Inspection of Youth Offending
Archwilio Rhaglen Troseddwyr Ifanc

Criminal Justice Joint Inspection
Arolygiad ar y Cyd Cyfiawnder Troseddol

Core Case Inspection of youth offending work in England and Wales

Report on youth offending work in:

Doncaster

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Foreword

This Core Case Inspection of youth offending work in Doncaster 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 64% 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 57% of the time, and the work to make each individual less likely to reoffend was done well enough 66% of the time. A more detailed analysis of our findings is provided in the main body of this report, and summarised in a table in Appendix 1. These figures can be viewed in the context of our findings from Wales and the regions of England inspected so far – see the Table below.

Overall, we consider this a disappointing set of findings in relation to work to reduce the *Risk of Harm to others*, but other areas of work required less improvement, and the Service was motivated to learn from this inspection and improve practice for the future.

Andrew Bridges
HM Chief Inspector of Probation

October 2010

	Scores from Wales and the English regions that have been inspected to date			***Scores for Doncaster***
	Lowest	**Highest**	**Average**	
'Safeguarding' work *(action to protect the young person)*	*38%*	*91%*	*67%*	***64%***
***'Risk of Harm to others'* work** *(action to protect the public)*	*36%*	*85%*	*62%*	***57%***
'Likelihood of Reoffending' work *(individual less likely to reoffend)*	*50%*	*87%*	*69%*	***66%***

Acknowledgements

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

Lead Inspector	*Steve Woodgate*
Inspectors	*Helen Rinaldi*
CCI Assessor	*Dave Cohen*
Support Staff	*Andy Doyle*
Publications Team	*Catherine Calton; Alex Pentecost; Christopher Reeves*
Editor	*Alan MacDonald*

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Scoring – and Summary Table

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

***Safeguarding* score:**	
This score indicates the percentage of *Safeguarding* work that we judged to have met a sufficiently high level of quality. This score is significant in helping us to decide whether an early further inspection is needed.	
Score:	***Comment:***
64%	***MODERATE improvement required***

Public Protection – Risk of Harm score:	
This score indicates the percentage of Risk of Harm work that we judged to have met a sufficiently high level of quality. This score is significant in helping us to decide whether an early further inspection is needed.	
Score:	***Comment:***
57%	***SUBSTANTIAL improvement required***

Public Protection - Likelihood of Reoffending score:	
This score indicates the percentage of Likelihood of Reoffending work that we judged to have met a sufficiently high level of quality.	
Score:	***Comment:***
66%	***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 will now be done in order to safeguard the child or young person from harm, to make them less likely to reoffend, and to minimise any identified *Risk of Harm to others* (YOS Manager)

(4) the plan of work with the case is regularly reviewed and correctly recorded in Asset with a frequency consistent with national standards for youth offending services (YOS Manager)

(5) there is evidence in the file of regular quality assurance by management, especially of screening decisions, as appropriate to the specific case (YOS Manager).

Furthermore:

(6) in all cases a fresh set of Asset documentation is created at the start of each order and at each review, incorporating relevant previous information as appropriate (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

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

- Thirty of the children and young people who responded were clear about why they had to attend the YOS; 25 had been told by staff what would happen when they did. Nearly all felt that YOS staff listened to them and were interested in helping them.
- Twenty-seven children and young people reported that their YOS worker had discussed their referral order contract or supervision plan with them, and 20 had been given a copy of it to keep.
- Twenty-six of the thirty-one respondents said they had completed a questionnaire about their needs as part of their supervision by the YOS; all said YOS staff had taken action to deal with problems they had raised. Five respondents said that during their time in contact with the YOS there had been things in their life that made them afraid, and in four cases the YOS had helped them.
- Respondents reported receiving help with a wide range of issues, particularly ETE, substance misuse, and understanding their offending.
- Eighteen children and young people reported a satisfaction level of 70% or more with the service they had received, with 11 being completely satisfied. Twenty-three out of twenty-nine thought they were less likely to offend as a result of their work with the YOS.

Victims

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

- Victims reported a range of positive experiences from their involvement with the YOS, mainly through attending referral order panel meetings and participating in restorative justice meetings. Seventeen were completely satisfied with the service they had received, and one was partly satisfied.
- All respondents felt the YOS had explained what they could offer and took into account their particular circumstances. They had been given a chance to talk about any worries they had about the offence, or the child or young person who had committed it.
- Nine had benefited from reparative work undertaken by the child or young person who had committed the offence.

