



HM Inspectorate  
of Probation

## The identification of safety concerns relating to children

---

HM Inspectorate of Probation

Research & Analysis Bulletin 2022/05

SEPTEMBER 2022

---

HM Inspectorate of Probation is committed to reviewing, developing and promoting the evidence base for high-quality probation and youth offending services. Our *Research & Analysis Bulletins* are aimed at all those with an interest in the quality of these services, presenting key findings to assist with informed debate and help drive improvement where it is required. The findings are used within the Inspectorate to develop our inspection programmes, guidance and position statements.

This bulletin was prepared by Kevin Ball (Senior Research Officer), Dr Laura Buckley (Research Officer), and Dr Robin Moore (Head of Research) from HM Inspectorate of Probation.

We would like to thank all those who participated in any way in our inspections. Without their help and cooperation, the collation of inspection data would not have been possible.

Please note that throughout the report the names in the practice examples have been changed to protect the individual's identity.

© Crown copyright 2022

You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit [www.nationalarchives.gov.uk/doc/open-government-licence](http://www.nationalarchives.gov.uk/doc/open-government-licence) or email [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third-party copyright information, you will need to obtain permission from the copyright holders concerned.

This publication is available for download at:

[www.justiceinspectorates.gov.uk/hmiprobation](http://www.justiceinspectorates.gov.uk/hmiprobation)

ISBN: 978-1-915468-15-4

Published by:

HM Inspectorate of Probation  
1st Floor Civil Justice Centre  
1 Bridge Street West  
Manchester  
M3 3FX

The HM Inspectorate of Probation Research Team can be contacted via [HMIProbationResearch@hmiprobation.gov.uk](mailto:HMIProbationResearch@hmiprobation.gov.uk)

# Contents

---

Executive summary .....	4
1. Introduction .....	6
2. Findings.....	10
2.1 Classifying safety concerns .....	10
2.2 Quality of assessment.....	15
2.3 Misclassifications in assessment.....	19
3. Conclusion .....	26
References .....	28
Annex A: Methodology .....	31
Annex B: Safety classifications by type of disposal inspected .....	34

## Executive summary

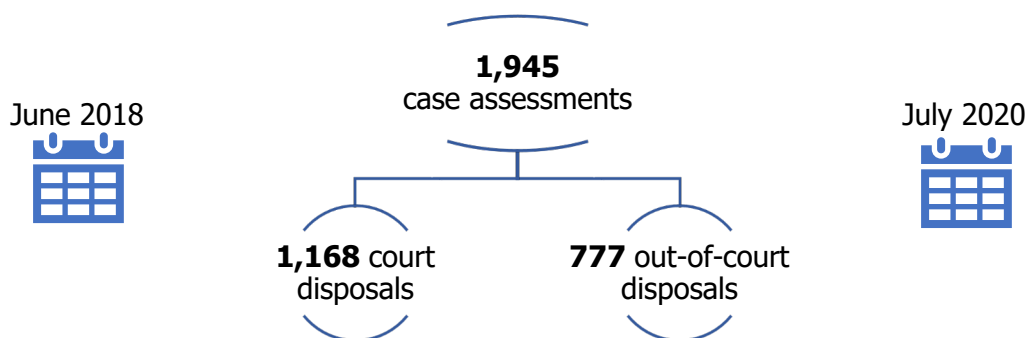
---

### Context

A key objective for those delivering youth offending services is to keep children and other people safe, which sits alongside and supports the all-important nurturing and strengths-focused work that helps children to realise their potential. The focus in this bulletin is upon the *assessment* stage of youth justice work, recognising that it is vital to identify all potential safety concerns and sources of harm in order to mitigate and prevent any dangers. We provide examples of what good and poor assessment looks like in practice, including areas for further attention.

### Approach

The findings presented are based on 43 inspections of youth offending services conducted between June 2018 and February 2020. We present the prevalence rates of safety concerns in relation to both court disposals and out-of-court disposals, and set out the types of safety concerns encountered. Much of the report is based upon a qualitative analysis of the commentaries provided by inspectors in their evaluation of individual cases.



### Key findings and implications

- For many children supervised by youth offending teams (YOTs), there are concerns in relation to their own safety and/or the safety of other people, often other children. Across the cases we inspected, there was a high/very high safety and wellbeing classification in about three in ten (31 per cent) of the cases and a high/very high risk of serious harm classification in about two in ten (19 per cent) of the cases – prevalence rates were higher for court disposals compared to out-of-court disposals.
- The safety concerns relating to the children themselves and to other people were often overlapping and intertwined, with links to the following:
  - carrying knives or other weapons
  - illegal drug possession
  - drug and alcohol misuse
  - adversity and trauma
  - care experience
  - criminal exploitation, including county lines
  - mental health issues
  - domestic abuse
  - family issues
  - negative peer influences.
- The quality of assessment in relation to the safety of the child and the safety of others was more likely to be judged sufficient for those children on court disposals

compared to those on out-of-court disposals. In relation to the latter – particularly for community resolutions – there were instances of assessments not being completed at all, assessments being completed by unqualified or untrained staff, and the use of tools which did not sufficiently consider all relevant circumstances and the full context, hindering a whole-child approach.

- In a relatively large minority of cases, the safety classifications deemed appropriate by the inspector differed from that recorded by the case manager – it was usually judged that the classification should have been higher. Inaccurate classifications of safety concerns can have damaging consequences, especially when classification is too low, as the child loses opportunities for support by the YOT and other partners, and potential victims can be left without protection. Failing to address safety concerns in relation to others can also be seen as potentially detrimental to the individual child as it leaves them in danger of further criminalisation, perhaps imprisonment, and at risk of moral injury (Williamson et, 2021).
- When assessing the safety of the child, common problems included:
  - poor use of assessment tools and insufficient documentation leading to important factors being overlooked
  - a lack of professional curiosity
  - overlooking significant factors which put the child in danger, with concerning comments from the child about their risks not being explored
  - an insufficient focus on safety concerns alongside identified protective factors
  - insufficient attention being paid to contextual safeguarding
  - a lack of consideration of potential future risks and adverse outcomes
  - an assumption that risks were addressed through periods in custody
  - a failure to recognise heightened concerns when reviewing.
- When assessing the safety of others, misclassification was often driven by these issues:
  - a poor understanding of risk of serious harm
  - a failure to note all elements of risk
  - an insufficient use of partner information
  - over-optimism about risks and contexts, with a minimisation of serious events or underplaying factors linked to risk of serious harm
  - accepting the child's account without seeking further information or enacting professional curiosity
  - assessments remaining out of date and not being reviewed following new information and events
  - too little or no consideration of future risks and the potential for escalation.
- High workloads and other staffing problems sometimes undermined the quality of assessment of safety issues. Sound assessments of safety concerns were more likely where YOT case managers:
  - were organisationally supported by strong partnership arrangements
  - had ready access to all required information
  - had time to reflect and review their practice with managers and colleagues
  - displayed professional curiosity and an analytical mindset in understanding the life of the child.

# 1. Introduction

---

This bulletin focuses upon the assessment stage of youth justice work and the role that this plays in keeping the child and others safe. Alongside the focus on supporting the positive pro-social development of children, accurate and evaluative assessment of a child's own safety and the safety of others is the bedrock of effective youth justice work.

The Youth Justice Board's standards for children in the youth justice system 2019 set out the following requirements:

- out-of-court disposals: 'YOTs must undertake a timely and accurate, suitable and sufficient assessment of risk and of need for all children referred to the YOT'
- court disposals: 'make sure that the assessment is dynamic and ongoing and is commenced at the start of every order and for every pre-sentence report. It should take account of the child's broader context, previous offending, impact on victims, public protection, safety and wellbeing, and factors that influence desistance from crime'.

HM Inspectorate of Probation is clear that work to keep the child and others safe sits alongside and supplements the all-important supportive, nurturing and strengths-focused work with children. In our joint statement with the Youth Justice Board, we reinforced this message:

*'When working with children both HM Inspectorate of Probation and the Youth Justice Board (YJB) advocate actions to reduce a risk of harm – to that child or others, better worded as ensuring safety and wellbeing of all. We are in complete agreement that access to services for children is crucial in meeting their needs and preventing offending and reoffending.'*

*'As set out in the HM Inspectorate of Probation standards framework for inspecting youth offending services, the focus is upon the delivery of high-quality, well-focused, personalised and coordinated services which engage and assist children.'* (HM Inspectorate of Probation/Youth Justice Board, 2022)

It is a relatively small minority of children whose behaviour poses a risk of serious harm; they can often be highly vulnerable and have experienced crime and trauma in their own lives. Helpful guidance for working with children who pose a risk of serious harm is set out by the Children and Young People's Centre for Justice (2022) in Scotland; it is stated that practitioners should:

- 'put the child at the centre and develop a shared understanding within and across agencies
- use common tools, language and processes
- consider the child as a whole
- promote closer working where necessary with other practitioners.'

