



Inspection of
Youth
Offending

Archwilio Rhaglen Troseddwyr Ifanc



Arolygiad ar y Cyd Cyfiawnder Troseddol

Core Case Inspection of youth offending work in England and Wales

Report on youth offending
work in:

Staffordshire

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Foreword

This Core Case Inspection of youth offending work in Staffordshire took place as part of the Inspection of Youth Offending programme. We have examined a representative sample of youth offending cases from the area, and have judged how often the Public Protection and the Safeguarding aspects of the work were done to a sufficiently high level of quality.

We judged that the Safeguarding aspects of the work were done well enough 74% of the time. With the Public Protection aspects, work to keep to a minimum each individual's *Risk of Harm to others* was done well enough 64% of the time, and the work to make each individual less likely to reoffend was done well enough 75% of the time. A more detailed analysis of our findings is provided in the main body of this report, and summarised in a table in Appendix 1. These figures can be viewed in the context of our findings from Wales and the regions of England inspected so far – see the Table below.

Overall, we consider this an encouraging set of findings. The senior management team had a clear understanding of what good practice looked like and showed themselves committed to improving the quality and consistency of their work with children and young people. Implementation of current improvement plans, along with the recommendations from this inspection, would provide good prospects for the future of Staffordshire YOS.

Andrew Bridges
HM Chief Inspector of Probation

March 2011

	Scores from Wales and the English regions that have been inspected to date			Scores for Staffordshire
	Lowest	Highest	Average	
'Safeguarding' work <i>(action to protect the young person)</i>	37%	91%	67%	74%
'Risk of Harm to others' work <i>(action to protect the public)</i>	36%	85%	62%	64%
'Likelihood of Reoffending' work <i>(individual less likely to reoffend)</i>	43%	87%	70%	75%

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Contents

	Page
Acknowledgements	4
Scoring – and Summary Table	4
Recommendations	7
Next steps	7
Service users’ perspective	8
Sharing good practice	10
1. ASSESSMENT AND SENTENCE PLANNING	11
1.1 Risk of Harm to others (RoH)	11
1.2 Likelihood of Reoffending (LoR)	12
1.3 Safeguarding	14
2. DELIVERY AND REVIEW OF INTERVENTIONS	17
2.1 Protecting the public by minimising Risk of Harm to others	17
2.2 Reducing the Likelihood of Reoffending	18
2.3 Safeguarding the child or young person	19
3. OUTCOMES	21
3.1 Achievement of outcomes	21
3.2 Sustaining outcomes	22
Appendix 1: Summary	23
Appendix 2: Contextual information	24
Appendix 3a: Inspection data chart	25
Appendix 3b: Inspection data	26
Appendix 4: Role of HMI Probation and Code of Practice	26
Appendix 5: Glossary	27

Scoring – and Summary Table

This report provides percentage scores for each of the 'practice criteria' essentially indicating how often each aspect of work met the level of quality we were looking for. In these inspections we focus principally on the Public Protection and Safeguarding aspects of the work in each case sample. Accordingly, we are able to provide a score that represents how often the *Public Protection* and *Safeguarding* aspects of the cases we assessed met the level of quality we were looking for, which we summarise here. We also provide a headline 'Comment' by each score, to indicate whether we consider that this aspect of work now requires either **MINIMUM, MODERATE, SUBSTANTIAL** or **DRASTIC** improvement in the immediate future.

<i>Safeguarding score:</i>	
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.	
Score: 74%	Comment: MODERATE improvement required

<i>Public Protection – Risk of Harm score:</i>	
This score indicates the percentage of Risk of Harm work that we judged to have met a sufficiently high level of quality. This score is significant in helping us to decide whether an early further inspection is needed.	
Score: 64%	Comment: MODERATE improvement required

<i>Public Protection - Likelihood of Reoffending score:</i>	
This score indicates the percentage of Likelihood of Reoffending work that we judged to have met a sufficiently high level of quality.	
Score: 75%	Comment: MODERATE improvement required

We advise readers of reports not to attempt close comparisons of scores between individual areas. Such comparisons are not necessarily valid as the sizes of samples vary slightly, as does the profile of cases included in each area's sample. We believe the scoring is best seen as a headline summary of what we have found in an individual area, and providing a focus for future improvement work within that area. Overall our inspection findings provide the 'best available' means of measuring, for example, how often each individual's *Risk of Harm to others* is being kept to a minimum. It is never possible to eliminate completely Risk of Harm to the public, and a catastrophic event can happen anywhere at any time – nevertheless a 'high' *RoH* score in one inspected location indicates that it is less likely to happen there than in a location where there has been a 'low' *RoH* inspection score. In particular, a high *RoH* score indicates that usually practitioners are 'doing all they reasonably can' to minimise such risks to the public, in our judgement, even though there can never be a guarantee of success in every single case.

