action if they do not comply.

Case assessment score

Within the case assessment, overall 78% of work to ensure the sentence was served was done well enough.

Key Findings

1. This area of practice remained the strongest and had improved since the last inspection.
2. Case managers were skilled in engaging children and young people, and children and young people recognised this by telling us that case managers had time for them and wanted the best for them.
3. Children and young people have received very good support and help from the speech and language therapist, which has improved their levels of communication and understanding.

Explanation of findings

1. In order to help children and young people comply with their orders, case managers were particularly adept at identifying potential barriers to engagement. Examples of this included agreeing where they should meet, addressing any safety issues, considering language and cultural differences and making time to develop trusting relationships. Most children and young people we spoke to told us how case managers took time to get to know them, and were able to support their ambitions.

Quote from a child or young person

"*The YOT gives you the time to sit back and think about what you are doing. The work with the YOT shows you that it's not all about you. That carrying a knife presents a danger to yourself, not just others.*"

2. The same young person had always wanted to work in the IT industry. His case manager had helped him with his college application and he was successful in getting onto an IT course.

3. Parents/carers had been involved in assessment in almost all cases. Case managers respected the work of the parenting officer, who was able to support parents/carers, including all those whose children go to custody. The parenting officer supported parents to access other services such as the Intensive Family Intervention Team. Offers of a parenting course received mixed reactions but, on the whole, the parents/carers found this experience relevant and helpful

4. Planning often included diversity needs and discussions with case managers showed that individual learning styles were known and understood.

5. The speech and language therapist was based in the YOS for two days per week. They were held in high regard by their colleagues. Following the introduction of a screening tool, the therapist was able to carry out relevant work. Examples of this work included the production of a visual timetable for a young person who was not complying, and an amended appointment card to make it easier for children and young people to understand their appointments. Letters and other documents had been made more readable both visually and in terms of content. Training to both case managers and panel members had been completed, helping to improve their communication with children and young people as well as providing support in education placements.
6. There were a few children and young people whose entrenched attitudes to offending or gang issues made them particularly difficult to engage with. These children and young people needed a different and bespoke approach. Case managers were unsupported in moving these issues forward. We were surprised that there were no mentors or schemes in place to assist those aged under 18 to exit gangs.
7. The YOS responded appropriately following breach and non-compliance and following a new sentence. Case managers tried to offer some continuity for children and young people, but many children and young people did experience frequent changes to their case managers.

