Inspection of Youth Offending
Archwilio Rhaglen Troseddwyr Ifanc

Criminal Justice Joint Inspection
Arolygiad ar y Cyd Cyfiawnder Troseddol

Core Case Inspection of youth offending work in England and Wales

Report on youth offending work in:

Hartlepool

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2010

Foreword

This Core Case Inspection of youth offending work in Hartlepool 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 41% 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 52% of the time, and the work to make each individual less likely to reoffend was done well enough 53% 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.

These figures can be viewed in the context of our findings from the region inspected so far. To date, the average score for *Safeguarding* work has been 63%, with scores ranging from 38-82%, the average score for *Risk of Harm* work has been 57%, with scores ranging from 36-85%, and the average score for *Likelihood of Reoffending* work has been 65%, with scores ranging from 50–82%.

We found that improvements were needed in the quality of assessment and planning and work to manage vulnerability and Safeguarding. We also found that work with children's services was not sufficient in all cases to safeguard all children and young people. There were a significant number of children and young people who were vulnerable due to either their own or other people's actions.

We noted that staff had good working relationships with children and young people, and that some retained contact with the YOS when their orders had finished.

Overall, we consider this a disappointing set of findings, with the performance around vulnerability and Safeguarding being of particular concern.

Andrew Bridges
HM Chief Inspector of Probation

January 2010

Acknowledgements

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

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Contents

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 *Safeguarding* 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:	***Comment:***
41%	***DRASTIC improvement required***

***Public Protection – Risk of Harm* score:**	
This score indicates the percentage of *Risk of Harm* 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:	***Comment:***
52%	***SUBSTANTIAL improvement required***

***Public Protection - Likelihood of Reoffending* score:**	
This score indicates the percentage of *Likelihood of Reoffending* work that we judged to have met a sufficiently high level of quality.	
Score:	***Comment:***
53%	***SUBSTANTIAL 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) a timely and good quality assessment and plan, using Asset, is completed when the case starts (Chair of the Management Board)

(2) specifically, a timely and good quality assessment of the individual's vulnerability and *Risk of Harm to others* is completed at the start, as appropriate to the specific case manager (YOS Manager)

(3) as a consequence of the assessment, the record of the intervention plan is specific about what will now be done in order to safeguard the child or young person's well-being, to make them less likely to reoffend, and to minimise any identified *Risk of Harm to others* (YOS Manager)

(4) the plan of work with the case is regularly reviewed and correctly recorded in Asset with a frequency consistent with national standards for youth offending services (YOS Manager)

(5) there is evidence in the file of regular quality assurance by management, especially of screening decisions, as appropriate to the specific case (YOS Manager).

Furthermore:

(6) that in relevant cases, the work undertaken by the YOS and Children's Services is consistent and complimentary in reducing vulnerability and protecting those at risk of harm (Chair of the Management Board and Local Safeguarding Children Board)

(7) that records held, both electronic and paper, provide an accurate and timely account of the case to aid continuity of services for children and young people (All staff)

(8) that there is contingency planning to ensure that the quality of work with children and young people is maintained when there are vacancies within the YOS (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.

Given the disappointing scores for Safeguarding work we will undertake a reinspection, which will be scheduled for approximately 12 months time.

Service users' perspective

Children and young people

Twenty-two children and young people completed a questionnaire for the inspection.

- All the children and young people knew why they had to attend the YOS and felt that staff had explained things clearly and often enough to help them understand what was expected of them.
- For those who received a referral order, the details had been explained to them and all had been given a copy of their contract.
- For those subject to other orders, all but three children and young people had been given a copy of their plan.
- When asked "Did you feel as if the YOS staff were really interested in helping you?" and "Did staff listen to you?" 18 children and young people said "yes, completely" and four said "mostly".
- All children and young people felt that they had been helped by the YOS staff, most often with their education and with understanding their offending.

Victims

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

- All those who responded stated that YOS staff had explained what services were on offer to them.
- One respondent felt that proper consideration had not been given to ongoing safety issues.
- Three people had benefited directly from the reparative work undertaken by children and young people.
- Ten people were completely satisfied with the services they had received.