Recommendations (primary responsibility is indicated in brackets)

Changes are necessary to ensure that, in a higher proportion of cases:

- (1) a timely and good quality assessment and plan, using Asset, is completed when the case starts (YOS Manager)
- (2) specifically, a timely and good quality assessment of the individual's vulnerability and *Risk of Harm to others* is completed at the start, as appropriate to the specific case (YOS Manager)
- (3) as a consequence of the assessment, the record of the intervention plan is specific about what action will be taken 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*; with diversity needs being recognised as appropriate to the case (YOS Manager)
- (4) the plan of work with the case is regularly reviewed and correctly recorded in the case record with a frequency consistent with national standards for youth offending services (YOS Manager)
- (5) *Risk of Harm to others* is regularly reviewed, with changes anticipated where possible, recognised when they occur and responded to appropriately (YOS Manager)
- (6) sufficient attention is given to the safety of victims (YOS Manager)
- (7) there is evidence in the file of regular quality assurance by management, especially of screening decisions and plans to manage vulnerability or *Risk of Harm to others*, as appropriate to the specific case (YOS Manager).

Next steps

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

Service users' perspective

Children and young people

Forty-two children and young people completed a questionnaire for the inspection.

- ◇ All children and young people who had received a referral order understood what their contract was and had received a copy to keep. Just under three-quarters of those subject to other sentences knew what a supervision plan was and almost three-quarters had been given a copy to keep.
- ◇ The overwhelming majority of children and young people had discussed with their YOS worker the work they would undertake at the YOS. They said YOS staff were really interested in helping them and listened to what they had to say. Most said the YOS tried to deal with the things they needed help with.
- ◇ Two children and young people identified specific needs that would make it harder to take a full part in their sessions, and said that the YOS took action to address these.
- ◇ YOS workers made it easy for children and young people to understand how they could be helped whilst they were involved with the YOS. Many children and young people said YOS workers explained things clearly.
- ◇ Almost half the children and young people had received help with ETE and over half of those who had a problem with ETE felt that they had made progress. Similarly almost half of those who had a health problem said that it had improved. One wrote "*my mates respect me more for drinking less, so they don't see me as an alcoholic now*". Just over three-quarters of children and young people said their life had improved a result of work with the YOS.
- ◇ Nearly half the group felt that the YOS had enabled them to understand their offending. Over one-third had help with making better decisions and improving relationships. One wrote "*I get on better with my family and my mom...it makes me think twice before I do bad things*".
- ◇ All except two said work with the YOS had made them less likely to offend. One wrote "*[I] come in to school more and [do not] think about stealing or even trying to steal and...think before I do it and of the consequences*" and another wrote "*I know that there's more ways to go around stuff and you don't have to get in trouble to have a good time*".

Victims

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

- ◇ All the victims had the chance to talk about worries that they might have concerning the offence or offender. They said that the YOS paid sufficient attention to their safety.
- ◇ Three said their individual needs had been taken into account by the YOS.
- ◇ When asked how satisfied they were with the work of the YOS, three were completely satisfied.

Sharing good practice

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

Assessment and Sentence Planning General Criterion: 1.2h	Jade, who had received a referral order, did not attend school and had poor family relationships. The case manager quickly referred Jade to a learning support worker and arranged support for her mother. Jade had now attended school for four months without truanting. Whereas previously, they could not be in the same room as each other, Jade's mother accompanied her to the review panel and they had been seen laughing and joking.
Delivery and Review of Interventions General Criterion: 2.3e	Luke was immature. He was supported in attending a Prince's Trust programme by three YOS workers on a rota. He was gradually encouraged to take more responsibility for his own journeys. The support enabled Luke to develop his independent living skills and ensured he received appropriate education.
Delivery and Review of Interventions General Criterion: 2.2a	Liam was severely dyslexic. On one occasion when the case manager thought that Liam was misreading people's feelings, he cut out faces with different expressions and they discussed what the person might have been feeling. They also produced a poster using the image of a spider as a prison with each leg representing a consequence of going to prison.
Delivery and Review of Interventions General Criterion: 2.2c & 2.3b	Sean had significant alcohol problems that were founded in his familial experience, along with much alcohol related offending. The case manager brought together a team of professionals to work with Sean. These included a substance misuse worker, mentor, forensic psychologist, social workers and police. They worked together closely and at times of concern met to share information. As a consequence, the public were protected, and Sean's drinking and his involvement with the police reduced.
Outcomes General Criterion: 2.3e	Lee wanted to join the army; however, this was likely to be delayed because his order was due to end close to the entry date. The case manager spoke to the recruiting officer to ensure that he understood how Lee was progressing at the YOS. As a result, Lee joined the army immediately his order ended.

All names have been altered.