Sharing good practice

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

Delivery and Review of Interventions **General Criterion: 2.2**	Kyle (aged 17) received a 12 month referral order for two offences of assault. At this point Kyle was attending a local college for one day a week, doing a plumbing course in which he had no interest. From the beginning of the order the case manager prioritised finding a more suitable course and despite several setbacks Kyle has now completed an E2E programme and is moving on to an NVQ2 Sport Active Leadership course with Doncaster Rovers Football Club.

Delivery and Review of Interventions **General Criterion: 2.3**	Ben was 17 years old and subject to a 4 month DTO. He had complex mental health needs, including being diagnosed with a serious behavioural disorder. There had been comprehensive intervention pre-sentence with excellent multi-agency working. Community mental health workers visited Ben in custody and attended planning meetings in order to ensure that the appropriate interventions took place in custody and to facilitate a seamless transition back to the community.

Delivery and Review of Interventions **General Criterion: 2.3**	Fifteen year old Daniel was on a youth rehabilitation order for committing assaults when drunk. His relationship with his mother had been deteriorating, compounded by her own alcohol misuse. Dealing with Daniel's alcohol misuse was tackled straightaway, with work on thinking skills and victim awareness planned to start later once drinking had reduced and family relationships been stabilised. Home visiting was used appropriately to monitor the family situation, and the substance misuse worker provided support to Daniel's mother with her drinking problem and to help improve family relationships.

All names have been changed.

1. ASSESSMENT AND SENTENCE PLANNING

1.1 Risk of Harm to others (RoH):

General Criterion:

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

Score:	***Comment:***
63%	***MODERATE improvement required***

Strengths:

(1) A RoSH screening was completed in 30 (79%) of the 38 cases inspected. All but four of the screenings were completed on time.

(2) We considered the RoSH classification was correct in 28 (93%) of the 30 screenings.

(3) Twelve cases required a RoSH analysis and these were completed in all but one case. Ten were completed on time.

(4) Details of the RoSH assessment and management were appropriately communicated to all relevant staff and agencies in 16 out of 18 cases (89%).

(5) Two cases in the sample met the criteria for MAPPA. One case had already been referred to MAPPA and the other was notified on time. The initial level (Level 1) was correct.

Areas for improvement:

(1) Of the 38 cases inspected the RoSH screening was inaccurate in five cases and had not been done at all in a further eight.

(2) RoSH assessments did not draw adequately on all appropriate information in nine relevant cases (30%). Four of the eleven RoSH analyses completed were of insufficient quality. This was due to a number of factors including previous relevant behaviour and *RoH* to victims not being fully considered.

(3) A RMP was completed in only 2 of the 12 cases where one was required. These two plans were completed on time but were not of sufficient quality and lacked effective management oversight. Deficiencies related to insufficient attention to victim issues, a lack of clarity about roles and responsibilities of those involved with the case, and planned responses being unclear or inadequate.

(4) In 18 cases where there were potential *RoH* issues, but there was no requirement for a RMP, the need for planning to take account of these factors was not recognised in five and not acted upon in six of these cases.

(5) Sentence plans and referral order contracts did not prioritise *RoH* objectives in 9 out of 24 relevant cases (37%).

(6) In 13 out of 15 relevant cases management oversight had not ensured the *RoH* assessment or RMP was timely or of sufficient quality.

1.2 Likelihood of Reoffending:	
General Criterion: *The assessment of the LoR is comprehensive, accurate and timely and uses Asset and other relevant assessment tools. Plans are in place to reduce LoR*.	
Score: ***63%***	***Comment:*** ***MODERATE improvement required***

Strengths:

(1) An initial assessment of the LoR was completed in 30 cases (79%). Only three were completed late.

(2) Where completed, there was an active engagement of the child or young person in the initial assessment in 21 cases (70%).

(3) Where appropriate, the majority of initial assessments were informed by contact with agencies responsible for physical, emotional and mental health; substance misuse; the police; and secure establishments.

(4) There was an intervention plan or referral order contract in 83% of relevant cases. The large majority of plans or contracts set relevant goals and focused on achievable change; gave a clear shape to the order; and reflected the purposes of sentencing and national standards.

(5) In the majority of cases substance misuse and education and training services; the police; and secure establishments were involved in the planning process.

(6) Objectives in the sentence plan or referral order contract took account of victim issues in 19 out of 27 relevant cases (70%).

(7) All of the nine custodial cases inspected had a custodial sentence plan, six of which had been completed on time. Seven plans sufficiently addressed factors related to offending, and four out of five relevant cases took account of positive factors in the child or young person's life. Three out of four plans took account of Safeguarding needs.

