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:

Plymouth

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2010

Foreword

This Core Case Inspection of youth offending work in Plymouth 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 70% 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 66% of the time, and the work to make each individual less likely to reoffend was done well enough 74% 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 regions inspected so far. To date, the average score for *Safeguarding* work has been 64%, with scores ranging from 38-82%, the average score for *Risk of Harm* work has been 60%, with scores ranging from 36-85%, and the average score for *Likelihood of Reoffending* work has been 66%, with scores ranging from 50-82%.

We found that there was a good level of support from partner agencies, including education, substance misuse and accommodation services. Engagement with children and young people and parents/carers was also good, supported by effective home visiting and ongoing contact from case managers.

The quality of work being done was better than the quality of assessment and planning. It is important that assessment work is done well to support interventions and the delivery of services to children and young people.

There had been a gap in the management of staff, resulting in a lack of formal and thorough induction, supervision and quality assurance processes. This has been recognised by the Management Board, who have already taken steps to provide additional management support to staff.

We found numerous examples of work being done not supported by robust planning or by clearly recorded evidence. This meant that the information systems that managers relied on were not as accurate as they needed to be in order to inform future planning decisions.

Further work needs to be undertaken to meet the needs of black and minority ethnic children and young people, both in the identification and response to their specific needs and to recognise and deal with wider diversity issues.

Overall, we consider this a broadly encouraging set of findings and we judge that this YOS has promising prospects for the future.

Andrew Bridges
HM Chief Inspector of Probation

March 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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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:***
70%	***MODERATE 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:***
66%	***MODERATE 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:***
74%	***MODERATE improvement required***

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

(2) 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 (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) all staff receive comprehensive and timely induction and ongoing supervision and training (Chair of Management Board)

(7) issues relating to diversity are assessed and planned for, with particular attention given to the needs of black and minority ethnic children and young people (YOS Manager).

Next steps

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

Service users' perspective

Children and young people

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

- Of the four children and young people who had received a referral order, all said that the YOS worker had discussed this with them. Two of them had been given a copy of their contract.
- Only one child or young person knew what a sentence plan was.
- To the question, "*Did you feel as if the YOS staff were really interested in helping you?*", five children and young people said "*yes, completely*"; four replied, "*mostly*"; two replied, "*not much*"; and one replied, "*not at all*".
- Four children and young people completed a *What do YOU think?* questionnaire, four did not and another four could not remember whether they had completed one or not.
- In order to improve the service, children and young people felt that they should be able to see their worker more often; and that their worker should be there at arranged appointments.

Victims

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

- All the victims had received a clear explanation about what the service could offer them and had the opportunity to discuss any worries they had.
- One victim had benefited from reparative work undertaken by the child or young person.
- One person felt that the YOS had not paid attention to their safety.
- One victim would have liked some follow-up when the child or young person had completed the intervention; another was completely satisfied with the service received.

Sharing good practice

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

Assessment and Sentence Planning **General Criterion: 1.1**	Accommodation was needed for a 17 year old male, with known fire setting tendencies, on his release from custody. The housing department allocated a placement in a mixed setting, where vulnerable people and families were also housed, so the case manager contacted the fire brigade and arranged a joint risk assessment with the accommodation provider. The accommodation provider followed the advice of the fire officer and, amongst other things, kept a record of any visitors to the flat. The YOS worker undertook home visits and checked for any lighters. As a result, the young person was able to move into suitable accommodation and the *RoH* to other people living at the address was kept to a minimum.
Delivery and Review of Interventions **General Criterion: 2.2**	Natalie was a vulnerable young woman missing school and acting as a carer for her siblings, owing to her mother's learning disabilities. She was suspicious of professionals and drank as a means of escape. Within an action plan order the YOS encouraged her to produce an alcohol awareness fact sheet, based on her research on the internet. This served to improve her information technology skills as well as developing her knowledge of the effects of alcohol on young women. The YOS worker marked her positive work and attendance with a certificate which increased her sense of achievement. By the end of the order, Natalie was in full-time education, had not reoffended and she had considerably reduced her alcohol intake.
Outcomes **General Criterion: 3.2**	A young person with a learning disability needed to open a bank account. The case manager spoke with the bank manager to alert him to the young person's needs and communication difficulties. The young person was then prepared for the type of questions he would be asked and the case manager accompanied him to the interview. The young person was able to participate in the meeting and gained considerable self-esteem from managing a new experience in a positive way.

