HM Inspectorate of Probation
Arolygiaeth Prawf EM

Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

Full Joint Inspection of Youth Offending Work in **Croydon**

An inspection led by HMI Probation

independent inspection of youth offending work

July 2013

Foreword

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

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

We chose to inspect in Croydon primarily because of performance against the National Youth Justice Reoffending Outcome Indicator and the results of our Core Case Inspection in December 2011.

Successful diversion through triage of those children and young people with more minor offences has resulted in Croydon Youth Offending Service working with a small group of children and young people with entrenched patterns of offending behaviour. Work with these children and young people and their parents/carers, both in terms of engagement and the delivery of interventions, was good and we saw case managers who were committed to the individual's interests and ensured that, wherever possible, they completed their sentence successfully.

We did, however, identify shortfalls in practice, particularly in the assessment and management of both vulnerability and the risk of harm posed by children and young people to other people. These issues had been identified in previous inspections, but the Youth Crime Prevention and Youth Offending Service Management Board had not held the team to account for implementing the recommendations and performance had continued to be unsatisfactory.

The recommendations made in this report are intended to assist Croydon in its continuing improvement by focusing on specific key areas. We strongly advise that both the Youth Offending Service and the Youth Crime Prevention and Youth Offending Service Management Board take full note of their intent and work together in taking these recommendations forward.

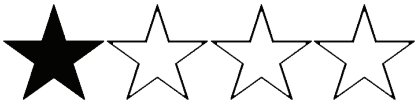
Liz Calderbank
HM Chief Inspector of Probation

July 2013

Summary

Reducing the likelihood of reoffending 

Overall, work to reduce reoffending was unsatisfactory. Case managers at Croydon Youth Offending Service (YOS) were carrying high caseloads often exhibiting complex needs and involving both vulnerability and a risk of harm to others. Pre-sentence report writing was strong. The range of support provided, together with the quality of the work carried out with most children and young people and their parents/carers was good. Deficiencies in some assessments and planning, however, meant that the work was not always focused on the areas of most need. As reviews did not pick up the earlier omissions, the work was not as useful in tackling the causes of offending behaviour as it should have been. This was particularly evident in custodial cases which were delivered in a fragmented way that did not promote continual progress. With the exception of education, training and employment outcomes, not enough progress had been made in too many cases.

Protecting the public 

Overall, work to protect the public and actual or potential victims was poor. Only half of the work to manage the risk of harm posed and to protect other people was carried out satisfactorily. In too many cases there were deficiencies in assessment and planning which carried through to the work undertaken. In these cases there was a concentration on process i.e. getting the forms completed, and an apparent lack of understanding of the purpose of the work. Previous convictions and behaviour were often either ignored or not seen as relevant. Little attention was given to the victim or sometimes they were not even identified. Categorisation was seen as 'the answer' – 'he is high risk'. This made planning more difficult than it needed to be as there had been no identification of what might happen, to whom and in what circumstances. Hence a plan was not focused on actions to protect or to prevent harm. In these circumstances, it is unsurprising that the work carried out to manage the risk of harm posed to others was not good enough in too many cases.

Protecting children and young people 

Overall, work to protect children and young people and reduce their vulnerability was unsatisfactory. Just over half of the work to manage vulnerability was carried out satisfactorily. In too many cases, yet again, there were deficiencies in assessment and planning that carried through to the work undertaken. In these cases there was often a failure to recognise factors that might make a child or young person vulnerable, particularly where they were moving around or living with adults who were not their parents. There was again a concentration on process, i.e. getting the forms completed, and an apparent lack of understanding of the point of the work. Emotional/mental health and substance misuse was not always addressed and physical health needs were not routinely recognised or identified. Police work to identify those at risk of sexual exploitation was good but case managers were not using police intelligence to help identify broader vulnerability issues. Management oversight of the work to manage vulnerability was judged to be ineffective due to the failure to identify the deficiencies in assessment and planning.

Ensuring the sentence is served 

Overall, work to ensure that the sentence was served was good. Throughout the course of the order, starting at the assessment and pre-sentence report stages, the engagement by case managers with children and young people and their parents/carers was good in most cases. Specific individual needs were recognised and difficulties identified to promote the successful completion of the sentence. Case managers were committed to the interests of the children and young people they were working with and paid attention to their well-being. As part of that engagement, case managers generally recognised when enforcement was necessary and carried it out.

Governance 

Overall, governance was not effective. The Head of YOS was an active member of the Youth Crime Prevention and YOS Management Board and was well connected to other partnership forums. The Board was cooperative, focused on problem solving and aimed at translating the strategic direction into operational delivery. It had been established in its current format for 18 months and there were many examples of successful partnership work promoted through the Board.

The challenge and support to the YOS, an essential component of a Management Board, had not been as effective as it needed to be however. As a result, the YOS had not successfully implemented the recommendations from previous inspections and performance had continued to be unsatisfactory in some key areas including safeguarding. Members acknowledged that the Board was still developing and that there were improvements to be made.

Recommendations

Post-inspection improvement work should focus particularly on the following:

1. Initial assessments and their reviews are completed to a sufficient quality with particular reference to risk of harm and vulnerability (Head of YOS).
2. Sentence plans are meaningful to children and young people and their parents/carers, drive the delivery of appropriate interventions and are reviewed when necessary (Head of YOS).
3. There is active planning to protect actual and potential victims and children and young people themselves (Head of YOS).
4. Quality assurance arrangements, including management oversight, ensure that assessments and plans, and their reviews, are adequate and inform the delivery of interventions (Head of YOS).
5. All those involved with a case work together and share information throughout the sentence, in a way that makes sense to the child or young person and their parents/carers (Head of YOS).
6. The work of the YOS, in particular the management of vulnerable children and young people and those who pose a risk of harm to others, is fully supported and challenged by the Management Board (Chair of the Youth Crime Prevention and YOS Management Board).
7. Data on appropriate local outcome measures, including health, education, training and employment and safeguarding, are received, scrutinised by the Management Board and used to improve services to children and young people and their parents/carers (Chair of the Youth Crime Prevention and YOS Management Board).
8. The recommendations of the inspection are fully and successfully implemented (Chair of the Youth Crime Prevention and YOS Management Board).

Contents

Foreword 1

Summary 2

Recommendations 3

Theme 1: Reducing the likelihood of reoffending 6

Theme 2: Protecting the Public 13

Theme 3: Protecting the child or young person 18

Theme 4: Ensuring that the sentence is served 23

Theme 5: Governance 27

Appendix 1 Contextual information about the area inspected 31

Appendix 2 Contextual information about the inspected case sample 32

Appendix 3 Acknowledgements 32

Appendix 4 Inspection arrangements 33

Appendix 5 Scoring approach 34

Appendix 6 Criteria 35

Appendix 8 Glossary 36

Appendix 8 Role of HMI Probation and Code of Practice 38

Reducing the likelihood of reoffending

1

Theme 1: Reducing the likelihood of reoffending

What we expect to see

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

Case assessment score

Within the case assessment, overall 55% of work to reduce reoffending was done well enough.

Key Findings

1. Assessments were not always based on good enough information and had sometimes been copied without updating. Reviews did not always pick up missing information or recognise relevant changes.
2. Pre-sentence reports (PSRs) were generally of a good quality.
3. Planning did not consistently include all the areas that needed to be addressed. In particular, substance misuse and health were often missing. Again, this was not always remedied at the review stage.
4. Work to address offending behaviour was largely of good quality. Children and young people and their parents/carers were positive about the help they received.
5. Custodial sentences were not delivered as a single, integrated sentence.
6. Progress had been made in education, training and employment (ETE) outcomes in most cases.