1. ASSESSMENT AND SENTENCE PLANNING

1.1 Risk of Harm to others (RoH):

General Criterion:

The assessment of RoH is comprehensive, accurate and timely, takes victims' issues into account and uses Asset and other relevant assessment tools. Plans are in place to manage RoH.

Score:

67%

Comment:

MODERATE improvement required

Strengths:

- (1) An Asset RoSH screening was completed in almost all cases. Most of these were timely.
- (2) We judged that the initial RoSH classification was appropriate in most cases.
- (3) A full RoSH analysis had been completed in the great majority of cases where indicated by the RoSH screening. Three-quarters of these were timely.
- (4) An RMP was produced at the start of the sentence in more than three-quarters of those cases assessed by the YOS as medium or higher RoSH.
- (5) In those cases without an RMP, the need to plan for *RoH* issues had been recognised and acted on in five out of six relevant cases.
- (6) Six cases met the criteria for MAPPA. All of these were notified to the MAPPA Coordinator and, if appropriate, referred to MAPPA. All except one of the referrals were timely. The initial MAPPA level was appropriate in all cases.

Areas for improvement:

- (1) Almost one-third of cases did not include an accurate RoSH screening.
- (2) Almost half the relevant cases did not include a full RoSH assessment of sufficient quality. The most common reasons were that the risk to victims, or previous relevant behaviour, was not fully considered. In one-third of cases, the assessment did not draw adequately on all appropriate available information. In one example a further offence, which was significantly more serious than the index offence, was progressing through court but was not acknowledged in the RoSH assessment.

- (3) Almost one-third of relevant cases did not include a timely RMP and almost two-thirds did not include an RMP of sufficient quality. The most common reasons were that the planned response was unclear or inadequate, or that roles and responsibilities were not clear. In some others, the needs of victims had not been included where relevant.
- (4) The need to plan to address *RoH* had been recognised in only one-third of cases without an RMP, but where *RoH* was present.
- (5) Details of *RoSH* assessments and management had not been clearly communicated to all relevant staff and agencies in well over one-third of cases where required.
- (6) Management oversight of the RMP was not effective in three-quarters of cases. Oversight of the *RoH* assessment was not effective in almost two-thirds of cases. The main reasons were that inadequate plans or assessments were countersigned, others were not countersigned, and sometimes the countersigning was not timely. In some cases, managers had appropriately identified deficits but had not then ensured that these were addressed.

1.2 Likelihood of Reoffending:	
<p><i>General Criterion:</i></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><i>Score:</i></p> <p>72%</p>	<p><i>Comment:</i></p> <p><i>MODERATE improvement required</i></p>

Strengths:

- (1) An initial assessment of LoR was completed in the great majority of cases. Over three-quarters were also timely.
- (2) There had been active engagement with the parent/carer when carrying out the initial assessment in most cases.
- (3) Most initial assessments had been sufficiently informed by information from the police, or the secure estate where required or providers. Over three-quarters of relevant assessments were informed by information received from mental health services and almost three-quarters by substance misuse services.
- (4) Three-quarters of initial assessments were reviewed at appropriate intervals.

- (5) A custodial sentence plan was produced in all except two relevant cases, and all except one of these were timely. ETE, substance misuse, emotional or mental health and motivation were all addressed in well over three-quarters of custodial sentence plans where needed. Safeguarding needs were recognised, and positive factors included, in most relevant plans.
- (6) Almost all cases included a community intervention plan or referral order contract. Most were timely and sufficiently addressed the main factors that had been assessed as linked to offending. Almost three-quarters of relevant plans took account of Safeguarding needs and included positive factors.
- (7) The overwhelming majority of plans reflected the purpose of the sentence and National Standards. Well over three-quarters focused on achievable change and set relevant goals.
- (8) The child or young person was actively and meaningfully involved in the planning process in most cases. Parents/carers were sufficiently involved in three quarters of relevant cases.
- (9) YOS workers were actively and meaningfully involved throughout the custodial planning process in all except two cases.
- (10) Other workers and relevant agencies were appropriately involved in planning throughout the sentence in most cases.
- (11) The intervention plan had been reviewed at appropriate intervals in all cases in custody and in almost three-quarters of cases in the community.

Areas for improvement:

- (1) Half the cases did not include an initial assessment of LoR that was of sufficient quality. The most common reason was that evidence was unclear or insufficient. In some cases, key factors relating to the offending had not been identified; for example, a child or young person who continued to deny their offence was assessed as having no concerns with their motivation to change. The date that the assessment was undertaken was not always clear; in some cases, the first entry in the electronic record was a number of months after the date claimed for the assessment. Sometimes what was presented as an initial Asset was a clone of one produced during a previous order.
- (2) In one case, the needs of a young person with a disability relevant to both assessment and planning had not been reflected throughout the case, including within the RoSH assessment.
- (3) The case manager had not assessed and, where relevant, recorded the learning style of the child or young person in almost half the cases.
- (4) Only just over half of the initial assessments were informed by use of a *What do YOU think?* or other appropriate self-assessment.
- (5) There was insufficient evidence that the initial assessment had been informed by children's social care services in one-third of cases. In three relevant cases, the initial assessment had not been informed by contact with the ASB team; these cases included an example where the offence was breach of an ASBO.