Sharing good practice

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

Assessment and Sentence Planning **General Criterion: 1.1d**	John, a 17 year old, received a DTO for an offence of burglary. He had the same case manager from the start of the order, who had developed an excellent understanding of both the high *RoH* John posed to others and also his vulnerability due to his family relationships, lifestyle and his own offending behaviour. The case manager had appropriately referred the case to MAPPA and had liaised closely with other agencies such as the police and health services to gather information and adapt working practices to a style that was most likely to have the greatest impact.
Delivery and Review of Interventions **General Criterion: 2.2a**	Beth, a 15 year old girl, received a referral order for a section 39 assault. She was a heroin user. YOS staff and Beth's parents were actively involved in motivating her to comply with the order and also in engaging with local drug services. Beth managed to reduce her methadone use and was able to attend college on a regular basis, through effective inter-agency working and contact via regular home visits.
Outcomes **General Criterion: 3.1a**	Sam, a 16 year old young man, serving a custodial sentence, made a complaint to his case manager as he did not get on with a member of the YOS staff. The complaint was investigated by a manager who concluded that the young person and staff member had a clash in personalities that may have adversely impacted on the way in which Sam engaged with the YOS when he was released. The manager visited Sam in custody and discussed his complaint with him. As a result, on his release, Sam worked with other staff enabling him to engage with the community part of his sentence.

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: ***60%***	***Comment:*** ***SUBSTANTIAL improvement required***

Strengths:

(1) A RoSH screening had been completed in all but one case and from those 37, 30 had been completed on time.

(2) YOS staff assessed that 16 cases needed a full RoSH analysis, and this had been completed in all but two cases.

(3) In the one case which had been referred to MAPPA, accurate and timely information had been provided to the panel and the YOS had made an appropriate contribution to the decision making processes.

(4) Home visits had been used effectively to monitor and respond to risk issues and to develop and maintain relationships with parents/carers. Appropriate responses had been made when new information had come to light during such visits.

(5) A RMP had been completed in 12 of the 14 cases where the full analysis indicated the need.

Areas for improvement:

(1) Of the 37 RoSH screenings completed as part of the process of assessing *RoH,* less than half were accurate.

(2) Of the 14 where RoSH full analyses had been completed, only half were done on time and of these only five were of sufficient quality. The analysis tended to focus only on the current offence and did not take into account previous convictions and significant or worrying behaviours. The analyses also failed to specify the nature and level of risk to actual and potential victims, including siblings, and in two cases failed to take into account diversity issues.

(3) RoSH assessments did not always take into account other agencies assessments, this being most noticeable with a lack of information from children's services. Current arrangements did not facilitate effective gathering and sharing of risk information, including cases where there had been involvement from children's services. The YOS had been given four licences to enable them to access the children's services information system. Checks had been undertaken at the court stage; however, none of these checks had been recorded. Furthermore, YOS staff were unable to add critical information nor was the system rechecked during the order. This situation meant that vital information could be missed from the system.

(4) Where a RMP had been completed, half had been done on time; however, only one was of a sufficient quality. RMPs tended to repeat information in the analysis rather than be an effective planning document to manage risks. Plans did not define clear roles and responsibilities, give a planned response, provide for the needs of victims or incorporate diversity issues. RMPs also failed to link with child protection and care plans and ISSP involvement.

(5) In five cases the risk level had been classified as low when, in the judgement of the inspection team, the correct level should have been medium. In each case this had been caused by staff not utilising and linking all known and available information.

(6) In nine cases the *RoH* issues had not been recognised or acted upon.

(7) Risk levels and information had not been consistently recorded, resulting in a number of cases having the wrong risk classification recorded. This had implications for managers who were reliant on accurate information to ensure that the right cases were drawn into risk and vulnerability forums.

(8) Management oversight of *RoH* issues had been effective in less than one-quarter of cases. A contributory factor was a lack of a shared understanding of vulnerability thresholds.

1.2 Likelihood of Reoffending:	
General Criterion: *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.*	
Score: ***47%***	***Comment:*** ***SUBSTANTIAL improvement required***

Strengths:

(1) There had been an initial assessment of LoR in 33 of the 38 cases (87%). Of these, 24 had been completed on time.