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: ***64%***	***Comment:*** ***MODERATE improvement required***

Strengths:

(1) A RoSH screening had been completed in all but three cases. 70% of these had been completed on time. Of the 11 assessments that were late, a number had been done weeks and months into the order.

(2) Classification of RoSH levels was assessed as being accurate in 90% of cases; all cases accepted by MAPPA met the criteria and had been allocated to the appropriate level.

Areas for improvement:

(1) Full RoSH assessments had been undertaken in 11 of the 15 applicable cases, of these only eight had been done in a timely manner. Half of those completed were considered to be of sufficient quality. Some lacked clear victim information, including specific details on how to promote victim safety and, in a few cases, did not make reference to diversity issues, including the impact of attitudes towards black and ethnic minority people.

(2) Just over half (18 out of 35) of the RoSH screenings were accurate; they often did not reflect previous convictions and risky behaviours displayed by the child or young person. Staff knowledge on the use of the screening tool also varied, some staff had not been confident about where to record information and of the significance of a range of information sources, such as parent/carer views. Risk training had taken place a few weeks prior to the inspection and many staff commented on how they would use systems differently; a positive indicator for the quality of future risk screening and assessments.

(3) A RMP had been completed in only half of the cases where one should have been produced. Of these, one-quarter had been done on time and one-third

were of sufficient quality. There was no single reason why RMPs were insufficient, and we noted a range of factors, including victim safety not being addressed, a lack of clear roles and inadequate responses.

(4) Management oversight of *RoH* had not been effective in all cases, although we saw some good examples where case managers had been asked to reconsider information. If a case manager assessed *RoH* as low, it was not countersigned. If this classification was incorrect, there was no consistent way that it could be identified and altered.

(5) Staff were not always familiar with the screening, assessment or planning tools. For some case managers there had been no effective training to enable them to fully utilise existing skills to work within the YOS environment.

(6) There were a number of cases that did not require a RMP but which, nonetheless, indicated potentially harmful behaviour that needed to be addressed. Planning of specific interventions for this purpose had occurred in 9 of the 15 cases.

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: ***71%***	***Comment:*** ***MODERATE improvement required***

Strengths:

(1) Initial assessments of the LoR had been completed in all cases in the sample. 81% of these had been completed on time. Case managers were good at reflecting positive influences within Asset.

(2) In assessing if there had been active engagement with the child or young person or their parents/carers, we looked for evidence of careful attention to the views and thoughts they expressed and whether these had been considered by the case manager in order to form a judgement. We found sufficient evidence that there had been an active engagement with the child or young person in 84% of the sample and with parents/carers in 79% of relevant cases.

(3) Assessments usually drew on information held by other relevant agencies, including children's social care services (76%); ETE providers (73%); emotional and mental health services (73%); and the accommodation

worker. Case managers sought advice and information from colleagues from these agencies when making their assessment, although the recording of the outcomes of the discussions was not always clear.

(4) Within the intervention plans, case managers had paid due attention to accommodation, ETE and thinking and behaviour issues.

(5) 76% of plans had taken into account Safeguarding needs and 83% included positive factors in the child or young person's life.

(6) In most cases there was evidence of prioritisation or sequencing according to *RoH* (85%) and Safeguarding (84%). Where identified, plans were sensitive to diversity issues.

(7) There was evidence that other agencies had been actively involved in the planning process. This was very noticeable with ETE, secure establishments, the police, substance misuse and mental health workers. There was a sense that staff valued and understood each others' roles and knew how agencies could contribute to interventions.

(8) The child or young person had been involved in the planning process in 83% of cases and parents/carers in 71%. However, plans were rarely signed by children and young people.

Areas for improvement:

(1) 67% of initial assessments had been completed to a sufficient quality. We found assessments with unclear or insufficient evidence, some undertaken late; a few that failed to identify all factors that had contributed to offending and a failure to identify diversity issues.

(2) There was inconsistent practice within the YOS as to how case managers should assess the child or young person's learning style. A questionnaire had been introduced, but we found it had been used in only a few cases. Where it had been completed, case managers did not always know how to incorporate the findings into the assessment or plans.