- (6) Almost half the relevant cases did not include a custodial sentence plan that sufficiently addressed factors most related to offending. In particular, family and personal relationships were not addressed in over half the plans where required, living arrangements in half, lifestyle issues in well over one-third, and thinking and behaviour in just over one-third.
- (7) Only slightly more than one-third of community plans integrated relevant aspects from the RMP and were prioritised according to *RoH*. For example, in one case the RMP indicated work to address anger management, but this was not reflected in the sentence plan. Only one-third of plans were sequenced according to offending-related need. Very similar patterns were repeated in custodial sentence plans.
- (8) The child or young person's learning needs or style were incorporated in less than half of those community intervention plans or referral order contracts where required.
- (9) Almost half the relevant community intervention plans or referral order contracts did not respond to other diversity needs of the child or young person. There was no pattern to the type of needs that were overlooked, which included race and ethnicity, gender issues, disability and the needs of looked after children. In one example, the only parent did not speak English, but there was no consideration about how she would be supported in engaging with the work undertaken with her child.
- (10) Almost half the community intervention plans did not include realistic timescales and one-third did not give clear shape to the whole order.

1.3 Safeguarding:	
<p>General Criterion:</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>Score:</p> <p>70%</p>	<p>Comment:</p> <p>MODERATE improvement required</p>

Strengths:

- (1) An Asset vulnerability screening had been completed in the great majority of cases. Most of those completed were timely.
- (2) Safeguarding needs were reviewed as appropriate in three-quarters of cases.
- (3) The secure estate had been made aware of vulnerability issues prior to, or immediately on, sentence in all except one case.

- (4) The YOS made a contribution, in three-quarters of relevant cases, to other assessments and plans designed to safeguard the child or young person.

Areas for improvement:

- (1) Over one-third of cases did not include a vulnerability screening that was of sufficient quality. For example, significant drugs or emotional health problems, or binge drinking, were sometimes not always recognised as a vulnerability concern. In other cases, involvement in gangs was not recognised as a concern.
- (2) A VMP had not been produced at the start of the sentence in almost half of the cases where required.
- (3) Less than one-third of relevant cases included a VMP of sufficient quality. The most common reasons, apart from when the VMP had not been completed, were that the planned response was unclear or inadequate, or roles and responsibilities were unclear. In two cases, relevant diversity needs had not been recognised in the VMP. Some VMPs for custodial cases focused solely on custodial issues and ignored other aspects of vulnerability; and some duplicated a previous plan, and did not reflect current circumstances.
- (4) Only just over a half of completed VMPs had contributed to, or informed planned interventions; and in only one-third of relevant cases had they clearly informed other plans.
- (5) Copies of other agencies' plans were not available on file in almost half of those relevant cases where these existed.
- (6) Management oversight of the vulnerability assessment and VMP was effective in only just over one-third of relevant cases. Inadequate plans were countersigned and some VMPs were not countersigned. In other cases, managers had identified deficits but had not then ensured that they were addressed. There were also examples, including cases recorded as medium or high vulnerability, where a robust oversight regime would have identified the need for management involvement. There was a lack of clarity about which cases should be referred to the MORF (Management of Risk Forum) process and a lack of consistency in which cases were referred.

OVERALL SCORE for quality of Assessment and Sentence Planning work: 71%

COMMENTARY on Assessment and Sentence Planning as a whole:

Staffordshire YOS employed a MORF process to share information about, and review, cases that were assessed as high or very high RoSH or vulnerability. Cases assessed as medium RoSH or vulnerability could be referred to MORF subject to agreement of a line manager. All professionals involved in the case were invited to the meeting. This was a positive development whose full potential had still to be realised.

A comprehensive Public Protection Policy was in place that included clear expectations for the assessment, planning and management oversight of cases with raised RoSH or vulnerability.

The Management Board and YOS manager had commissioned an external investigation into the reasons for a recent decline in previously strong performance against some YJB national indicators. Alongside this work, an ambitious, but recent, improvement plan had been put in place to seek to address shortcomings in practice. The YOS manager was also undertaking a range of other actions designed to improve the quality and consistency of practice and of management oversight across the three YOS offices.

Following a reorganisation within Staffordshire Children's Services the YOS will shortly be located in a section with a specific focus on Safeguarding.

2. DELIVERY AND REVIEW OF INTERVENTIONS

2.1 Protecting the public by minimising Risk of Harm to others (RoH):

General Criterion:

All reasonable actions have been taken to protect the public by keeping to a minimum the child or young person's RoH.

