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

Reinspection report on youth offending work in:

Bournemouth and Poole

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Foreword

This Core Case Reinspection of youth offending work in Bournemouth and Poole 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.

We judged that the Safeguarding aspects of the work were done well enough 36% 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 36% of the time, and the work to make each individual less likely to reoffend was done well enough 45% 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 Wales and the regions of England inspected so far – see the Table below.

Overall, we consider this a very disappointing set of findings. At the time of the previous inspection, published in 2010, the Management Board was already aware of the poor performance of the YOT and, whilst attempts had been made to bolster operational management, a permanent YOT manager was not appointed until August 2010. Subsequently, a number of training events took place including Assessment, Planning, Interventions, Supervision, Safeguarding and risk management. The learning from these is unfortunately not reflected in the inspection of the initial assessments and plans, as the commencement dates of the case sample pre-date the training. Discussion with case managers indicated that recent practice is different however, and some improvement in later assessments and plans was seen. Disappointingly, at the time of the reinspection, there was still no full, permanent management team in place. This needed to be resolved as a matter of urgency to support both the staff and the YOT Manager to take forward the necessary improvements in service delivery to children and young people, their parents/carers and the public. We repeat the recommendations made in the previous inspection report and we will reinspect in 12 months.

Andrew Bridges
HM Chief Inspector of Probation

June 2011

	Scores from Wales and the English regions that have been inspected to date			***Scores for Bournemouth and Poole*** *(previous inspection)*
	Lowest	**Highest**	**Average**	
'Safeguarding' work *(action to protect the young person)*	*37%*	*91%*	*68%*	***36%*** *(46%)*
***'Risk of Harm to others'* work** *(action to protect the public)*	*36%*	*85%*	*63%*	***36%*** *(43%)*
'Likelihood of Reoffending' work *(individual less likely to reoffend)*	*43%*	*87%*	*70%*	***45%*** *(55%)*

Acknowledgements

We would like to thank all the staff from the Youth Offending Team, 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. *(Previous inspection results).*

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:***
36% *(46%)*	***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:***
36% *(43%)*	***DRASTIC 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:***
45% *(55%)*	***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. Overall our inspection findings provide the 'best available' means of measuring, for example, how often each individual's *Risk of Harm to others* is being kept to a minimum. It is never possible to eliminate completely Risk of Harm to the public, and a catastrophic event can happen anywhere at any time – nevertheless a 'high' *RoH* score in one inspected location indicates that it is less likely to happen there than in a location where there has been a 'low' *RoH* inspection score. In particular, a high *RoH* score indicates that usually practitioners are 'doing all they reasonably can' to minimise such risks to the public, in our judgement, even though there can never be a guarantee of success in every single case.

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 (YOT Manager)

(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 (YOT 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 from harm, to make them less likely to reoffend, and to minimise any identified *Risk of Harm to others* (YOT 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 (YOT Manager)

(5) there is evidence in the file of regular and effective quality assurance by management as appropriate to the individual case with specific emphasis on the assessment and management of vulnerability and *Risk of Harm to others* (YOT Manager).

Furthermore:

(6) action to implement the recommendations is taken without delay to improve services to children and young people and progress is rigorously monitored (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.

We will reinspect in approximately 12 months time, given our particular concerns about *Risk of Harm* and *Safeguarding* work.

Sharing good practice

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

Assessment and Sentence Planning **General Criterion: 1.3**	John, a 17 year old, received a four month DTO. On release, he planned to go to live with his partner who had a one year old child. His case manager and social worker agreed that it would be better for him to go to his foster carer's address and stay there for the 10 day duration of his curfew. After this time, the plan was for him to move towards living with his partner. The agencies worked together to plan a phased move which included emotional support to the couple from psychological services. Unfortunately the relationship broke down before the plans could be implemented; however, John benefited from the emotional support.
Delivery and Review of Interventions **General Criterion: 2.2**	When David received a six month YRO, ETE was the main offending-related factor identified by him and his case manager, and it was prioritised in his intervention plan. With the help of Connexions, David identified that he was interested in a woodwork course at Poole College which he started in September 2010. Unfortunately, the breakdown of a relationship and a move to Dorset meant that he was unable to continue on the course. The case manager liaised with Connexions in Dorset and David was able to attend an equivalent course in his new local area.

Both names have been altered.