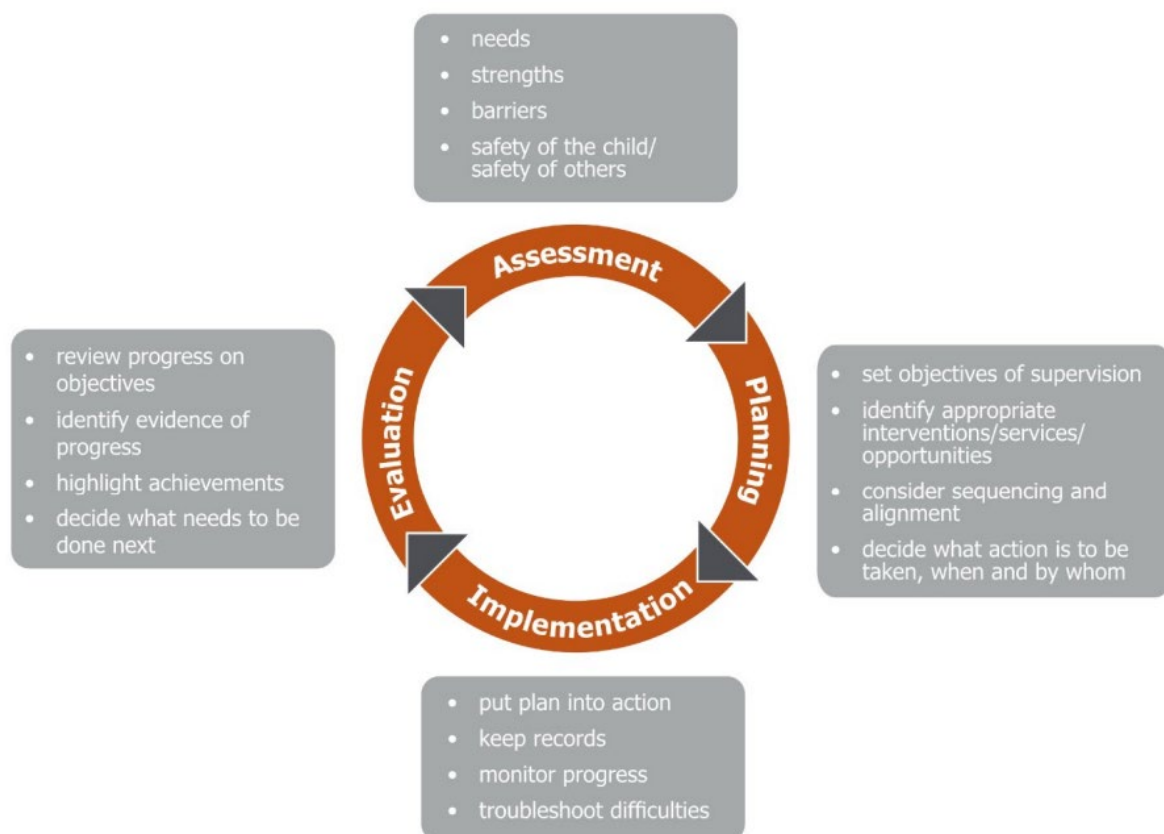
Also in Scotland, the Framework for Risk Assessment, Management and Evaluation (FRAME) emphasises that assessment is a process that involves four key aspects – Identification, Analysis, Evaluation and Communication – while the getting it right for every child (GIRFEC) national practice model promotes the participation of children and their families in gathering information and making decisions as central to assessing, planning and taking action.

The GIRFEC model also defines needs and risks as two sides of the same coin. A similar point is made by Kemshall (2021) in terms of desistance and risk management. She concludes that a blended approach of *protective integration* helps to promote safety for all, while supporting desistance from offending and antisocial behaviour. Children need to be able to safely integrate back into family and friendship groups, education or employment, and the wider community. Thus, practitioners need to remain mindful of safety concerns while working with partners to support the child’s pro-social development.

Within England and Wales, the main structured assessment tool used by YOT practitioners is *AssetPlus*. It was designed to combine the assessment of offending-related needs and risk of serious harm with the insights of the Good Lives Model of rehabilitation and desistance theory (Baker, 2014; Wong and Horan, 2021). Practitioners are required to identify and analyse concerns relating to the safety of the child and to others, individual and social needs, strengths and protective factors – the latter being those positive and constructive elements of a child’s life and circumstances.

Judgements about the quality of YOT work by our inspectors are structured according to the ASPIRE model for case supervision (see Figure 1), which recognises that for delivery to be tailored to the individual child, both assessment and planning must be undertaken well.

**Figure 1: ASPIRE model**



We expect to see assessment that is proportionate to the nature of the child’s offending, circumstances and the type of sentence. We look for evidence from a range of sources, including case records and interviews with case managers. We judge the quality of the assessment process in its entirety, and we do not require the use of any specific assessment

tool or document in out-of-court disposal cases. Within our standards framework,<sup>1</sup> the assessment standard and key questions are as follows:

Assessment is well-informed, analytical and personalised, actively involving the child and their parents/carers.

- Does assessment sufficiently analyse how to support the child's desistance?
- Does assessment sufficiently analyse how to keep the child safe?
- Does assessment sufficiently analyse how to keep other people safe?

Our inspection standards are grounded in evidence, learning and experience. In terms of recent evidence, Holmes and Smith focus on the concept of Transitional Safeguarding in our [Academic Insights paper 2022/03](#). Considerations for direct practice include the need for assessments to balance an evaluation of both the individual needs and developmental stage of the young person and the structural and contextual factors that influence their lives. Furthermore, the impact of trauma and adversity should be explored in relation to an individual's offending behaviour and decision-making, and professionals must be alert to the potentially re-traumatising effects of describing past harms.

In our [Academic Insights paper 2020/07](#), Firmin sets out how Contextual Safeguarding has changed the response of child protection systems to young people at risk of significant harm in extra-familial settings and relationships. Different forms of extra-familial harm present various welfare risks, and plans to address these harms need to attend to the contexts and associated environmental factors. Attention is then given by Firmin to how staff working in a youth justice context can integrate a Contextual Safeguarding approach, including through incorporation within assessment frameworks.

More generally, in our [Academic Insights paper 2022/04](#), Chard states as follows:

'Risk assessment should not simply be based upon immediately identifiable risk factors but should be located within the history of the family and the experiences of the child, as well as within structural issues related to poverty, educational and social exclusion, and the availability and ability to access services.'

There is further relevant learning from serious child safeguarding incidents. In their review of such incidents, the Child Safeguarding Practice Review Panel (2021) report that there is often a lack of 'professional curiosity' and 'over-optimism', with assumptions remaining unchanged in spite of continuing or spiralling risk. They set out the following learning in relation to assessment:

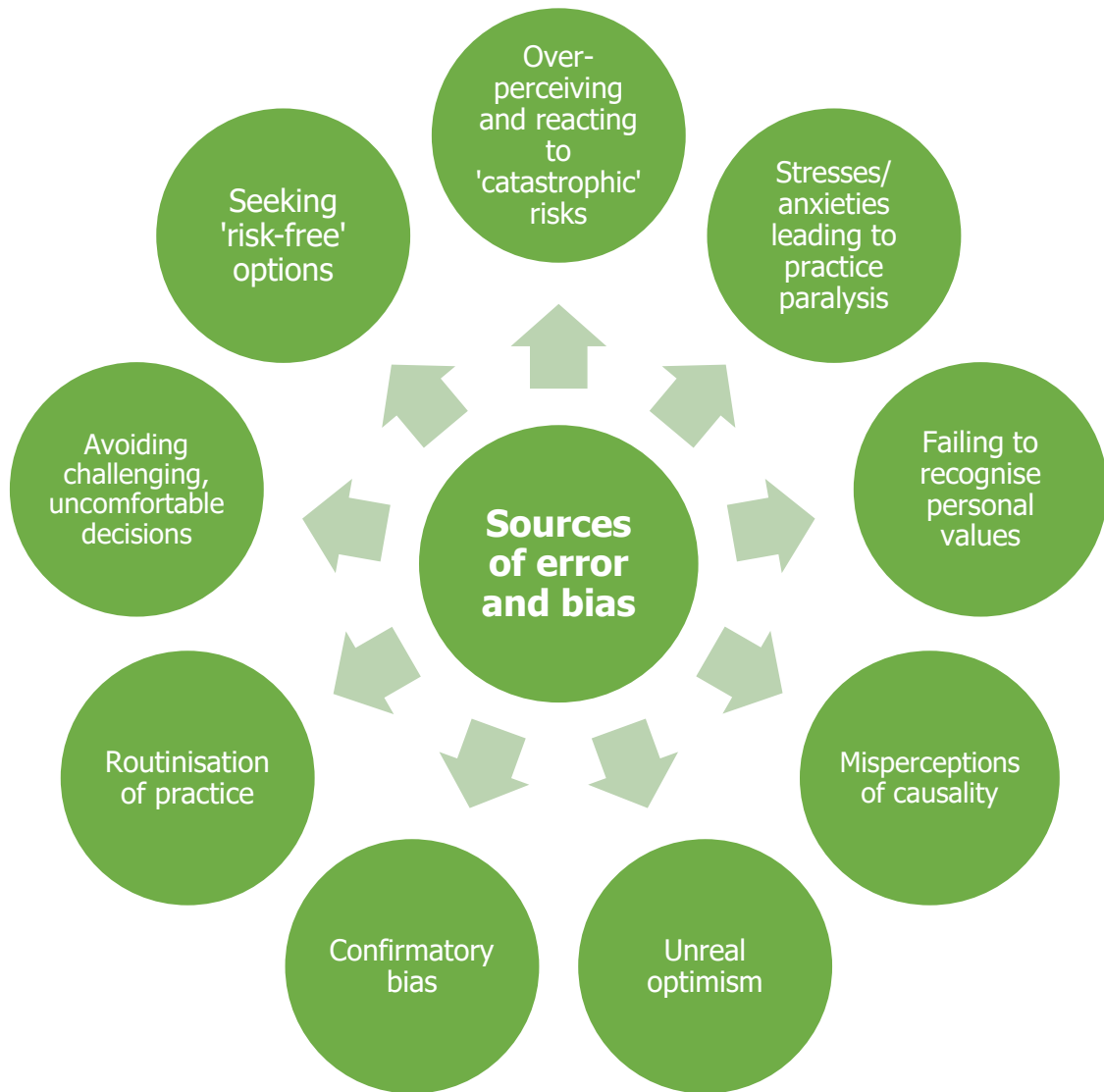
- a mindset of 'respectful uncertainty' supports the effective identification of risk factors and the mitigation of risk, underpinned by comprehensive assessment
- up-to-date and appropriate evidence-based tools support assessment but they require critical reflection about the evidence to inform next steps
- in assessing risk in adolescents, it is important to understand and observe a 'risk trajectory'.

---

<sup>1</sup> The full standards framework can be found here: <https://www.justiceinspectors.gov.uk/hmiprobation/about-our-work/our-standards-and-ratings/>. There are assessment standards for both court disposals and out-of-court disposals, with further information at the lower prompt level.



A wide-ranging field of literature on risk perception has identified a number of potential sources of error and bias, which have been summarised by Kemshall in our [Academic Insights paper 2021/14](#), as set out in the figure below. To minimise error and ensure that decisions are balanced, reasoned and well-evidenced, Kemshall highlights the need for practitioners to seek and critically appraise information, and adopt an open, honest and reflective approach. At the organisational level, senior managers need to ensure that risk policies, procedures and assessment tools are unbiased and fit for purpose, with appropriate quality assurance, monitoring and training in place.



