Youth Justice Board
Bwrdd Cyfiawnder Ieuenctid

Case File Audit 21st – 22nd March 2016 Bromley YOS

Background

Following a poor Inspection outcome in February 2015 the YJB, with agreement from Bromley YOS and the Management Board agreed to undertake a case file audit one year post inspection. When completing this audit the YJB used the HMIP Info path tool and followed the case advice guidance used in inspections. The YOS provided a list of all cases which had commenced from 1st September 2015 as it was felt that the most significant changes would be evident from this point following the introduction of a new Deputy and Head of Service.

Audited Cases

A total of 20 cases were audited by 7 different members of YJB staff. At the time of the audit Bromley YOS held approximately 80 cases. The quota audited is comparable with the number that would be inspected during a Short Quality Screening Inspection (SQS) by HMIP.

Following the Inspection outcome in February 2015 the YJB had completed some initial case file reads and were able to identify clearly where the deficits in case management were. The YJB were able to see that there had been improvements in the quality of case management most notably that all cases had the correct documentation completed and on the system. There was greater evidence of management oversight but this still does not represent the true level of oversight according to new processes and policies.

Conclusion

The YOS should feel confident that the direction of improvement is upward and that with a stable, established team with clear expectations and consistency which is underpinned by good quality training and support then improvements will continue. It was pleasing to see the distance that has been travelled.

For ease of reading the following report has been grouped into themes.

1. Good Practice

- Case Workers knew the young people and were able to identify the needs of individuals which was pleasing to see.
- The use of a Restorative Justice Conference was impressive and the impact for both young person and victim.
- Case Workers had developed good working relationships with Electronic Monitoring Company to share information on high risk cases.
- Strong use of the in house Substance Misuse and Education workers.

- One asset used a template for analysis which helped the author to focus on linking back to offending, re offending, risk and vulnerability.

2. Assessments

Assets were generally completed within National Standards timescales.

Authors were generally able to identify diversity needs of young people in assessments but did not follow this through into planning.

Further Improvements:

There was evidence of back dating Assets on the system which is poor practice. Where delays occur reasons for this should be noted on the case management system.

Assets contained lots of information from a range of sources however authors struggled to analyse this information and draw clear conclusions on the links with offending and reoffending.

There was little evidence of the young person's voice in assets. Whilst "What do you think" questionnaires had been completed with young people we only saw evidence in one asset where information from this had been used to inform analysis.

Authors focussed on the factors against desistence rather than those for desistence and supporting these in the work with young people.

3. Reports

Pre sentence reports (PSR) were overall of a sufficient standard - The YOS would benefit from ensuring that PSR proposals detail exactly how the proposal will address the needs identified for that individual.

Further Improvements:

- Referral Order reports - were far too long. Often 5/6 pages in length. Guidance suggests that these should be no more than 2 pages in length and should act as a platform for discussion at the panel. Referral Order reports should also not specify interventions. A suggestion would be that authors use a phrase such as "the panel may wish to consider including ……."
- Gate keeping - This was not always evident. There is only a gatekeeping form for PSR's which is then stored in a paper file. Auditors could not always locate the gatekeeping form or reference on the case management system that this had occurred.

4. Planning

Plans were evident on the case management system which is a significant improvement from the inspection. There was good evidence of referrals to specialists in house and their involvement which improved outcomes for the young people

Further Improvements:

- Panel members could play a greater role in the creation of Referral Order contracts and draw on community interventions and resources.
- Plans often focussed on the factors against desistence rather than supporting and building on the factors for desistence.
- Case Workers struggled to ensure plans were SMART. Most plans were not specific or had measurable outcomes and frequently used professional language that a young person would not understand.
- Whilst it was possible to see how case workers had pulled through identified needs from the asset to the plan it was not always evident how the plan was delivered through the content in contacts.
- There was a number of cases where the young person was prescribed medication to manage diagnosed conditions but refused to take. The impact of this was not fully explored by case workers to understand how this effected engagement nor supported the benefits of taking the medication.
- Plans rarely incorporated the young person's diversity needs eg: being specific as to which materials will be used to match a young person's learning style/need despite this being identified in some assessments which was positive.
- Case managers need to think more creatively about engaging young people and not just rely on standard "off the shelf" interventions. This was particularly prominent in cases where there was non compliance.
- When working with young people in custody plans very much focused on the standard work of the custodial facility and did not fully explore the resettlement needs of the young person. For example a young person who had a history of fire setting yet no targeted invention on this was considered which could have reduced the risk on release.
- There was no evidence of others plans incorporated into the YOS plan eg where a child was on a CIN plan the associated actions were not in the YOS plan.
- Reparation often appeared to be completed first on an order. It is questionable about how much impact this will have without any under pinning offending behaviour work first. It also means less contact with the case worker in the critical early stages of engagement.
- There was limited reference to exit planning and a "step down" process for when orders were ending.