Score:

69%

Comment:

MODERATE improvement required

Strengths:

- (1) MAPPA were used effectively in all cases where referrals had been made. Decisions were always clearly recorded, then followed through, acted upon and reviewed appropriately.
- (2) Relevant YOS staff contributed effectively to MAPPA processes in all relevant cases both in custody and in the community. The contribution of other agencies to MAPPA was effective in all cases.
- (3) Case managers and other relevant staff contributed effectively to other multi-agency meetings in the great majority of relevant cases.
- (4) Purposeful home visits were carried out throughout the sentence, in accordance with the *RoH* posed by the child or young person, in the great majority of applicable cases.
- (5) An appropriate level of resources had been allocated to almost all cases, according to the *RoH* posed in the case.
- (6) Where specific interventions had been planned to manage *RoH*, they were then delivered as planned most cases.

Areas for improvement:

- (1) *RoH* was not reviewed thoroughly in-line with the required timescales in just over one-third of cases. It was not reviewed following a significant change in over half of relevant cases. For example, in one case the YOS was aware from the police of allegations of serious further assaults but took no action until a PSR was requested. Specific interventions to manage *RoH* were not reviewed following a significant change in over one-third of cases in the community.

- (2) Changes in *RoH* factors had been anticipated where feasible in less than half the relevant cases. Where changes occurred, they were acted on appropriately in only half the cases.
- (3) Sufficient attention had been given to assessing the safety of victims in only half the cases where required. A high priority was then given to victim safety throughout the sentence in less than half the relevant cases. Case managers were unclear as to the processes for making contact with victims and for ensuring that case managers became aware of any concerns.
- (4) Management oversight of *RoH* throughout the sentence was effective in well under half of cases in the community and in less than two-thirds of those in custody.

2.2 Reducing the Likelihood of Reoffending:	
<p>General Criterion:</p> <p><i>The case manager coordinates and facilitates the structured delivery of all elements of the intervention plan.</i></p>	
<p>Score:</p> <p>81%</p>	<p>Comment:</p> <p>MINIMUM improvement required</p>

Strengths:

- (1) Well over three-quarters of interventions that were delivered in the community were clearly designed to reduce the LoR and were of good quality.
- (2) Almost three-quarters of delivered interventions were implemented in-line with the intervention plan and appropriate to the child or young person’s learning style.
- (3) YOS workers were appropriately involved in the review of interventions in custody in all except one case.
- (4) The correct Scaled Approach intervention level was allocated in all cases. The appropriate level of resources had then been allocated throughout the case, according to the assessed LoR, in almost all cases.
- (5) All requirements of the sentence had been implemented in well over three-quarters of cases.
- (6) YOS workers actively motivated and supported the children and young people, and reinforced positive behaviour, in the great majority of cases in both custody and the community.
- (7) Parents/carers were actively engaged by YOS workers throughout the sentence in almost all cases in both custody and the community.

Areas for improvement:

- (1) Delivered interventions were not sequenced appropriately in over half of cases. In over one-third of cases, they were not reviewed appropriately.
- (2) In one-third of relevant cases, delivered interventions did not sufficiently incorporate all diversity issues. The areas of deficit included race and ethnicity, gender issues, disability and the needs of looked after children.

2.3 Safeguarding the child or young person:

General Criterion:

All reasonable actions have been taken to safeguard and reduce the vulnerability of the child or young person.

Score:

80%

Comment:

MINIMUM improvement required

Strengths:

- (1) All necessary immediate action was taken to safeguard or protect the child or young person, or any other affected child or young person, in all cases where required during the custodial phase of a sentence.
- (2) Purposeful home visits were carried out throughout the sentence, in accordance with Safeguarding needs, in almost all applicable cases.
- (3) Referrals to ensure Safeguarding had been made in all relevant cases in custody, and in three-quarters of relevant cases in the community.
- (4) YOS workers and ETE services, health and substance misuse services and the police cooperated to promote the Safeguarding and well-being of the child or young person in the community in the great majority of cases where required. Where other agencies were involved in a case, they and the YOS almost always worked together well. In one example, the good relationship between an educational provider and the case manager led to a tutor letting the case manager know that a child or young person had been seen with alcohol during the weekend.
- (5) During the custodial phase of sentence, all relevant agencies jointly promoted the Safeguarding and well-being of the child or young person in almost all cases.
- (6) All agencies cooperated to ensure the continuity of mainstream services through the transition from custody to the community in the overwhelming majority of cases.

- (7) Specific interventions to promote Safeguarding were identified in over three-quarters of relevant cases in both custody and the community. These were then delivered in almost all cases where they had been identified.
- (8) All relevant staff promoted the well-being of the child or young person throughout the sentence in the great majority of cases.