Explanation of findings

1. Assessment

1.1. The assessment of what was causing children and young people to offend was not considered good enough in over one-third of the cases we inspected. This was largely due to unclear or insufficient information. In a small number of cases the assessment was a copy of a previous one with little or no update and, separately, there were several where previous assessments or information from other agencies had not been taken into account. Learning styles and basic literacy were not routinely assessed.

1.2. Emotional and mental health had not been assessed well enough in one-third of cases. Case managers were supported by health specialists through screening tools to identify appropriate referrals; however, overall the health needs of children and young people were not consistently identified.

1.3. The majority of PSRs were considered to be of good quality. Where this was not the case it was mainly due to the lack of good quality assessment of the risk of harm posed to others.

1.4. Reviews were not always carried out when required, such as on release from custody, and where they were, they were not considered satisfactory in nearly half of cases. In 13 cases, reviews were copies of previous assessments without update.

2. Planning for interventions

2.1. We considered that the planning was not good enough in over half of the cases we inspected. In particular, work to address physical and mental health, substance misuse and care arrangements was missing. Although young people understood their orders, they and their parents/carers knew little about the planning. Of those whom we interviewed, there was a general lack of understanding amongst children and young people and parents/carers of what was involved in their plans.

2.2. Additionally, intervention plans were not always reviewed as appropriate and where they were, the quality of the review was often not adequate.

Comments from children or young people about planning

One young person (who had just a few weeks left on his order) commented:

"I think there is one, but I haven't seen it yet. I think I'm due to go over it with my case manager next week. I don't know really".

Another, referring to a planning meeting, told us:

"There is me, my mum, my case worker and two people I don't know. Not sure who they are or why they're there, but it's always same two".

2.3. Those working with the Child and Adolescent Mental Health Service (CAMHS), substance misuse workers and/or the speech and language therapist had good care plans. These were shared with children and young people, their parents/carers and other professionals and jointly reviewed as needs and risks evolved. They were used to help inform others of the best way to work, for example communication methods.

3. Delivery of interventions

3.1. There was a range of interventions and support delivered by case managers and specialist workers. Children and young people and parents/carers spoke positively about the work that had been carried out by various teams and workers.

3.2. Where interventions were delivered they were largely of good quality, delivered as their design intended and sufficient attention was paid to reinforcing positive factors. In nearly two-thirds of cases there was an appropriate balance between addressing offending behaviour, managing the risk of harm posed to others and the vulnerability of the child or young person.

3.3. In over one-third of cases delivered, interventions were not consistent with the assessment or plan. This was mainly because although planned, the interventions had not been carried out. In cases where we judged there was a need for input to address emotional and mental health and substance misuse, it had not been carried out in nearly two-thirds. Work to change attitudes to offending, thinking and behaviour and to improve motivation had only been delivered in around half of the cases and restorative justice featured in only 8 out of 27 relevant cases.

3.4. Custodial work needs to be delivered as an integrated package so that the child or young person knows from the outset what will happen on release and can work towards that being successful. We judged that custodial sentences were not delivered as a single integrated sentence in all but 3 out of 16 cases. In 11 cases the custodial plan did not provide a clear plan for the whole of the sentence and in six there was insufficient link between the work carried out in custody and in the community

3.5. Through CAMHS, there was good and timely access to dedicated mental health professionals (a forensic psychologist and a psychiatric nurse) for those who were assessed as having a clinical mental health need (Tier 3 & 4 provision). For those who did not reach that threshold, the YOS was able to refer into universal health services.

Comments from children or young people and parents/carers about interventions

Healthy Living Project

One young person commented:

"It keeps me off the roads, keeps me out of trouble. It's not just art, it's people to look up to. They work and run a business and stuff. It keeps me busy. If I weren't here I'd be getting into trouble but instead it's made me want to work".

Gangs work

A young person told us:

"He was young like us, he knows. We looked at gang-related crime and the sorts of sentences people got and how much more trouble you got into if you're in a gang. And we looked at how to avoid situations of gang-related crime by, like, what to do, say if a rival gang member gets on the same bus as you. You get off, walk away don't you, avoid the confrontation. In the past I wouldn't have, but now I'm just right away from all that".

Parenting work

One parent said that she would have *"collapsed without their support"*, while another referred to the worker as her *"rock"*.

Another parent commented:

"I couldn't have done this without them. They would look into any queries I might have. They come to see me. I can sit and unwind and don't feel silly. We have built up a rapport and if I have problem I tell them everything. They are my problem solver, they work with other areas, bring in information I wouldn't have thought of".

Bridging Project

A parent told us:

"He tries to get other people to have him as the middle man so he can chase my son up, ring him and remind him he has appointments. I can't say enough about them, I have wanted to give up on my son, but they have just kept going".

A young person commented:

"He takes me to my appointments and waits downstairs for me. I wouldn't go if he didn't take me. I just wouldn't bother. I had to leave my course but he's helping me. He's trying to get me back on it and trying to get me an apprenticeship so I can get a job. He hasn't given up".

3.6. There was effective partnership working between health professionals, CAMHS, a speech and language therapist, substance misuse workers and case managers. Where needs had been assessed appropriately, a range of individualised interventions was delivered in both clinical and community venues chosen by the child or young person (school, home or council buildings including the YOS). The introduction of complementary therapies (hypnotherapy, acupuncture and the use of a massage chair) had been well received by children and young people and promoted engagement and attendance.

Comment from parents/carers about sharing information

"Sometimes we missed or were late for appointments as we were given the wrong information about times. It kept being changed. It was just a mis-communication though, as there were lots of different people involved".

"He had been working with the NSPCC and CAMHS before he was arrested but when NSPCC stopped their involvement and he was transferred to the YOS, the counselling wasn't continued but I don't know why".

3.7. All of the cases we inspected were complex. Most children and young people had more than one agency or specialist working with the case manager. This made the sharing of information essential, both between professionals and with the child or young person and their parent/carer. It was not always evident that this was happening or, where it was, that it was timely. One result of this was that referrals were sometimes duplicated by case managers and specialist workers or that one worker was unaware that a referral had been made by the other.

4. Initial outcomes

4.1. At the point of inspection we judged that progress had been made in ETE in most cases. In all other areas of offending-related need; however, there had been insufficient progress made in around half of the cases. Reductions in seriousness and frequency of offending were seen in less than half.

4.2. In over one-third of cases there had been inadequate attention paid to maintaining positive outcomes. In particular, exit strategies (i.e. what support will be available when the child or young person finishes their court order) were not always considered.

Case illustration

The work of the YOS and the relationship fostered with his mentor helped Ken, a 17 year old who had received a custodial sentence, to make significant progress following his release. The intensive mentoring had included home visits and encouraged him to undertake offending behaviour work, attend ETE provision and disassociate from a previous peer group. Following his release from custody Ken had not reoffended, had ceased his cannabis use and rebuilt his family relationships.

