



Inspection of  
Youth  
Offending

*Archwilio Rhaglen Troseddwy'r Ifanc*



Arolygiad ar y Cyd Cyfiawnder Troseddol

# Core Case Inspection of youth offending work in England and Wales

Report on youth offending  
work in:

**Derbyshire**

ISBN: 978-1-84099-534-3

2012



## Foreword

Our Core Case Inspection of youth offending work in Derbyshire was undertaken as part of our Inspection of Youth Offending programme. This inspection focuses exclusively on the work undertaken by Youth Offending Teams with children and young people who have already committed an offence.

Its purpose is to assess if the work is of a sufficiently high standard to protect both the public from any harm resulting from the child or young person's offending behaviour and the child or young person themselves, whether from their own behaviour or any other source.

The inspection is based on a rigorous examination of a representative sample of cases supervised by the Youth Offending Service. Our findings are shown in the table below, outlined against those for Wales and the regions of England inspected so far. A more detailed analysis is provided in the main body of this report, and summarised in a table in Appendix 1.

Derbyshire Youth Offending Service benefited from enthusiastic staff who were committed to their work with children and young people who had offended. Overall, there was positive work with other agencies and good use was made of resources within the service and in the wider community to reduce reoffending and sustain progress. There remained scope for improvement at the assessment and planning stage of work with children and young people, and in the effectiveness of management oversight of practice at that point.

Overall, we consider this a creditable set of findings, demonstrating considerable improvement since our last inspection in 2007.

*Liz Calderbank*  
*HM Chief Inspector of Probation*

*June 2012*

	Scores from Wales and the English regions that have been inspected to date			Scores for Derbyshire
	Lowest	Highest	Average	
<b>'Safeguarding' work</b> <i>(action to protect the young person)</i>	37%	91%	68%	<b>78%</b>
<b>'Risk of Harm to others' work</b> <i>(action to protect the public)</i>	36%	86%	62%	<b>72%</b>
<b>'Likelihood of Reoffending' work</b> <i>(individual less likely to reoffend)</i>	43%	88%	71%	<b>79%</b>

## **Acknowledgements**

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

<i>Lead Inspector</i>	<i>Joy Neary</i>
<i>Inspector</i>	<i>Iolo Madoc-Jones</i>
<i>Practice Assessor</i>	<i>Cliff Warke</i>
<i>Local Assessors</i>	<i>Sarah Afolabi; Andrew Kaiser</i>
<i>Support Staff</i>	<i>Andy Doyle</i>
<i>Publications Team</i>	<i>Alex Pentecost; Christopher Reeves</i>
<i>Assistant Chief Inspector</i>	<i>Julie Fox</i>

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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<sup>1</sup>. 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.

<b>Safeguarding score:</b>	
This score indicates the percentage of <i>Safeguarding</i> 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.	
<b>Score:</b> <b>78%</b>	<b>Comment:</b> <b>MINIMUM improvement required</b>

<b>Public Protection – Risk of Harm score:</b>	
This score indicates the percentage of <i>Risk of Harm</i> 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.	
<b>Score:</b> <b>72%</b>	<b>Comment:</b> <b>MODERATE improvement required</b>

<b>Public Protection - Likelihood of Reoffending score:</b>	
This score indicates the percentage of <i>Likelihood of Reoffending</i> work that we judged to have met a sufficiently high level of quality.	
<b>Score:</b> <b>79%</b>	<b>Comment:</b> <b>MINIMUM improvement required</b>

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.

<sup>1</sup> An explanation of how the scores are calculated can be found in Appendix 5

## **Recommendations for improvement**

(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, using Asset, is completed at the start of sentence (Head of Service)
- (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 (Head of Service)
- (3) as a consequence of the assessment, the custodial plan and community 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* (Head of Service)
- (4) specifically, vulnerability and risk management plans are completed where needed and are of good quality (Head of Service)
- (5) oversight by management is effective in ensuring the quality of practice with respect to Safeguarding and *Risk of harm to others*, as appropriate to the specific case (Head of Service).

## **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.

## Making a difference

Here are some examples of work in Derbyshire YOS that impressed us.

### Assessment and Sentence Planning

#### General Criterion: 1.3c

Damien, aged 14, had completed previous supervision positively, but at the start of this community sentence he seemed sullen and unwell. He had also failed to attend school for three months. His case manager suspected drug use and was concerned for Damien's health as well as his repeat offending. She contacted the police and other agencies to find out more about the young person and his associates and discovered that he was involved with older drug users and using drugs himself. He was thus at risk of being harmed by others as well as by his own behaviour. Immediate steps were taken to protect Damien before work could start with him on his offending and his education needs.

This case showed the importance and usefulness of an investigative approach to assessment by the case manager, recognising that there was more to the situation than initially appeared. Her work and that of the other agencies involved meant that a vulnerable young person was protected from harm.

### Delivery and Review of Interventions

#### General Criterion: 2.2a

Jordan was convicted of an assault on another young person which included kicking his head whilst he was on the ground. At court, Jordan had denied kicking the victim's head, and showed little remorse for his actions. He was sentenced to a referral order and at the initial community panel meeting the victim worker read out a victim impact statement, which identified the injuries sustained, including several weeks of paralysis (palsy) to one side of the victim's face.

The victim impact statement had a powerful effect on Jordan and his family and for the first time he admitted that he had kicked the victim in the head. The victim worker suggested an intervention which was included in the referral order contract. It was arranged for Jordan to have a meeting with a representative from the organisation Headway, which supported people and their families affected by head injuries. This involved the mother of a young man who was subject to a brain injury after an assault, talking to him about the effects this had on her, her son and the wider family. She fed back to the panel how positively Jordan had participated, describing him as the most engaged and attentive young person she had spoken to. Jordan completed the rest of his referral order successfully and had not reoffended by the time of the inspection.