1. ASSESSMENT AND SENTENCE PLANNING

1.1 Risk of Harm to others (RoH):

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:	***Comment:***
45%	***SUBSTANTIAL improvement required***

Strength:

(1) An RoSH screening was completed in 76% of cases.

Areas for improvement:

(1) RoSH screenings were accurate in only 49% of cases and 54% were not completed on time.

(2) We judged the classification of RoSH recorded by the YOT to be incorrect in 21% of cases. Where the assessed level was incorrect, it understated the risk level in all but one case.

(3) The RoSH screening indicated the need for a full RoSH analysis in 19 cases. A full analysis was carried out in 17 cases; however, of these, eight were not completed on time and only six were assessed as being of sufficient quality. In a significant number, the risk to victims was not considered, previous behaviour was not taken into account and diversity issues were not reflected.

(4) RMPs were not completed in 40% of cases requiring them. Of those that were completed, 60% were not timely and 87% were judged to be of insufficient quality. Of the nine RMPs completed, consideration of diversity and of victim issues was missing from three, and the planned response was unclear or inadequate in four.

(5) The assessment of *RoH* did not draw adequately on all appropriate information in 36% of cases. Where there were *RoH* issues that did not meet the threshold of RoSH, these had not been recognised or acted upon in any of the relevant cases. Details of *RoH* were not appropriately communicated to all relevant staff and agencies.

(6) There had been effective management oversight of the assessment of *RoH* and the planning for risk management in less than 10% of the case sample.

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: ***42%***	***Comment:*** ***DRASTIC improvement required***

Strengths:

(1) There was an intervention plan or referral order contract in 81% of cases. Most plans did reflect sentencing purposes and the national standards for contact.

(2) Custodial plans were reviewed at appropriate intervals in four out of five cases.

Areas for improvement:

(1) In 10 cases out of the 38 we inspected, there had been no initial assessment carried out. Of those completed, under half were timely and 76% were not reviewed at appropriate intervals.

(2) The quality of the initial assessment was sufficient in only 32% of cases. The main reasons for it being insufficient were unclear and/or insufficient evidence and failure to identify diversity issues and/or offending-related factors. Learning style had not been assessed in 70% of cases.

(3) Children and young people and their parents/carers were not actively engaged in carrying out the assessment in 43% and 50% of cases respectively. In 71% of cases, information from the self-assessment questionnaire *What do YOU think?* was not taken into account.

(4) Contact with other agencies to inform the initial assessment was insufficient in a number of cases (children's social care services 39%; ETE providers 36%; emotional/mental health services 56%; and substance misuse services 81%).

(5) The timeliness of intervention plans was judged to be sufficient in less than two-thirds of cases. Half did not sufficiently address offending-related factors and the majority did not integrate RMPs, take into account Safeguarding needs or respond appropriately to diversity issues. Around half of the plans did not give clear shape to the order, focus on achievable change, set relevant goals or establish realistic timescales. None were prioritised according to the *RoH* posed. The objectives within most plans did not include appropriate Safeguarding work, were not sequenced according to offending-related need and were not sensitive to diversity issues. Less than one-third took sufficient account of victims' issues.

(6) Community intervention plans were not reviewed in 71% of cases.

(7) Children and young people and their parents/carers were insufficiently involved in the drawing up of sentence plans in most cases, as were external agencies.

(8) Custodial sentence planning was not carried out in two out of seven cases we inspected. Of the completed plans, two did not sufficiently address offending-related factors, three did not integrate RMPs and two did not take into account Safeguarding needs or diversity issues. None incorporated learning style.

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) A screening of the child or young person's vulnerability had been undertaken in 75% of cases.

(2) Of the six children and young people sentenced to custody with vulnerability issues, this was communicated effectively to the custodial institution in all cases.

Areas for improvement:

(1) The initial screening of vulnerability was undertaken on time in less than half of cases and was of a sufficient quality in only 35%.

(2) The assessment of Safeguarding needs was appropriately reviewed in just 46% of cases.

(3) We judged that there should have been a VMP in 22 cases in the sample. Only nine had a VMP and of those, four were not completed on time and only one was considered to be of sufficient standard. In five plans the planned response was unclear or inadequate, roles and responsibilities were unclear and diversity issues were not considered. VMPs did not contribute to interventions in any of the cases we saw.

(4) There had been no effective management oversight of the assessment of vulnerability issues.