5. Leadership, management and partnership

5.1. We found that case managers generally understood the principles of effective practice.

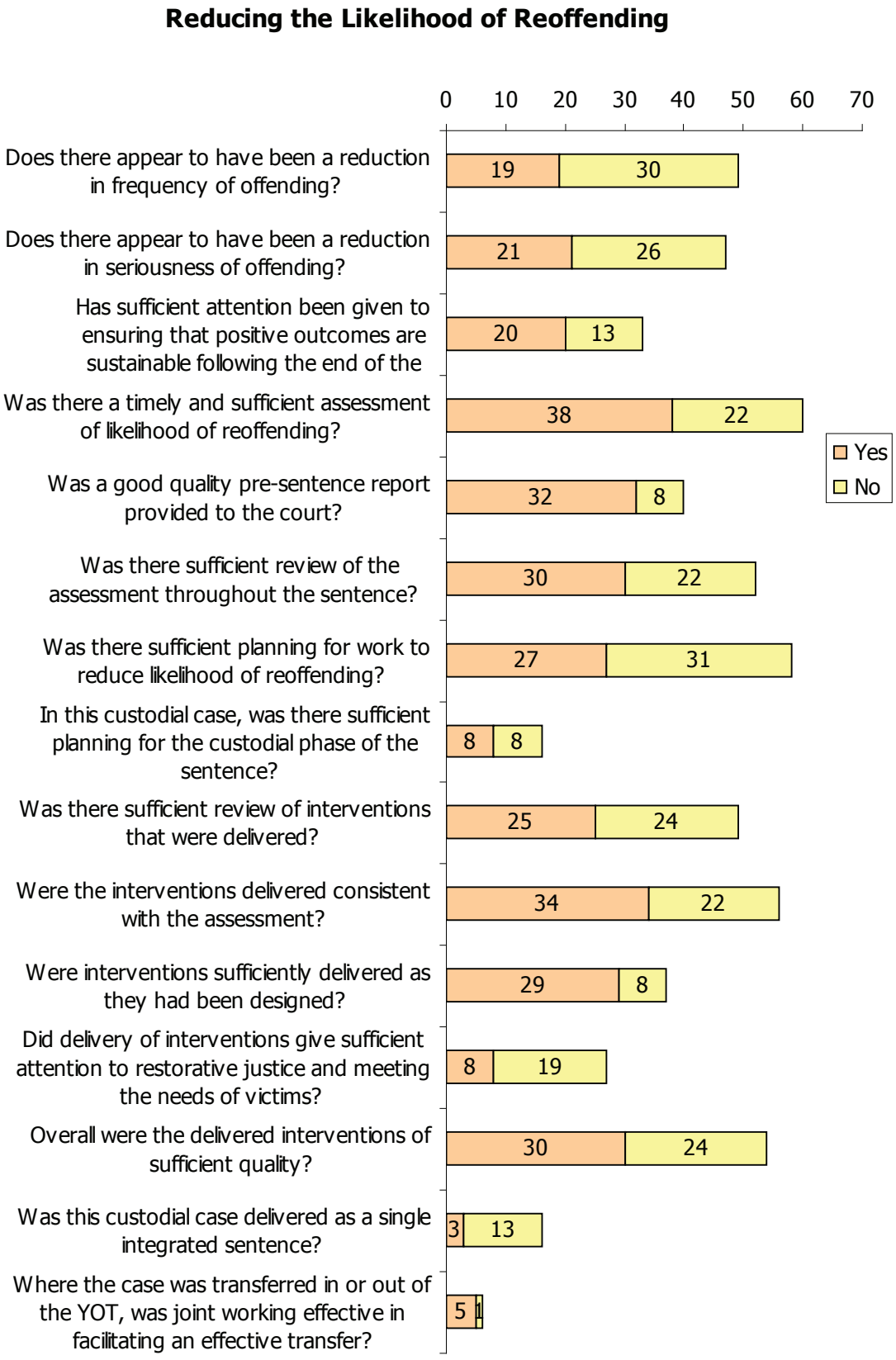
5.2. The procedures for management oversight of initial assessment and planning had not picked up the missing sources of information or the gaps in planning.

Summary

Overall, work to reduce reoffending was unsatisfactory. Case managers at Croydon YOS were carrying high caseloads often exhibiting complex needs and involving both vulnerability and a risk of harm to others. PSR writing was strong. The range of support provided, together with the quality of the work carried out with most children and young people and their parents/carers was good. Deficiencies in some assessments and planning, however, meant that the work was not always focused on the areas of most need. As reviews did not pick up the earlier omissions, the work was not as useful in tackling the causes of offending behaviour as it should have been. This was particularly evident in custodial cases which were delivered in a fragmented way that did not promote continual progress. With the exception of ETE outcomes, not enough progress had been made in too many cases.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 62 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Protecting the Public

2

Theme 2: Protecting the Public

What we expect to see

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

Case assessment score

Within the case assessment, overall 49% of work to protect the public was done well enough.

Key Findings

1. In just under half of the cases we inspected the assessment of the risk of harm posed was judged to be good enough and planning was considered satisfactory in a similar proportion.
2. The assessment of the risk of harm posed to others and the subsequent reviews were not carried out well enough in too many cases. Consideration of actual or potential victims had not always taken place.
3. In over half of the cases inspected, planning to protect others was not active or robust.
4. Unsurprisingly, the work to manage the risk of harm posed to others was not satisfactory in over half of the cases and, of particular concern, there was an absence of interventions to protect victims.
5. The management oversight of work to manage the risk of harm posed was judged to be largely ineffective. This was due to the deficiencies in assessment and planning not being picked up.

Explanation of findings

1. Assessment

1.1. Assessing the risk of harm posed to others was not carried out well enough in over half of the cases we inspected. A significant deficit was the lack of consideration of actual and potential victims, even where there had been repeat offences against the same victim. Previous offences and relevant behaviour had also been ignored in some assessments. Of more concern was that case managers did not always recognise risk factors such as behaviour in the home or victims living in the same vicinity or attending the same school.

1.2. There was too much reliance on the questions within the Risk of Serious Harm (RoSH) form. The labelling or categorisation of risk as, for instance, high seemed to be viewed, in some cases, as an end in itself rather then an attempt to assess what the dangers might be. The assessment did not always consider or describe who might be at risk and from what. Patterns of past and present behaviour were not sufficiently analysed to allow informed consideration of what future behaviour might be.

1.3. Reviews were too often a copy of a previous assessment with little or no update; hence any initial deficits were not recognised or rectified. It was not always recognised that a change in circumstances or a significant event might increase or decrease risk.

2. Planning for interventions

2.1. This made planning to protect victims more difficult as the nature of the potential risk was unclear. Planning to manage the risk of harm posed to others was not considered to be good enough in over half of the cases. Out of 47 cases requiring a risk management plan, 17 did not have one. Of those completed, six did not identify or take into account victims' issues. Risk management planning for custodial cases showed a similar picture.

2.2. There was, again, a focus on getting the risk management plan (the form) 'done' rather than making active plans to protect actual and potential victims.

2.3. Reviews of planning were carried out in all but eight cases; however, most were judged to be unsatisfactory; a number were copies of previous plans without sufficient update.

3. Delivery of interventions

3.1. Possibly as a result of this approach to planning, in over half of the cases inspected work to manage the risk of harm posed to others was not carried out satisfactorily. Interventions identified in the planning were not always delivered and in some cases, the need to manage risk had not been recognised by case managers. Home visits, as part of risk management, had not always been carried out.

3.2. Of particular concern, but not surprising given the deficits in assessment, was the lack of effective work to protect actual or potential victims in 24 out of 37 relevant cases.

3.3. Where there were multi-agency arrangements in place to manage risk, they were judged to be effective in four out of the five relevant cases. The YOS police officers also played a key role in protecting the public and had been effectively integrated into the YOS. They identified all arrests of children and young people supervised by the YOS in the previous 24 hours and alerted case managers. They also gathered intelligence on specific cases to inform case managers. This only happened, however, when case managers were proactive in requesting information and that was inconsistent.

Case illustration

Malcolm, a 16 year old on a youth rehabilitation order (YRO) for burglary was placed in Croydon by another local authority. The Croydon case manager was proactive in asking for assessments and plans to be reviewed when significant events occurred. There was good intervention work delivered by the (Croydon) case manager, substance misuse worker and the gangs worker in a coordinated way, with a particular emphasis by all three on community integration and positive activities. Several incidents triggered the need for emergency reviews and actions and Croydon YOS was the driving force for these. There was strong management oversight; the relevant manager was involved at appropriate stages (usually to escalate matters with equivalent colleagues at a neighbouring YOT) and helped to ensure that actions were taken in response to imminent risks and needs.