This was a creative, well-targeted intervention which had a positive outcome.

## Outcomes

### General Criterion: 3.1a

Tom had assaulted a school student of his own age, during an argument over remarks made on the social networking site, Facebook. Tom had little understanding of the impact of his behaviour on others but as the victim did not want to take part in any restorative justice process, the case manager decided to tackle Tom's poor temper control and lack of awareness in another way. Noting that Tom's preferred learning style was a mix of visual and kinaesthetic (practical), she designed victim awareness exercises to undertake with him, including selecting stories and pictures about violent offences from newspapers. Tom put these onto cards where he wrote about the impact of crime on individuals, their families and communities.

Similar methods were used to help Tom become aware of what happened in his body when he became angry and what he could do to calm himself down. Tom's case manager taught him how he could avoid contact with his victim and what he could do differently if they did get into another argument. This proved successful, and Tom applied the skills he had learned when next confronted by the victim. He complied with his sentence and had not reoffended by the time of the inspection, a positive outcome in a situation which had looked as though it could escalate into further violence.

All names have been altered.

## Service users' perspective

### Children and young people

Thirty-eight children and young people completed a questionnaire for the inspection.

- ◇ Those on a referral order knew what their referral order contract was and said it had been discussed with them. All but one of those who knew what a sentence plan was had had their plan discussed with them.
- ◇ All the children and young people who answered the particular question knew why they had to come to the YOS. Almost all thought that YOS staff were really interested in helping them and listened to them.
- ◇ Almost all remembered completing a *What do YOU think?* questionnaire or other self-assessment form at the start of their sentence.
- ◇ All said that staff made it easy to understand how the YOS could help them. One commented "*[my YOS worker] explains everything to me and she also tells me the truth and is straight up with me*". Another child or young person said "*[my YOS worker] uses words I understand and explained things better*".
- ◇ All the children and young people said that staff took action to deal with the things they needed help with. Over half said that the YOS had helped them understand their offending. Between one-third and a half reported receiving help with ETE issues, family relationships, drug and/or alcohol use, and making better decisions. Several noted that they were now attending school or college, or had started apprenticeships. Others talked about reduced drug use – one said "*my life is better now I'm off drugs & I plan on keeping it that way*".
- ◇ Some children and young people commented on what had changed in their lives since coming to the YOS. One said "*I'm keeping out of trouble and getting on with my Mum, and keeping to my ABC [anti-social behaviour contract]*". Another noted "*things at home have got better and I'm thinking about things before I do them*".
- ◇ A few thought that their work with the YOS had made no difference to the likelihood of them reoffending but most thought it had made them a lot less likely to get into trouble. One said that being kept busy and being subject to electronic monitoring had really helped him. Another explained "*I've done lots of sessions on offending and it has made me realise what it is like for the victim when offending and how they would feel*".
- ◇ Most children and young people were largely satisfied with the work of the YOS and some were completely satisfied. Several had practical suggestions for improving the service and these have been passed to the YOS.

## Victims

Forty-nine questionnaires were completed by victims of offending by children and young people. This was a very high number of returns when compared with inspections to date.

- ◇ All who responded to the questionnaire indicated that the YOS had explained what service it could offer, and all who answered the particular question thought that their individual needs had been taken into account.
- ◇ All were clear that they had the chance to talk about any worries connected with the offence or the child or young person who had committed it.
- ◇ For those who did have concerns about their safety, all were satisfied with the attention the YOS paid to this.
- ◇ Overall, the vast majority were completely satisfied with the service provided to them, and the remainder were largely satisfied.
- ◇ Twenty-four respondents made additional comments; the great majority praising the information and support provided by Derbyshire YOS. These were typical comments: *"I was happy with the service, I was kept up to date. I was glad the YOS got involved to discuss my safety, I felt reassured"*. Another person noted *"The service was wonderful, fully explained throughout the young person's order. My thoughts/opinions were fully taken into account. The liaison officer was excellent throughout"*.
- ◇ A few people made suggestions for improvement in contact arrangements with victims and increasing the amount of information provided. These have been passed to the YOS. Another couple of respondents commented on types of punishment and on sentencing issues, which were not within the remit of the inspection so were not included here.

## 1. ASSESSMENT AND SENTENCE PLANNING

**OVERALL SCORE: 73%**

### 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:**

**74%**

**Comment:**

**MODERATE improvement required**

**Strengths:**

- (1) An Asset RoSH screening was completed in all but one case. Most screenings were undertaken on time.
- (2) A full RoSH analysis was completed where required in all except 4 cases out of 34.
- (3) RMPs were prepared at the start of sentence in all except 3 out of 24 cases where this was required, i.e. where the RoSH had been assessed as medium or higher.
- (4) The need to plan to manage *RoH* had been recognised in all but six relevant cases where an RMP had not been produced or was not required.
- (5) A small number of cases met the criteria for MAPPA. The single case that required management at MAPPA Level 2 or above had been referred appropriately in a timely way.

**Areas for improvement:**

- (1) The RoSH screening was not accurate in six cases. In most cases this was because previous relevant behaviour had not been considered.
- (2) In nine cases, the RoSH classification was judged to be incorrect at the start of sentence. For seven of these, the classification was too low. At the time the cases in our sample started, it was common practice in the YOS to reduce the RoSH classification - for example, from medium to low - for children and young people going into custody. The YOS had updated its guidance to staff and case managers told us that this practice had now ceased. However, the

previous practice clearly had an impact at the start of sentence for some custodial cases in the sample. It was worth noting here that, given the small numbers of children and young people receiving a custodial sentence, we needed to look at some cases starting as far back as 2010 in order to achieve a sufficient sample for the inspection. So, the practice we were looking at was two years old in some cases.