OVERALL SCORE for quality of Assessment and Sentence Planning work: 42%

COMMENTARY on Assessment and Sentence Planning as a whole:

The previous inspection identified that not all staff were confident in the use of the Asset assessment tool and there remained evidence of this in the initial assessments. Whilst Assets were in place in nearly three-quarters of the cases that we inspected, a significant number had been 'cloned' (copied from a previous assessment) and some had been repeatedly 'cloned', without amendment or addition, over a period of months. Some of the cases we saw were confusing, with categories of *RoH* or vulnerability that clearly required plans but had none. Conversely, there were cases with plans in place but no Assets.

It seemed to us that there remained a lack of understanding about the point of assessment and planning and that there was tendency to merely put something on the system. For example, we saw a number of completed paper learning style questionnaires where the information was filed but had not been analysed to determine the learning style. Often, salient information in the core Asset was not recognised as being pertinent to the assessment of vulnerability or RoH. It seemed that a broad understanding of those concepts was missing. Planning, particularly for vulnerability and *RoH*, again seemed to be largely an exercise in form completion rather than action focused. Referral order contracts particularly, were repetitive, unimaginative and failed to recognise diversity, consisting mainly of standard reparation and work at the attendance centre.

The process for management oversight had clearly fallen down as there were a significant number of assessments and plans that were unsigned.

2. DELIVERY AND REVIEW OF INTERVENTIONS

2.1 Protecting the public by minimising Risk of Harm to others (RoH):	
General Criterion: *All reasonable actions have been taken to protect the public by keeping to a minimum the child or young person's RoH.*	
Score: ***34%***	***Comment:*** ***DRASTIC improvement required***

Strength:

(1) Appropriate resources to manage *RoH* were allocated throughout the sentence in 89% of cases.

Areas for improvement:

(1) *RoH* had been reviewed quarterly, in line with the requirements of national standards, in only 17% of cases. Of the 22 cases where there had been a significant change during the course of supervision, this had prompted a review in only two.

(2) Changes to *RoH* factors were anticipated, identified and acted upon in less than one-third of relevant cases.

(3) Case managers contributed effectively to multi-agency meetings in the community in only half of the cases inspected. This improved to two-thirds of custody cases.

(4) Purposeful home visits were carried out in accordance with the level *RoH* posed and Safeguarding issues in just over half of cases.

(5) There had been a full assessment of victim safety in only 5 of 21 relevant cases and high priority had been given to victim safety in only 5% of cases.

(6) Specific interventions to manage the *RoH* posed were delivered as planned in only 50% of relevant cases and reviewed following significant changes in only 7%.

(7) There had been very little effective management oversight of the management of *RoH.*

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: ***51%***	***Comment:*** ***SUBSTANTIAL improvement required***

Strengths:

(1) The YOT was appropriately involved in reviews in custody in five out of seven cases.

(2) Appropriate resources were allocated according to the assessed LoR in 74% of cases.

(3) Where custodial penalties were imposed, YOT workers actively involved parents/carers in 75% of relevant cases and supported and encouraged the child or young person in 71% of cases.

Areas for improvement:

(1) Interventions were delivered in line with the intervention plan in less than one-third of cases and were designed to reduce the LoR in just over half. In most cases they were not of good quality, appropriate to learning style or sequenced or reviewed appropriately. Diversity was not incorporated in 63% of interventions.

(2) In the community, workers from the YOT actively supported and encouraged the child or young person throughout the sentence in less than two-thirds of cases. YOT workers had not actively engaged parents/carers in 42% of community cases.

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: ***30%***	***Comment:*** ***DRASTIC improvement required***

Strength:

(1) During custodial sentences, staff had supported and promoted the well-being of the child or young person in 71% of cases.

Areas for improvement:

(1) Where action was required to Safeguard children and young people, it had not been taken in two cases in custody, nor had necessary referrals been made to other relevant agencies. In the community, action had not been taken in 9 out of 12 cases, nor had the necessary referrals been made.

(2) In the community, YOT workers and other agencies, including children's social care services, ETE, emotional/mental health services and substance misuse services had worked together to promote Safeguarding and well-being in less than half the cases inspected. It was a similar picture for those children and young people in custody, with the exception of substance misuse work which improved slightly to 60% of cases. There was very little joint work to ensure a smooth transition from custody to community.