(2) Initial assessments included positive factors in most cases and there was evidence that information had been obtained and used to assess ETE and health needs. In addition, where children and young people had been in custody, information from the YOIs had been incorporated into assessments.

(3) An intervention plan had been produced in all but two cases and 76% had been completed on time. In relevant cases plans usually included interventions to address attitudes to offending, thinking and behaviour and ETE.

(4) Intervention plans reflected the purpose of sentencing in 76% of cases and focused on achievable change in 71%.

(5) In 76% of cases intervention plans had been sequenced according to offending related needs.

(6) ETE agencies had been involved in the review of plans in 26 of 33 relevant cases. Reviews had taken place for both custody cases. Housing support services had been involved in four of the six relevant cases.

Areas for improvement:

(1) In completing an assessment of LoR there was evidence of active engagement with children and young people in only 30% of cases and with parents/carers in 36%.

(2) Initial Assessments were of a sufficient quality in 12 out of 33 cases. Factors that caused assessments to be insufficient included failure to identify diversity factors, unclear and insufficient evidence and a failure to identify vulnerability issues.

(3) Assessments did not routinely incorporate previous or current assessments from children's services, including those children and young people subject to a CAF.

(4) *What do YOU think?* questionnaires had been completed in only two cases in the sample. Children and young people had rarely been given the opportunity to complete these at the start of new orders.

(5) Of the 36 intervention plans produced only 13 were judged to address the factors relating to offending sufficiently. Intervention plans lacked objectives to address living arrangements, physical health needs, family and personal relationships, emotional and mental health needs and perception of self and others. Some workers had completed interventions plans to a standard formula and as a result they did not address individual needs.

(6) Safeguarding issues, including the impact of domestic violence, had been included in only four of the 30 intervention plans where they were needed. Plans incorporated the child or young person's learning style in only two cases. There was no routine assessment of learning styles.

(7) The intervention plans gave a clear shape to the order on just over half of the cases (54%); set relevant goals in two-thirds; and set realistic timescales in under half (40%). Only 37% of plans had met national standards.

(8) Intervention plans had been prioritised according to *RoH* in 18 of the 31 relevant cases; were inclusive of Safeguarding needs in just 6 of the relevant 26 cases; and sensitive to diversity issues in four of those 26. Half of the plans took account of victim issues.

(9) Plans had been reviewed at appropriate intervals in 46% of cases.

(10) Where reviews had taken place, children and young people had been actively involved in 43% of these and parents/carers in 30%.

(11) The health needs of children and young people had not been drawn into assessment and planning due to a long term vacancy of the nurse's post. It was positive to note that this position had been filled and staff had commented on the support available.

(12) Children's services had been actively and meaningfully involved in the planning processes in 6 of 19 where needed; physical health services in one of the appropriate four cases; Substance misuse in 17 of 27 cases; the ASB team in one of six cases; and police in none of four relevant cases.

1.3 Safeguarding:	
General Criterion: *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.*	
Score: ***41%***	***Comment:*** ***DRASTIC improvement required***

Strengths:

(1) Hartlepool had two remand foster carers used as an alternative to remand in secure establishments. Both of these carers were under the line management responsibility of the YOS's operational support manager.

(2) Vulnerability screenings had been completed in all but one case and completed on time in all but eight.

Areas for improvement:

(1) There were four licences available for the Children's Services Department's information database. Checks were made for each child or young person listed for court, which ensured that current information was sought for each

offence, but there was no system to record the outcome of these checks on the YOS's systems.

(2) Twelve of the 37 vulnerability screenings had been completed to a sufficient standard. Screenings tended to minimise the impact to children and young people who lived with domestic violence. In addition, they did not always record the risks posed by children and young people's own behaviour, including substance misuse, and on occasions did not consider the effect of entrenched attitudes towards crime and violence as a part of every day life.

(3) Inspectors judged that of the 38 cases in the sample, there were 31 cases where there were clear vulnerability issues. This was a high proportion of the sample with evidence that children and young people had been vulnerable from their own actions and from those of other people. This figure represented a substantially higher number than the 17 cases assessed as vulnerable by YOS staff. During interviews staff were able to relate factors which had contributed to vulnerability and seemed to be aware of Safeguarding needs; however, these did not correspond with recorded screening or assessments. The conclusion drawn was that the threshold for vulnerability was too high, resulting in some cases where factors were not acted upon.