5. Risk and Vulnerability

Assessment of risk was adequate in most cases which is big improvement from the previous audit.

Further Improvements:

- In the majority of cases it was felt that vulnerability was under assessed. Often this was because factors relating to a young person risk of harm were not considered to also make them vulnerable Both risk and vulnerability management plans need further attention. Too often these included cut and paste information from assets and did not specifically home in on the risks.
- Both RMP's and VMP's need to be specific. Plans should clearly state what the identified risks/concerns are and what action will/is being taken to address including specifically by whom, how and when.
- When a young person received subsequent orders too often the ROSH documents was just duplicated without any updating.
- Staff need to consider CSE in all cases, including that of young males and ensure this is referenced. HMIP see this as good practice.

6. Management Oversight

From discussions with managers and through the Improvement Board it is evident that the level of management oversight has increased however this was not always obvious in the case management system.

Further Improvements:

- Only a gatekeeping form exists for PSR's resulting in a lack of consistency across Referral Order and Breach reports.
- Where managers had identified actions these had been recorded on the case management system but no evidence of follow up to ensure they had been completed.
- Very few examples on the case management system where cases had been discussed in supervision.
- A number of cases indicated that where there should have been escalation this had not been documented and evidenced.
- Evidence from compliance panels was sparse and how this is recorded varied.
- There was limited evidence of risk panel discussions and detail as to who was involved.
- Management oversight needs to be more visual on the case management system and contacts added by managers when discussions and decisions on a case have happened.
- Managers need to ensure that when QA'ing a report they cross reference with assessment documentation to ensure no discrepancies eg: in one report the assessment of risk was different in the ROSH and PSR.

7. Work with partners

There was evidence in a number of cases that the working relationship between the YOS and the court is fractured. There was evidence that the courts disregard YOS assessments, proposals and knowledge of the young person. This had resulted in negative outcomes for the young people.

There was strong evidence of the work with both Substance Misuse and Education specialists within the team.

There was evidence of working relationships with schools and the sharing of information in a timely manner.

There was evidence that at an operational level the working relationship with children's social care is not functioning smoothly.

Further Improvements:

- Where there had been issues identified with the court there appears no clear mechanism for discussing these.
- There was little evidence of children's social care involvement with young people that straddled both services. Also there was an impressions that children social care saw "the offender" rather than a child in need. This was evident in cases regarding housing, a court proposal of Remand to LA and possible child protection.
- There appears to have been no escalation in the cases audited beyond operational level to resolve any issues/barriers.

Recommendations:

- Dip sample vulnerability/safety and well-being plans bi monthly with staff to identify enhance their ability to cross reference information and the combined needs of the young person.
- Encourage case workers to think creatively about engagement and link this with the factors for desistance.
- Develop and implement gatekeeping/QA forms for breach and RO reports.
- Ensure that QA documents are scanned and attached to the case management system.
- To broaden case managers understanding of desistence and how this can be embedded into planning and delivery.
- Review the cases held by Level 1 staff to identify the need for additional management support and oversight.
- Consider when Reparation is sequenced into planning to ensure the greatest impact rather than to just tick a box.

YJB Case File Audit March 2016 Kathryn Wyatt

Amended by Natasha Richards 20.4.16

- Ensure that the management oversight is visual by evidencing on the system and consistent.
- To ensure the outcome of compliance panels is clearly recorded on the case management system.
- All case managers to use a consistent format when writing contacts to ensure there is a link back to planned intervention e.g.: Aim, Content, Outcome, Safeguarding/Risk, Actions.
- The voice of the child needs to be enhanced in both assessments and planning. Use of the WDYT must be used for analysis rather than just reference. Plans need to be written in YP friendly language and signed.
- As a service consider how the learning and speech and language needs of YP are assessed and used to inform assessment and planning.
- Strengthen the relationship between YOS and Social Care at an Operational Level and ensure that staff feel confident to utilise the escalation processes where necessary.
- Ensure and where applicable reference CSE in all assessments to evidence this has been considered.
- Ensure that the relationship with the court is strengthened and that there is a clear chain of communication both at an operational and strategic level. (invite to management board if not a member)