(3) Within Plymouth YOS, we found five cases where the initial assessment had been informed by the *What do YOU think?* form. We found that they had been given on previous orders, usually the first, but then children and young people had not been given the opportunity to complete subsequent questionnaires, even when they had received new sentences.

(4) Just over half of the intervention plans had been completed on time. This had resulted in a delay in starting the work with children and young people and had the potential to impact on motivation.

(5) Whilst 66% of the initial assessments had been reviewed, new information had not always been added nor had case managers used the review assessment to fully analyse any changes.

(6) 57% of intervention plans had addressed factors linked to offending. Plans had not been particularly well written and mainly contained wide objectives, such as offending behaviour work, rather than giving a clear indication of the specific work that was to be done. Just over half of the plans had set relevant goals.

(7) Not all staff were confident in using the care first system, which accessed services for children and young people's information. This had resulted in information not being accessed or added to the system.

(8) Only 47% of intervention plans incorporated the RMP and 46% had taken into account victim issues.

(9) Intervention plans had been reviewed in 67% of cases. Where reviews had taken place, there was little evidence of changes to objectives to reflect any progress made, or to record amendments to plans needed to keep a child or young person engaged. We noted that where there had been a change in case manager, they would often have to discover afresh how best to work with the child or young person.

(10) Children's social care services had been actively and meaningfully involved in planning processes in 58% of relevant cases, including those involving Looked After Children, within the community and those who had gone into custody.

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: ***66%***	***Comment:*** ***MODERATE improvement required***

Strengths:

(1) We expect that a vulnerability screening is undertaken on all cases and in Plymouth YOS one had been completed in 86% of cases, with 73% of these being done on time. The secure establishment had been made aware of vulnerability issues in all but one case upon sentence. We also evidenced some sensitive work to prepare children and young people for how specific vulnerabilities, including bullying, could be managed in custody.

(2) Safeguarding needs had been reviewed in 84% of cases, although this meant that there had been six cases where these needs had not been reassessed.

Areas for improvement:

(1) Vulnerability screenings were accurate in only 56% of cases and tended only to focus on any risks of self-harm and suicide and not on the risks posed by other people, including parents/carers and partners. Case managers did not

record the impact of a range of factors that could contribute to a child or young person's vulnerability, including, but not exclusively, their race and ethnicity, being a Looked After Child, domestic abuse within the home and how drug use was funded. Case managers were often aware of these issues but had not incorporated them into the screenings.

(2) We considered that there should have been a VMP in 19 of the cases in the sample. However, there were only six, with only four having been completed on time. The six completed VMPs were of a sufficient quality.

(3) There was no system for identifying those cases that were wrongly assessed, nor was there clear management guidance on how to use the screening tool to incorporate all factors. Case managers were of the view that they could only consider any risks posed of self-harm or suicide.

(4) Copies of other agencies' plans were not always available on the file. There was not always a record or other evidence to show what contribution the YOS had made to wider plans designed to safeguard the child or young person, including care plans, pathway plans or the CAF.

OVERALL SCORE for quality of Assessment and Sentence Planning work: 69%

COMMENTARY on Assessment and Sentence Planning as a whole:

There had been a vacancy within the management team for a period of time, which had impacted on the work of the YOS in a number of ways. Management oversight of work was often lacking, despite efforts by a recently appointed manager who had begun to introduce supervision and some performance measures. It was positive to note that staff had received training in risk management, which had enabled them to reflect on their practice. During interviews many staff were able to describe how they would assess, plan and manage risk differently. Equally positive was the use of case manager forums, which allowed staff to discuss practice and share ideas, with the intention of identifying good practice and aiding consistency. The recent appointment of two new managers should enable case managers to access clear guidance and professional development. It is disappointing that issues of supervision and training had not been addressed, as this was a recommendation from the previous inspection in 2006. The previously available induction for staff was not always evident. We evidenced some good practice in relation to assessment and planning from staff, who demonstrated a good understanding of factors that contributed to offending and the importance of engaging children and young people and their families.

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: ***69%***	***Comment:*** ***MODERATE improvement required***

Strengths:

(1) We noted some good examples of the management of *RoH*, in conjunction with staff from partner agencies.