(4) Of the 17 VMPs produced only four were assessed as sufficient. Plans failed to provide a clear and defined response, roles and responsibilities were unclear and plans were not linked to other agencies. Examples included a lack of joint planning with ISSP and an absence of involvement with children's services. VMPs failed to provide a set of clearly defined actions to reduce and respond to vulnerability. Inspectors noted that the impact of domestic violence had not been fully and actively considered, even in cases where there was prior injury to children and young people.

(5) Interventions to address vulnerability factors were rarely included in the intervention plans.

(6) There was an absence of joint response and work between the YOS and children's services. This was noted at all stages of orders including initial assessment, planning and review. There were no records held of the checks made with children's services, limited access to the information system and no method for the YOS to add to this information system. In some cases there were clear disagreements about the levels of risk faced by children and young people and inspectors noted inconsistent responses. Case managers described their frustrations with a lack of timely and clear response from children's services and cases in the sample confirmed this.

(7) Safeguarding needs had not been reviewed in all cases, either in line with national standards or in response to a significant change in needs. CAF processes were not embedded into practice and on occasions the YOS had not been invited to relevant meetings. We assessed that an appropriate contribution had been made through the CAF in three of the 15 relevant cases.

(8) The lack of joint work with children's services and the tendency to underestimate vulnerability had the potential to leave children and young people at risk. There had been effective management oversight of vulnerability in six of the 33 cases where it had been needed.

OVERALL SCORE for quality of Assessment and Sentence Planning work: 48%

COMMENTARY on Assessment and Sentence Planning as a whole:

Recently developed skills in assessment may provide the basis for improved practice in the future. In interviews case managers were often able to relate and describe key issues affecting children and young people's level of *RoH*, offending and vulnerability. They were also able to describe what needed to be done. However, very little of this knowledge was transferred onto formal systems including YJB assessment and planning documents and onto the Careworks case management system. This had the effect that workers activity bore little resemblance to recorded plans, and case managers then had great difficulty in successfully tracking and managing the cases.

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: ***48 %***	***Comment:*** ***SUBSTANTIAL improvement required***

Strengths:

(1) Staff had made an effective contribution to MAPPA meetings and had followed through and acted on actions agreed to reduce risks.

(2) There had been purposeful home visits conducted in accordance with *RoH* and LoR in over 70% of cases. Where there was involvement from ISSP there had been an appropriate increase in home visits.

Areas for improvement:

(1) *RoH* had been reviewed in line with national standards in less than half of the cases. The YOS management had instructed staff to review cases. However, where this had been completed some key features had been missed. The process of active and thorough review was not an embedded practice.

(2) Plans had been reviewed in nine out of 23 cases where there had been a significant change, including allegations of new offences and changes in behaviour.

(3) Changes in *RoH* and acute factors were noted in 25 cases. Of these, the risks had been anticipated in five cases, identified in 13 and responded to appropriately in 11.

(4) There were two cases in the sample that were eligible for MAPPA consideration, one of these had been subject to a referral. Notification to MAPPA and the decisions made through the process had not been clearly recorded onto the case management system, nor were actions incorporated into RMPs.

(5) The purpose and use of home visits were not usually identified and managed through the RMPs.

(6) A full assessment of victim safety had been carried out in eight of 25 relevant

cases. Assessments often failed to consider work needed to protect siblings, family members and potential victims.

(7) High priority had been given to victim safety in one of 11 relevant cases, including those where victims themselves could be deemed as vulnerable.

(8) Appropriate resources had been allocated according to the assessed *RoH* in just over half of all cases.

2.2 Reducing the Likelihood of Reoffending:	
General Criterion: *The case manager coordinates and facilitates the structured delivery of all elements of the intervention plan.*	
Score: ***65%***	***Comment:*** ***MODERATE improvement required***

Strengths:

(1) All but one intervention plan had been designed to reduce the LoR, and these had been sequenced appropriately in 72% of cases.