- (3) Where a full RoSH analysis was completed, this was not of sufficient quality in 51% of cases. Previous relevant behaviour (as opposed to convictions) was not always considered fully, nor was ongoing risk to victims. Examples of this included previous and continuing violence towards family members. Case managers did not always draw upon appropriate information from other agencies or victims, for example where the victim of an assault had suffered previous bullying at school from the same young person.
- (4) In 31% of cases the RoSH analysis was not timely; in some cases it was completed several months into the sentence which made it difficult to see how it could influence the intervention plan or RMP.
- (5) Two-thirds of initial RMPs were not completed to a sufficient quality and one-third were not timely. The most common gaps in completed RMPs were that the planned response to *RoH* concerns was unclear or inadequate, roles and responsibilities of those involved in the plan were not clear, and victims' issues were not covered adequately. In many cases it was not clear who was going to do what and when to protect whom.
- (6) Details of *RoH* assessment and management were not appropriately shared with other relevant agencies in 38% of cases.
- (7) Management oversight of the initial *RoH* assessment was effective in 54% of relevant cases. Oversight of the RMP completed at the start of sentence was effective in half the cases where it was needed. Whilst assessments and RMPs were countersigned, and there was evidence of management involvement in the cases, the gaps in quality noted above indicated that the oversight had not always been *effective*.

<b>1.2 Likelihood of Reoffending:</b>	
<p><b>General Criterion:</b></p> <p><i>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.</i></p>	
<p><b>Score:</b></p> <p><b>73%</b></p>	<p><b>Comment:</b></p> <p><b>MODERATE improvement required</b></p>

### **Strengths:**

- (1) An initial assessment of LoR was completed in all except one case. Over three-quarters were completed on time.
- (2) Diversity factors were identified well in all cases. This included disability, and issues affecting Looked After Children. Just under one-third of the cases (a high figure) were children in the care of a local authority. In Derbyshire there were a number of private children's homes where other local authorities, for example some London Boroughs, placed children away from their home area. The YOS took responsibility for sentences passed on these children and young people if they offended although they were not in the care of Derbyshire County Council.
- (3) In 88% of cases there was sufficient engagement with parents/carers when carrying out the initial assessment. The child or young person had been actively involved in the initial assessment in 82% of the sample.
- (4) The child or young person's learning style had been assessed at the start of sentence in over three-quarters of the cases. Case managers used a short, colourful, locally devised questionnaire to engage children and young people in thinking about how they learned best.
- (5) Almost all initial assessments of LoR were informed by contact with or information from children's social care services. In all relevant cases, information had been included from physical health services. All but five included information from emotional/mental health services where this was applicable and it was a similar figure for substance misuse services. All assessments were informed by contact with the ASB team where needed, and by information from the police in all but 6 out of 38 cases. Previous assessments from ETE providers had been drawn on in 80% of the sample.
- (6) A timely sentence plan was produced in all the custodial cases inspected. All the plans addressed ETE issues and all except one tackled substance misuse concerns where this was relevant. Safeguarding needs were taken into account in the plan in 11 out of 14 applicable cases and all except three included objectives related to Safeguarding.
- (7) YOS workers were actively and meaningfully involved throughout the custodial planning process in all except one custodial case inspected. The custodial sentence plan was reviewed as required in all but two instances.
- (8) A community intervention plan or referral order contract was produced in all 60 cases where one was required. It was timely in all except eight cases, and sufficiently addressed offending-related factors in all but seven. Physical health issues, substance misuse, ETE, thinking and behaviour issues and attitudes to offending were tackled in almost all plans where needed.
- (9) Safeguarding needs were taken into account in community intervention plans or referral order contracts in 72% of relevant cases. There was an appropriate response to the child or young person's diversity needs in the plan or contract in 71% of cases. Examples included interventions adapted to meet the needs of individuals with learning difficulties including Attention Deficit Hyperactivity Disorder. In over one-third of the sample, children and young people were faced with disabilities; most of these related to learning issues.

- (10) Parents/carers had been actively and meaningfully involved in the planning process in three-quarters of the sample. The child or young person had been similarly involved in just under this number.
- (11) The community intervention plan or referral order contract was reviewed at appropriate intervals in 50 out of 60 relevant cases.
- (12) Substance misuse workers, ETE providers, accommodation providers and physical health workers were sufficiently involved in the planning process throughout the sentence in over 80% of relevant cases.

***Areas for improvement:***

- (1) The initial assessment of LoR was not of sufficient quality in 37% of cases. There were several common reasons for this. Firstly, evidence was sometimes unclear or insufficient; rather than creating a new assessment, case managers regularly updated earlier assessments by revising information on the original Asset. This made it difficult to see what the assessment had been at the start of the sentence we were inspecting. Secondly, vulnerability concerns and offending-related factors had not always been identified in the assessment. Issues missed included the young person's immaturity, status as a Looked After Child, and experience of being abused.
- (2) Where the child or young person had completed a *What do YOU think?* self-assessment questionnaire, this was not used to inform the initial assessment in just over one-third of the cases.
- (3) Six of the custodial sentence plans lacked attention to some factors which had been identified as most closely linked to offending. Most commonly these included emotional/mental health factors, thinking and behaviour issues, the child or young person's attitude to offending, and their motivation to change. Several custodial establishments used standardised formats for sentence planning which did not easily match with the Asset. So factors closely linked to a child or young person's offending as assessed by the YOS did not always feature in the custodial plan, especially where there the custodial element of the sentence was short.
- (4) Where there was an RMP, it was integrated into the custodial sentence plan in only three out of ten cases. Positive factors were not included in the plan in six cases. Five lacked an appropriate response to identified diversity needs, for example lack of maturity or disability, and ten did not incorporate the child or young person's learning style.
- (5) In custodial sentence plans, objectives were prioritised according to *RoH* in 21% of cases. Objectives were sequenced according to offending-related factors in 31% and took account of victims' issues in 53% of relevant cases.
- (6) Community intervention plans and referral order contracts did not address neighbourhood as a factor closely linked to offending in four out of nine cases where it was relevant. Under half of the plans or contracts integrated RMPs where this was needed. 54% included positive factors in the plans/contracts and 58% incorporated the child or young person's learning needs or style.
- (7) Under half of the community intervention plans and referral order contracts set relevant goals for the child or young person or realistic timescales for the

achievement of objectives. For example, one young person was affected by dyslexia and had the reading age of a much younger child. His intervention plan included nine objectives, which did not fit his individual capacity. Most plans were lengthy and written as though they were 'action points' for the case manager rather than being clear about what the child or young person had to achieve. Plans and contracts focused on achievable change in 58% of cases.