(8) The YOS was actively and meaningfully involved throughout the custodial planning process in eight out of nine cases, and plans were reviewed at appropriate intervals in five out of seven relevant cases.

Areas for improvement:

(1) Of the 38 cases inspected 16 (42%) lacked an initial assessment of the LoR that was of sufficient quality. This was due to an assessment not being done (eight cases), containing unclear or insufficient evidence, or failing to identify factors related to the child or young person's offending, including those that made them vulnerable.

(2) There was insufficient evidence of active engagement with the child or young person's parents/carers in the initial assessment in 11 relevant cases (42%).

(3) In only two cases had the case manager assessed the learning style of the child or young person. A *What do YOU think?* questionnaire was completed by the child or young person in only seven cases; and the YOS had recognised the need to increase the number of cases in which it was completed.

(4) Where appropriate, 15 assessments (50%) were not informed by contact or previous assessments from children's social care services, and 13 (43%) were not informed by ETE services.

(5) A community intervention plan or referral order contract was not completed on time in half of all cases. In 13 cases (36%) plans/contracts did not address the factors linked to offending sufficiently. Where relevant, four out of six did not integrate RMPs, 6 out of 17 (35%) did not take into account safeguarding needs, 11 (52%) did not take into account positive factors in the child or young person's life, and 18 (67%) did not take into account the learning needs and style of the child or young person.

(6) Intervention plans (for cases in custody and the community) and referral order contracts were not prioritised according to any *RoH* in nine cases (38%), and did not include appropriate Safeguarding work in five cases (33%).

(7) Custodial sentence plans did not integrate with RMPs in four out of five cases, and did not take into account the learning needs and style of the child or young person in four out of seven relevant cases.

(8) Children's social care services were not meaningfully and actively involved in the planning process throughout the sentence in 9 out of 15 relevant cases. Accommodation and mental health services were similarly not involved in 6 out of 14, and 8 out of 12 cases respectively.

(9) Where relevant, community intervention plans and referral order contracts were not sequenced according to the factors linked to offending in nine cases (36%), and four out of six were not clearly integrated with RMPs. Specific or realistic timescales for the achievement of objectives were not set in 12 cases (40%). However, these deficiencies were not necessarily reflected in the actual delivery of the interventions.

(10) The LoR was not reviewed at appropriate intervals in 24 cases (63%), and likewise intervention plans were not reviewed at appropriate intervals in 13

cases (36%). The child or young person, and their parent/carer, were not actively involved in the planning process in 16 (42%) and 20 (67%) cases respectively.

1.3 Safeguarding:	
General Criterion: *The assessment of Safeguarding needs is comprehensive, accurate and timely and uses Asset and other relevant assessment tools. Plans are in place to manage Safeguarding and reduce vulnerability.*	
Score: ***61%***	***Comment:*** ***MODERATE improvement required***

Strengths:

(1) A vulnerability screening was completed in 30 (79%) of the cases inspected. All but four of the screenings were completed on time.

(2) In three out of four cases of vulnerable young people receiving custodial sentences, the establishment was made aware of the vulnerability issues prior to, or immediately following sentence.

(3) VMPs contributed to and informed interventions in four out of six cases.

(4) There was evidence of a contribution to the CAF and other assessments and plans concerned with Safeguarding in six of the seven relevant cases. Copies of other plans (care, pathway, protection, etc) were available on the file in 12 out of 14 applicable cases.

Areas for improvement:

(1) The vulnerability screening was insufficient in 13 out of 30 cases (43%), and not completed at all in a further eight cases. Safeguarding needs were not reviewed as appropriate in 22 cases (58%).

(2) A VMP was completed in only 6 of the 15 cases where one was required and only five of these were completed on time. Only two were of sufficient quality. In some of these documents the roles and responsibilities of those involved in the case were unclear, and planned responses were unclear or inadequate.

(3) In some cases behaviours such as excessive drinking or drink driving were rightly assessed as presenting a *RoH*, but overlooked as a source of vulnerability to the child or young person themselves.

(4) VMPs contributed to and informed plans, other than the intervention plan, in only two out of four cases.

(5) In 16 out of 19 applicable cases the vulnerability assessment had required more effective management oversight.