(2) The YOS had been actively involved in the review of interventions in both custody cases.

(3) Staff had actively motivated and supported children and young people through the sentence in both custody cases and in over 80% of community cases.

(4) Positive behaviour had been reinforced in all but one case. Cases evidenced that staff had recognised and used opportunities to reflect good and improved behaviour and attitudes by children and young people.

(5) Parents/carers had been actively engaged throughout the sentence in 70% of cases. Examples evidenced the use of a variety of methods to keep parents/carers engaged, including use of the FIP team, telephone calls and face-to-face meetings.

(6) ISSP had been used effectively in relevant cases and their intervention had been flexible and adapted to specific needs. Staff undertook frequent home visits and had used parents/carers to help monitor behaviour and compliance. There was good and timely communication between YOS staff and members of ISSP, which had enabled timely responses to changes in behaviour and breach action where needed. There were also examples of how staff had been creative in their approach to engaging with children and young people.

Areas for improvement:

(1) Just under one-third of interventions plans had been appropriately reviewed for community cases.

(2) Interventions had been adapted to meet the learning style and diversity needs of children and young people in less that half of the cases.

(3) Just over half of the interventions delivered were of good quality.

2.3 Safeguarding the child or young person:	
General Criterion: *All reasonable actions have been taken to safeguard and reduce the vulnerability of the child or young person.*	
Score: ***44%***	***Comment:*** ***DRASTIC improvement required***

Strengths:

(1) All necessary and immediate action had been taken to safeguard and protect both children and young people in custody, including identifying how one was vulnerable whilst in custody.

(2) There had been good work with ETE providers in 88% of cases where this was needed, with clear communication of issues and joint responses to changes in behaviour. Case managers had been able to reinforce work undertaken at school and there was some effective information sharing to help safeguard children and young people.

(3) There was effective joint work between the YOS and secure establishment staff throughout the custodial phase and in preparation for release.

Areas for improvement:

(1) All necessary immediate action had been taken to protect and safeguard children and young people in 11 of the 26 community cases where action had been needed.

(2) Where there were other children and young people identified (siblings, peer group and schoolmates), who were in need of Safeguarding and protection, necessary action had been taken in three of 18 relevant cases.

(3) Referrals to ensure Safeguarding of children and young people had not been made in all relevant cases. It was of concern to note that appropriate referrals had been made in only six out of 21 needed.

(4) Vulnerability, linked to accommodation issues, had not been identified and addressed in all cases, including for those children and young people who lived with parents/carers where there was evidence of domestic violence.

(5) Where needed, there had been effective joint work between the YOS and children's services in only one-third of cases, including looked after children and young people.

(6) Although the work of partner agencies was evident, there was a lack of joint working to provide a consistent and complimentary service to children and young people. This was noted in relation to physical health, emotional and mental health, substance misuse and the ASB team. Cases showed that work tended to be completed in isolation from general case management and, as a result, case managers had not always been in a position to consolidate the input of partner agencies or accurately reassess plans to manage risk, reoffending and Safeguarding.

(7) Specific interventions to promote Safeguarding had been identified in 11 of the 28 relevant cases and incorporated into only five VMPs. The delivery of these interventions had not occurred in all cases and significant change did not prompt review.

(8) All relevant staff had supported and promoted the well-being of the child or young person in just over half of all cases.

OVERALL SCORE for quality of Delivery and Review of Interventions work: 53%

COMMENTARY on Delivery and Review of Interventions as a whole:

This was the highest scoring area of performance and recent work by the YOS to build and develop assessment skills had contributed to plans to reduce reoffending. Case managers were committed to working with children and young people. However, a lack of joint working had impacted on their ability to deliver effective work. There had been a recent directive from the management team to undertake reviews on all cases in line with national standards.

3. OUTCOMES

3.1 Achievement of outcomes:	
General Criterion: *Outcomes are achieved in relation to RoH, LoR and Safeguarding.*	
Score: ***34%***	***Comment:*** ***DRASTIC improvement required***

Strength:

(1) Two-thirds of the children and young people complied with the requirements of the sentence. Of those others who had not complied, breach action had been taken sufficiently well in all but two cases.