- (8) In community intervention plans and referral order contracts, objectives were prioritised according to *RoH* and sequenced according to offending-related factors in under half of the cases. Whilst case managers were generally clear in discussion with us which objectives had priority and what work needed to be tackled first, this was not always evident on the written plan.

<b>1.3 Safeguarding:</b>	
<p><b>General Criterion:</b></p> <p><i>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.</i></p>	
<p><b>Score:</b></p> <p><b>72%</b></p>	<p><b>Comment:</b></p> <p><b>MODERATE improvement required</b></p>

**Strengths:**

- (1) An Asset vulnerability screening was completed in all cases in the sample. In most instances it was completed on time.
- (2) Vulnerability concerns had been clearly communicated to custodial establishments before or at the time of sentence in all except one case.
- (3) Where needed, to safeguard the child or young person, case managers had contributed to other assessments and plans, for example care plans for Looked After Children.
- (4) Safeguarding needs were reviewed as needed in 84% of cases.

**Areas for improvement:**

- (1) Just under one-third of vulnerability screenings were not of sufficient quality. The most common reason for this was that factors identified elsewhere in the case were not then reflected in the screening. This meant that some vulnerability issues for the child or young person were missed, for example significant alcohol use.

- (2) No VMP was completed at the start of sentence in 16 cases where one was needed. This included a case where the young person was in custody.
- (3) There were gaps in quality in 63% of VMPs completed at the start of sentence. The main reasons for this were that roles and responsibilities of those involved in the plan were unclear, and the planned response was inadequate or unclear. For example, where a young person was identified as affected by domestic abuse from her partner, the VMP did not address this sufficiently. Just under half of the VMPs were timely.
- (4) Where a VMP was prepared at the start of sentence, it had clearly informed the planned interventions in 56% of relevant cases, and contributed to the plans of other agencies in 57%.
- (5) Management oversight of the initial vulnerability assessment was not effective in 46% of relevant cases. As with oversight of *RoH* assessment and RMPs, managers had been clearly involved in many cases, but the quality issues noted above indicated that this had not been completely effective.

### **COMMENTARY on Assessment and Sentence Planning as a whole:**

Case managers were often using Asset to record a chronology of events, rather than using it to *analyse* vulnerability issues, *RoH*, and factors making the child or young person more likely to offend, at the start of sentence and at review points. In some cases it had therefore become more of a 'form to fill in' than an assessment tool which then contributed appropriately to sentence planning and planning to manage vulnerability and *RoH*. Where Asset was used well as an analysis, it helpfully included the child or young person's view of their situation, from *What do YOU think?* as well as their parents/carers views.

The YOS had been undertaking quality improvement work in relation to RMPs and VMPs, and we saw that the plans produced *later* in the cases we inspected were of better quality than the initial ones. This indicated that the improvement work being undertaken was having a positive impact.

To try and ensure that all offending-related factors were tackled in intervention planning, the practice in the YOS was to include a large number of objectives in the initial community plan. This had the effect of making intervention plans overlong and not apparently 'friendly' to the children or young people, many of whom had difficulties with literacy. It therefore made it harder for the child or young person (and their YOS workers) to see exactly what outcomes were supposed to be achieved in the first few months. Fewer objectives, focused on achievable change, would have enabled both the child or young person and their YOS workers to chart progress more effectively.

## 2. DELIVERY AND REVIEW OF INTERVENTIONS

**OVERALL SCORE: 84%**

### 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:**

**79%**

**Comment:**

**MINIMUM improvement required**

**Strengths:**

- (1) *RoH* was reviewed thoroughly in line with required timescales in 76% of cases. In the remaining cases, reviews were mostly timely but there were some gaps in their quality.
- (2) Changes in *RoH* factors were anticipated where feasible in 80% of applicable cases, and identified swiftly and acted upon appropriately in a similar percentage of cases.
- (3) Purposeful home visits were carried out throughout the course of the sentence in accordance with the *RoH* posed in almost all the relevant cases.
- (4) Effective use of MAPPA was made in the single case in the sample that was managed at Level 2. Decisions taken within MAPPA were clearly recorded, followed through and acted upon, and reviewed appropriately. The case manager, other YOS staff, and staff from other agencies all contributed effectively to MAPPA processes while the child or young person was in custody and in the community.
- (5) Case managers and other relevant staff all contributed effectively to other multi-agency meetings held in custodial establishments, and in all but 2 out of 41 instances to similar meetings in the community.
- (6) Where specific interventions had been identified to manage *RoH* in the community, these had been delivered as planned in 71% of cases, though not all had been reviewed following significant change.
- (7) Appropriate resources had been allocated according to *RoH* posed in 89% of cases.