## 2. Findings

The findings presented in this bulletin are based upon the case assessment data from 43 YOT inspections conducted between June 2018 and July 2020. We inspected 1,168 court disposals and 777 out-of-court disposals, with inspectors making judgements about the quality of assessment in these individual cases. Further information about the inspections and the analysis undertaken can be found in Annex A.

In the following sections, we seek to explore the types of safety concerns that children face as well as those they pose, and provide examples highlighting what good assessment looks like in practice. We also provide insights into the main reasons why inspectors deemed some safety classifications to be incorrect.

### 2.1 Classifying safety concerns

#### 2.1.1 Safety of the child

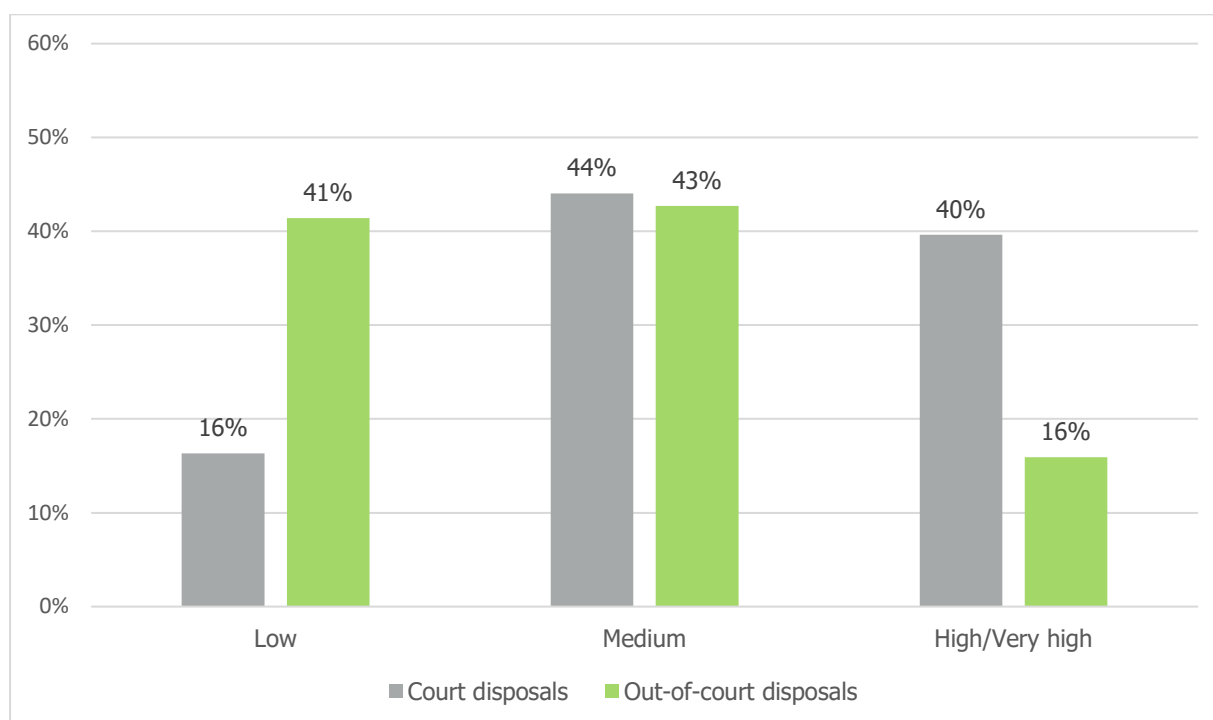
Taking into consideration the range of factors in the child's life which have the potential to undermine their safety and wellbeing, case managers decide upon the most appropriate classification. There are four classification levels:

Very high	<ul style="list-style-type: none"><li>•The negative safety and wellbeing concern could happen immediately, and the impact will be serious.</li></ul>
High	<ul style="list-style-type: none"><li>•A high risk that a potential negative safety and wellbeing outcome will occur, and the impact could be serious.</li></ul>
Medium	<ul style="list-style-type: none"><li>•Some risk of safety and wellbeing concerns identified, but they are unlikely to cause serious safety and wellbeing adverse outcomes unless circumstances change.</li></ul>
Low	<ul style="list-style-type: none"><li>•No specific behaviours, events, or people likely to cause an adverse outcome.</li></ul>

In all inspected cases, inspectors recorded the safety and wellbeing classification, as judged by the case manager. As might be expected, a higher proportion of children on court orders had a high/very high safety and wellbeing classification (40 per cent) compared to those on out-of-court disposals (16 per cent). The percentages of each classification are presented in Figure 2 below.<sup>2</sup>

<sup>2</sup> See Annex B for a tabular breakdown.

**Figure 2: Safety and wellbeing classification according to case manager**



We can see that for a significant proportion of the children supervised by YOT's, and especially those on court orders, there were serious concerns regarding their safety and wellbeing. Further evidence in relation to the vulnerability of these children can be found when looking at the percentage of inspected cases where the child had been subject to a Child Protection Plan<sup>3</sup> or Section 47 enquiry<sup>4</sup> during the disposal inspected. For those subject to court disposals, approximately one in five were found to have a plan or enquiry (22 per cent), while for those on out-of-court disposals, this figure was slightly lower at 14 per cent.

In addition, whereas only around 1.5 per cent of the general population are likely to be a 'Looked After Child',<sup>5</sup> children in conflict with the law are much more likely to be looked after, with nearly 50 per cent of under 21-year-olds in contact with the criminal justice system having spent time in care – Day (2021) states that 'the disproportionate representation of care-experienced children in the youth justice system therefore remains a significant and persistent challenge to academics and policy makers'. Approximately a quarter (26 per cent) of children in our sample of court orders were looked after at some point in the sentence, and around one in ten (nine per cent) of those subject to out-of-court disposals.

---

<sup>3</sup> Any child which has been the subject of a child protection case conference where a decision has been made that they have suffered serious harm or are at risk of suffering serious harm must have a child protection plan.

<sup>4</sup> Under Section 47 of the Children Act 1989, where a local authority has reasonable cause to suspect that a child is suffering or likely to suffer significant harm, it has a duty to make such enquiries as it considers necessary to decide whether to take any action to safeguard or protect the child's welfare.

<sup>5</sup> Calculated using ONS Mid-Year Estimates and <https://homeforgood.org.uk/statistics>.

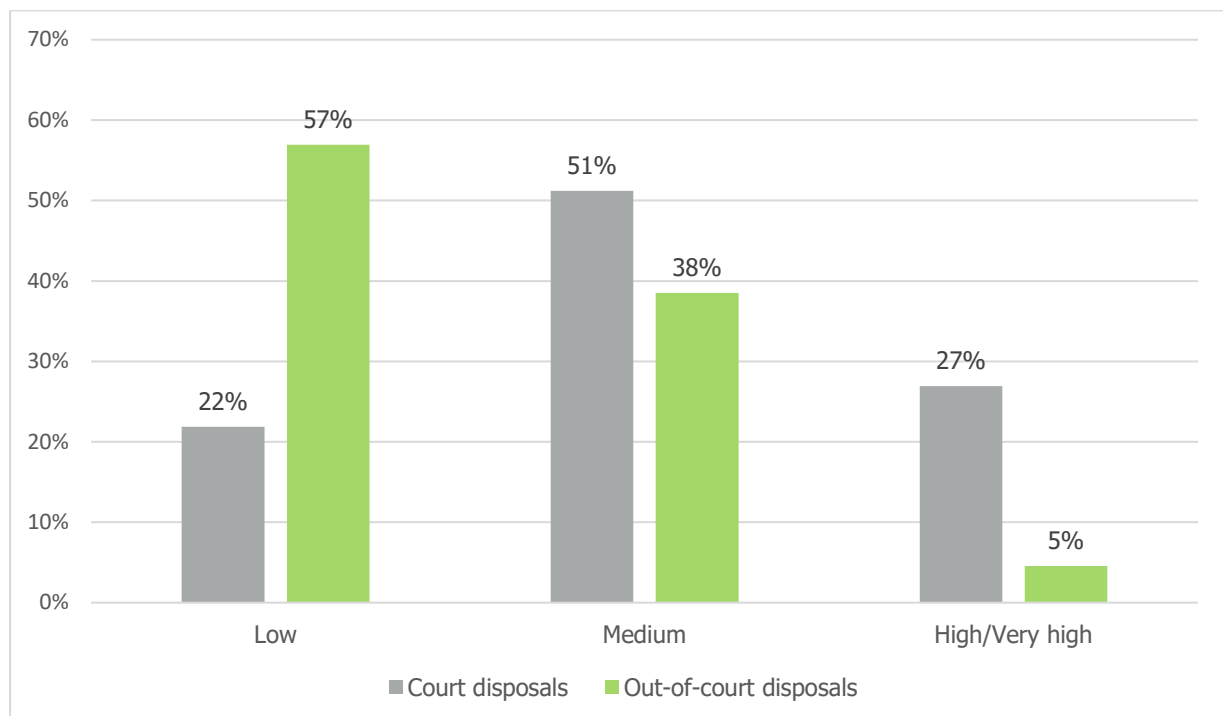
### 2.1.2 Safety of other people

Taking into consideration the relevant information and evidence relating to a child and all contextual factors, case managers decide upon the most appropriate classification in terms of risk of serious harm. Once again, there are four classification levels:

Very high	•The risk of serious harm concern could happen imminently, and the impact would be serious. Case will need increased case supervision.
High	•High risk that a potential risk of serious harm outcome will occur, and the impact could be serious. Case may need increased supervision.
Medium	•Some risk of harm concerns have been identified, but is unlikely to cause serious harm unless circumstances change. Can be managed under normal case management.
Low	•No specific behaviours, events, or people likely to cause an adverse outcome.

In all cases, inspectors recorded the risk of serious harm classification, as judged by the case manager. As with the safety and wellbeing classification, a higher proportion of children on court orders had a high/very high risk of serious harm classification (27 per cent) compared to those on out-of-court disposals (five per cent). The percentages are set out in Figure 3 below.