OVERALL SCORE for quality of Assessment and Sentence Planning work: 62%

COMMENTARY on Assessment and Sentence Planning as a whole:

The practice in most of the sample inspected had been for the YOS to have a single continuous Asset document for each case, running through successive orders and reviews. Additional paragraphs were inserted in each section at each passing 'case stage' or review. In some instances these were undated, and in others it was not clear whether the date indicated was the date the entry had been due or the date it was actually made. Consequently, there was no definitive record of previous Asset assessments or plans that had been finalised or 'locked'. The current version of Asset often contained too much previous information that was no longer relevant while giving insufficient attention to current issues and concerns. The YOS was in the process of changing this practice to align with YJB guidance.

The YOS had a process of reviewing cases presenting a *RoH* at bi-weekly *RoH* management meetings, and this included an element of planning. However, documents from this process were not available in some of the case files inspected, and the process was not fully integrated into the electronic case files. Details of the meetings were not always entered on to contact logs, and in many cases the process appeared to be used in place of Asset RMPs. This may have given rise to the low number of RMPs seen in the cases inspected.

Where screenings or assessments were insufficient, this was generally because they had overlooked some significant issue or behaviour, or that they did not contain a sufficient analysis of the information presented.

In those cases where management oversight was judged to be insufficient this was often where assessments and/or plans that required improvement had been signed-off, or action had not been taken to address the fact that they had not been completed.

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: ***54%***	***Comment:*** ***SUBSTANTIAL improvement required***

Strengths:

(1) Appropriate resources had been allocated according to the assessed *RoH* throughout the sentence in 86% of cases.

(2) Case managers and other staff contributed effectively to multi-agency meetings (other than MAPPA), in seven out of eight cases in custody and in all 13 relevant cases in the community.

Areas for improvement:

(1) The *RoH* had not been thoroughly reviewed in-line with the required timescales in 20 out of 32 applicable cases (63%). This included one case previously subject to a local management review following reports of suspected and potentially dangerous sexual behaviour.

(2) The *RoH* had not been thoroughly reviewed in 14 out of 19 cases following a significant change (74%).

(3) Changes in factors related to the *RoH* posed by the child or young person were not anticipated where feasible in 7 out of 15 cases (47%). In 12 cases where such factors had changed this was not identified or appropriately acted upon in four and seven cases respectively.

(4) Although there was evidence of home visits being made in many instances (particularly those on ISSP), this was done specifically and throughout the sentence in response to the level of *RoH* in only 14 out of 22 cases (64%), and in response to Safeguarding issues in only nine out of 14 (64%). The YOS was aware this needed improvement.

(5) Insufficient priority was given to the safety of victims in 13 out of 20 relevant cases (65%), and a full assessment of safety was carried out where required in only eight out of 17 cases (47%).

(6) Specific interventions to manage *RoH* in the community were delivered as planned in only 13 out of 20 cases, and reviewed following a significant change in only 8 out of 12 cases. Specific interventions to manage *RoH* in the custodial phase of DTOs were delivered as planned in three out of five cases.

(7) There was effective management oversight of the *RoH* in only three out of six cases in custody, and 2 out of 21 cases in the community.

2.2 Reducing the Likelihood of Reoffending:	
General Criterion: *The case manager coordinates and facilitates the structured delivery of all elements of the intervention plan.*	
Score: ***78%***	***Comment:*** ***MINIMUM improvement required***

Strengths:

(1) Appropriate resources to address the LoR were allocated to 86% of the cases throughout the sentence.

(2) Twenty-nine cases were subject to the scaled approach. The initial intervention level was clear in all but one case, and correct in 24 cases (83%).

(3) In 89% or more of the community cases interventions incorporated diversity issues, and were assessed to be of good quality and designed to address LoR.

(4) The YOS worker had reinforced positive behaviour and actively motivated and supported the child or young person throughout the sentence in 94% and 86% of cases respectively. In 70% of cases they had actively engaged the parents/carers where appropriate.

(5) In all except one case in custody YOS staff had been appropriately involved in the review of interventions delivered, had reinforced positive behaviour and actively motivated and supported the child or young person throughout the sentence. In all cases they had actively engaged the parents/carers where appropriate.

Area for improvement:

(1) In 14 out of 35 cases interventions in the community were not delivered in-line with the intervention plan, were not appropriate to the offender's learning style in 15 (43%), and not reviewed appropriately in 17 (51%). They were not sequenced appropriately in 12 out of 23 cases (44%).

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: ***84%***	***Comment:*** ***MINIMUM improvement required***

Strengths:

(1) In all seven relevant cases all necessary immediate action was taken to safeguard and protect the child or young person, and immediate action was taken to safeguard and protect any other affected children or young people.

(2) All necessary referrals to ensure Safeguarding were made to other agencies in 12 out of 13 cases in custody and the community.