There was also evidence of good joint working with the police and Multi-Agency Public Protection Arrangements (MAPPA); where information sharing was effective and when the risks both to and from the young person reached unsafe levels, he was made subject to an emergency move to protect those at risk.

4. Initial outcomes

4.1. Overall, we judged that the YOS had not done enough to manage the risk of harm posed in over half of the cases inspected. This was largely due to the shortfalls in assessment and planning.

5. Leadership, management and partnership

5.1. Case managers appeared to have an understanding of the procedures for the management of risk of harm. However, it was less clear that there was a thorough understanding of the *purpose* of risk assessment and planning or the components of risk. Of concern was the lack of recognition of behaviour that might cause harm to others and the lack of identification of potential victims.

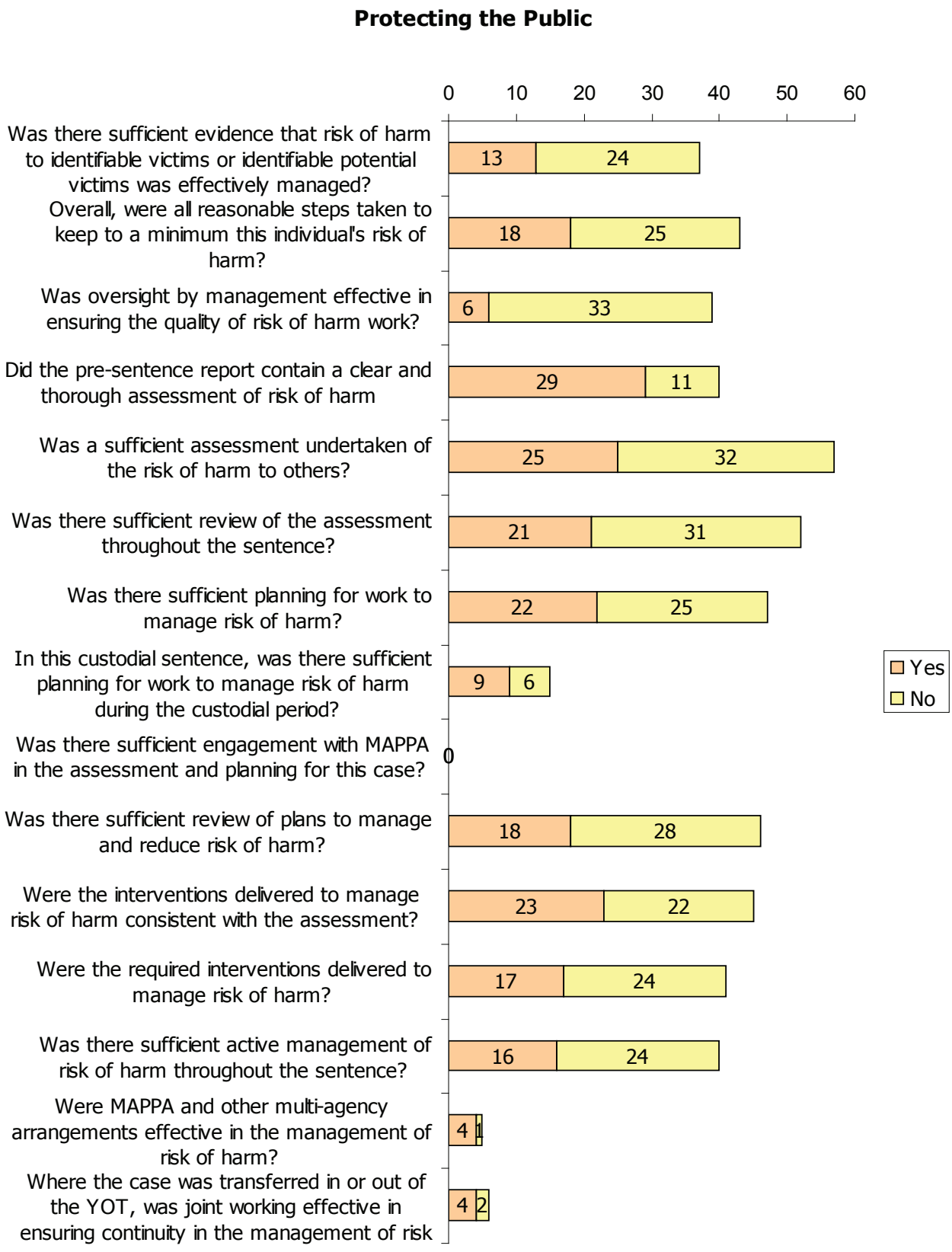
5.2. We judged that management oversight of work to manage the risk of harm to others was not effective and, again, this was mainly due to deficiencies in assessment and planning not being addressed. In some cases, managers also seemed to have failed to recognise risk factors or identify potential victims. It seemed to us that, on too many occasions, the focus on getting the processes completed had taken priority. All of these factors contributed to our concern about this area of work.

Summary

Overall, work to protect the public and actual or potential victims was poor. Only half of the work to manage the risk of harm posed and to protect other people was carried out satisfactorily. In too many cases there were deficiencies in assessment and planning which carried through to the work undertaken. In these cases there was a concentration on process i.e. getting the forms completed, and an apparent lack of understanding of the purpose of the work. Previous convictions and behaviour were often either ignored or not seen as relevant. Little attention was given to the victim or sometimes they were not even identified. Categorisation was seen as 'the answer' – 'he is high risk'. This made planning more difficult than it needed to be as there had been no identification of what might happen, to whom and in what circumstances. Hence a plan was not focused on actions to protect or to prevent harm. In these circumstances, it is unsurprising that the work carried out to manage the risk of harm posed to others was not good enough in too many cases.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 62 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Protecting the child or young person

3

Theme 3: Protecting the child or young person

What we expect to see

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

Case assessment score

Within the case assessment, overall 55% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. In over half of the cases we inspected the assessment of vulnerability was considered satisfactory.
2. Vulnerability was not always recognised, however, and the assessment of this aspect in both community and custody was considered unsatisfactory in too many cases. Where this was the case, reviews had not always remedied the situation.
3. Planning to safeguard children and young people and manage their vulnerability was not helped by this lack of recognition and we judged nearly two-thirds of vulnerability plans to be ineffective.
4. In a number of cases, the need for mental health and substance misuse work had not been recognised or carried out. Physical health needs were not consistently identified.
5. The management oversight of vulnerability was judged to be ineffective in the majority of cases due to a failure to identify the shortfalls in assessment and planning. Safeguarding practice needed to improve.
6. YOS police officers were proactive in trying to identify those at risk of sexual exploitation through the use of police intelligence.

Explanation of findings

1. Assessment

1.1. The assessment of vulnerability was not carried out well enough in just under half of the cases we inspected, in both community and custody. In some cases vulnerability had not been recognised, behaviour and its impact had been ignored or previous assessments had not been taken into account.

1.2. There was a health checklist in use but it was not known to all YOS practitioners and any physical health needs largely went unidentified and therefore unmet.

1.3. Reviews had not remedied this. A number of assessments had not been reviewed and, where they were, some were copies of previous assessments with little or no update.

1.4. Where children and young people were living with adults other than their parents, YOS workers were not sufficiently aware of the need to clarify the relationship to determine whether the adult had authority to make decisions about them. This can have significant repercussions where children and young people move around or go missing.

1.5. There was effective partnership work with missing children and young people. Meetings were convened in a timely manner and used effectively to locate them and to ensure that they returned home. 'Return' interviews were not fully utilised, however, to fully understand these episodes and aid future planning.

2. Planning for interventions

2.1. Planning to address vulnerability and safeguarding was not considered adequate in nearly two-thirds of cases. In 18 relevant cases, plans were not made to address vulnerability.