**Figure 3: Risk of serious harm classification according to case manager**

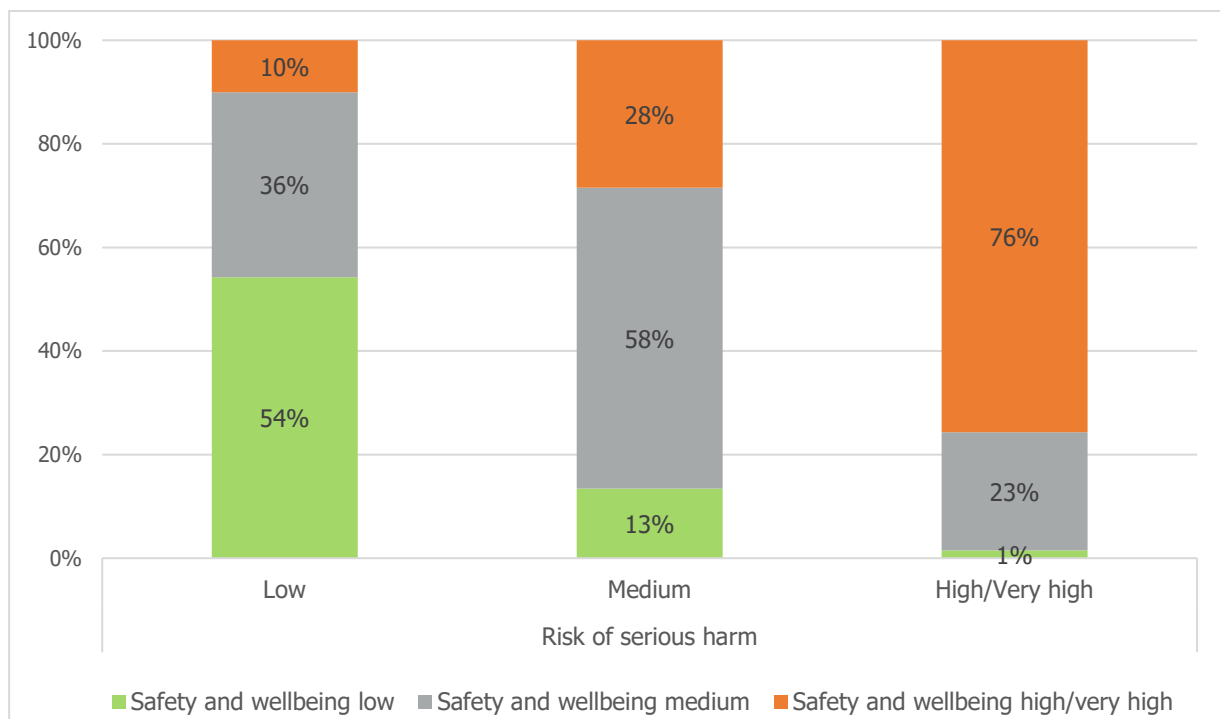


Children displaying violent behaviours make up a large and growing proportion of the statutory YOT caseload (see, for example, [Academic Insights paper 2021/13](#)), and within the cases we inspected, 'violence against the person' was the most common current offence – recorded in 48 per cent of the court disposal cases and 44 per cent of the out-of-court disposal cases. However, it is important to recognise that 'violence against the person' covers a broad spectrum of offences from the relatively minor (even non-contact) to the gravest crimes.

### 2.1.3 Overlapping safety concerns – key themes

The safety concerns relating to the children themselves and to other people were often intertwined and very much 'two sides of the same coin'. Across all the court disposals and the out-of-court disposals we inspected, the two classifications aligned in six out of ten of the cases. In those cases where there was a high/very high risk of serious harm classification, there was a corresponding high/very high safety and wellbeing classification in about three-quarters (76%) of the cases (see Figure 4), demonstrating the need to think about the safety and wellbeing of all.

**Figure 4: Safety and wellbeing classifications by risk of serious harm classification**



In each inspected case, a summary is produced by inspectors, which includes details of the identified safety concerns. Thematic analysis of a sample of the court disposal commentaries revealed the following major themes, further demonstrating the overlapping safety concerns in relation to the children themselves and to other people:

- Carrying knives or other weapons

*"Jay was assaulted by a group of peers approximately one year ago, and it is assessed that his index offence (possession of an offensive weapon) is linked to his distorted view that carrying a knife will make him feel safe."*<sup>6</sup>

- Illegal drug possession

*"Joshua was supplying small amounts of cannabis and being paid to do so. The YOT tried to establish the extent to which he was being exploited and looked for ways for him to disclose this, for example, through the groupwork programme. The groupwork was designed to help him gain insight into exploitation."*

- Drug and alcohol misuse

*"Simon, a 17-year-old boy, received a three-month referral order for taking his mum's car and going for a practice drive to a local car park when he had been drinking. A positive case based on a thorough and detailed assessment, well planned interventions, good engagement with parent and the panel members. Work delivered as planned and a positive outcome for the boy with no repeat of the offence."*

- Adversity and trauma

*"Neil has significant adversity and trauma and family relational issues which has impacted on his desistance."*

- Care experience

*"Chris was a 16-year-old boy serving a twelve-month youth rehabilitation order for possession of a bladed article, ten incidents of criminal damage, and attempted burglary. Chris was a 'Looked After Child', and he had been in approximately twenty places within a year. He had complex needs, including fire-setting placing himself and others at risk. There were other concerns around violence and aggression and being in possession of a knife."*

- Criminal exploitation, including county lines

*"Ivan was 18 years old and received a six-month custodial sentence for possession of a weapon and drugs. The YOT had known Ivan since he was 15, and he had been a 'Looked After Child' since that time. Ivan was believed to have been exploited, and now was at risk of exploiting others."*

- Mental health issues

*"Harold was 17 years old; he was sentenced to a referral order for possession of a knife. Harold presented with many complex needs including psychosis, homelessness, and involvement in drug distribution. His risk of serious harm to others and risk to self are inextricably linked, and he was assessed as high risk across all three domains of serious harm to others, likelihood of reoffending, and safety and wellbeing."*

---

<sup>6</sup> Other research studies have reported children carrying knives because they were scared and wanted to be able to protect themselves (see Gray et al., 2021).

- Domestic abuse

*"There is a history of social care involvement with the family, with the children having been subject to Child in Need and Care Plans in the past due to neglect and domestic abuse concerns."*

- Family issues

*"Leonard was a 14-year-old boy sentenced to a 12-month youth rehabilitation order for theft of a cycle. He had previous offences for burglary, including other cycle thefts from a home. Leonard was assessed as medium risk of serious harm due to aggression in the family home. Leonard lived in a chaotic household with two older siblings who were involved with offending, and he lacked positive male support and parental boundaries."*

- Negative peer influences

*"Jake was 18 years old and received a three-month referral order for motoring offences while under the influence of cannabis. He had an emerging pattern of motoring offending under the influence of drugs, and he had access to vehicles via his older peer group. He has experienced trauma from family experiences and was taken into care for a short period. Jake was moved from a mainstream school due to his behaviour, and placed into alternative provision."*

## 2.2 Quality of assessment

In all inspected cases, our inspectors judged whether the quality of assessment was sufficient, considering the range of information gathered and the circumstances and characteristics of the individual child. In relation to the safety of the child, it is considered whether assessment satisfies the following requirements:



clearly identify and analyse any risks to the child's safety and wellbeing



draw sufficiently on available sources of information, including other assessments, and involve other agencies where appropriate



analyse controls and interventions to promote the safety and wellbeing of the child.

Assessment should clearly identify the nature of any risk, why that risk is present, and the likelihood and imminence of the risk to the child. This should include any external sources of concern, such as familial abuse or neglect, exploitation by older or more sophisticated offenders, sexual exploitation or bullying, as well as internal sources which could include mental or physical health, substance misuse, risk-taking or a low sense of self-worth. The YOT should also consider the impact of the child's own behaviour on their safety and wellbeing, which should include identifying any physical or mental health concerns, missing from home episodes, substance misuse or risk-taking behaviour.

In terms of the safety of others, it is considered whether assessment satisfies the following requirements:



clearly identify and analyse any risk of harm to others posed by the child, including identifying who is at risk and the nature of that risk



draw sufficiently on available sources of information, including past behaviour and convictions, and involve other agencies where appropriate



analyse the controls and interventions used to manage and minimise the risk of harm presented by the child.

We expect any and all factors related to risk of harm – not just factors related to risk of serious harm – to be set out, described, and analysed. Furthermore, risk of harm assessments should take into consideration the following:

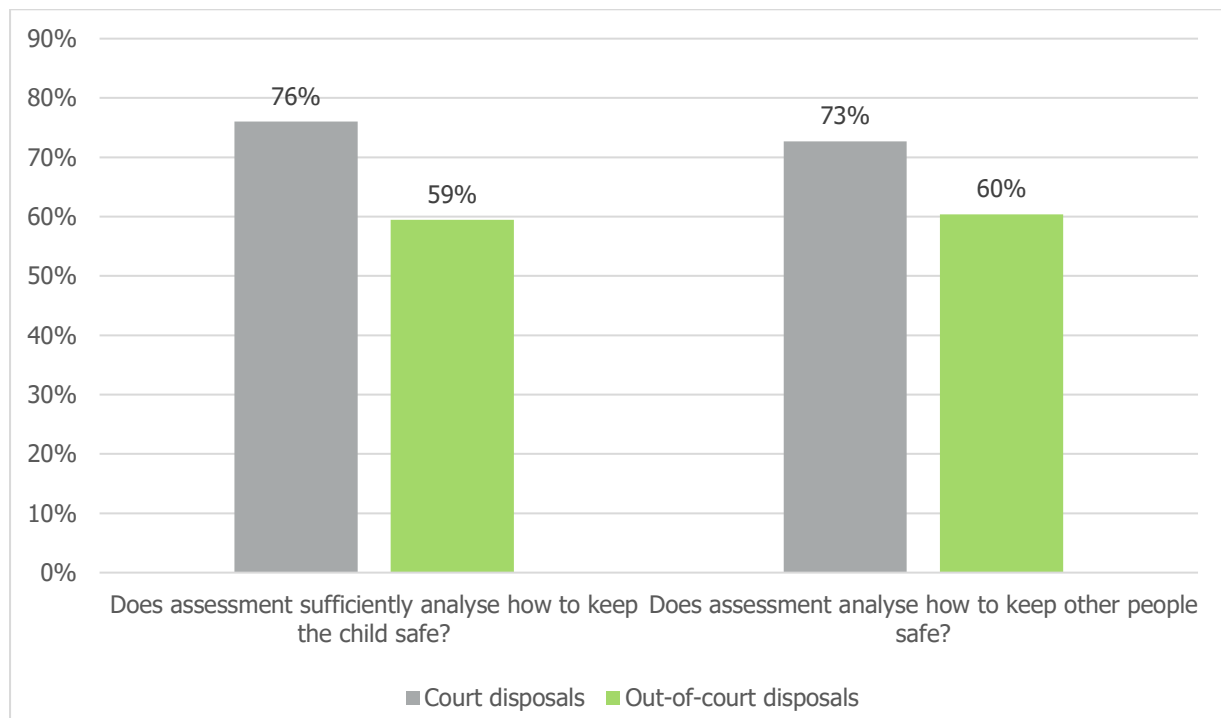
- static risk factors, including age, gender and nature, number and circumstances of previous convictions
- dynamic risk factors including acute risk factors which have the potential to change quickly, and stable risk factors that may change over a longer period
- strengths of the child, including internal protective factors
- resources available to the child or external protective factors
- capacity and motivation to change.