(3) YOS staff and those from ETE and substance misuse services, the police and secure establishments worked together to promote the Safeguarding and well-being of the child or young person in the community in 88% or more of cases. The figure for such inter-agency working was 73% for emotional and mental health services, and 67% for children's social care services.

(4) Where cases were in custody YOS staff and those from other agencies worked together to promote the Safeguarding and well-being of the child or young person in all relevant cases, except in relation to children's social care services.

(5) In most cases YOS workers and relevant agencies worked together during the transition from custody to community to ensure continuity in the provision of mainstream services, except in relation to children's social care services.

(6) Specific interventions to promote Safeguarding in the community were identified in 95% of cases and incorporated in the VMP in four of the five cases where one was present. They were delivered in 72% of applicable cases.

(7) In both applicable cases in custody specific interventions to promote Safeguarding were identified and delivered where necessary. However, they were not incorporated in VMPs.

(8) The well-being of the child or young person was supported and promoted by all relevant staff in all cases in custody, and 92% of those in the community.

Areas for improvement:

(1) YOS workers and children's social care services worked together to promote the Safeguarding and well-being of the child or young person while in custody, and to ensure continuity in the provision of services during the transition to the community, in only one of two cases.

(2) Specific interventions to promote Safeguarding in the community were reviewed every three months or following a significant change in only 7 out of 13 cases.

(3) There had been effective management oversight of Safeguarding and vulnerability needs in only 5 out of 15 cases in the community and neither of the two relevant cases in custody.

OVERALL SCORE for quality of Delivery and Review of Interventions work: 73%

COMMENTARY on Delivery and Review of Interventions as a whole:

The YOS had a system of resource allocation meetings that aimed to prioritise interventions across the YOS caseload, although in some cases this resulted in the intervention plan not being delivered in the timescale originally intended.

While activity to safeguard the child or young person was sufficient in most cases, work to keep to a minimum the child or young person's *RoH* was often given insufficient attention.

We found good levels of contact between YOS staff and the children and young people. There was good use of home visiting to support offending related work but not specifically to assist in the management of vulnerability and *RoH* issues.

Case managers demonstrated a high level of enthusiasm and commitment to their work with the children and young people, although the quality of the planning and work undertaken was not always reflected in the case records

The YOS had developed a wide range of high quality interventions, supported by strong partnership working, although in several cases inspected a single session on victim awareness or thinking skills delivered by a partner agency was not considered sufficient.

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: ***61%***	***Comment:*** ***MODERATE improvement required***

Strengths:

(1) In all but two cases where the child or young person had not complied with the sentence, the enforcement action taken by the YOS was appropriate.

(2) There had been a reduction in the frequency of offending in 36% of cases and in the seriousness of offending in 44%.

(3) All reasonable action had been taken to keep the child or young person safe in 28 out of 30 cases (93%).

Areas for improvement:

(1) The *RoH* was not effectively managed in 13 out of 28 cases (46%). This was mainly due to insufficient assessment and planning.

(2) The child or young person had not complied with all the requirements of the sentence in 21 cases (55%).

(3) The practice of running a single Asset assessment document throughout the life of the case meant that in many instances only the current Asset scores were available, and any change over time could not be assessed. In 15 cases where previous scores were available, there had been a reduction in only six.

(4) Based on an assessment of the whole case record, even where previous Asset scores were unavailable, the most predominant areas where there had been improvement in the child or young person's situation (both in absolute numbers and the proportion that had improved) were ETE (14 out of 32 cases) and lifestyle (10 out of 34 cases).

(5) There had been a reduction in risk factors linked to Safeguarding in only 7 out of 18 cases (39%).

3.2 Sustaining outcomes:	
General Criterion: *Outcomes are sustained in relation to RoH, LoR and Safeguarding.*	
Score: ***78%***	***Comment:*** ***MINIMUM improvement required***

Strengths:

(1) Full attention had been given to community integration issues in 29 out of 36 cases in the community (81%) and in eight out of nine cases in custody.

(2) Action had been taken or plans were in place to ensure that positive outcomes were sustainable in 25 out of 36 cases in the community (69%) and in eight out of nine cases in custody.