(2) Case managers had effectively contributed to multi-agency meetings in 82% of custody and community cases. There was evidence that some case managers actively requested information about the child or young person's attitudes and behaviour whilst in custody, in order to make judgements about *RoH*.

(3) We found that there had been accurate identification of cases that met the criteria for MAPPA, and a timely referral had been made. It was initially disappointing to note that a case had been deregistered following a meeting where the YOS staff had not been able to attend and present relevant risk information. This had quickly been rectified by the case manager.

(4) Purposeful home visits had been carried out throughout the course of the sentence, in accordance with the level of *RoH* posed, in 88% of cases and 90% of cases where there were Safeguarding issues.

Areas for improvement:

(1) There was evidence of timely RoSH reviews in 63% of the cases. In less than half (41%) of cases the case manager had identified a significant change which should have triggered a review of the *RoH* posed. Case managers had missed the opportunity to anticipate changes in *RoH.*

(2) A high priority had been given to victim safety in less than half of the cases in the sample (46%) and a full assessment of the safety of victims had been carried out in just over half of the relevant cases.

(3) Appropriate resources had been allocated to address the assessed *RoH* throughout the sentence in 84% of the sample.

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: ***83%***	***Comment:*** ***MINIMUM improvement required***

Strengths:

(1) Partner agencies provided a range of interventions which were aimed at reducing the LoR. Substance misuse, ETE and accommodation being most commonly noted. The education worker had made effective links with mainstream and alternative education provision and had facilitated children and young people's return to education. Case managers also supported young people to access Connexions, utilising three-way meetings and introductions. We also noted a number of cases where the accommodation worker had maintained good contact with housing providers, to ensure effective placements and support to manage risks and behaviour.

(2) Interventions had been delivered in line with the intervention plan in 81% of cases and, in the main, were appropriately sequenced.

(3) The majority of interventions had been designed to reduce the LoR, with staff able to utilise a range of methods, including bought packages and work devised by case managers.

(4) There was evidence of a range of reparative opportunities, including work to address issues, within residential children's homes.

(5) Although not always formally assessed, case managers had adapted work to meet the learning style of children and young people in 86% of the cases. We evidenced some good individual examples of sensitive work to meet some diversity needs, although issues of how race and ethnicity impacted on children and young people and their victims were missing in most cases where they were relevant.

(6) Appropriate resources had been allocated according to the assessed LoR in 84% of cases.

(7) It was evident from discussions with case managers and from case records that children and young people had been actively supported and motivated throughout the sentence, with case managers recognising the additional importance of this for those in secure establishments. Equally, we found that positive behaviour had been recognised and reinforced.

(8) Parents/carers had been actively engaged throughout the sentence in over 70% of custody and community cases.

Areas for improvement:

(1) There appeared to be no system to protect and maintain independent accommodation for Looked After Children, if they received a custodial sentence. In one case, this meant that suitable accommodation had been lost and, on release, the accommodation available increased their LoR and vulnerability.

(2) Interventions had been reviewed appropriately in only 57% of the cases; this had resulted in case managers assessing the impact of interventions on an ad hoc rather than systematic basis.

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: ***77%***	***Comment:*** ***MINIMUM improvement required***

Strengths:

(1) In all but one relevant custody case, there was evidence that all necessary immediate action had been taken to safeguard and protect the child or young person. This was also the case in 76% of community orders. Where action had not been taken, this tended to be because vulnerability issues had not been identified at the assessment stage.

(2) In over 80% of cases, immediate action had been taken to protect other children and young people affected.

(3) Necessary referrals to ensure Safeguarding had been made in all of the relevant custody cases and in all but four of the community cases.

(4) We found evidence of prompt joint work with other agencies to promote Safeguarding. Work to promote emotional and mental health and sexual health had been used to good effect, as were the links with the police.

(5) For children and young people who moved from custody back into the community, we evidenced some good continuity of interventions in relation to ETE, substance misuse and accommodation. This continuity had been achieved less often with children's social care services and with physical health services.

(6) Interventions in the community, promoting Safeguarding, were evident in 82% of relevant cases and incorporated into the VMP that had been produced. Performance was slightly better for custody cases.

(7) Case managers and other relevant staff had supported and promoted the well-being of the child or young person throughout the course of the sentence in 82% of custody and 79% of community cases.