If there is an identified person at risk (for example, parent, sibling, peer, partner, or ex-partner), this should be clearly highlighted. Assessment should clearly state the nature of any risk to others, why that risk is present, and the likelihood and imminence of the risk. Where specific actual or potential victims cannot be identified, assessment should look for patterns in previous behaviour, and explain any group of potential victims, such as peers, partners, or shop security staff. Where risk factors indicate that the child could cause multiple types of future harm (such as sexual harm, physical harm, or emotional harm), assessment should clearly state which type of harm is likely to be caused to which potential victims.

Across the inspected cases, assessment of safety concerns, both in relation to the child and to others, was more likely to be judged sufficient for those children on court disposals than those on out-of-court disposals. As set out in Figure 5 below, assessment was deemed to be sufficient in approximately six out of ten of the inspected cases for children subject to out-of-court disposals. We further examined the quality of delivery of out-of-court disposals in our [Research & Analysis Bulletin 2021/05](#), reporting how assessment was less likely to be judged sufficient for community resolutions compared to youth conditional cautions. There were instances of assessments not being completed at all, assessments being completed by unqualified or untrained staff, and the use of tools which did not sufficiently consider all relevant circumstances and the full context, hindering a whole-child approach. We also found that limited work with other relevant agencies, such as schools, social services or police, could lead to an incomplete view of relevant safety issues and inadequate assessments. Given that many out-of-court disposals last only a few months, important information was sometimes missed until it was too late.



**Figure 5: Sufficiency of assessment, by type of disposal**



As set out in the previous section, safety concerns relating to the children themselves and to other people are often overlapping and intertwined, further promoting the need for a holistic response from the YOT and its partners. This is illustrated within the following practice examples.

### Good practice examples

#### Criminal exploitation

*Ben, a 16-year-old boy, had previously received two custodial sentences. On this occasion, he was given an 18-month youth rehabilitation order with intensive supervision and surveillance for several incidents of robbery and burglary. The YOT had significant concerns in relation to Ben being a victim of child criminal exploitation through county lines.*

*The assessment and plan were comprehensive with input from a range of agencies to manage the range of safety concerns and needs. There were daily risk briefings and regular complex strategy meetings with appropriate action plans. The YOT was able to provide a range of interventions which included mentoring and positive activities.*

#### Knife crime

*Samuel, a 16-year-old boy, was arrested in possession of a bladed article. He had no previous convictions and was given a nine-month referral order, with conditions of completing appropriate offence-related programmes, victim awareness work, and twenty hours reparation activity. By the time of his sentencing, Samuel was under investigation for new and more serious offences of robbery and burglary. Samuel's referral order was revoked, and he was resentenced to a two-year youth rehabilitation order with intensive supervision.*

*There was a comprehensive, analytical, assessment by the YOT of the offending and his circumstances, followed by a sound plan to deliver appropriate services to Samuel. He engaged well but did not attend all sessions – this was appropriately challenged by his*

caseworker. Samuel eventually realised the impact that his antisocial peers were having upon him and sought help and support from the caseworker. With a voluntary package of curfew and electronic tag to support his desire to break from these peers, Samuel restarted education, and had obtained a part time job.

### **Trauma and complex lives**

*Kelvin, now an 18-year-old young man, had received a three-month referral order for taking a motor vehicle without the owner's consent. He had previously been in care but had returned to live with his mother after a period in foster care and placement.*

*Kelvin was nine years old when his father went to prison for the rape and attempted murder of Kelvin's mother. He had a diagnosis of Obsessive-Compulsive Disorder, which appeared to be well managed with coping strategies in place. Some of his friends were known to the police, and Kelvin understood that his peer group could have a negative influence upon him.*

*The assessment contained a detailed analysis of Kelvin's traumatic experiences, and the protective factors in place to keep him safe. Before meeting Kelvin, the case manager requested information from social care, the Child and Adolescent Mental Health Service (CAMHS), substance misuse services, and the police, and he had maintained contact with professionals to review any changes to Kelvin's safety and wellbeing. The impact of the pandemic on the Kelvin's mental health was monitored, and additional coping strategies were implemented.*

### **Poor practice example**

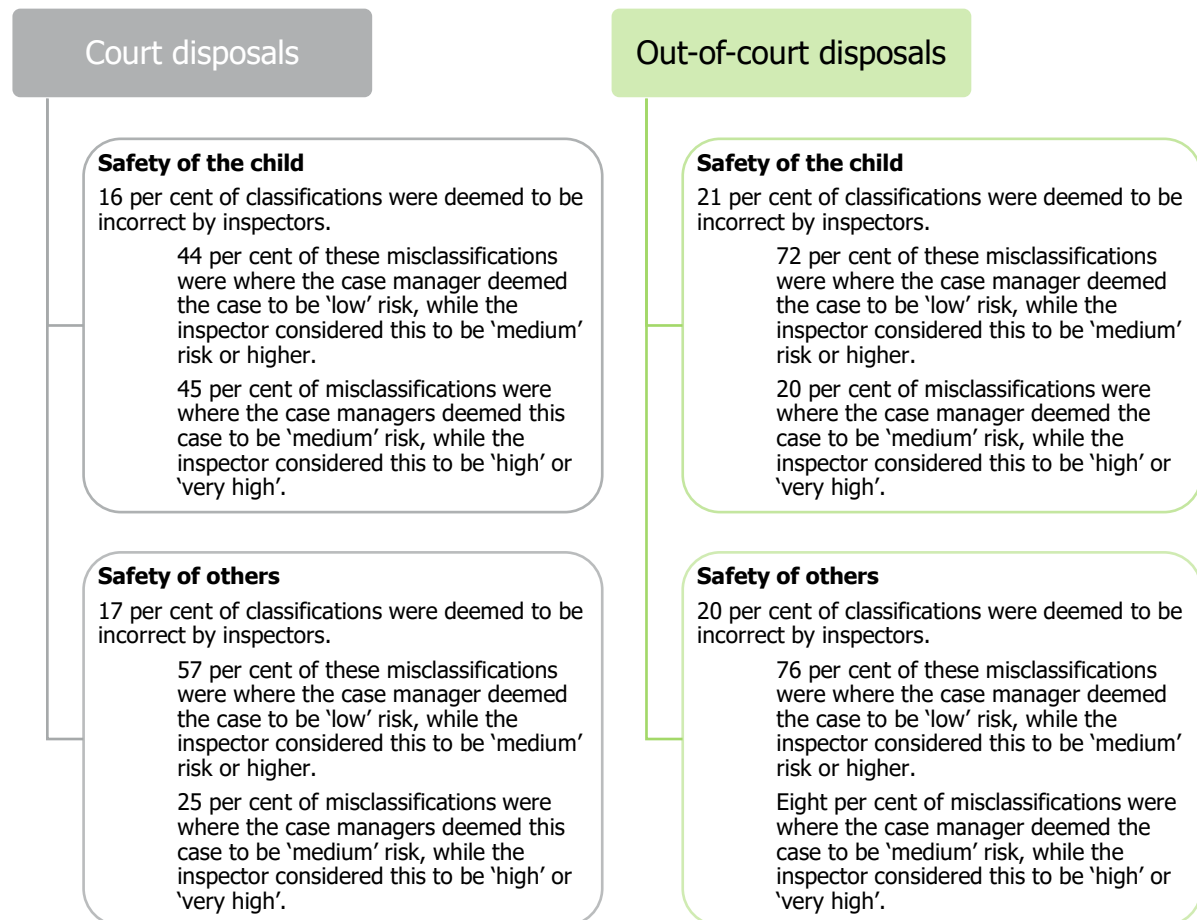
#### **Sexual abuse, care experience, domestic violence**

*Sameena, now 18 years old, had been placed on a referral order when aged 17 following threatening behaviour towards care staff. She had previously left the parental home following violent behaviour, and there were allegations of other assaults and threats to care home staff, which were not pursued.*

*Sameena had mental health needs and other vulnerabilities. She had previously reported sexual assault by a male relative, and she had reported being in an abusive relationship with a male, about whom limited information was known. Unfortunately, there was a failure to sufficiently assess the safety issues and the dangers from others – the intervention plan was therefore insufficient. There should have been an escalated referral to mental health services, and there was a lack of professional curiosity or appropriate response when there were significant changes or new information about Sameena's safety. There had been limited impact from the work undertaken with Sameena.*

## 2.3 Misclassifications in assessment

Our inspectors record what they consider to have been the correct classification at the start of the sentence in relation to the safety of the child and the safety of others. In a large minority of cases, the classification deemed appropriate by the inspector differed from that recorded by the case manager. As set out below, it was usually judged that the classification should have been higher.