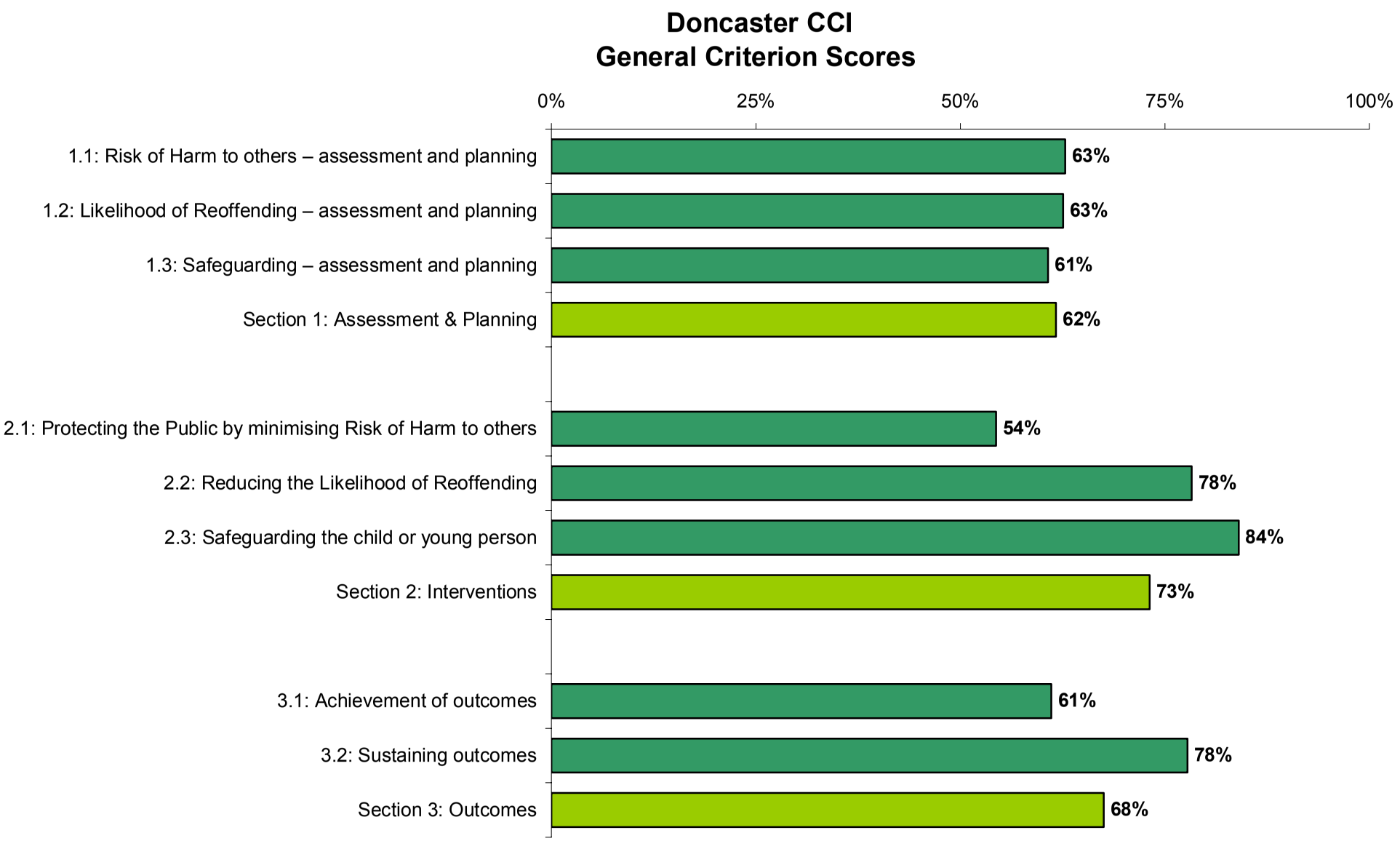
OVERALL SCORE for quality of Outcomes work: 68%

COMMENTARY on Outcomes as a whole:

The practice of not creating a fresh Asset assessment at each review resulted in there being no record of previous Asset scores in many cases. This denied the YOS the possibility of using changes in scores over time to evidence the progress being made by the children and young people under its supervision.

There was a high return rate in the victim and children and young people questionnaires for this inspection which reflects a good level of engagement by the YOS with service users. Victims in particular reported a high level of satisfaction with the service they had received.

Appendix 1: Summary



Appendix 2: Contextual information

Area

Doncaster YOS was located in the *Yorkshire & the Humber* region of England.

The area had a population of 286,866 as measured in the Census 2001, 11.1% 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 Doncaster was predominantly white British (97.7%). The population with a black and minority ethnic heritage (2.3%) 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 2008/2009, at 58 per 1,000, were above the average for England/Wales of 46.

YOS

The YOS boundaries were within those of the South Yorkshire police area. The South Yorkshire Probation Trust and the Doncaster Primary Care Trust covered the area.