(8) We found effective management oversight of Safeguarding and vulnerability needs in 88% of custody cases.

Areas for improvement:

(1) Joint work between the YOS and services for children and young people had been effective in 67% of cases. For custody cases, we evidenced effective joint working in only two of the nine cases where we judged it should have occurred.

(2) Reviews of interventions to support Safeguarding had taken place in half of the community cases and in 71% of custody cases.

(3) Effective management oversight had occurred in less than half of the community cases.

OVERALL SCORE for quality of Delivery and Review of Interventions work: 77%

COMMENTARY on Delivery and Review of Interventions as a whole:

Performance in delivery and review of interventions was higher than in assessment and planning. We noted that case managers were undertaking work which did not specifically feature on the plan. The joint work between case managers and other agencies remained a generally positive feature. The planned increase in management capacity should enable all staff to develop the quality of the written plans to accurately reflect the actual work undertaken. A lack of formal reviewing of interventions for RoH, LoR and for Safeguarding made it difficult at times for staff to track progress and identify what worked with children and young people.

3. OUTCOMES

3.1 Achievement of outcomes:	
General Criterion: *Outcomes are achieved in relation to RoH, LoR and Safeguarding.*	
Score: ***64%***	***Comment:*** ***MODERATE improvement required***

Strengths:

(1) Enforcement action was taken sufficiently well in 75% of cases where it had been needed.

(2) We looked for evidence to see if the public had been better protected through successful management of *RoH*, and expected that all reasonable steps had been taken in the case. In Plymouth YOS we found that *RoH* had been effectively managed in 76% of cases.

(3) There had been an overall reduction in the Asset score in exactly half of the cases in the sample. The factors that had reduced the most were ETE, neighbourhood, living arrangements and thinking and behaviour.

(4) Reductions in factors linked to Safeguarding were evident in two-thirds of relevant cases.

(5) In 84% of the sample, all reasonable action had been taken to keep the child or young person safe.

Areas for improvement:

(1) Factors linked to offending that had reduced the least included: perception of self and others (25%); emotional and mental health (38%); motivation to change (44%); and attitudes to offending (46%).

(2) In 16 of the 38 cases the child or young person had not fully complied with the requirements of the sentence.

3.2 Sustaining outcomes:	
General Criterion: *Outcomes are sustained in relation to RoH, LoR and Safeguarding.*	
Score: ***85%***	***Comment:*** ***MINIMUM improvement required***

Strengths:

(1) We evidenced that full attention had been given to community integration issues in 84% of community orders and 82% of custody cases.

(2) In 91% of custody cases, there had been plans in place, or action taken, to ensure that positive outcomes achieved were sustained. This also applied to 84% of community orders.

Area for improvement:

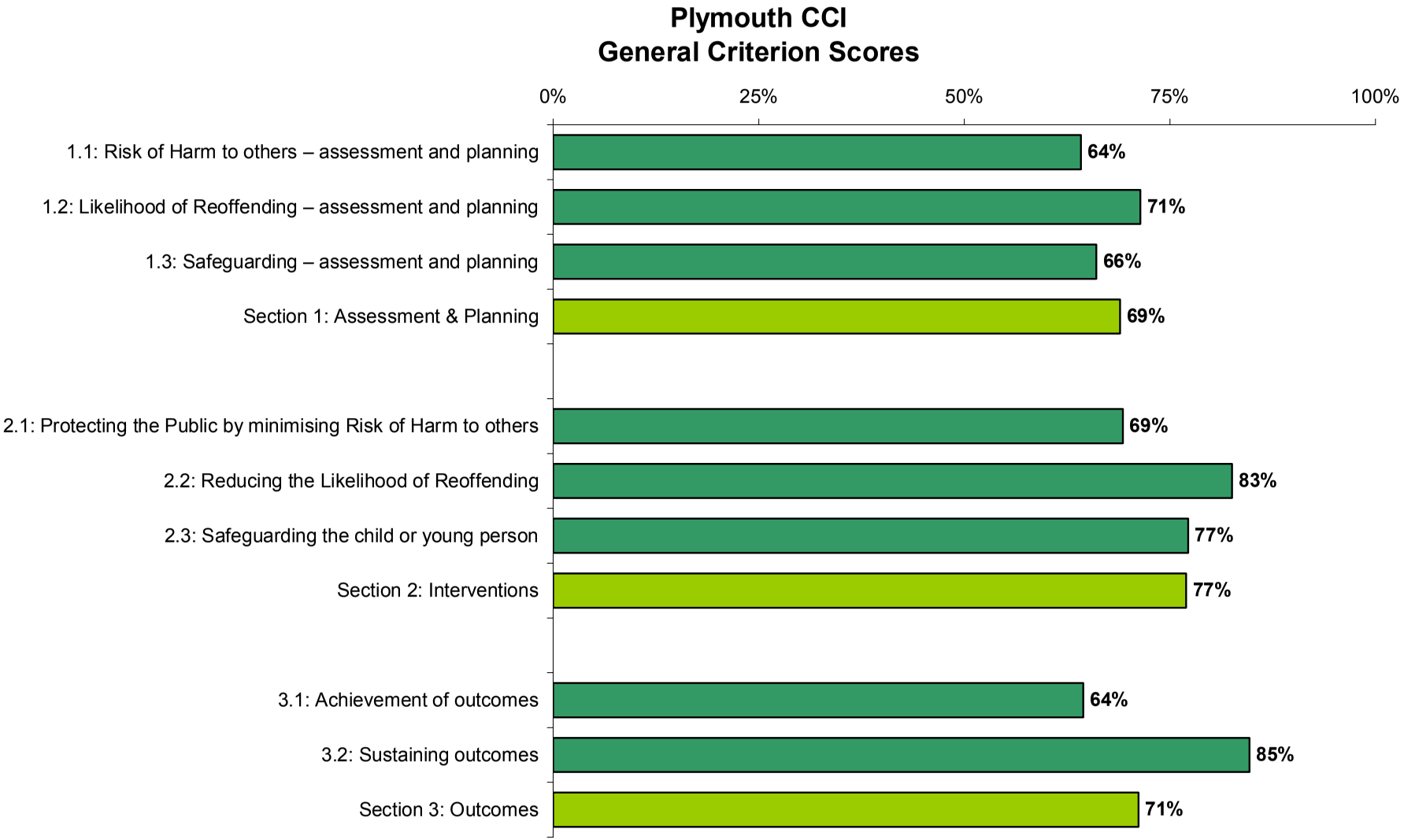
(1) The lack of joint work with services for children and young people undermined the potential for outcomes to be sustained for Looked After Children.

OVERALL SCORE for quality of Outcomes work: 71%

COMMENTARY on Outcomes as a whole:

Plymouth YOS needed to develop systems to identify and then plan for the specific outcomes they want their children and young people to achieve. They were not alone in this and faced similar challenges to other YOSs. By increasing the number of reviews held, this should result in more reliable information being available to managers.

Appendix 1: Summary



Appendix 2: Contextual information

Area

Plymouth YOS was located in the South-West region of England.

The area had a population of 240,720 as measured in the Census 2001, 10.5% of which were aged 10 to 17 years old. This was slightly higher than the average for England/Wales, which was 10.4%.

The population of Plymouth was predominantly white British (98.4%). The population with a black and minority ethnic heritage (1.6%) was below the average for England/Wales of 8.7%.

Reported offences for which children and young people aged 10 to 17 years old received a pre-court disposal or a court disposal in 2008/2009, at 43 per 1,000, were below the average for England/Wales of 46.

YOS

The YOS boundaries were within those of the Devon and Cornwall police and probation areas. The Plymouth Primary Care Trust covered the area.

The YOS was located within the Services for Children and Young People. It was managed by the YOS Management Board partnership.

The YOS Management Board was chaired by the Assistant Director of Services for Children and Young People. All statutory partners attended regularly.

The YOS headquarters was in the city of Plymouth. The operational work of the YOS was based in a variety of community-based locations. The Intensive Supervision and Surveillance Programme was provided by the YOS.