2.2. Specifically, there was insufficient attention paid to physical and mental health, substance misuse and care arrangements.

3. Delivery of interventions

3.1. In 17 out of 41 cases where plans were in place, the work to manage vulnerability did not follow the plan, nor were other interventions carried out to safeguard children and young people in over half of the cases requiring them. This was largely because the need for safeguarding work was not recognised by the case manager or line manager in some cases. In particular, there was an absence of emotional and mental health work in eight cases and substance misuse work in ten cases where it was required.

3.2. YOS workers working with Looked After Children were not routinely invited to the reviews held by children's social care services, missing the opportunity for both agencies to coordinate joint work.

3.3. The YOS police officers routinely used police intelligence to research all children and young people in the Croydon borough, who were repeatedly reported as missing from home to identify potential victims of sexual exploitation. Vulnerable cases were referred to the Safer London Partnership Empower Team (a support programme addressing young women's experiences of sexual violence and exploitation).

4. Initial outcomes

4.1. In just under half of the cases we inspected we judged that there had not been effective management of vulnerability and safeguarding and that the YOS had not done enough to keep the child or young person safe. This was largely due to deficiencies in assessment and planning.

Case illustration

Reggie was 16 when he received a six month YRO for aggravated vehicle taking. He had complex needs including mental health problems and heavy and prolonged use of drugs. He was both vulnerable and posed a risk of harm to other people. Reggie was involved with a number of agencies including CAMHS and intensive mentoring and had a high number of appointments each week aimed at managing his risk and vulnerability; some of these were voluntary. The case manager coordinated all the activities ensuring they were integrated. Compliance was managed particularly well giving thoughtful consideration to the balance between engagement and enforcement. Reggie responded well and largely complied.

5. Leadership, management and partnership

5.1. Most of the case managers we interviewed appeared to have a sound understanding of the procedures for the management of vulnerability. However, it was again less clear that there was a thorough understanding of the purpose of the work.

5.2. Case managers understood escalation processes and felt that they worked well when used; senior managers were involved where necessary. From a number of the cases that we saw, these processes needed to be used too often however.

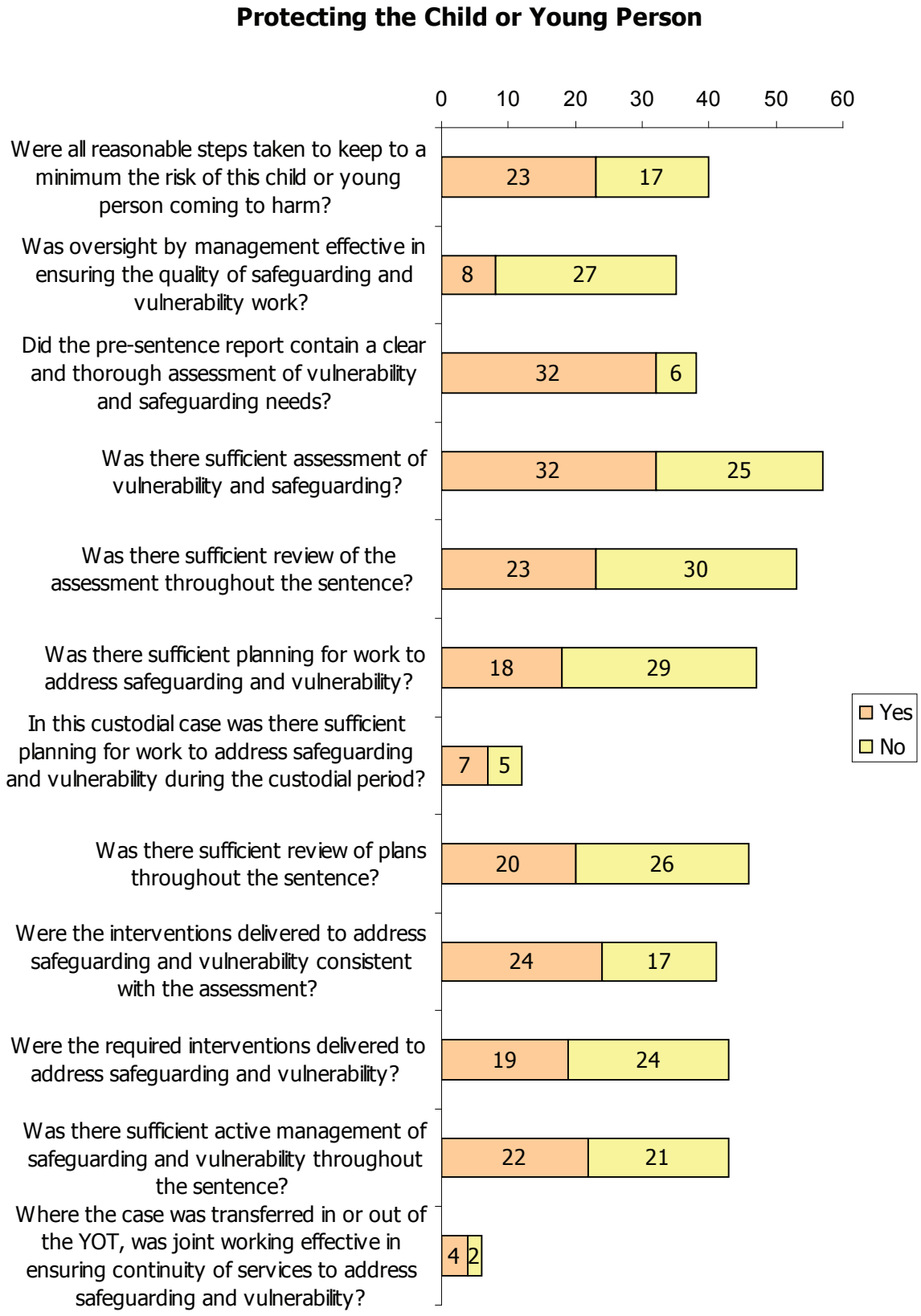
5.3. Management oversight of the work to manage vulnerability was judged to be ineffective in the majority of cases where it was necessary. There were no systems in place to scrutinise the quality of safeguarding practice or vulnerability planning within the YOS.

Summary

Overall, work to protect children and young people and reduce their vulnerability was unsatisfactory. Just over half of the work to manage vulnerability was carried out satisfactorily. In too many cases, yet again, there were deficiencies in assessment and planning that carried through to the work undertaken. In these cases there was often a failure to recognise factors that might make a child or young person vulnerable, particularly where they were moving around or living with adults who were not their parents. There was again a concentration on process, i.e. getting the forms completed, and an apparent lack of understanding of the point of the work. Emotional/mental health and substance misuse was not always addressed and physical health needs were not routinely recognised or identified. Police work to identify those at risk of sexual exploitation was good but case managers were not using police intelligence to help identify broader vulnerability issues. Management oversight of the work to manage vulnerability was judged to be ineffective due to the failure to identify the deficiencies in assessment and planning.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 62 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Ensuring that the sentence is served

4

Theme 4: Ensuring that the sentence is served

What we expect to see

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

Case assessment score

Within the case assessment, overall 73% of work to ensure the sentence was served was done well enough.

Key Findings

1. Engagement of children and young people and their parents/carers was a key strength of Croydon YOS, both at the early stages of assessment, PSR writing and planning and further on throughout the order.
2. The identification of the specific needs of individuals and the problems they might face in successfully completing their sentence was also good.
3. In most cases the YOS had paid sufficient attention to the well-being of the child or young person.
4. Where there was a lack of compliance and enforcement of the order was necessary, the response of the YOS was appropriate.

Explanation of findings

1. Assessment

1.1. There was good engagement with most children and young people and their parents/carers to carry out the assessment and in writing the PSR. This meant that, from the start, case managers were establishing good working relationships which were more likely to be effective, helping to change behaviour.