The YOS was located within the Early Intervention and Prevention section of the Doncaster Metropolitan Borough Council Directorate of Children and Young People's Services. It was managed by the Interim Assistant Director of Early Intervention and Prevention who also chaired the YOS Management Board. All statutory partners attended regularly.

The YOS Headquarters was in the town of Doncaster, and the operational work of the YOS was based in the same location. ISSP was provided in-house.

YJB National Indicator Performance Judgement

The YJB National Indicator Performance Judgement available at the time of the inspection was dated 10 May 2010.

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

On these dimensions, the YJB scored Doncaster 19 of a maximum of 28 (for English YOTs); on this basis the YOS was judged by the YJB to be performing well.

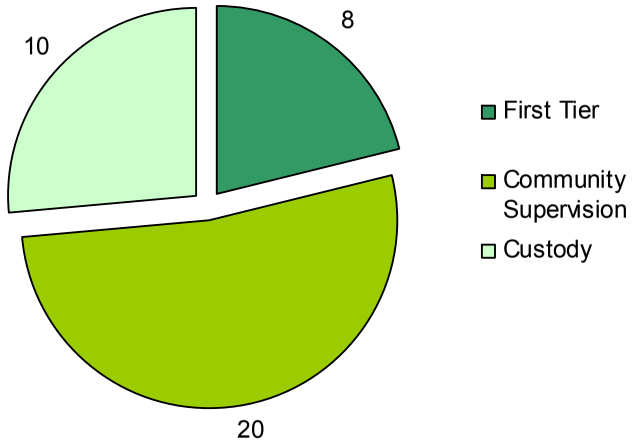
Doncaster's reoffending performance was judged by the YJB to be improving and significantly better than similar "family group" YOTs.

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

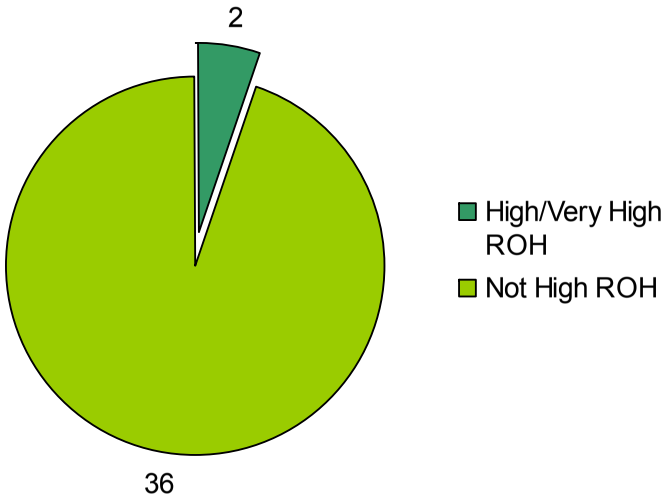
http://www.yjb.gov.uk/en-gb/practitioners/Monitoringperformance/Youthjusticeplanning/