YJB Performance Data

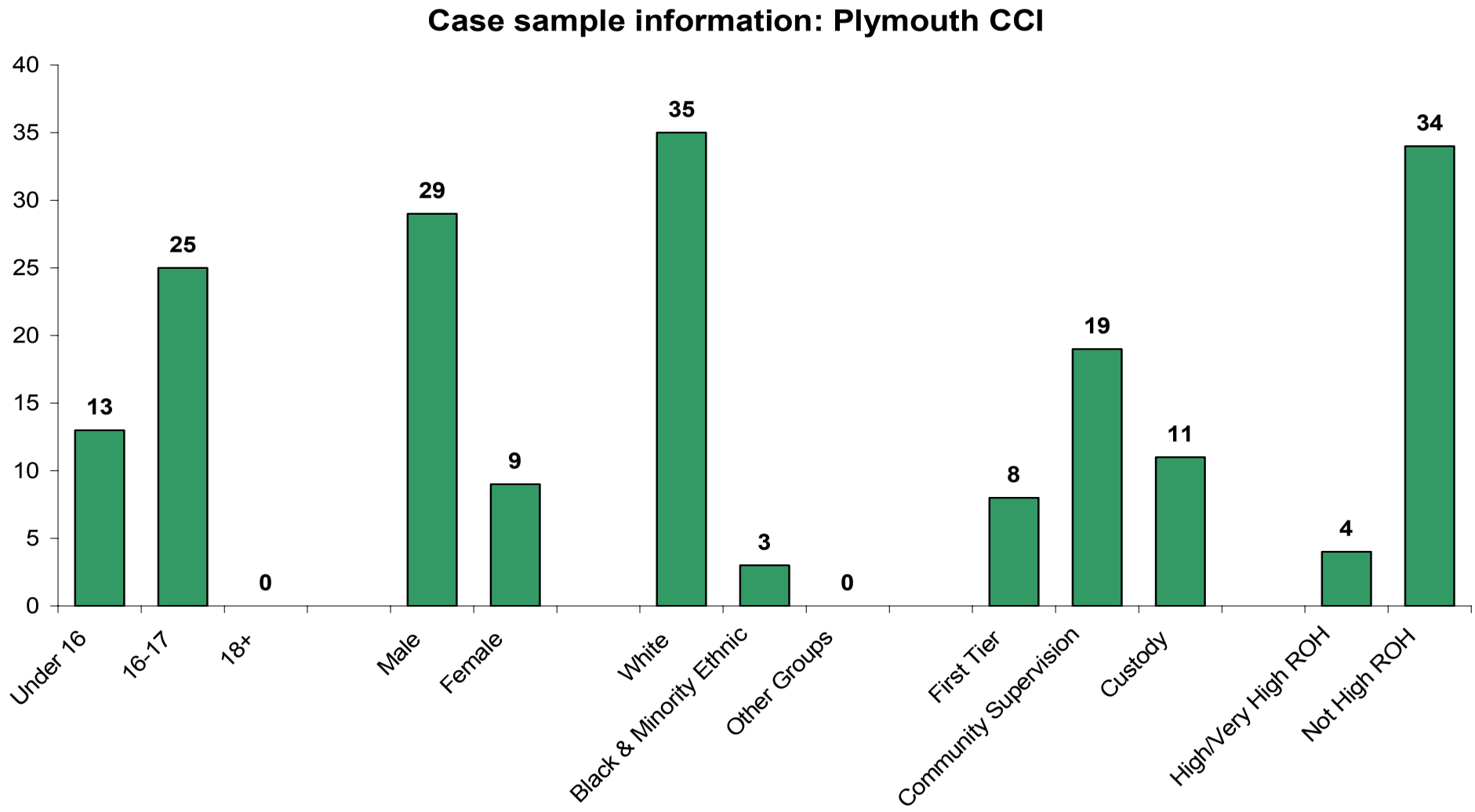
The YJB summary of national indicators available at the time of the inspection was for the period April 2008 to March 2009.

Plymouth's performance on ensuring children and young people known to the YOS were in suitable education, training or employment was 64.8%. This was an improvement on the previous year, but below the England average of 72.4%.

Performance on ensuring suitable accommodation by the end of the sentence was 96.8%. This was an improvement on the previous year and better than the England average of 95.3%.

The "Reoffending rate after 9 months" was 103%, worse than the England average of 85% (see Glossary).

Appendix 3a: Inspection data chart



Appendix 3b: Inspection data

Fieldwork for this inspection was undertaken in December 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
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*
Safeguarding	The ability to demonstrate that all reasonable action has been taken to keep to a minimum the risk of a child or young person coming to harm
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