### 2.3.1 Safety of the child

The commentaries recorded by our inspectors provide rationales for why they disagreed with the case manager classification in relation to the safety of the child. In some instances, inspectors felt that YOT workload or staffing problems undermined the quality of assessment. Other key themes were as follows:

- poor use of assessment tools and insufficient documentation of the case, leading to important factors being overlooked
- a lack of multi-agency input into the assessment process
- a lack of professional curiosity, with the caseworker too readily accepting the version of events given by the child or their parents/carers without cross referencing this with other evidence that was, or could have been, available. In other cases, concerning comments from the child about their risky situation were only briefly explored or were overlooked altogether
- assessment focusing upon a single issue and overlooking other significant factors

which put the child in danger, such as potential grooming or drug taking. There were examples where the child was not identified as a victim, for example, a child was portrayed by a practitioner as exploiting others for gifts when the evidence suggested they were being groomed

- an insufficient focus on safety concerns alongside the identified protective factors, thus failing to understand the whole context of the child's life
- insufficient attention being paid to contextual safeguarding, such as the influence of peers involved in criminal activity, gangs, and carrying knives
- managers not always considering potential future risks and possible adverse outcomes
- unjustified assumptions that risks were addressed through periods in custody
- a failure to recognise heightened concerns when reviewing.

In many of the misclassified cases, the levels and complexities of the vulnerabilities faced by the child had not been fully appreciated and recognised by the case manager. Assessments did not always consider emotional difficulties or mental health issues. This could include evidence of self-harm, displaying signs of depression and anxiety, substance misuse, the impact of criminal justice involvement, or traumatic brain injury (see [Academic Insights paper 2021/09](#)). Inspectors recorded some children presenting considerable mental health needs, such as psychosis and difficulties in regulating emotions, who were inappropriately classified as medium in terms of safety and wellbeing when this should have been higher.

*"The vulnerability of the young person was not recognised. The psychiatric report states he may become a high risk of suicide if he has a prolonged custodial sentence and clearly identifies that this is a young person who has been traumatised by witnessing his friend being tortured and murdered in front of him."*

Trauma was not always properly recognised, such as having been physically abused, raped, exposed to dangerous situations, or having experienced bereavement.

*"This child had experienced considerable childhood trauma. This includes his mother being a heroin addict, his father being murdered in the front garden of the family home, one brother being killed in a car crash, and another dying by suicide. He was originally removed from the family home and placed with extended family but due to their verbal and physical abuse towards him, he was later placed in the care of the local authority."*

Risks and challenges at home were not always given enough consideration, or not analysed in sufficient depth, such as emotional abuse, family breakdown, or domestic abuse.

*"Jamie was subject to a Child Protection plan due to neglect and emotional abuse and there was evidence of Jamie witnessing domestic abuse within the home, which was fuelled by dad's alcohol use. Despite these concerns, the case manager cited neglect and domestic abuse as being 'possible' adverse outcomes and scored safety and wellbeing as medium rather than high."*

Finally, vulnerability related to criminal and sexual exploitation was not always fully considered, particularly in cases involving country lines.

*"The assessment is a pull through from a previous assessment whilst on remand and does not adequately reflect the current circumstances in respect of the conviction for drug supply linked to criminal exploitation by older/entrenched"*

*offenders. When combined with other safety concerns, this increases the safety and wellbeing level to high."*

### **Poor practice example**

#### **Safety and wellbeing misclassification**

*Chris, a 14-year-old boy, received a six-month referral order for an offence of common assault and criminal damage. The victim in both instances was his mother.*

*Numerous vulnerabilities were identified in the initial assessment including cannabis use, difficulties with emotional regulation as the result of trauma, neglect, witnessing domestic violence between his parents, his father being in prison, his mother being a drug user, and currently not being in mainstream school due to behaviour.*

*The case manager had assigned a low safety and wellbeing classification which the inspector highlighted as incorrect. The case manager had been well supported by their manager in relation to the case and had been given a lot of reflective time and supervision discussing the details. This led the inspector to note that they had concerns as to how the case still had a low safety and wellbeing classification, particularly as the case manager had identified all the risk factors and was addressing some of them in practice.*

### **2.3.2 Safety of others**

The commentaries recorded by our inspectors also provide rationales for why they disagreed with the classifications of risk of serious harm assigned by the case manager. Key themes were as follows:

- a poor understanding of risk of serious harm
- assessments characterised by a failure to note all elements of risk, and in some instances, little or no consideration of risk of serious harm at all
- an insufficient use of partner information
- over-optimism about the child's risks and contexts, with a minimisation of serious events or underplaying factors which should have alerted the case manager to high risk
- accepting the child's account or views without seeking further information or enacting professional curiosity
- assessments remaining out of date and not being reviewed in the light of new information and events
- too little or no consideration of future risks and the potential for escalation.

Across a number of the cases which had an incorrect classification, specific potential concerns relating to the safety of others appeared to have been underplayed by the case manager. Frequently, involvement in county lines (see [Academic Insights paper 2021/01](#)), other drug dealing, and gangs was not addressed.

*"Jake was assessed as medium risk of harm and vulnerability at the pre-sentence report stage, but this should have been high. He was shot in the arm shortly before sentence and no review was carried out until July. He is involved in gangs and drug dealing, and although he has undertaken gangs/violence work, this does not appear to be having an impact."*

Some children had displayed highly aggressive behaviour which was not taken into account when considering the risk that they may potentially pose to others.

*"The nature of the offence was violence against a vulnerable male victim who was street homeless. This child has a history of trauma within family relationships including experiencing domestic violence, both his parents suffering from mental illness, and neglect. He was previously a Child-in-Need. There were limitations on the planning and interventions to keep the victim safe and limited work on addressing trauma. I did not agree with the case management assessment of risk of serious harm and felt it should have been higher than medium. I asked the case manager to review the current plan to take these factors into account."*

*"The offence involved repeatedly stabbing a knife into an internal door at home while threatening his sister. While this is fully articulated in the assessment, my view is that this results in passing the threshold of low to medium in contrast to the views of the case manager."*

The carrying of weapons was also sometimes underplayed as a safety factor, particularly where there were other concerns regarding factors which may impact on the child's behaviour.

*"The index offence is possession of a knife. Furthermore, the young person is described as being in chaos due to recently being forced to move from home, extensive substance misuse resulting in hospitalisation, worrying lifestyle involving significant risk of Child Sexual Exploitation, and mental health concerns. Based on the information available to me, I would deem this as a medium risk of serious harm case as a minimum, rather than low which was assigned by the case manager."*

*"The child had two offences of knife possession within a few months of each other, with the current offence involving a machete with a 12-inch blade. The fact that he is easily manipulated by others, has attention deficit hyperactivity disorder and oppositional defiant disorder<sup>7</sup>, and low levels of maturity were not analysed in relation to the risk he could pose to others. As such, I believe that the risk of serious harm level should have been assigned as higher than medium."*

In our [Academic Insights paper 2022/08](#), Holt sets out how child to parent abuse can cause a wide range of harms, to the parent/carer, to the child, and to the wider family and community. She notes that there are clear implications for youth justice practice in relation to initial identification and screening, with disclosure being difficult for many parents/carers, and differing structural and familial contexts. Across the cases we inspected, we found instances where the child had committed offences against members of their family and also partners/ex-partners, and that this had not been given sufficient weight:

*"Jess was subject to a Referral Order for an offence of assault against her younger brother. There is a history of social care involvement with the family, with the children having been subject to Child-in-Need plans in the past due to neglect and domestic violence concerns. The initial assessment completed contains relevant information and analysis, however, ultimately concludes that she does not pose a risk to children. Shortly following this assessment there is a further incident in the*

---

<sup>7</sup> Oppositional defiant disorder (ODD) is a type of behavioural disorder, mostly diagnosed in childhood. Children with ODD can be uncooperative, defiant, and hostile towards peers, parents, teachers, and other authority figures.

*home involving Jess assaulting her brother and mother and she is placed in foster care as a result. There is no review of the assessment at this stage."*

*"Max was assessed as medium risk of serious harm which was not agreed by the inspector. Max's controlling behaviour towards partners, his previous incidences of sexualised behaviour, and the lack of understanding of the effects his offence had on his partner were insufficiently considered in the assessment."*

Harmful sexual behaviour by children, which goes beyond normal sexual exploration and experimentation, encompasses a range of behaviours (Children and Young People's Centre for Justice, 2022), and we found that in some cases there was a failure to analyse the risks associated with the sexual element of an offence, with other risks appearing to take precedence.

*"There has been a lack of focus in this case on sexually harmful behaviour and healthy relationships. The index offence was one of victim intimidation, where there had been allegations of rape, and yet the focus of the case and risk management has focused on his use of weapons, his peers and associates, and his own vulnerability. The lack of focus around relationships and sexually harmful behaviour has led to this case being misclassified as medium risk of serious harm when this should be high."*

In other cases, the mental health of the child and the impact that this may have on the safety of others was not always fully assessed.