Areas for improvement:

- (1) There were a few cases where necessary immediate action had not been taken to safeguard the child or young person in the community. However, there were no inspected cases where such actions remained outstanding.
- (2) In one-third of relevant cases, specific interventions to promote Safeguarding in the community were not reviewed as required, i.e. every three months or following a significant change.
- (3) Management oversight of Safeguarding and vulnerability needs had not been effective in one-third of relevant cases in custody and almost two-thirds of relevant cases in the community.

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

COMMENTARY on Delivery and Review of Interventions as a whole:

Agreement had been reached to improve the use of police resources within the YOS, with effect from January 2011. This was intended to assist the focus given to contact with victims and the ability of the YOS to assess and respond to their needs.

Staffordshire YOS had a long-standing arrangement with the Engage service. This provided psychological interventions to children and young people, as appropriate, and supported case managers or other health specialists in the YOS.

Staffordshire was also a pilot area for the provision of Intensive Fostering as a robust alternative to custody.

3. OUTCOMES

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

3.1 Achievement of outcomes:

General Criterion:

Outcomes are achieved in relation to RoH, LoR and Safeguarding.

Score:

68%

Comment:

MODERATE improvement required

Strengths:

- (1) Where the child or young person had not complied with the requirements of the sentence, appropriate enforcement action had been taken in two-thirds of cases.
- (2) The overall Asset score had reduced during the course of the sentence in well over half of cases. This was higher than the average for YOTs inspected to date. Those factors relating to offending which showed the most frequent improvement during the course of the sentence were ETE, living arrangements, attitudes to offending, thinking and behaviour, motivation to change and lifestyle. Each had improved in well over one-third of relevant cases.
- (3) There appeared to be a reduction in the frequency and seriousness of offending, during the course of the sentence to date, in more than two-thirds of cases. This was better than the average for YOTs inspected to date.

Areas for improvement:

- (1) In those cases where, overall, all reasonable actions had not been taken throughout the sentence to manage and minimise *RoH*, insufficient assessment and planning were identified as the main problem areas.
- (2) Similar reasons were cited in most cases where, overall, sufficient actions had not been taken to safeguard the child or young person.

3.2 Sustaining outcomes:

General Criterion:

Outcomes are sustained in relation to RoH, LoR and Safeguarding.

Score:

87%

Comment:

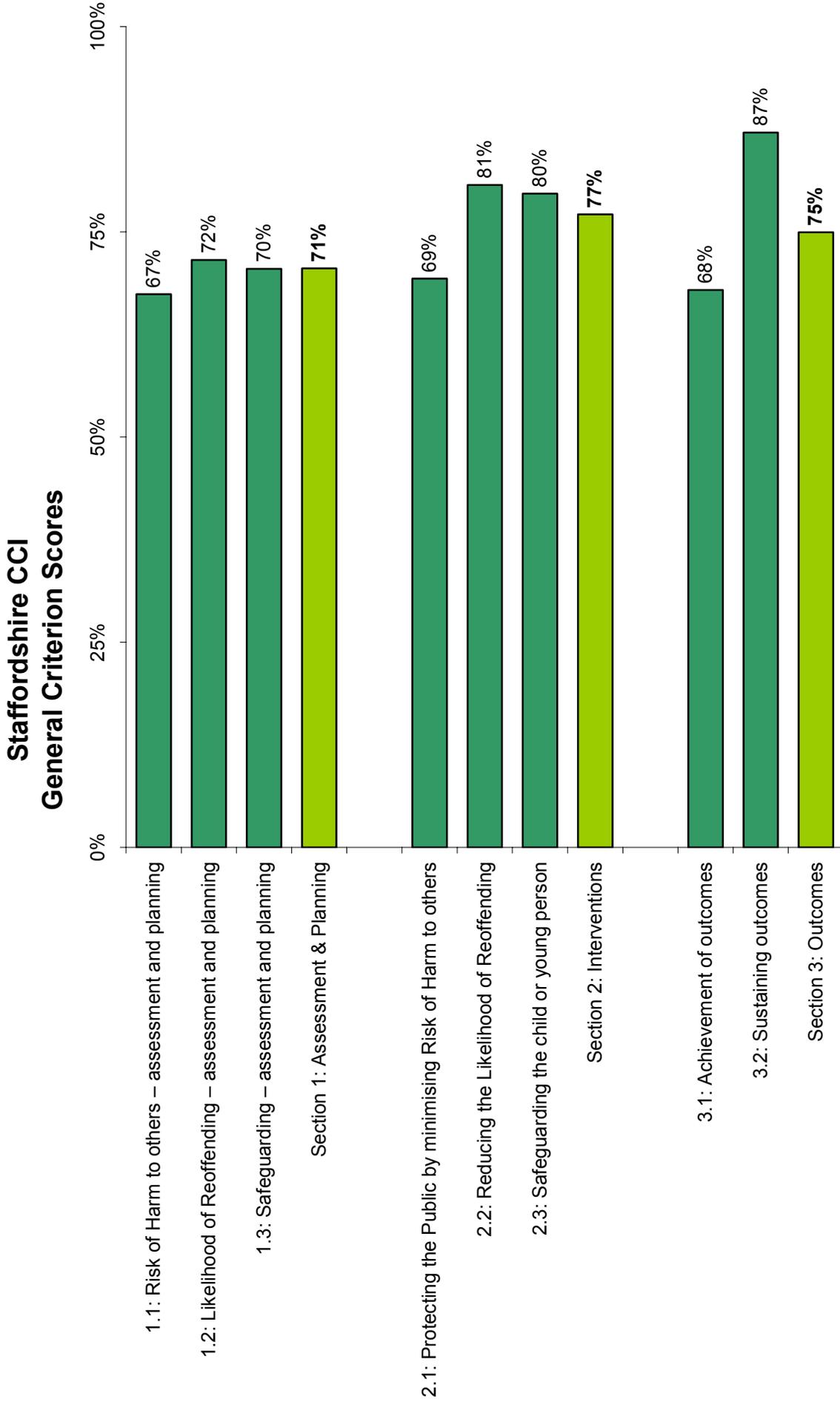
MINIMUM improvement required

Strengths:

- (1) Full attention had been given to community reintegration issues in all except one case during the custodial phase of the sentence, and in most cases in the community.
- (2) Similarly, action had been taken, or plans put in place, to ensure that positive outcomes were sustainable, in all except one case in custody and in the great majority of cases in the community.

OVERALL SCORE for quality of Outcomes work: 75%

Appendix 1: Summary



Appendix 2: Contextual information

Area

Staffordshire YOS was located in the West Midlands region of England.

The area had a population of 806,744 as measured in the Census 2001, 10.6% of which were aged 10 to 17 years old. This was slightly higher than the average for England/Wales, which was 10.4%.

The population of Staffordshire was predominantly white British (97.6%). The population with a black and minority ethnic heritage (2.4%) was below the average for England & Wales of 8.7%.

Reported offences for which children and young people aged 10 to 17 years old received a pre-court disposal or a court disposal in 2009/2010, at 22 per 1,000, were below the average for England/Wales of 38.

YOS

The YOS boundaries were within those of the Staffordshire police area. The West Midlands and Staffordshire Probation Trust, and the North Staffordshire Combined Healthcare and South Staffordshire Primary Care Trusts covered the area.

The YOS was located within the Children's Services sub-directorate of the People directorate in Staffordshire County Council. It was managed by the Head of Staffordshire YOS.

The YOS Management Board was chaired by the Head of Families First. All statutory partners were members of the Board and, with exception of health representatives, all attended regularly.

The YOS Headquarters was in the county town of Stafford. The operational work of the YOS was based in Lichfield, Newcastle under Lyme and Stafford.

YJB National Indicator Performance Judgement

The YJB National Indicator Performance Judgement available at the time of the inspection was dated July 2010.

There were five judgements on reoffending; first time entrants; use of custody; accommodation; and employment, education and training.

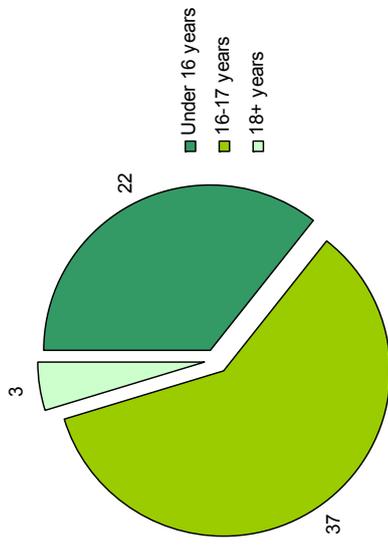
Full details of these judgements can be obtained from the YJB.

For a description of how the YJB's performance measures are defined, please refer to:

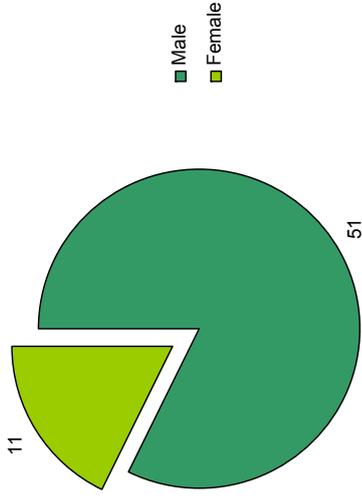
<http://www.yjb.gov.uk/en-gb/practitioners/Monitoringperformance/Youthjusticeplanning/>