Appendix 3a: Inspection data chart

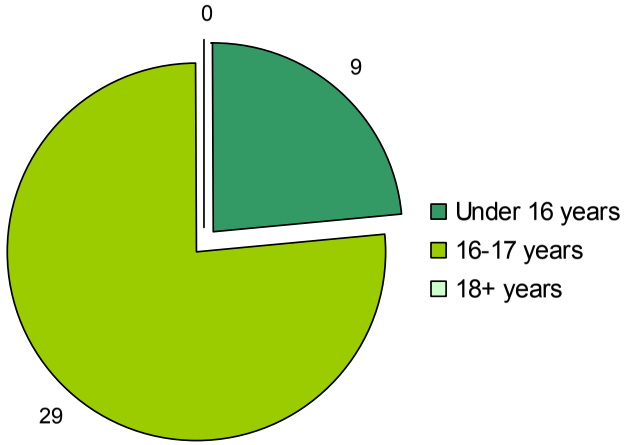
Case Sample: Sentence Type



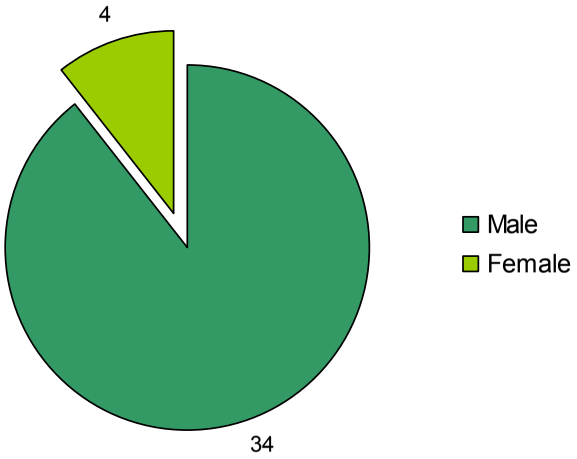
Case Sample: Risk of Harm



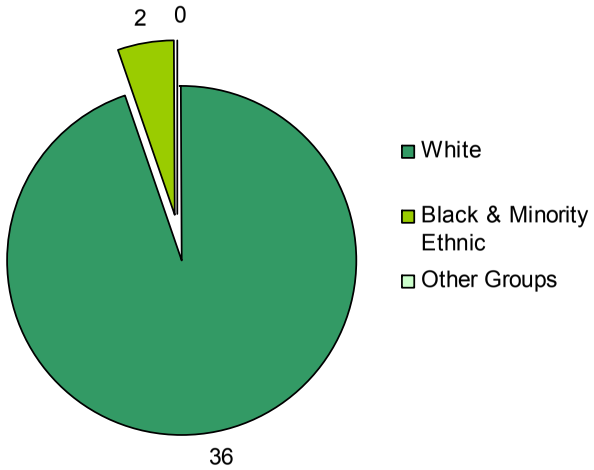
Case Sample: Age at start of Sentence



Case Sample: Gender



Case Sample: Ethnicity



Appendix 3b: Inspection data

Fieldwork for this inspection was undertaken in July 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	Employment, training and education: work to improve an individual's learning, and to increase their employment prospects
FTE	Full-time equivalent
HM	Her Majesty's
HMIC	HM Inspectorate of Constabulary
HMI Prisons	HM Inspectorate of Prisons
HMI Probation	HM Inspectorate of Probation
Interventions; *constructive* and *restrictive* interventions	Work with an individual that is designed to change their offending behaviour and/or to support public protection. A *constructive* intervention is where the primary purpose is to reduce Likelihood of Reoffending. A *restrictive* intervention is where the primary purpose is to keep to a minimum the individual's *Risk of Harm to others*. Example: with a sex offender, a *constructive intervention* might be to put them through an accredited sex offender programme; a *restrictive intervention* (to minimise their *Risk of Harm*) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case. NB. Both types of intervention are important
ISSP	Intensive Supervision and Surveillance Programme: 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
LoR	Likelihood of Reoffending. See also *constructive* Interventions
LSC	Learning and Skills Council
LSCB	Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality.

MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher *Risk of Harm to others*
Ofsted	Office for Standards in Education, Children's Services and Skills: the Inspectorate for those services in England (not Wales, for which see Estyn)
PCT	Primary Care Trust
PPO	Prolific and other Priority Offender: designated offenders, adult or young, who receive extra attention from the Criminal Justice System agencies
Pre-CAF	This is a simple 'Request for Service' in those instances when a Common Assessment Framework may not be required. It can be used for requesting one or two additional services, e.g. health, social care or educational
PSR	Pre-sentence report: for a court
RMP	Risk management plan: a plan to minimise the individual's *Risk of Harm*
RoH	*Risk of Harm to others.* See also *restrictive* Interventions
'RoH work', or 'Risk of Harm work'	This is the term generally used by HMI Probation to describe work to protect the public, primarily using *restrictive interventions,* to keep to a minimum the individual's opportunity to behave in a way that is a *Risk of Harm to others*
RoSH	Risk of Serious Harm: a term used in Asset. HMI Probation prefers not to use this term as it does not help to clarify the distinction between the *probability* of an event occurring and the *impact/severity* of the event. The term *Risk of Serious Harm* only incorporates 'serious' impact, whereas using '*Risk of Harm'* enables the necessary attention to be given to those offenders for whom lower *impact/severity* harmful behaviour is *probable*
Safeguarding	The ability to demonstrate that all reasonable action has been taken to keep to a minimum the risk of a child or young person coming to harm.
SIFA	Screening Interview for Adolescents: Youth Justice Board approved mental health screening tool for specialist workers
SQIFA	Screening Questionnaire Interview for Adolescents: Youth Justice Board approved mental health screening tool for YOT workers
VMP	Vulnerability management plan: a plan to safeguard the well-being of the individual under supervision
YJB	Youth Justice Board for England and Wales
YOI	Young Offenders Institution: a Prison Service institution for young people remanded in custody or sentenced to custody
YOIS+	Youth Offending Information System: one of the two electronic case management systems for youth offending work currently in use in England and Wales. See also Careworks
YOS/T	Youth Offending Service/Team