(3) Specific interventions to promote Safeguarding in the community had been identified and delivered in just over one-third of cases. These interventions had been appropriately reviewed in only 18% of relevant cases. Of the three relevant cases in custody, only one had had specific Safeguarding interventions identified and delivered.

(4) In the community, staff had supported and promoted the well-being of the child or young person in only 49% of cases.

(5) There was very little effective management oversight of vulnerability and Safeguarding needs.

OVERALL SCORE for quality of Delivery and Review of Interventions work: 40%

COMMENTARY on Delivery and Review of Interventions as a whole:

The previous inspection identified that many interventions were delivered through the local, police run, attendance centre. Case managers often received little feedback from those actually working with the children and young people and did not integrate any learning achieved into supervision. This had not changed and case managers did not seem to consider asking for information. Interventions were standardised and paid little attention to individual need or circumstances. The programmes at the attendance centre were delivered on a rolling basis making it difficult to sequence these interventions appropriately. The quality of the content was unknown as far as we could tell, and the success of the outcomes was not monitored or measured.

Individual work with children and young people appeared to be severely hampered by the lack of suitable YOT accommodation and a significant number of contacts were carried out at home, whether or not that was suitable. We saw meetings with children and young people recorded as having taken place in their

bedrooms, in workers' cars and in the porch at the YOT. This also made enforcement of contacts less straightforward.

Finally, we saw a number of cases where children and young people had been placed in inappropriate accommodation including bed and breakfast and hostel accommodation.

3. OUTCOMES

Our inspections include findings about initial outcomes, as set out in this section. In principle, this is the key section that specifies what supervision is achieving, but in practice this is by necessity just a snapshot of what has been achieved in only the first 6-9 months of supervision, and for which the evidence is sometimes only provisional.

3.1 Achievement of outcomes:	
General Criterion: *Outcomes are achieved in relation to RoH, LoR and Safeguarding.*	
Score: ***35%***	***Comment:*** ***DRASTIC improvement required***

Areas for improvement:

(1) *RoH* had been effectively managed in 25% of relevant cases. This was mainly due to insufficient assessment and planning.

(2) Where enforcement action had been required, this had been done sufficiently well in just over half of the cases.

(3) We judged that there had been little or no progress made in relation to the identified offending-related factors in 63% of cases.

(4) There appeared to be a reduction in the frequency and seriousness of offending in only 35% and 42% of cases respectively (compared with 55% and 58% found in the previous inspection).

(5) There had been a reduction in risk factors relating to Safeguarding in only 14% of cases and we judged that Safeguarding had not been effectively managed in 71% of cases. This was mainly due to insufficient assessment and planning.

3.2 Sustaining outcomes:	
General Criterion: *Outcomes are sustained in relation to RoH, LoR and Safeguarding.*	
Score: ***32%***	***Comment:*** ***DRASTIC improvement required***