Data Summary

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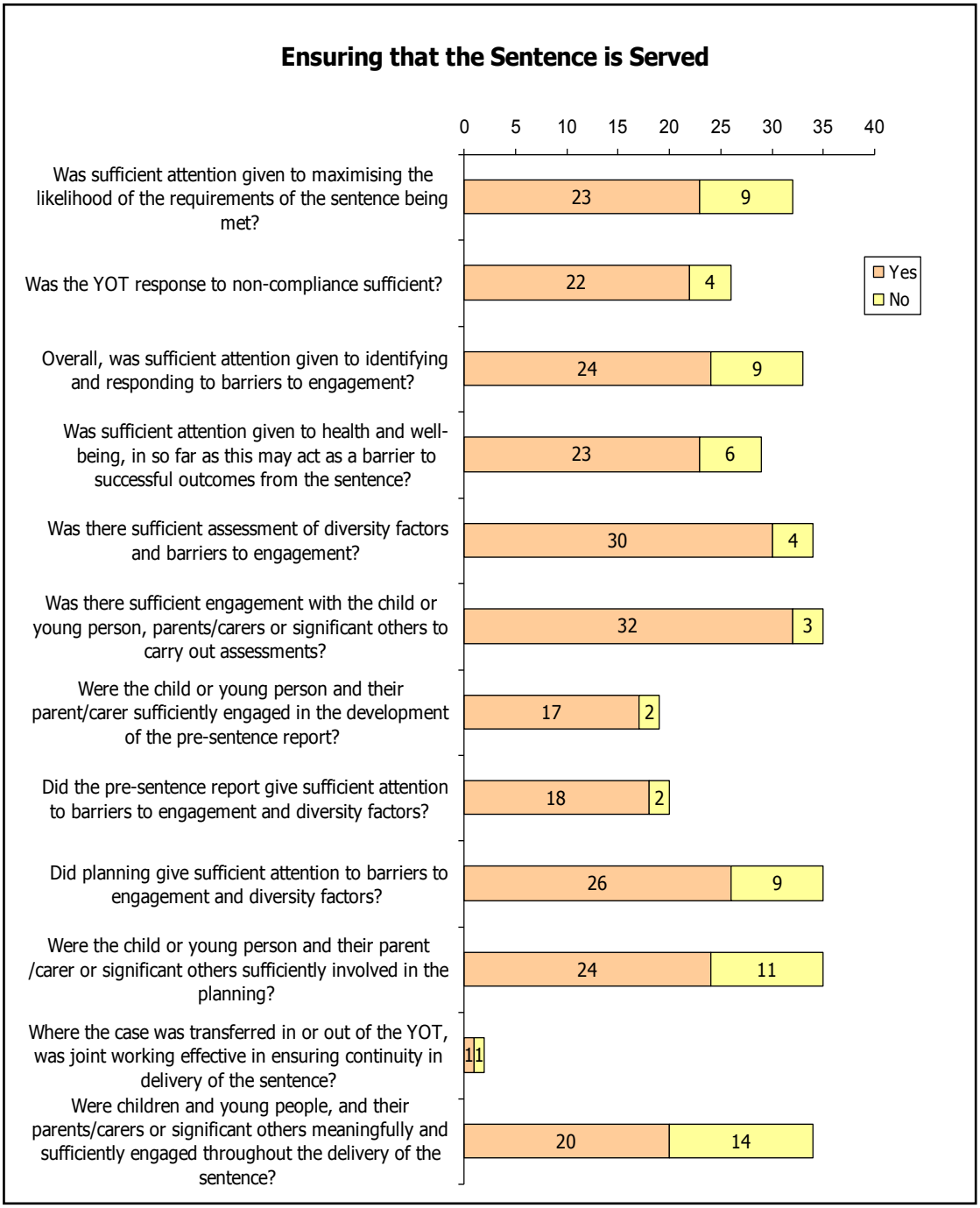

Governance and partnerships

5

Theme 5: Governance and partnerships

What we expect to see

Effective governance, partnership and management arrangements should be in place. These enable the YOS to meet national and local criminal justice and related objectives, and to deliver and maintain good quality services.

Key Findings

1. Governance and partnerships were not yet effective in improving the quality of service delivery, in public protection or in reducing reoffending.
2. The relationship between the local authority and the police at all levels was creating problems, and undermining effective service delivery and improvement.
3. The Partnership Board has a very clear and accurate understanding of the improvements that it has achieved so far, and of work that still needs to be done.
4. There have been improvements to health and ETE provision.
5. The YOS staff team lacked specific and targeted training and management oversight and support.

Explanation of findings

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

1.1. There has been a reduction in the number of first time entrants to the criminal justice system in Islington. The Partnership Board is confident that this is a result of prevention work targeting children and young people through schools at a young age.

1.2. The recently published Youth Crime Strategy set out the Partnership Board's intentions to reduce offending. It identifies three clear strands of work: prevention of children and young people coming into crime and being drawn into gangs; the management of those already involved in offending and gangs, and finally the management of those who are directing and controlling gangs and ongoing criminal activity. The strategy talks about 'Turning off the tap' or stopping the flow of children and young people into gangs and acquisitive crime.

1.3. The threat to the realisation of the strategy is in the nature of the relationship between the local authority and the police. Currently the police are targeting those that commit most of the more serious crime; this strategy has resulted in a number of custodial sentences and removal of some of the key gang members from the community. This should be an ideal opportunity for the partners and the YOS to target those who might want to extradite themselves from the gangs, but there was no joint approach and a valuable opportunity to 'turn off the tap' has been missed.