Areas for improvement:

(1) *RoH* had been effectively managed in 32% of cases.

(2) Asset scores had reduced in ten cases. However, without systematic reviews case managers found it difficult to evidence change and improvement using this measure. From these ten cases there was evidence to show that there had been some positive changes to motivation, attitudes to offending, self-perception, ETE and lifestyle.

(3) From the sample there was a reduction in frequency of reoffending in 29% and a reduction in the seriousness of offending in 14% of cases.

(4) There had been a reduction in factors linked to Safeguarding in 23% of relevant cases.

(5) All reasonable action to keep the child or young person safe had been taken in just under half of the cases.

3.2 Sustaining outcomes:	
General Criterion: *Outcomes are sustained in relation to RoH, LoR and Safeguarding.*	
Score: ***59 %***	***Comment:*** ***SUBSTANTIAL improvement required***

Strengths:

(1) Attention had been given to community integration in 61% of cases.

(2) Where positive outcomes had been achieved, action had been taken or plans had been made to ensure that they could be sustained in just over half of the cases.

Areas for improvement:

(1) *RoH* had been effectively managed in 32% of relevant cases.

(2) Reviews and reassessments had not been undertaken systematically and therefore reductions in asset scores had not been calculated.

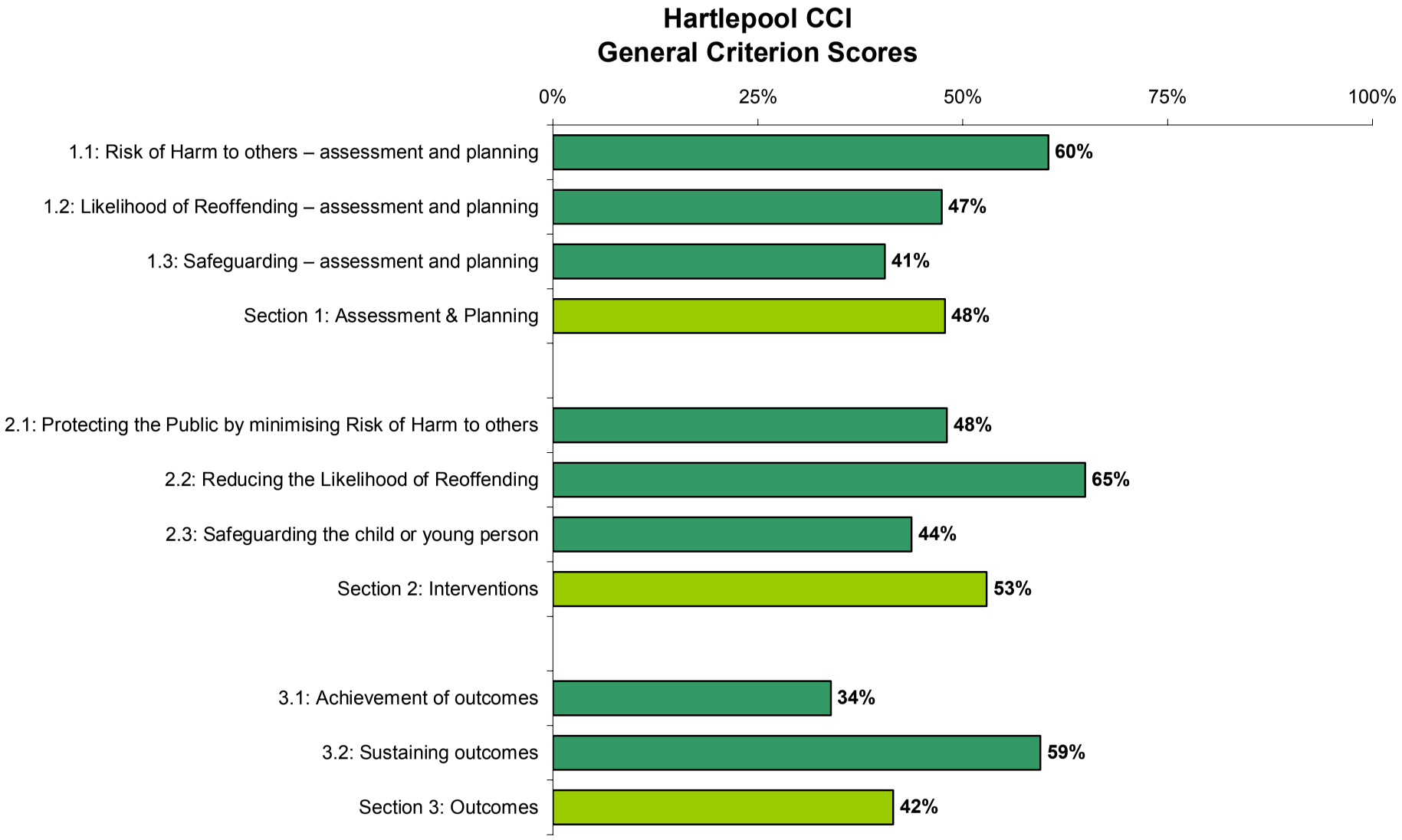
(3) Objectives in plans did not contain outcome measures and staff found it difficult to see where plans and interventions had impacted.