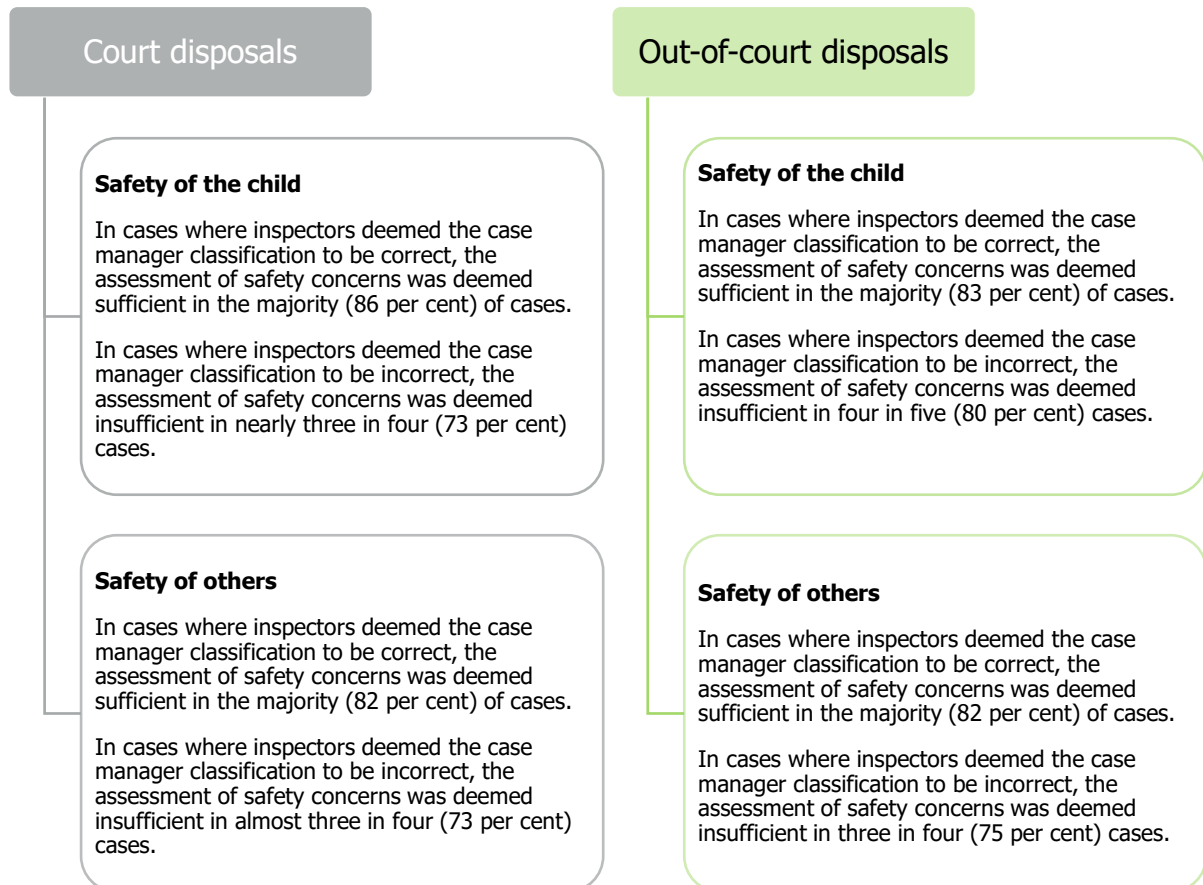
*"The assessment of low risk of serious harm has been discussed with the case manager, as I consider that this case requires a higher classification. Although there is a clear risk management plan, there is nothing on this with regards to addressing the child's mental health. He has a history of violence within the home, including trying to drown his sister and stabbing the family dog. This young person has foetal alcohol syndrome and was adopted when he was two years old. In my assessment, there is a strong link between his childhood (and ongoing) trauma and his alcohol use, which is invariably linked to his offending."*

In some cases, there was insufficient consideration of victim impact and/or a lack of attention paid to victim empathy. As set out in the following example, the victims were often other children.

*"The case manager's assessment of medium risk of serious harm contradicts the police assessment which assigned the child as posing a high risk of harm to others. A high classification seems reasonable given the 18-month period of harassment against the victim who was also a child. The case manager indicated that she felt the child did not fully understand and/or intend to cause the victim harm, but this should not impact on the assessment of risk to the victim or any further victims. There is insufficient focus on the extensive psychological impact on the young female victim whose life has been affected to the extent that she has problems with mental health and sleeping, is fearful of going out, and has had to delay going to university because of her fears."*

### 2.3.3 Consequences of misclassification

Unsurprisingly, inspectors were less likely to judge assessment to be sufficient, in relation to the safety of the child and the safety of others, when they considered that there had been an initial misclassification by the case manager.



Inaccurate low classifications of safety concerns can have damaging consequences in terms of the support offered by the YOT and partners, and the consideration given to protecting potential victims and society. The problem can of course flow the other way; if a classification is too high, then resources are wasted which could have been deployed to a more pressing case. However, the focus in the following practice examples is upon the more prevalent problem of underestimating safety concerns, which can have immediate negative consequences for the child and others.

#### Poor practice examples

##### Violence, peers, sexual exploitation and family issues

*Hilary, a 15-year-old girl, was initially sentenced to a six-month referral order for assault. This was subsequently extended by three months twice, once for a breach and secondly for a further assault. Neither the assessment, the plan, nor the reviews mentioned the index offence at all. The subsequent breach and assault conviction were also not included in any documents. Thus, there was no assessment of the risk of harm Hilary posed to others, and no offence-focused work was considered. The case manager was unaware of the group-enabled nature of the offending, the further conviction for assault, nor that there had been repeat victimisation.*

*Conversely, Hilary's vulnerability around her home living conditions and her vulnerability to*



*sexual exploitation were explored in more detail. Work was delivered by the Independent Sexual Violence Advisor, the case manager, and by Children's Services. A private foster placement was sought and secured. However, Hilary then became pregnant, and did not want to disclose who the father was. Hilary went missing on a visit home, the placement became unsustainable, and she was returning to the family home.*

*The inspector raised concerns with the YOT practitioner and manager, who recognised the need for a new and comprehensive assessment. Hilary's case was to be discussed at the next risk strategy meeting and plans were being developed to prepare for her return to the parental home.*

### **Weapons, gang involvement, drug dealing**

*Asif, a 17-year-old boy, had been sentenced to a 12-month youth rehabilitation order for possession of knives and drugs. He had previous convictions involving knives and drugs, and had not complied with YOT supervision in the past. Asif was assessed as medium in terms of his own safety and the safety of others at the pre-sentence stage; this should have been high given Asif's involvement with knives, gangs and drug dealing.*

*Asif was wounded by shooting before his sentence, yet no review was carried out for several weeks. He was remanded to a YOI, and was due to be transferred to an adult prison in a few months when he turned eighteen. Asif was a 'Looked After Child' and had been the subject of several placements.*

*Asif was referred to a gangs' intervention project, but did not engage well. Upon release he was due to be transferred to probation. There was a lot of multi-agency working around the case; however, Asif had experienced four YOT caseworkers, a change in social worker, and a placement out of his home area. The case was characterised by a lack of continuity in care.*

### **Domestic violence, trauma, attachment**

*Jerome, a 15-year-old boy, had been given a community resolution for an offence of assault against his mother. The assessment missed that Jerome has a diagnosis of attention deficit hyperactivity disorder, and a diagnosis of post-traumatic stress disorder – he had witnessed his father assaulting his mother at a young age. Both his father and the father of his siblings had restraining orders in place. Jerome's mother was sent to prison for three years when Jerome was 18 months old for a serious assault. This significant life event had not been explored in terms of any impact in relation to attachment. Jerome lived with his grandmother during that time. His grandmother was now terminally ill, and this was not considered for the effect on Jerome's emotional wellbeing. His mother had a history of drug use, yet the assessment did not explore whether she was using drugs when she was pregnant with Jerome.*

*There was insufficient consideration of this traumatic history on Jerome's current lifestyle. There should have been a referral to social care, as the family did not have a social worker assigned to them. There was no consideration of how Jerome's mother could be protected from further violence.*

*Our inspector commented that had these "obvious questions been asked, the assessment and delivery of interventions would have been very different."*

### 3. Conclusion

---

Well-informed, analytical and personalised assessment is the starting point for effective work with children. We expect to see assessment that is proportionate to the nature of the child's offending, circumstances and the type of sentence. It should incorporate all available sources of information and seek to understand the whole context of the child's life.

Wherever possible, the child and their parents/carers should be meaningfully involved in the assessment process, helping to build the vital trusting personal relationships which can be a powerful vehicle for change.

The focus in this bulletin has been upon the identification of safety concerns. Understanding and minimising the safety concerns which a child faces, and which they may themselves pose, does not in any way undermine the constructive and nurturing work which should be undertaken with children to foster their positive development. Safety is a fundamental human need (Maslow, 1954); feeling physically and psychologically safe better enables children to thrive and flourish.

We have shown that for many children supervised by YOTs, there are concerns in relation to their own safety and/or the safety of other people, often other children. The safety concerns relating to the children themselves and to other people are often overlapping and intertwined, with links to a number of areas, including the carrying of knives or other weapons, drug and alcohol misuse, adversity and trauma, domestic abuse, care experience, criminal exploitation, and mental health issues.

Across the cases we inspected, the quality of assessment in relation to the safety of the child and the safety of others was more likely to be judged sufficient for those children on court disposals compared to those on out-of-court disposals. In relation to the latter – particularly for community resolutions – there were instances of assessments not being completed at all, assessments being completed by unqualified or untrained staff, and the use of tools which did not sufficiently consider all relevant circumstances and the full context, hindering a whole-child approach.

Out-of-court disposals provide a form of diversion from court and the more formal criminal justice system, with the goal of helping children to desist from offending before it becomes more serious and entrenched. They provide opportunities to ensure that children receive the right help at the right time in a proportionate and holistic manner. However, because out-of-court disposals are primarily designed to be used for crimes of a less serious nature, there can be an unfortunate tendency to overlook safety concerns. Identifying these concerns, either in relation to the children themselves or others, is important to prevent long-lasting effects on life outcomes. YOTs need to pay sufficient attention to such issues and not assume that they will be picked up by other agencies. Safety concerns can of course escalate over time, and well-focused, personalised and coordinated multi-agency activity has the potential to benefit both the children and wider society in the longer term.<sup>8</sup>

In a relatively large minority of the cases we inspected, the safety classifications deemed appropriate by the inspector differed from that recorded by the case manager – it was

---

<sup>8</sup> See Williams and Franklin (2021) for an analysis of the costs upon children's services in relation to later crisis support compared to earlier interventions.

usually judged that the classification should have been higher. We have set out common causes of these misclassifications, including a lack of professional curiosity, an insufficient use of partner information, over-optimism about risks and contexts (with a minimisation of serious events), and too little or no consideration of the potential for escalation. We urge all youth offending services to pay attention to these issues – getting the safety classifications correct is vitally important for both the children and the community, facilitating access to wider resources to bolster safety where this is required, while providing the platform for constructive activities.

It is clear that robust assessment is more likely when YOT case managers are organisationally supported by strong partnership arrangements with statutory, community and voluntary agencies which facilitate good information flows. Assessment that draws from multiple sources of information such as police, children's social services, schools, parents and YOT records of siblings, can build a more complete picture of the child's life, including factors influencing the child's offending and relevant safety concerns. Robust assessment is further supported when case managers have the time to reflect and review their practice with managers and colleagues, and where they display professional curiosity and an analytical mindset in understanding the life of the child. To support reflective practice and practitioner development and learning, further information, case summaries, and links to other resources can be found in our [effective practice guide for case supervision](#).