1.4. The police have invested considerable resources to a range of interventions across the London boroughs to reduce gang crime through the creation of gang units, in addition to supporting a number of other initiatives which support the YOS both directly and indirectly.

1.5. Despite this, the failure to co-locate police officers to the YOS has had a detrimental effect on the YOS's ability to effectively reduce offending and protect the public.

1.6. We found that since the previous inspection there had been improvements in the oversight that leaders and managers have of the education that children and young people receive. Those aged under 16 were closely and effectively monitored, resulting in education packages that closely reflected their needs.

1.7. There has been improved management oversight of the education of young people aged 16-18 through the Post-16 Education Group, attended by key staff and education providers in the borough. The group has received regular updates of the ETE status of the post-16 cohort and this has helped service managers target support to those young people who are most difficult to engage.

1.8. However, information that service managers have been using in the post-16 education group to review performance does not present a full picture of young people's participation in ETE. Their participation at a college, training provider or in employment requires greater scrutiny, using up to date information so that managers and partners can review and plan interventions for this cohort more effectively.

1.9. Inspectors found good arrangements in place for assuring the quality of alternative provision. The local authority has successfully reduced the number of children and young people placed in alternative provision.

1.10. Overall, we found that leaders and managers had a reasonable oversight of the effectiveness of their actions in securing ETE places for children and young people and helping them make progress. However, *planning* for this aspect was not set out cohesively and the impact of some developments, such as individual learning plans for children and young people, was not known.

1.11. One of nine priorities in The Children and Young People's Health Strategy for Islington 2015-2020 was related to improving the health outcomes of children and young people known to the YOS. There was a keen focus on helping to address the needs of this group and this was reflected in the fact that the YOS has been provided with some good resources.

1.12. There was good representation at the YOS Partnership Board, with people of the correct seniority attending and able to make decisions. We saw evidence of a detailed report provided to the Board about health, which included progress made, concerns and plans for future work.

2. Partnerships – effective partnerships make a positive difference

2.1. While it is clear that some partnerships are effective and are making a positive difference this is inconsistent across all partners. We saw some good progress with health and ETE, but work with social care was variable and there were significant issues between the local authority and the police.

2.2. Since our previous inspection a Health Leads Sub Group had been introduced. This forum allowed the relevant health providers and commissioners to be able to explore health provision at the YOS in detail. We saw evidence that action had been taken, such as detailed audits, and that agencies had been held to account. The subgroup was fully sighted on the issues and had a corresponding action plan.

2.3. However, some of the concerns raised in the previous inspection were still to be resolved. Despite sustained efforts to improve children and young people's access to YOS based Child and Adolescent Mental Health Services (CAMHS), difficulties still remain. Emotional and mental health services were critical, given the level of trauma experienced by many of the children and young people in Islington. There continued to be a lack of clarity from case managers about the referral process, as well as about the interventions delivered, and this led to them not referring cases even where a need had been identified. At the time of this inspection the CAMHS worker had a caseload of five children and young people, which was low given the experiences of many children and young people in this area.

2.4. There was good joint working between the YOS and the Care Leaving Services. Children and young people who were remanded into care/custody were allocated to this team. Social workers were sufficiently skilled and prepared to work with this cohort, ensuring that children and young people's offending behaviour was considered as one aspect of their needs, rather than as their sole need. There was evidence of persistence, tenacity and creative thinking to promote positive outcomes for these children and young people.

2.5. We noted very good use of foster placements, even for 'hard to place' children and young people, where this was assessed as being in their best interests. In addition, the YOS maintained case responsibility for some children and young people placed outside of the borough. Reoffending rates for Looked After Children have reduced.