OVERALL SCORE for quality of Outcomes work: 41%

COMMENTARY on Outcomes as a whole:

The YOS was located in the Community Safety and Prevention Division of the Regeneration and Neighbourhoods Department, and not within the children's services, which is the most common location. Whilst it is not the role of this inspectorate to advise on location, this report highlights that there is a lack of integrated working to safeguard and protect children and young people. The management board need to consider how these issues are to be rectified. It was very positive to have the Director of Children and Adult Services attend the feedback meeting, and we were reassured that issues raised were to be considered immediately.

Appendix 1: Summary



Appendix 2: Contextual information

Area

Hartlepool YOS was located in the North-East region of England.

The area had a population of 88,611 as measured in the Census 2001, 11.6% 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 Hartlepool was predominantly white British (98.8%). The population with a black and minority ethnic heritage (1.2%) was below the average for England/Wales of 8.7%.

Reported offences for which children and young people aged ten to 17 years old received a pre-court disposal or a court disposal in 2008/2009, at 69 per 1,000, were above the average for England/Wales of 46.

YOS

The YOS boundaries were within those of the Cleveland police force and The Middlesbrough and County Durham probation trust areas. Hartlepool PCT covered the area.

The YOS was located within the Community Safety and Prevention division of the Regeneration and Neighbourhoods Department. It was managed by the Head of Community Safety and Prevention. The Chair of the Management Board was the Assistant Director (Planning & Service Integration) Children and Adult Services.

The YOS Headquarters was in the town of Hartlepool. The operational work of the YOS was based in Hartlepool and its districts. ISSP was provided by the Teesside consortium.