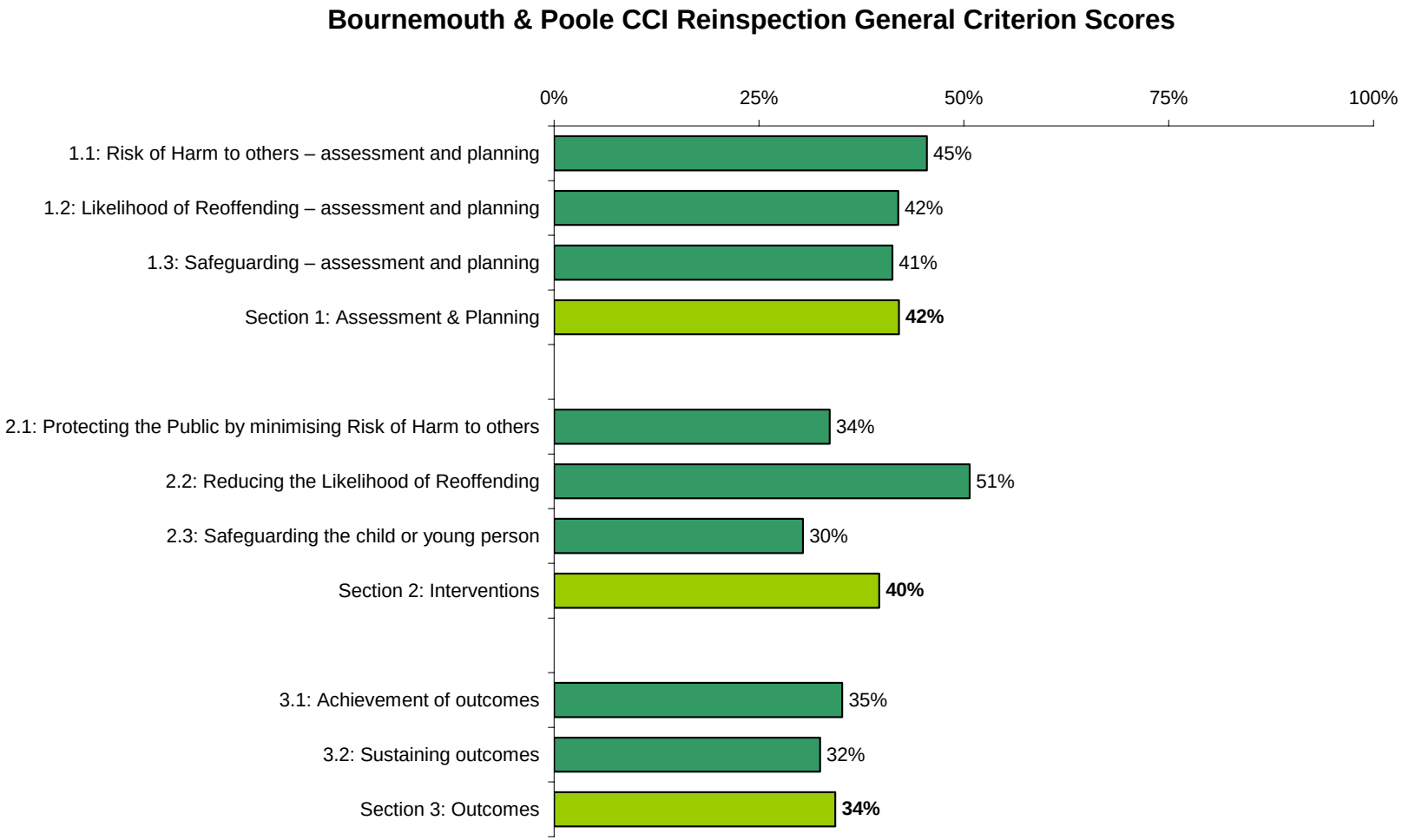
Areas for improvement:

(1) Full attention had not been paid to community integration in 61% of community cases and 71% of those in custody.

(2) Action had been taken, or plans were in place to ensure positive outcomes were sustainable in only 27% of community sentences and 17% of custodial cases.

OVERALL SCORE for quality of Outcomes work: 34%

Appendix 1: Summary



Appendix 2: Contextual information

Area

Bournemouth and Poole YOT was located in the South West region of England.

The area had a population of 163,444 (Bournemouth) and 138,288 (Poole) as measured in the Census 2001, 8.4% (Bournemouth) and 9.9% (Poole) of which were aged 10 to 17 years old. This was lower than the average for England/Wales, which was 10.4%.

The population of Bournemouth and Poole was predominantly white British (96.7% - Bournemouth and 98.2 - Poole). The population with a black and minority ethnic heritage (3.3% - Bournemouth and 1.8% - Poole) was below the average for England/Wales of 8.7%.

Reported offences for which children and young people aged 10 to 17 years received a pre-court disposal or a court disposal in 2009/2010, at 36 per 1,000, were below the average for England/Wales of 38.

YOT

The YOT boundaries were within those of the Dorset police, and the Probation Trust. It covered the two local authorities of Bournemouth and Poole.

The YOT was located within the Children's Learning and Engagement Service of Bournemouth local authority with staff employed by both authorities. The YOT Management Board was chaired by the Head of Children and Young People, Social Care, Poole. The YOT was based and delivered operations in Kinson, a suburb of Bournemouth. ISS was provided directly by a small team in the YOT.

Youth Justice Outcome Indicators 2011/2012 onwards (to replace YJB National Indicator Performance Judgements)

The national youth justice indicators for England have been replaced by three outcome indicators. These indicators will also be used in Wales.

1. The reoffending measure is a count of the number of 10 to 17 year olds who reoffend within 12 months of their conviction.

2. The first time entrants measure counts the number of young people given their first pre-court or court disposal and thus entering the youth justice system within each year.