### **Areas for improvement:**

- (1) *RoH* was not reviewed thoroughly following significant change in 37% of cases. Information about new offences was not always reflected in a review, sometimes because the matter had not yet come to court and/or the child or young person did not admit the matter. In such instances, we still expected attention to be given to potential *RoH* issues.
- (2) In 11 cases out of 40, the case manager had not paid sufficient attention to assessing the safety of victims, and in 12 cases not enough priority had been given to victims' safety throughout the sentence. For example, the court had imposed a restraining order in one case inspected, but the case manager had no details of this and there was no ongoing monitoring of that victim's safety.
- (3) Specific interventions to manage *RoH* during the custodial element of sentences were not delivered as planned in 4 out of 13 cases or reviewed following significant change in two out of three instances.
- (4) Management oversight of *RoH* has been effective throughout the sentence in just under half the relevant cases while the child or young person was in custody. The figure was higher for cases in the community but in both settings the issues related mainly to shortcomings in the *initial* assessment and planning which had not been rectified until later in the sentence.

<b>2.2 Reducing the Likelihood of Reoffending:</b>	
<b>General Criterion:</b> <i>The case manager coordinates and facilitates the structured delivery of all elements of the intervention plan.</i>	
<b>Score:</b> <b>86%</b>	<b>Comment:</b> <b>MINIMUM improvement required</b>

### **Strengths:**

- (1) Work undertaken in the community to tackle LoR issues throughout the sentence was consistently positive; workers drew on a range of resources both within the YOS and in the wider community. Interventions were implemented in line with the plan in three-quarters of cases.
- (2) The requirements of the sentence had been implemented in all except three cases. In one case, a requirement to undertake unpaid work was not started until four months into the community order. In other cases, remands into custody on fresh charges meant that activity requirements had not commenced.

- (3) Delivered interventions were judged to be of good quality in 80% of the sample and appeared designed to reduce the LoR in 90%.
- (4) Interventions were appropriate to the learning style of the child or young person in 80% of cases, and incorporated their diversity needs in 84%. For example, one young woman had an auditory learning style. Her case manager took care to discuss issues with her, rather than use written worksheets.
- (5) In all relevant cases, the YOS was involved in the review of interventions in custody.
- (6) The initial Scaled Approach intervention level allocated by the YOS was appropriate in all cases.
- (7) Appropriate resources were allocated according to the LoR in all but three cases.
- (8) YOS workers actively motivated and supported children and young people and reinforced their positive behaviour while they were in custody. They did the same in almost all cases in the community.
- (9) Throughout the sentence, YOS workers actively engaged parents/carers where appropriate. This included support with parenting in some cases.

**Area for improvement:**

- (1) Delivered interventions were not sequenced appropriately in 44% of cases, and not reviewed appropriately in 33%.

<b>2.3 Safeguarding the child or young person:</b>	
<p><b>General Criterion:</b></p> <p><i>All reasonable actions have been taken to safeguard and reduce the vulnerability of the child or young person.</i></p>	
<p><b>Score:</b></p> <p><b>86%</b></p>	<p><b>Comment:</b></p> <p><b>MINIMUM improvement required</b></p>

**Strengths:**

- (1) All necessary immediate action was taken to protect the child or young person, where appropriate, in custody and in the community.
- (2) In the same way, all necessary immediate action was taken to protect any other affected child or young person.

- (3) Necessary referrals to other agencies to ensure Safeguarding were made in all cases during the custodial element of sentence, and in all but 1 case out of 34 in the community.
- (4) Purposeful home visits were carried out in accordance with Safeguarding needs in all but 2 out of 44 relevant cases.
- (5) Joint work between the YOS and other agencies to promote the Safeguarding and well-being of the child or young person in the community was generally very good. The same was true for cases in custody.
- (6) Specific interventions to promote Safeguarding in custody were identified, incorporated those identified in the VMP, were delivered and were reviewed where needed in almost all cases in custody.
- (7) In almost all cases, YOS workers and other relevant agencies worked together well to ensure continuity of services in the child or young person's transition from custody to the community.
- (8) In the community, specific interventions to promote Safeguarding were identified, incorporated those identified in the VMP, and were delivered and reviewed where needed in over 70% of cases.
- (9) All relevant staff promoted the well-being of the child or young person throughout the course of the custodial element of the sentence. In the community, this was done in all but four cases.

#### ***Areas for improvement:***

- (1) The area where joint work to promote Safeguarding and the well-being of the child or young person in the community needed to improve was in relation to emotional/mental health services. In 10 cases out of 33 the joint work was not sufficient. For example, in one case, CAMHS had made a decision to treat a young person's Attention Deficit Hyperactivity Disorder with medication. Several months later, the medication had still not been prescribed, despite the case manager's efforts.
- (2) Management oversight of Safeguarding and vulnerability needs was not effective in just under half the cases in custody and just over one-third of the cases in the community. As before, the most common reason was that gaps in the *initial* assessment and planning had not been addressed until some way through the sentence.

#### **COMMENTARY on Delivery and Review of Interventions as a whole:**

Generally, there was good joint work between YOS workers and staff in other agencies to deliver interventions aimed at reducing vulnerability, managing *RoH*, and reducing factors linked to the child or young person's offending.

There were a number of structured interventions available to case managers and programmes staff had developed an 'Intervention Finder' which identified a

range of programmes relevant to particular offending-related factors such as thinking skills. Overall, attention was paid to the child or young person's individual needs and diversity factors in selecting and delivering interventions.

For historical reasons, health service boundaries did not match those of the YOS and two separate PCTs provided CAMHS services in the area. This was not ideal and the movement of children and young people within the county meant that service provision to children and young people supervised by the YOS was not always maintained adequately. Gaps in CAMHS provision had been identified in earlier inspections by Ofsted and the Care Quality Commission of services for children and young people (both published in May 2011), and service design improvements were being planned by the relevant PCTs at the time of our inspection. The Head of Service was contributing to this improvement work.