2.6. Further work is needed to integrate the work of the Child in Need Service with the work of the YOS.

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

3.1. As previously described, many staff within the YOS were new to working in Islington. The Partnership Board is confident that they have recruited people with the right skills and experience, and, generally, we would agree with this view. The local authority has tried to ensure that the YOS has a complement of high quality permanent staff. This has resulted in running with locum staff for a while, which has led to issues with staff turnover. A number of staff told us about the emotional impact of working with such a complex group of children and young people. One member of staff said: "*I don't watch the news at the weekend; I am always frightened that the next young person to be stabbed or to die, will be one of mine*."

3.2. The staff team undertake work that is incredibly challenging, and the scores in previous sections show that the YOS staff, both case workers and their managers, are struggling to navigate the complex systems and structures that exist. They are not currently being provided with the key tools to undertake their work, such as real-time intelligence, a lack of a clear and bespoke approach to gang members, and support in keeping gang members safe.

3.3. The fragmented response to these complex children and young people was in part due to a lack of clearly defined roles and responsibilities. Each partner agency needs to consider its contribution to supporting the YOS to manage risk and reduce reoffending.

3.4. The YOS management team have not yet developed and implemented much effective management oversight. They need the Partnership Board's support to embed a consistent approach to staff management and to meet the needs and expectations of the case managers.

3.5. The YOS had recognised that staff needed to be kept up to date with training in health, particularly because of the high turnover of staff, and so had developed a rolling training programme. Sessions included speech, language and communication needs, substance misuse language, myths, identifying sexual health needs, revised YOS health pathways and referral process, and case study based discussions. Although sessions had been planned around children and young people's mental health none had taken place. There were no planned sessions around addressing the physical health needs of this group of children and young people.

3.6. We were told that CAMHS were planning to give case managers training around post-traumatic stress disorder. Although this was only in the early stages of development it demonstrates a recognition that this is likely to be prevalent, given the level of violence in Islington.

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

4.1. There was clear evidence and examples that lessons are being learnt and that the Partnership Board are committed to turning that learning into positive outcomes for children and young people.

4.2. The Board now needs to focus its efforts on a number of key issues so that positive outcomes are achieved.

Interventions to reduce reoffending

6

Theme 6: Interventions to reduce reoffending

What we expect to see

This is an additional module and focuses specifically on interventions intended to reduce the likelihood of reoffending. We expect to see a broad range of quality interventions delivered well, linked to appropriate assessments and plans and which maximise the likelihood of sustainable outcomes being achieved. Effective leadership and partnership work needs to be evident in the delivery of interventions.

Case assessment score

Within the case assessment, overall 54% of interventions work was done well enough.

Key Findings

1. There have been improvements in the delivery of interventions to reduce reoffending, to protect the public and to keep children and young people safe; however, there were significant gaps in the delivery of interventions to prevent reoffending and desistance from crime.
2. There was some good one-to-one work delivered by case managers and other workers, but this was not part of a systematic approach to offending behaviour work.
3. There were no interventions to enable a child or young person to move out from a gang, or to effectively manage gang and serious youth violence.

Explanation of findings

1. Since the last inspection, the interventions team, who delivered a range of programmes and work, had been disbanded. At this inspection we saw some interventions delivered by partner agencies, but most were delivered by the case managers, who had not all received training on the delivery and were subsequently not able to identify whether or not they were making a difference.
2. There were some tensions between the police and the YOS in the delivery of an intervention to address vehicle theft. This illustrated the difficulties we found in the police relationship with the YOS. In this example the relationship limited children and young people's access to programmes which had been assessed as an essential part of their intervention plan. The police had prevented certain YOS children and young people from attending a vehicle crime project on the grounds that this would enable them to become better car/moped thieves. All consideration of the place of such an intervention in plans to reduce an individual young person's offending appeared to have been sidelined completely.
3. A Deputy Team Manager was in the early stages of trying to coordinate some group work delivery. It was also evident that some practitioners had had difficulty in accessing particular interventions including those to address driving offences and knife crime programmes. There were some programmes in development, but it was not clear whether these will appropriately target the right level of need.
4. Given the nature of offending and gang involvement that we saw, it was surprising that there were still no interventions available to address this issue.
5. It was not always clear how interventions contained in plans were linked or sequenced in accordance with assessed need. Furthermore, an evaluation of the impact of interventions was not always apparent.