YJB Performance Data

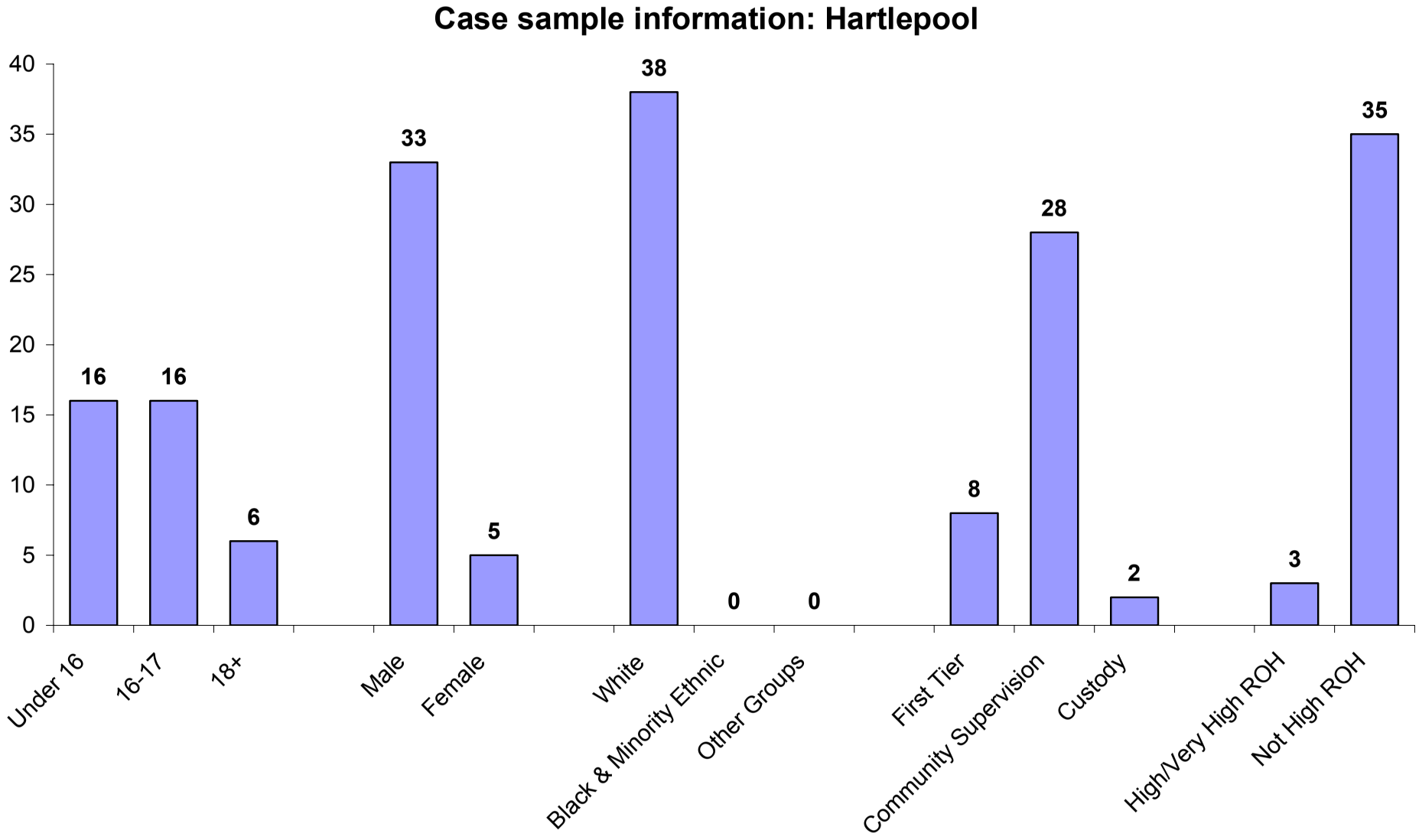
The YJB summary of national indicators available at the time of the inspection was for the period April 2008 to March 2009.

Hartlepool's performance on ensuring children and young people known to the YOS were in suitable education, training or employment was 77.8%. This was a decrease on the previous year, but above the England average of 72 %.

Performance on ensuring suitable accommodation by the end of the sentence was 95%. This was a slight reduction on the previous year and slightly worse than the England average of 95.3%.

The "Reoffending rate after 9 months" was 1.08%, slightly worse than the England average of 0.85%. (See Glossary).

Appendix 3a: Inspection data chart



Appendix 3b: Inspection data

Fieldwork for this inspection was undertaken in October 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 YOS.

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/inspectorates/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
FIP	Family Intervention Project
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; *constructive* and *restrictive* interventions	Work with an individual that is designed to change their offending behaviour and/or to support public protection A *constructive* intervention is where the primary purpose is to reduce Likelihood of Reoffending. A *restrictive* intervention is where the primary purpose is to keep to a minimum the individual's *Risk of Harm to others*. Example: with a sex offender, a *constructive intervention* might be to put them through an accredited sex offender programme; a *restrictive intervention* (to minimise their *Risk of Harm*) 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. NB. Both types of intervention are important
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 *constructive* 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 *Risk of Harm to others*
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 *Risk of Harm*
RoH	*Risk of Harm to others.* See also *restrictive* Interventions
'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 *restrictive interventions,* to keep to a minimum the individual's opportunity to behave in a way that is a *Risk of Harm to others*
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 *probability* of an event occurring and the *impact/severity* of the event. The term *Risk of Serious Harm* only incorporates 'serious' impact, whereas using '*Risk of Harm'* enables the necessary attention to be given to those offenders for whom lower *impact/severity* harmful behaviour is *probable*
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