### 3. OUTCOMES

#### OVERALL SCORE: 77%

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:**

**72%**

**Comment:**

**MODERATE improvement required**

**Strengths:**

- (1) Sufficient reporting instructions were given in order to carry out the sentence of the court in all except one case.
- (2) Where the child or young person had not complied with the sentence, appropriate action was taken by the YOS in all but 4 out of 24 cases.
- (3) Those factors related to LoR that, in our judgement, showed the most frequent improvement were ETE, substance misuse, and attitudes to offending. Each of these had improved by just over one-third – close to the average for YOTs inspected so far.
- (4) Since the start of the sentence, there appeared to be a reduction in the frequency of offending in 65% of cases where there was sufficient offending history to assess this. For reduction in the seriousness of offending the figure was 60%. Both outcomes were better than the average for YOTs inspected to date.
- (5) Where there was an identifiable victim or potential victim, there was evidence that *Risk of Harm* to them was managed effectively in 74% of cases.
- (6) All reasonable steps had been taken to keep to a minimum the risk of the child or young person coming to harm, either from themselves or from others, in 80% of relevant cases.

### **Area for improvement:**

- (1) Overall, all reasonable steps had been taken to keep to a minimum the individual's *RoH* in 61% of cases. In most cases where the work undertaken was not sufficient, there were gaps in assessment and planning at the *start* of sentence.

<b>3.2 Sustaining outcomes:</b>	
<b>General Criterion:</b> <i>Outcomes are sustained in relation to RoH, LoR and Safeguarding.</i>	
<b>Score:</b> <b>94%</b>	<b>Comment:</b> <b>MINIMUM improvement required</b>

### **Strengths:**

- (1) Full attention was given to community integration issues in all but one case in custody, and in all except three cases in the community. Case managers made good use of available resources both within the YOS and in the wider community.
- (2) Actions had been taken, or plans put in place, to ensure that positive outcomes were sustainable in all but one case in custody, and all except three cases in the community. We saw many examples of children or young people being linked with other organisations that could provide support once their contact with the YOS ended. This included referral to mentoring schemes and organisations providing constructive activities.

### **COMMENTARY on Outcomes as a whole:**

There had been an overall reduction in the Asset score since the start of sentence in 47% of the cases inspected.

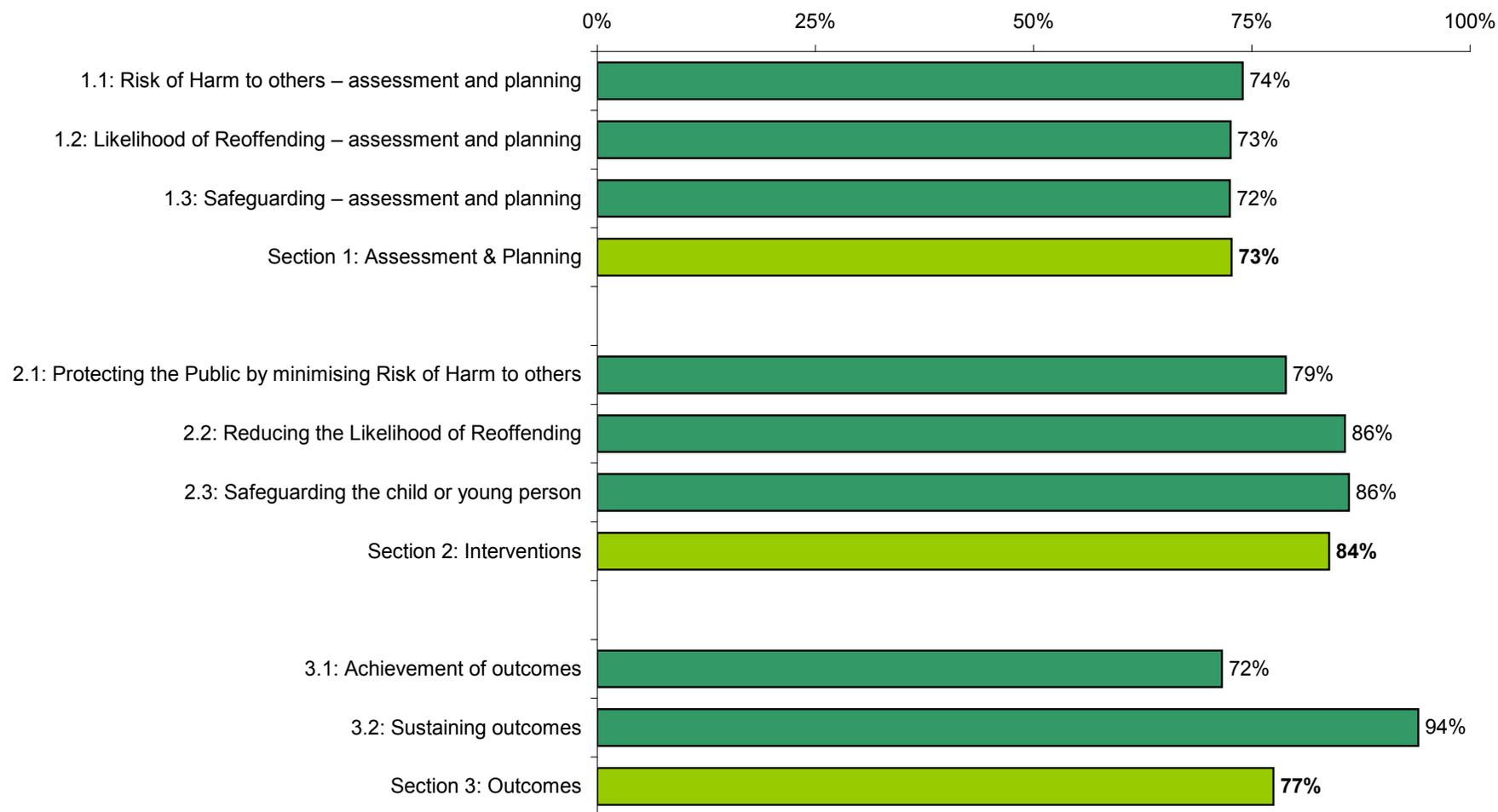
In our judgement, sufficient overall progress had been made to date in relation to the most significant factors that made the child or young person more likely to reoffend, in 53% of cases.