3. The use of custody for young people aged 10 to 17 years.

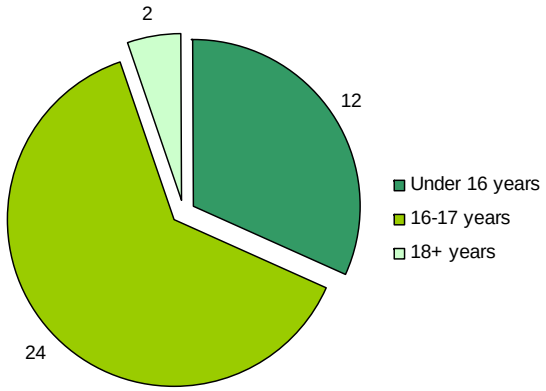
Data will be made available progressively through 2011, broken down by Local Authority area.

For further information about the YJB and the performance management of YOTs, please refer to:

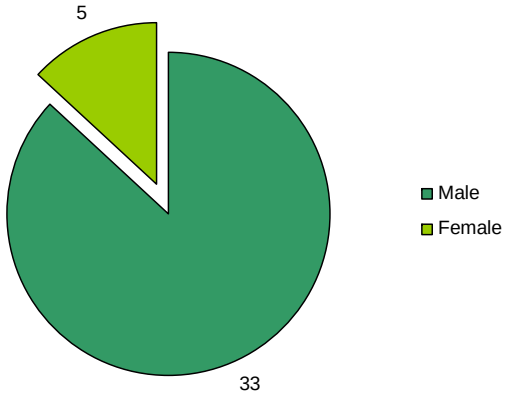
http://www.yjb.gov.uk/en-gb/practitioners/Monitoringperformance/

Appendix 3a: Inspection data chart

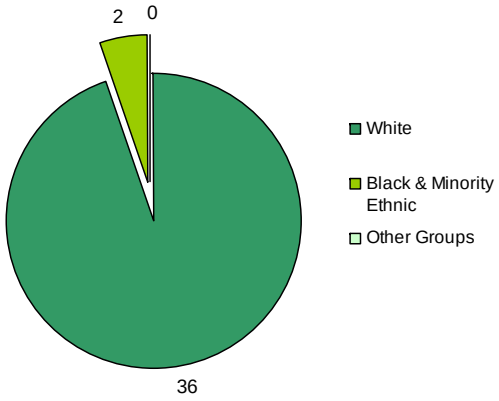
Case Sample: Age at start of Sentence



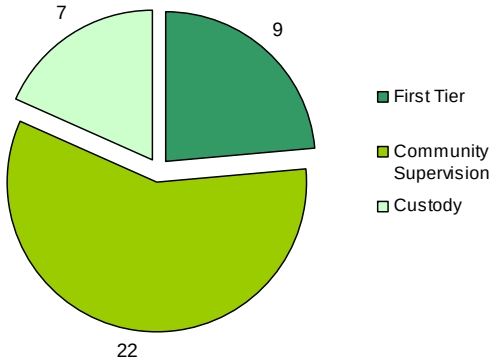
Case Sample: Gender



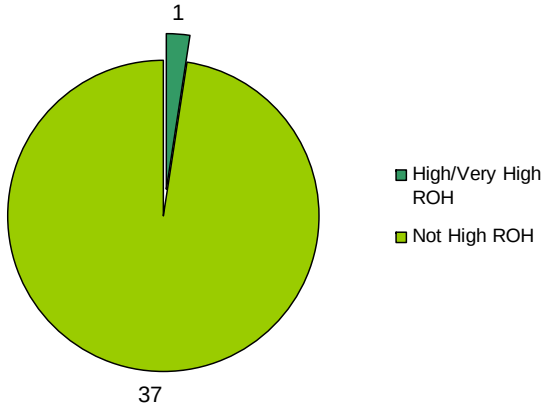
Case Sample: Ethnicity



Case Sample: Sentence Type



Case Sample: Risk of Harm



Appendix 3b: Inspection data

Fieldwork for this reinspection was undertaken in February 2011

The inspection consisted of:

- examination of practice in a sample of cases, normally in conjunction with the case manager or other representative.

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

Appendix 4: Role of HMI Probation and Code of Practice

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

http://www.justice.gov.uk/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
APIS	Assessment, Planning, Intervention, Supervision
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
ISS	Intensive Surveillance and Supervision: 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
ISSP	Intensive Supervision and Surveillance Programme: following the implementation of the Youth Rehabilitation Order this has been supervised by ISS
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
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