## References

---

- Baker, K. (2014). *AssetPlus Rationale*. London: Youth Justice Board.
- Chard, A. (2022). *Systemic Resilience*, HM Inspectorate of Probation Academic Insights 2022/04. Available at: <https://www.justiceinspectors.gov.uk/hmiprobation/wp-content/uploads/sites/5/2022/04/Academic-Insights-Chard-Systemic-Resilience.pdf> (Accessed: 19 July 2022)
- Children and Young People's Centre for Justice (2022). *Children and young people in conflict with the law: policy, practice and legislation – Section 5: Managing Risk of Serious Harm*. Available at <https://www.cycj.org.uk/resource/youthjusticeinscotland/> (Accessed: 19 July 2022).
- Day, A-M. (2021). *Experiences and pathways of children in care in the youth justice system*, HM Inspectorate of Probation Academic Insights 2021/11. Available at: <https://www.justiceinspectors.gov.uk/hmiprobation/wp-content/uploads/sites/5/2021/09/LL-Academic-Insights-v1.0-Day.pdf> (Accessed: 19 July 2022).
- Firmin, C. (2021). *Contextual Safeguarding*, HM Inspectorate of Probation Academic Insights 2020/07. Available at: <https://www.justiceinspectors.gov.uk/hmiprobation/wp-content/uploads/sites/5/2020/11/Academic-Insights-Contextual-Safeguarding-CF-Nov-20-for-design.pdf> (Accessed: 19 July 2022).
- Gray, P., Smithson, H. and Jump, D. (2021). *Serious youth violence and its relationships with adverse childhood experiences*, HM Inspectorate of Probation Academic Insights 2021/13. Available at: <https://www.justiceinspectors.gov.uk/hmiprobation/wp-content/uploads/sites/5/2021/11/Academic-Insights-Gray-et-al.pdf> (Accessed: 15 July 2022).
- HM Inspectorate of Probation (2017). *The Work of Youth Offending Teams to Protect the Public*. Manchester: HM Inspectorate of Probation.
- HM Inspectorate of Probation (2021a). *The quality of delivery of out-of-court disposals in youth justice*. Manchester.
- HM Inspectorate of Probation (2021b). *Multi-agency work in youth offending services*. Manchester.
- HM Inspectorate of Probation (2021c). *Inspection standards for youth offending services*. Manchester
- HM Inspectorate of Probation (2021d). *Effective practice guide: Youth effective case supervision*. Manchester.
- HM Inspectorate of Probation (2022a). *2021 Annual Report: inspections of youth offending services*. Manchester.
- HM Inspectorate of Probation/Youth Justice Board (2022). *Joint statement from HM Inspectorate of Probation and the Youth Justice Board*. Manchester.
- Holmes, D. and Smith, L. (2022). *Transitional Safeguarding*, HM Inspectorate of Probation Academic Insights 2022/03. Available at: <https://www.justiceinspectors.gov.uk/hmiprobation/wp->

[content/uploads/sites/5/2022/03/Academic-Insights-Holmes-and-Smith-RM.pdf](https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2022/03/Academic-Insights-Holmes-and-Smith-RM.pdf) (Accessed: 19 July 2022).

Holt, A. (2022). *Child to Parent Abuse*, HM Inspectorate of Probation Academic Insights 2022/08. Available at: <https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2022/08/Academic-Insights-Child-to-Parent-Abuse-Dr-Amanda-Holt.pdf> (Accessed: 05 September 2022).

Kemshall, H. (2021). *Risk and Desistance: A Blended Approach to Risk Management*, HM Inspectorate of Probation Academic Insights 2021/07. Available at: <https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2021/06/Academic-Insights-Kemshall.pdf> (Accessed: 19 July 2022).

Kemshall, H. (2021). *Bias and error in risk assessment and management*, HM Inspectorate of Probation Academic Insights 2021/14. Available at: <https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2021/12/Academic-Insights-Kemshall-1.pdf> (Accessed: 19 July 2022).

Kent, H. and Williams, H. (2021). *Traumatic Brain Injury*, HM Inspectorate of Probation Academic Insights 2021/09. Available at: <https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2021/08/Academic-Insights-Kent-and-Williams-LL-v2.0-RMdocx.pdf> (Accessed: 19 July 2022).

Maslow, A. H. (1954). *Motivation and personality*. New York: Harper and Row.

McGhee, J. and Waterhouse, L. (2007). 'Classification in Youth Justice and Child Welfare: In Search of 'the Child'', *Youth Justice*, 7(2), pp. 107-120.

O'Donnell, I. (2020). *An Evidence Review of Recidivism and Policy Responses*. Dublin. Department of Justice and Equality.

Pitts, J. (2021). *County Lines*, HM Inspectorate of Probation Academic Insights 2021/01. Available at: <https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2021/01/Academic-Insights-county-lines-.pdf> (Accessed: 19 July 2022).

Scottish Government (2016). *GIRFEC National Practice Model*. Available at: <https://www.gov.scot/publications/girfec-national-practice-model/> (Accessed: 19 July 2022).

Scottish Government (2021). *Youth justice: risk assessment management framework and evaluation guidance*. Available at: <https://www.gov.scot/publications/framework-risk-assessment-management-evaluation-guidance/> (Accessed: 19 July 2022).

The Child Safeguarding Practice Review Panel (2021). *Annual Report 2020: Patterns in practice, key messages and 2021 work programme*. Available at: <https://www.gov.uk/government/publications/child-safeguarding-practice-review-panel-annual-report-2020> (Accessed: 19 July 2022).

Wong, K. and Horan, R. (2021). *Needs assessment: risk, desistance and engagement*, HM Inspectorate of Probation Academic Insights 2021/03. Available at: <https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2021/03/Academic-Insights-Needs-assessment-risk-desistance-and-engagement-Wong-and-Horan.pdf> (Accessed: 19 July 2022).

Williams, M. and Franklin, J. (2021). *Children and young people's services: Spending 2010-11 to 2019-20*. London: Pro Bono Economics. Available at: <https://www.probonoeconomics.com/a-decade-of-change-for-childrens-services-funding> (Accessed: 16 July 2021).

Williamson, V., Murphy, D., Phelps, A., Forbes, D. and Greenberg, N. (2021). 'Moral injury: the effect on mental health and implications for treatment.' *The Lancet Psychiatry*, Vol. 8(6), pp. 453-455.

Youth Justice Board (2019). *Standards for children in the youth justice system 2019*. Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/957697/Standards\\_for\\_children\\_in\\_youth\\_justice\\_services\\_2019.doc.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/957697/Standards_for_children_in_youth_justice_services_2019.doc.pdf). (Accessed: 15 November 2021).

Youth Justice Board and Ministry of Justice (2020). *Assessing the needs of sentenced children in the Youth Justice System 2019/19: England and Wales*. Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/887644/assessing-needs-of-sentenced-children-youth-justice-system.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/887644/assessing-needs-of-sentenced-children-youth-justice-system.pdf) (Accessed: 15 July 2022).

## Annex A: Methodology

---

### Inspections of youth offending services

The findings presented in this bulletin are based on data from 43 youth inspections completed between June 2018 and February 2020 (fieldwork weeks), with the reports for 39 of these being published (as set out in Table A1 below).<sup>9</sup>

**Table A1: Youth inspections, June 2018 – February 2020**

Youth offending service	Month of report publication
Derby	August 2018
Hampshire	September 2018
Hertfordshire	September 2018
Bristol	September 2018
Sandwell	November 2018
Essex	December 2018
Warwickshire	December 2018
Blackpool	December 2018
Barking and Dagenham	December 2018
Hounslow	January 2019
Manchester	February 2019
Wandsworth	March 2019
Wrexham	March 2019
Western Bay	March 2019
Oldham	April 2019
Lambeth	April 2019
Sefton	May 2019
East Riding	May 2019
Liverpool	June 2019
South Tees	June 2019
Walsall	June 2019
Dudley	June 2019
Lancashire	July 2019
Sheffield	August 2019
Surrey	August 2019
Newham	September 2019

---

<sup>9</sup> Solihull, Stoke on Trent, West Berkshire, and Wokingham were pilot small YOT inspections and did not result in a published report.

Youth offending service	Month of report publication
Leeds	November 2019
Leicester City	November 2019
Croydon	December 2019
Brent	December 2018
Bradford	January 2020
Southampton	January 2020
Gloucestershire	January 2020
Nottingham City	March 2020
Camden	May 2020
Oxfordshire	May 2020
Luton	May 2020
Medway	June 2020
Cardiff	July 2020

## Case samples

### *Court disposals*

The cases selected were those of children who had been given court disposals and had been under YOT supervision for approximately six to eight months. This enabled work to be examined in relation to assessing, planning, implementation and reviewing.

The overall sample size in each inspection was set out to achieve a confidence level of 80 per cent (with a margin of error of five percentage points), and we ensured that the ratios in relation to gender, type of disposal, and risk of serious harm level/safety and wellbeing classification matched those in the eligible population.

### *Out-of-court disposals*

Similarly to court disposals, inspectors examined the assessment, planning and implementation stages of delivery. The cases selected were those of children who had commenced out-of-court disposals (community resolutions, cautions and conditional cautions) in the previous three to five months, with similar statistical and case-type considerations to domain two.

All sampled cases were allocated to individual inspectors. To support the reliability and validity of their judgements against our standards framework, all cases were examined using standard case assessment forms, underpinned by rules and guidance.<sup>10</sup>

## Analysis

In each case, inspectors recorded rationales for their judgements in relation to safety classifications and concerns, and a summary of the progress or otherwise of the case as a

---

<sup>10</sup> The reliability and validity of judgements was further supported through training and quality assurance activities.



whole. Themes in the areas under study were identified through randomising the cases, to ensure that experiences from a variety of YOTs were considered, and undertaking thematic analysis, using the *MVivo* software. Analysis continued until it was believed that the 'saturation point' had been reached, that is there were no further major themes likely to emerge from the narrative data.

## Annex B: Safety classifications by type of disposal inspected

		Court disposals		Out-of-court disposals		All disposals	
		n	%	n	%	n	%
All cases		1,168	100%	777	100%	1,945	100%
Safety and wellbeing classification according to the case manager	Low	188	16%	255	41%	443	25%
	Medium	507	44%	263	43%	770	44%
	High/Very high	456	40%	98	16%	554	31%
Inspector agreement (safety and wellbeing)		1,155	84%	617	79%	1,772	82%
Risk of serious harm classification according to the case manager	Low	252	22%	349	57%	601	34%
	Medium	590	51%	236	38%	826	47%
	High/Very high	310	27%	28	5%	338	19%
Inspector agreement (risk of serious harm)		1,155	83%	618	80%	1,773	82%