Both of these outcomes were close to the average for YOTs inspected to date.

The findings in respect of sustaining positive outcomes were some of the highest we have seen on this inspection programme.

## Appendix 1: Scoring summary of sections 1-3

### CCI Derbyshire General Criterion Scores



## Appendix 2: Contextual information

### Area

Derbyshire YOS was located in the East Midlands region.

The area had a population of 763,700 as measured in the ONS Mid Year Estimates 2010, 10.2% of which were aged 10 to 17 years old (Census 2001). This was slightly lower than the average for England/Wales, which was 10.4%.

The population of Derbyshire was predominantly white British (96%) (Resident Population Estimates by Ethnic Group 2009). The population with a black and minority ethnic heritage (4%) was below the average for England/Wales of 12%.

Reported offences for which children and young people aged 10 to 17 years old received a pre-court disposal or a court disposal in 2009/2010, at 24 per 1,000, were better than the average for England/Wales of 38.

### YOS

The YOS boundaries were within those of the Derbyshire Police area and the Derbyshire Probation Trust. There were two commissioning Primary Care Trusts; Derbyshire Primary Care Trust covered most of the area, while the Tameside and Glossop Primary Care Trust covered the northern part.

The YOS was located within the Chief Executive's Department. It was managed by the Head of Service, who was based within the Safer Derbyshire Partnership in the County Council.

The YOS Headquarters was in the Derbyshire County Council head office in Matlock. The operational work of the YOS was based in Buxton, Chesterfield and Ilkeston. Derbyshire YOS delivered its own ISS provision.

The YOS Management Board was chaired by a Strategic Director (Policy and Community Safety).

### Youth Justice Outcome Indicators 2011/2012 onwards

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.

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

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

## **Appendix 3: Inspection Arrangements**

Fieldwork for this inspection was undertaken in March 2012 and involved the examination of 62 cases.

### **Model**

The Core Case Inspection (CCI) involves visits to all 158 Youth Offending Teams in England and Wales over a three year period from April 2009. Its primary purpose is to assess the quality of work with children and young people who offend, against HMI Probation's published criteria, in relation to assessment and planning, interventions and outcomes. We look at work over the whole of the sentence, covering both community and custody elements.

### **Methodology**

The focus of our inspection is the quality of work undertaken with children & young people who offend, whoever is delivering it. We look at a representative sample of between 38 and 99 individual cases up to 12 months old, some current others terminated. These are made up of first tier cases (referral orders, action plan and reparation orders), youth rehabilitation orders (mainly those with supervision requirements), detention and training orders and other custodial sentences. The sample seeks to reflect the make up of the whole caseload and will include a number of those who are a high *Risk of Harm to others*, young women and black & minority ethnic children & young people. Cases are assessed by a small team of inspection staff with Local Assessors (peer assessors from another Youth Offending Team in the region). They conduct interviews with case managers who are invited to discuss the work with that individual in depth and are asked to explain their thinking and to show where to find supporting evidence in the record. These case assessments are the primary source of evidence for the CCI.

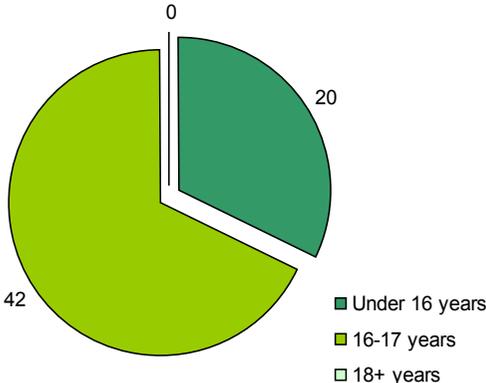
Prior to the inspection we receive copies of relevant local documents and a brief report from the Youth Justice Board. We also gather the views of service users (children & young people and victims) by means of computer and paper questionnaires.

### **Publication arrangements**

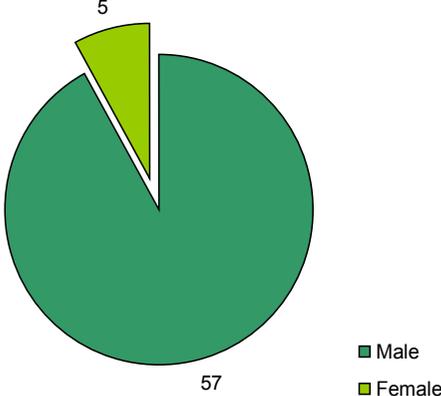
- Provisional findings are given to the YOS two weeks after the inspection visit takes place.
- A draft report is sent to the YOS for comment 4-6 weeks after the inspection, with publication following approximately 6 weeks later. In addition to a copy going to the relevant Minsters, other inspectorates, the Ministry of Justice Policy Group and the Youth Justice Board receive a copy. Copies are made available to the press and placed on our website.
- Reports on CCI in Wales are published in both Welsh and English.