6. Interventions were being offered by partner agencies, including the intensive family support programme IFIT. We observed a session where case managers received feedback and advice about potential proposals for pre-sentence reports. This session focused simplistically on a list of interventions that could be proposed as part of the plan. There was a lack of balance around the interventions and managing risk of harm to others and offending needs were not given the priority they needed. Instead, family support and education became the key interventions. While these are important supporting issues, they should not replace offending related interventions.
7. Children and young people who undertook reparation, could not always see the value to the community in the tasks they where undertaking, and on occasion were unprepared for the activity. The police offered some interventions, but children and young people were not routinely accessing these.
8. The Targeted Youth Support Team offered support and interventions to prevent antisocial and offending behaviour. We accompanied them during a few sessions. The Targeted Youth Support truck goes into the neighbourhood areas, identifies issues, and provides outreach to children and young people on a voluntary basis in order to reduce antisocial and criminal behaviour.

Appendices

Appendix 1 - Background to the inspection

Inspection arrangements

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

The majority of the Youth Offending Teams selected for these inspections are those whose performance – based on reoffending rates, National Youth Justice Outcome Indicators and supported by other information, such as recent inspections – is of significant concern. Periodically, we also include high performing areas to establish a benchmark of good practice.

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

Criteria

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

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

Methodology

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

Fieldwork for this inspection was undertaken on the weeks commencing:

05 October 2015 and 26 October 2015.

In the first fieldwork week we looked at a representative sample of 35 individual cases up to 12 months old, some current, others terminated. The sample included a number of those who are a high risk of harm to others, are particularly vulnerable, are young women, or are black and minority ethnic children and young people. Cases were assessed by a team of inspection staff. They examined these wherever possible with case managers, who were invited to discuss their work in depth, explain their thinking and identify supporting evidence in the record.

We also received copies of relevant local documents.

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

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

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

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

Scoring Approach

Details of how our inspection judgements are made can be found on our website.

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

Publication arrangements

A draft report is sent to the YOT for comment three weeks after the inspection, with publication approximately six weeks later. In addition, a copy goes to the relevant Ministers, other inspectorates, the Ministry of Justice Policy Group and the YJB. Copies are made available to the press and placed on our website.

FJI reports in Wales are published in both Welsh and English.

Further details about how these inspections are conducted can be found on our website in the document '*Framework for FJI Inspection Programme*' at:

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

Role of HMI Probation and Code of Practice

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

www.justiceinspectorates.gov.uk/hmiprobation

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

HM Chief Inspector of Probation

1st Floor, Manchester Civil Justice Centre

1 Bridge Street West

Manchester

M3 3FX

Appendix 2 - Acknowledgements

Lead Inspector	Yvonne McGuckian, *HMI Probation*
Deputy Lead Inspector	Colin Barnes, *HMI Probation*
Inspection Team	Jo Dowling, *HMI Probation* Nicola McCloskey, *HMI Probation* Mark Scott, *HMI Probation* Catherine Raycraft, *Care Quality Commission* Andrew Reid, *HM Inspectorate of Constabulary* Jon Bowman, *Ofsted Further Education and Skills* Sheena Doyle, *Ofsted Social Care* Simon Greenhalgh, *User Engagement Officer*, *User Voice*
	Robert McNichol, *Local Assessor*
HMI Probation Support Services	Lynne Osborn, *Support Services Officer* Stephen Hunt, S*upport Services Manager* Oliver Kenton, *Assistant Research Officer* Alex Pentecost, *Communications Manager*
Assistant Chief Inspector (Youth Justice)	Helen Mercer, *HM Inspectorate of Probation*

Criminal Justice Joint Inspection

Arolygiad ar y Cyd Cyfiawnder Troseddol

HM Inspectorate of Probation,
Civil Justice Centre
1 Bridge Street West
Manchester
M3 3FX

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