1.2. The assessment of diversity and barriers to engagement was satisfactory in over two-thirds of cases and was reflected in most PSRs.

2. Planning for interventions

2.1. Unfortunately, the assessment of diversity was not reflected in the planning where it was not taken into account in just under half of the cases. Where difficulties, for example with literacy or communication, had been identified, there was no evidence that this had been taken into account when planning how to carry out offending behaviour work or other interventions. This was likely to make the delivery less successful than it might be.

2.2. In nearly two-thirds of the cases, children and young people and their parents/carers were engaged in the planning. Where this was not the case, the plans did not reflect the views of the child or young person.

3. Delivery of interventions

3.1. Children and young people and their parents/carers were meaningfully engaged by case managers throughout the work with them in most cases.

3.2. The engagement of parents/carers where parenting work had been carried out was particularly strong, clearly supporting the work with children and young people through the support offered to them. The mentoring of children and young people was very effective at engaging them, and where it had been delivered, had also clearly helped parents/carers to support their children.

Comments about engagement

A young person told us:

"They interact with me and explain stuff like, so I can understand. And they help me get to meetings, they ring and remind me. They take time out and make an effort. I'm not just an offender to them".

A parent commented:

"She will tell me how it is, no messing. When kids get into trouble the first thing they look at and blame is the parent. I have guilt and feel misjudged as a parent. They let me know I'm not on my own. I'm not the only one. They assist me, not judge me".

4. Initial outcomes

4.1. Overall, we judged that the YOS had paid sufficient attention to the health and well-being of children and young people in most cases. Where this was not the case, it was because appropriate referrals had not been made or interventions not delivered.

4.2. The YOS had worked hard to ensure that children and young people engaged with the work and carried out their sentence. Where enforcement was necessary the YOS had responded satisfactorily. Interestingly though, this was not the perception of the parents/carers to whom we spoke.

Comments from parents/carers on enforcement

"They are not strict enough with his non-attendance. They haven't been hard on him. He needs to understand the consequences of his actions as part of his order. I've heard the word 'breach' mentioned, but it never happens. What does he have to do to be breached?".

"They need to be stricter and enforce the rules better. They need more authority. It shouldn't be 'do you want to go?' It should be 'you are'".

5. Leadership, management and partnership

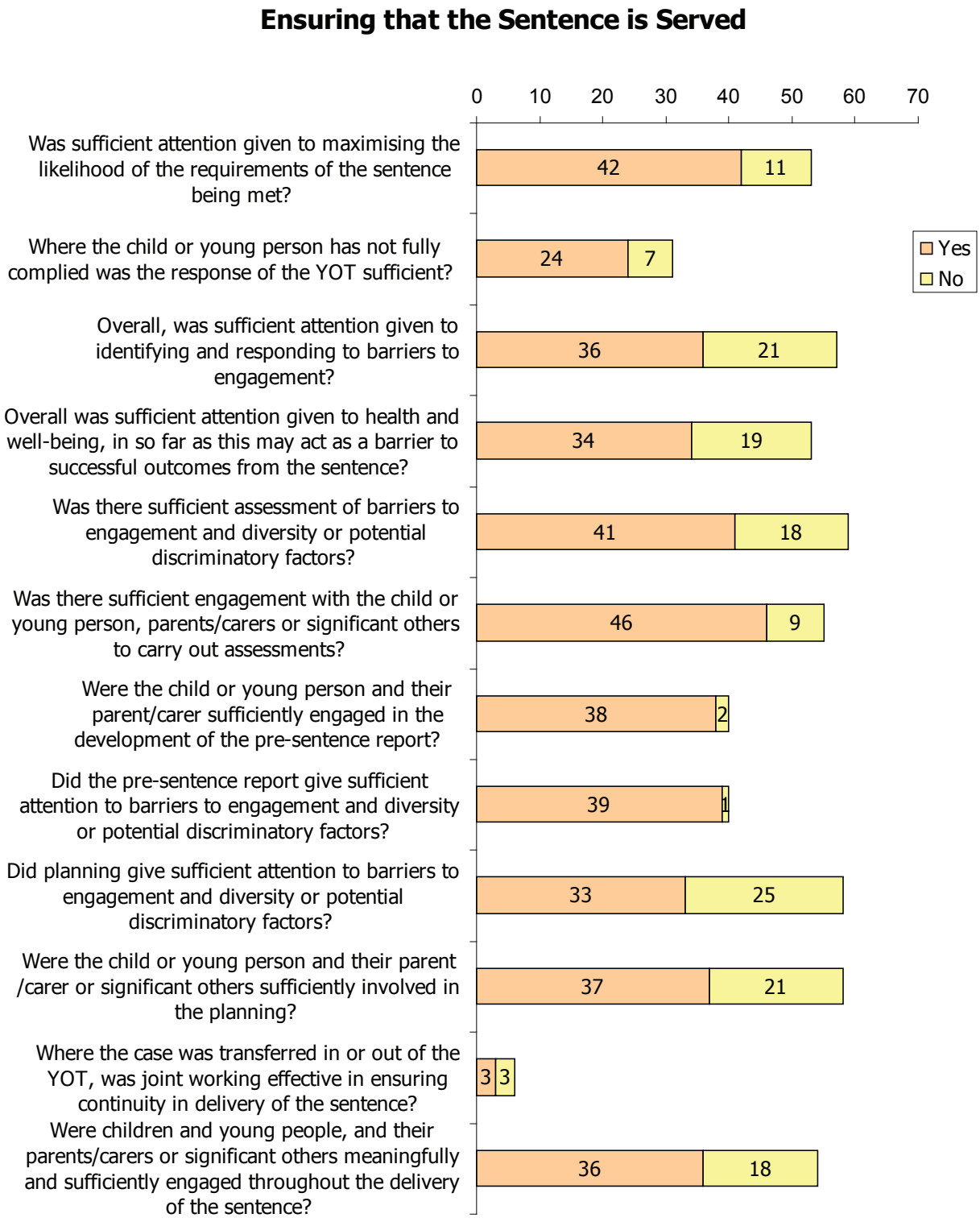
5.1. All case managers demonstrated an understanding of the policies and procedures for supporting engagement and ensuring compliance.

Summary

Overall, work to ensure that the sentence was served was good. Throughout the course of the order, starting at the assessment and PSR stages, the engagement by case managers with children and young people and their parents/carers was good in most cases. Specific individual needs were recognised and difficulties identified to promote the successful completion of the sentence. Case managers were committed to the interests of the children and young people they were working with and paid attention to their well-being. As part of that engagement, case managers generally recognised when enforcement was necessary and carried it out.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 62 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Governance

5

Theme 5: Governance

What we expect to see

The YOT[1] partnership and Management Board[2], provides sufficient governance to meet national and local criminal justice objectives, and delivers effective outcomes for children and young people who offend or who are likely to offend and the local community. Equality of opportunity and wider diversity issues are prioritised throughout. The YOT has developed partnerships, which work together to ensure effective outcomes for children and young people who offend or who are likely to offend and the local community. The YOT has in place workforce management that enables staff to deliver quality engagement and effective outcomes for children and young people who offend or who are likely to offend, and the local community.

Key Findings

1. The Youth Crime Prevention and YOS Management Board had been in place in its current format for approximately 18 months, following the merger of three boards.
2. The Board was cooperative and task focused, taking a problem solving approach. Members felt that information sharing had improved and duplication had been eliminated following the merger.
3. The Head of YOS was a key member of the Board and YOS business was a standing item on the agenda.
4. There had been insufficient scrutiny and support offered to the YOS in some areas of work. In particular the Board had failed to help and challenge the YOS to implement the recommendations from two previous inspections.