**Appendix 4: Characteristics of cases inspected**

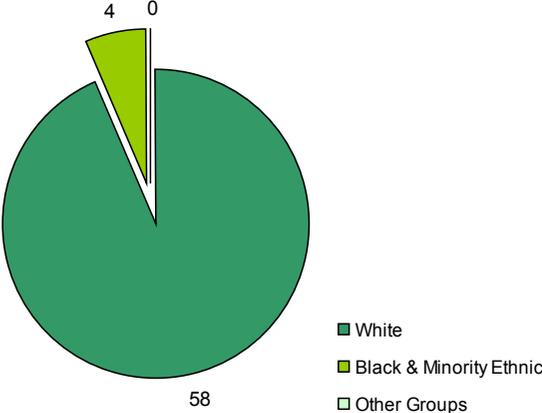
**Case Sample: Age at start of Sentence**



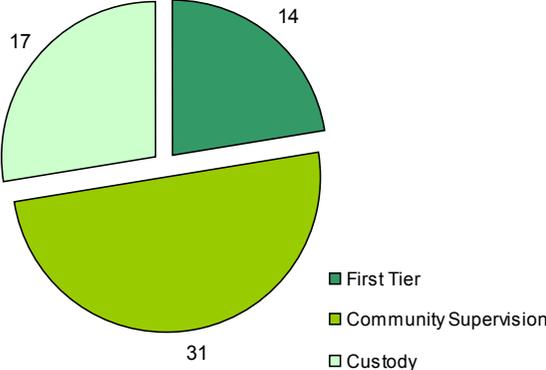
**Case Sample: Gender**



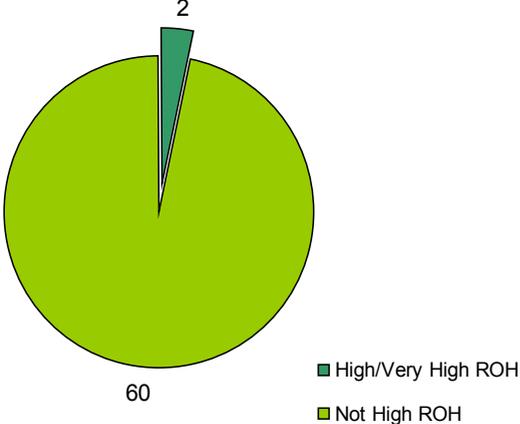
**Case Sample: Ethnicity**



**Case Sample: Sentence Type**



**Case Sample: Risk of Harm**



## Appendix 5: Scoring approach

This describes the methodology for assigning scores to each of the general criteria and to the *RoH*, *LoR* and Safeguarding headline scores.

A typical case consists of elements of work that were done well enough and others where there is room for improvement. Therefore, the question "what proportion of cases were managed well enough?" does not itself provide a meaningful measure of performance and is not useful to inform improvements.

Rather HMI Probation measure the more focused question "how often was each aspect of work done well enough?" This brings together performance on related elements of practice from all inspected cases.

Each scoring question in the HMI Probation inspection tool contributes to the score for the relevant general criterion and section in the report. The performance of the YOT on that aspect of practice is described within the section of the report linked to that criterion. Key questions then also contribute to one or more of the headline inspection scores. In this way the headline scores focus on the key outcomes whereas the general criterion scores include the underlying detail.

The **score for a general criterion** is the proportion of questions relating to that criterion, across all of the inspected cases, where the work assessed by that question was judged sufficient (i.e. above the line). It is therefore an average for that aspect of work across the whole of the inspected sample.

For **each section in the report** the above calculation is repeated, to show the proportion of work related to that section that was judged 'above the line'.

Finally, for each of the **headline themes**, the calculation is repeated on the key questions that inform the particular theme, to show the proportion of that aspect of work that was judged 'above the line'; thereby presenting the performance as an average across the inspected sample.

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.

## Appendix 6: Glossary

ASB/ASBO	Antisocial behaviour/Antisocial Behaviour Order
Asset	A structured assessment tool based on research and developed by the Youth Justice Board looking at the young person's offence, personal circumstances, attitudes and beliefs which have contributed to their offending behaviour
CAF	Common Assessment Framework: a standardised assessment of a child or young person's needs and of how those needs can be met. It is undertaken by the lead professional in a case, with contributions from all others involved with that individual
CAMHS	Child and Adolescent Mental Health Services: part of the National Health Service, providing specialist mental health and behavioural services to children and young people up to at least 16 years of age
Careworks	One of the two electronic case management systems for youth offending work currently in use in England and Wales. See also YOIS+
CRB	Criminal Records Bureau
DTO	Detention and training order: a custodial sentence for the young
Estyn	HM Inspectorate for Education and Training in Wales
ETE	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
HMIC	HM Inspectorate of Constabulary
HMI Prisons	HM Inspectorate of Prisons
HMI Probation	HM Inspectorate of Probation
Interventions; <i>constructive</i> and <i>restrictive</i> interventions	<p>Work with an individual that is designed to change their offending behaviour and/or to support public protection.</p> <p>A <i>constructive</i> intervention is where the primary purpose is to reduce Likelihood of Reoffending.</p> <p>A <i>restrictive</i> intervention is where the primary purpose is to keep to a minimum the individual's <i>Risk of Harm to others</i>. Example: with a sex offender, a <i>constructive intervention</i> might be to put them through an accredited sex offender programme; a <i>restrictive intervention</i> (to minimise their <i>Risk of Harm</i>) 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</p>
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 education, training and employment
LoR	Likelihood of Reoffending. See also <i>constructive</i> 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 <i>Risk of Harm to others</i>
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 <i>Risk of Harm</i>
RoH	<i>Risk of Harm to others</i> . See also <i>restrictive Interventions</i>
'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 <i>restrictive interventions</i> , to keep to a minimum the individual's opportunity to behave in a way that is a <i>Risk of Harm to others</i>
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 <i>probability</i> of an event occurring and the <i>impact/severity</i> of the event. The term <i>Risk of Serious Harm</i> only incorporates 'serious' impact, whereas using ' <i>Risk of Harm</i> ' enables the necessary attention to be given to those offenders for whom lower <i>impact/severity</i> harmful behaviour is <i>probable</i>
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 YOTs determine the frequency of contact with a child or young person, based on their RoSH and LoR
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/YOT/YJS	Youth Offending Service/ 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 young people who offend

## **Appendix 7: 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/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  
6<sup>th</sup> Floor, Trafford House  
Chester Road, Stretford  
Manchester, M32 0RS*