Appendix 3a: Inspection data chart

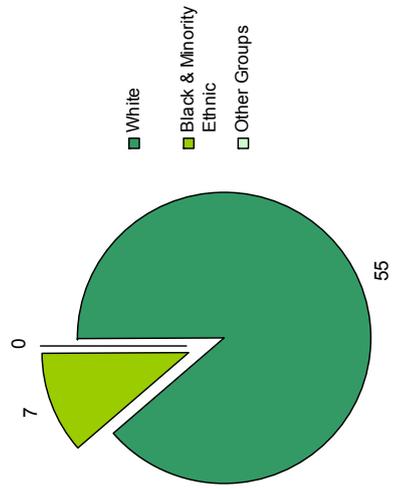
Case Sample: Age at start of Sentence



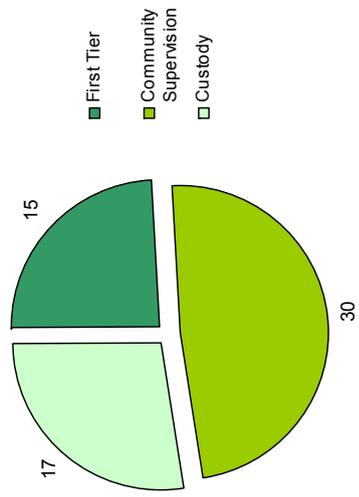
Case Sample: Gender



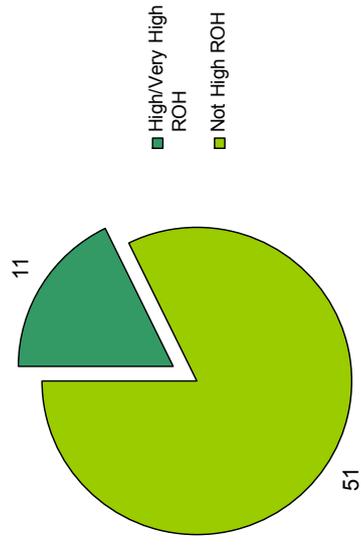
Case Sample: Ethnicity



Case Sample: Sentence Type



Case Sample: Risk of Harm



Appendix 3b: Inspection data

Fieldwork for this inspection was undertaken in December 2010.

The inspection consisted of:

- ◇ examination of practice in a sample of cases, normally in conjunction with the case manager or other representative
- ◇ evidence in advance
- ◇ questionnaire responses from children and young people, and victims

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

Appendix 4: Role of HMI Probation and Code of Practice

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

<http://www.justice.gov.uk/inspectorates/hmi-probation>

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

*HM Chief Inspector of Probation
2nd Floor, Ashley House
2 Monck Street
London, SW1P 2BQ*

Appendix 5: Glossary

ASB/ASBO	Antisocial behaviour/Antisocial Behaviour Order
Asset	A structured assessment tool based on research and developed by the Youth Justice Board looking at the young person's offence, personal circumstances, attitudes and beliefs which have contributed to their offending behaviour
CAF	Common Assessment Framework: a standardised assessment of a child or young person's needs and of how those needs can be met. It is undertaken by the lead professional in a case, with contributions from all others involved with that individual
CAMHS	Child and Adolescent Mental Health Services: part of the National Health Service, providing specialist mental health and behavioural services to children and young people up to at least 16 years of age
Careworks	One of the two electronic case management systems for youth offending work currently in use in England and Wales. See also YOIS+
CRB	Criminal Records Bureau
DTO	Detention and Training Order: a custodial sentence for the young
Estyn	HM Inspectorate for Education and Training in Wales
ETE	Education, Training and Employment: work to improve an individual's learning, and to increase their employment prospects
Family Group	Used by the YJB for comparative performance reporting, this is a group of YOTs identified as having similar characteristics
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 employment, training and education
ISSP	Intensive Supervision and Surveillance Programme: following the implementation of the Youth Rehabilitation Order this has been supervised by ISS
LoR	Likelihood of Reoffending. See also <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>
MORF	Management of Risk Forum
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>
<i>RoH</i>	<i>Risk of Harm to others. See also restrictive Interventions</i>
<i>'RoH work', or 'Risk of Harm work'</i>	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.
SIFA	Screening Interview for Adolescents: Youth Justice Board approved mental health screening tool for specialist workers
SQIFA	Screening Questionnaire Interview for Adolescents: Youth Justice Board approved mental health screening tool for YOT workers
VMP	Vulnerability management plan: a plan to safeguard the well-being of the individual under supervision
YJB	Youth Justice Board for England and Wales
YOI	Young Offenders Institution: a Prison Service institution for young people remanded in custody or sentenced to custody
YOIS+	Youth Offending Information System: one of the two electronic case management systems for youth offending work currently in use in England and Wales. See also Careworks
YOS/T	Youth Offending Service/Team