Explanation of findings

1. National and local criminal justice objectives are met

1.1. The Youth Crime Prevention and YOS Management Board had brought together the Community Safety Board, the Youth Crime and Prevention Board (which had managed the YOS) and the Turnaround Management Board. It was felt by members that this had improved outcomes through better information sharing and less duplication. Board members were cooperative and enthusiastic and took a problem solving approach. It was acknowledged that the Board was still developing as a group and was moving from considering only high level issues to looking at more meaningful, local issues for Croydon. The aim was to join strategy with action on the ground.

1.2. The Head of YOS was a key member of the Board and YOS business was a standing agenda item. Board members were able to give several examples of how the Board had responded to issues referred by the YOS, working together to resolve or improve the issue. In response to ETE data, there had been increased support offered to the YOS in the form of a personal advisor, with particular emphasis on helping with the transition from custody. In another example, as a result of the YOS submitting data showing that black and minority ethnic children and young people were disproportionately represented in offending statistics, police data on 'stop and search' had subsequently been examined to determine whether that was a contributory factor. The YOS improvement plan had identified the need to improve assessment through more home visiting and

1 We use the term YOT as this is in the legislation but this refers to all partnerships delivering services to children and young people who have offended or who are likely to offend.

2 This is likely to be broader than stated as it also relates to any strategic body which has responsibility for work with children and young people who have offended and/or those who are likely to offend. In legislation, the overall responsible person is the local authority Chief Executive.

the Family Resilience Service had agreed to undertake joint home visits with the YOS. The bid for Mayor of London Office for Policing and Crime (MOPAC) monies was supported by the Board through the Safer Croydon Partnership and was successful in obtaining money to support work with gangs.

1.3. Not all data had been examined effectively or understood. For instance, although data on the percentage of children and young people who were engaged in ETE showed a steady increase, the targets for pre and post-16 year olds were not separated and there was no detail of the actual provision such as what activities they were undertaking. It was not possible, therefore, to determine the quality of the education underpinning the rise.

1.4. Some problems faced by the YOS had gone unsupported by the Board. In particular, the performance issues raised by the previous inspection in 2011 had not been investigated in-depth. Whilst the improvement plan had regularly been presented to the Board, the difficulties faced by staff and managers in trying to manage high caseloads and the implications of failing to manage vulnerability and the risk of harm posed to others had not been recognised. This was particularly concerning as these areas had also been highlighted in the first inspection of youth offending work carried out in 2007.

2. Effective partnerships make a difference

2.1. The YOS was represented at the Croydon Safeguarding Children Board at both a strategic and operational level, using its membership to promote the safeguarding of children and young people who offend, for example, by producing a report on the implications of custody.

2.2. The YOS had developed effective relationships with many independent learning providers in the community. This had not been informed by an analysis of need, however, or by sufficient intelligence with regard to the employment opportunities in the locality. Some post-16 learning providers were not delivering functional skills in English, maths and ICT and not embedding these in their learning.

2.3. The health representative on the Youth Crime Prevention and YOS Management Board had a good understanding of the emotional and mental health needs of the children and young people working with the YOS. The YOS CAMHS service told us that all children and young people identified as needing emotional and/or mental health were seen by them; our inspection findings indicated that case managers were not always recognising those needs and referring on however. Croydon CAMHS provided monthly reports to the CAMHS Commissioning Group, although these were not routinely shared with the Head of YOS or the Board. The substance misuse workers also provided annual reports to the Head of YOS on referrals and outputs; however, these had not been examined by the Board. Physical health needs had not been considered.

3. Effective workforce leadership and management supports quality service delivery

3.1. Staff and managers were dealing with high caseloads of complex cases. Most staff felt that they were appropriately supported and supervised and managers were visible and accessible. However, we judged that, in the majority of cases, staff supervision or other quality assurance had not made a positive difference to the management of the case. The YOS CAMHS workers and substance misuse workers received regular line management, but inconsistent clinical supervision.

3.2. Staff also felt that arrangements for management oversight and countersigning worked effectively; our findings did not support this. We saw little evidence on file of management oversight of cases. Where we did see tasks identified by the manager for action, they were not always carried out or sufficiently followed up.

3.3. Complex case panels had been recently introduced in the YOS as a way of helping case managers take a more reflective approach to the work. Case managers referred their own cases and spent time with managers looking at the case in detail and considering the way forward. This seemed to us to be a useful vehicle for helping case managers; however, we were told by some that, useful though it was, they did not have time to take their cases to the panel.

3.4. The provision of training was described as satisfactory by the majority of staff, although some felt that not all needs were met and identified the need for more training in work with diversity and communication. Additionally, some reported that, whilst training was available, they did not have the time to attend. As a result of a recent safeguarding audit, the YOS had implemented a programme of safeguarding training for staff.

4. Positive outcomes are achieved and sustained

4.1. The reoffending data for Looked After Children indicated very positive outcomes and initial triage data was also encouraging, although the National Youth Justice Reoffending Outcome Indicator was less positive. The successful diversion of those with more minor offences had resulted in the YOS working with a smaller number of children and young people who had more entrenched offending behaviour. YJB data for reported offences for children and young people receiving a pre-court disposal or a court disposal were higher than the national average.

4.2. Other data was not robust enough to be useful to the Board in understanding whether there was true progress. For example, while data showed that there had been progress made in reducing the use of bed and breakfast accommodation, Board members were unable to say what the alternative accommodation actually was.

4.3. A similar lack of analysis of the ETE achievements of children and young people meant that the YOS was unable to demonstrate improvement in the quality of outcomes.

Summary

Overall, governance was not effective. The Head of YOS was an active member of the Youth Crime Prevention and YOS Management Board and was well connected to other partnership forums. The Board was cooperative, focused on problem solving and aimed at translating the strategic direction into operational delivery. It had been established in its current format for 18 months and there were many examples of successful partnership work promoted through the Board.

The challenge and support to the YOS, an essential component of a Management Board, had not been as effective as it needed to be however. As a result, the YOS had not successfully implemented the recommendations from previous inspections and performance had continued to be unsatisfactory in some key areas including safeguarding. Members acknowledged that the Board was still developing and that there were improvements to be made.

Appendices

Appendix 1

Contextual information about the area inspected

Croydon had a population of 363,400 as measured in the Census 2011. The youth population (those aged between 10 and 17 years old) accounted for 10% of the population. This was higher than the average for England/Wales as a whole, which was 9.4%.

The percentage of the youth population with a black or minority ethnic heritage was 40.9% (ONS, mid-year estimate 10-17 year olds, black and minority ethnic 2009). This was higher than the average for England/Wales, which was 14.1%.

Reported offences for which children and young people aged 10 to 17 years received a pre-court disposal or a court disposal in 2010/2011, at 39 per 1,000, were higher than the average for England/Wales of 33 (Youth Justice Board 2010-2011).

The proportion of young people in Croydon aged 16 to18 who were not in education, training or employment is estimated at 6.1%. This is the same as the average for England, which is estimated at 6.1% (Department for Education 2012).

Youth Justice Board indicators

The Youth Justice Board indicators are national measures of YOT performance:

Reoffending measures:

(i) Of those children and young people who received a reprimand, final warning, court conviction or who were released from custody or tested positive for a class A drug on arrest, the proportion who reoffend within a 12 month reporting period. This reoffending proportion for Croydon was 45.8%, worse than the 35.8% for England/Wales as a whole.

(ii) Of those children and young people who received a reprimand, final warning, court conviction or who were released from custody or tested positive for a Class A drug on arrest, the average number of reoffences within 12 months, per 100 such children and young people. For Croydon, there were 1.36 offences per child or young person who reoffends, worse than the 1.03 for England and Wales as a whole.

(Data based on April 2010 to March 2011 cohort)

First time entrants measure:

The number of children and young people who received their first reprimand, final warning or court conviction (and thus entered the youth justice system) in a 12 month period, as a proportion per 100,000 10-17 year olds in the general local population. The figure for Croydon was 630, compared to 595 for England and Wales as a whole.

(Data based on October 2011 to September 2012 cohort)

Use of Custody measure:

The number of children and young people receiving a conviction in court who are sentenced to custody in a 12 month period, as a proportion per 1,000 10-17 year olds in the general local population. The figure for Croydon was 1.48, compared to 0.72 for England and Wales as a whole.

(Data based on January 2012 to December 2012 cohort)

Appendix 2

Contextual information about the inspected case sample

In the first fieldwork week we looked at a representative sample of 62 individual cases up to 12 months old, some current, others terminated. These were made up of first tier cases (referral orders and reparation orders), youth rehabilitation orders (mainly those with supervision requirements), detention and training orders and other custodial sentences.

The sample sought to reflect the make up of the whole caseload and included a number of those who are a high risk of harm to others, are particularly vulnerable, are young women or are black and minority ethnic children and young people.

We have some doubts as to the accuracy of some of the evidence in the case records. This is because we found that in a number of cases there had been late access to the case records in the period between the announcement of the inspection and our visit and we are aware of at least one case where amendments to records were made. We are confident however that the scores are a reasonable reflection of the quality of youth offending work in Croydon.

Appendix 3

Acknowledgements

Lead Inspector	Jane Attwood, *HMI Probation*
Deputy Lead Inspector	Vivienne Clarke, *HMI Probation*
Inspection Team	Helen Davies, *HMI Probation*
	Mike Lane, *HMI Probation*
	Greg Maguire, *HMI Probation*
	Beverley Reid, *HMI Probation*
	Karen McKeown, *Ofsted*
	Maria Navarro, *Ofsted*
	Rob Bowles, *HMI Constabulary*
	Michelle Fordham, *Care Quality Commission*
	Rosie Winstanley, *Local Assessor*
	Jenny Daley, *Local Assessor*
	Anna Jones, *User Engagement Officer*
HMI Probation Support Services	Rob Turner, Support Services Manager
	Joanna Hewitt, *Support Services Officer*
	Oliver Kenton, *Assistant Research Officer*
	Alex Pentecost, *Publications Manager*
	Christopher Reeves, *Proof Reader*
Assistant Chief Inspector	Julie Fox, *HMI Probation*

Appendix 4

Inspection arrangements

The Full Joint Inspection (FJI) programme inspects youth offending work in a small number of local authority areas each year. It focuses predominantly on the quality of work in statutory community and custodial cases during the sentence up to the date of inspection. Its objective is to seek assurance that work is being done well enough to achieve the right outcomes. The four core themes for this inspection are:

- reducing the likelihood of reoffending
- protecting the public
- protecting the child or young person
- ensuring the sentence is served.

Methodology

Fieldwork for this inspection was undertaken on the weeks commencing:

29 April 2013 and 20 May 2013.

YOTs are informed 11 working days prior to the inspection taking place. The primary focus is the quality of work undertaken with children and young people who have offended, whoever is delivering it. Cases are assessed by a team of inspection staff with local assessors (peer assessors from another YOT). They examine these with case managers, who are invited to discuss their work in depth, are asked to explain their thinking and to identify supporting evidence in the record.

Prior to, or during, this first week we receive copies of relevant local documents. During the week in between, the data from the case assessments are collated and a picture about the quality of the work of the YOT emerges.

The second fieldwork week is the joint element of the inspection – HMI Probation are joined by colleague inspectors from the police, health, social care and education to explore in greater detail the themes which have emerged from the case assessments. In particular, the leadership, management and partnership elements of the inspection are explored, insofar as they contribute, or otherwise, to the quality of the work delivered.

During this week we also gather the views of others, including strategic managers, staff and service users – children and young people, parents/carers and victims, and where possible observe work taking place. From April 2013 we will also gather the views of children and young people through a questionnaire.

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

Publication arrangements

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

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

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

http://www.justice.gov.uk/about/hmi-probation/inspection-programmes-youth/full-joint-inspection-fji-of-youth-offending-work

Appendix 5

Scoring approach

This describes the methodology for assigning scores to each of the core themes:

- Reducing the likelihood of reoffending.
- Protecting the public.
- Protecting the child or young person.
- Ensuring that the sentence is served.

Inspection staff examine how well the work was done across the case - from assessment and planning to interventions and outcomes, focusing on how often each aspect of the work was done well enough. This brings together performance on related elements of practice from all inspected cases.

Each scoring question in the inspection tool contributes to the score for the relevant section in the report. In this way the core themes focus on the key outcomes.

This approach enables us to say how often each aspect of work was done well enough, and provides the inspected YOT with a clear focus for their improvement activities. Each core theme is assigned a percentage (quantitative) score which, along with a descriptor, is then given a provisional star rating.

Case assessment score	**Descriptor**	**Star rating**
80% +	Very good	
65% - 79%	Good	
50-64%	Unsatisfactory	
< 50%	Poor	

Each of these themes contains elements of leadership, management and partnership which cannot be evidenced through the scoring system for individual cases, and which are a particular focus of the work of partner inspectorates. A moderation process then takes account of these elements to determine the final descriptor.

Additional modules are scored on a similar basis.

If there are serious and unaddressed shortcomings, in individual cases, relating to the risk of the child or young person suffering or inflicting harm that leaves someone at risk, then this may constitute a limiting factor to the star rating.

Further details of this process can be found on our website.

http://www.justice.gov.uk/about/hmi-probation/inspection-programmes-youth

Appendix 6

Criteria

The aspects of youth offending work that are covered in the core themes in this inspection are defined in the Inspection Criteria for Full Joint Inspection. A copy of the inspection criteria is available on the HMI Probation website at the following address:

http://www.justice.gov.uk/about/hmi-probation/inspection-programmes-youth/full-joint-inspection

Separate criteria are published for each additional module inspected, which are available from the same address.

Appendix 7

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 child or 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
CJS	Criminal justice system. Involves any or all of the agencies involved in upholding and implementing the law – police, courts, Youth Offending Teams, probation and prisons
DTO	Detention and training order: a custodial sentence for the young
Estyn	HM Inspectorate for Education and Training in Wales
ETE	Education, training and employment: work to improve an individual's learning, and to increase their employment prospects
FTE	Full-time equivalent
HM	Her Majesty's
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 the 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
Likelihood of reoffending	See also *constructive* Interventions
LSC	Learning 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

MOPAC	Mayor of London Office for Policing and Crime
NSPCC	National Society for the Prevention of Cruelty to Children
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
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, for example 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
Risk of harm to others	See also *restrictive* Interventions
'Risk of harm to others 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
Scaled Approach	The means by which Youth Offending Teams determine the frequency of contact with a child or young person, based on their RoSH and likelihood of reoffending
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 Youth Offending Team workers
Turnaround	Turnaround is located within the Children, Families and Learning Department. The centre provides a central hub for young peoples services such as the YOS, the 18 Plus Team, housing advice
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 children and 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
YOS/YOT/YJS	Youth Offending Service/Youth Offending Team/Youth Justice Service. These are common titles for the bodies commonly referred to as YOTs
YRO	The youth rehabilitation order is a generic community sentence used with children and young people who offend

Appendix 8

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:

www.justice.gov.uk/about/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
6th Floor, Trafford House
Chester Road
Manchester
M32 0RS

Criminal Justice Joint Inspection

Arolygiad ar y Cyd Cyfiawnder Troseddol

HM Inspectorate of Probation,
6th Floor, Trafford House,
Chester Road, Stretford,
Manchester
M32 0RS

ISBN: 978-1-84099-607-4