



Inspection of  
Youth  
Offending

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Arolygiad ar y Cyd Cyfiawnder Troseddol

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

Report on youth offending  
work in:

## Oxfordshire

ISBN: 978-1-84099-439-1

2011



## Foreword

This Core Case Inspection of youth offending work in Oxfordshire 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 71% 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 56% of the time, and the work to make each individual less likely to reoffend was done well enough 68% 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 average set of findings. The service was already aware of some of the areas of work requiring improvement, and had the commitment, and plans in place, to address them.

*Andrew Bridges*  
*HM Chief Inspector of Probation*

*June 2011*

	Scores from Wales and the English regions that have been inspected to date			Scores for Oxfordshire
	Lowest	Highest	Average	
<b>'Safeguarding' work</b> <i>(action to protect the young person)</i>	37%	91%	68%	<b>71%</b>
<b>'Risk of Harm to others' work</b> <i>(action to protect the public)</i>	36%	85%	63%	<b>56%</b>
<b>'Likelihood of Reoffending' work</b> <i>(individual less likely to reoffend)</i>	43%	87%	70%	<b>68%</b>

## **Acknowledgements**

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

<i>Lead Inspector</i>	<i>Steve Woodgate</i>
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## Scoring – and Summary Table

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

<b><i>Safeguarding score:</i></b>	
This score indicates the percentage of <i>Safeguarding</i> work that we judged to have met a sufficiently high level of quality. This score is significant in helping us to decide whether an early further inspection is needed.	
<b><i>Score:</i></b> <b>71%</b>	<b><i>Comment:</i></b> <b><i>MODERATE improvement required</i></b>
<b><i>Public Protection – Risk of Harm score:</i></b>	
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.	
<b><i>Score:</i></b> <b>56%</b>	<b><i>Comment:</i></b> <b><i>SUBSTANTIAL improvement required</i></b>
<b><i>Public Protection - Likelihood of Reoffending score:</i></b>	
This score indicates the percentage of Likelihood of Reoffending work that we judged to have met a sufficiently high level of quality.	
<b><i>Score:</i></b> <b>68%</b>	<b><i>Comment:</i></b> <b><i>MODERATE improvement required</i></b>

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

## **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 (Head of Service)
- (2) specifically, a timely and good quality assessment of the individual's vulnerability and *Risk of Harm to others* is completed at the start, as appropriate to the specific case (Head of Service)
- (3) as a consequence of the assessment, the 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* (Head of Service)
- (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 (Head of Service)
- (5) there is regular and effective oversight by management, especially of screening decisions, that is clearly recorded within the case record, as appropriate to the specific case (Head of Service).

## **Next steps**

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

## Service users' perspective

### Children and young people

Seventy-four children and young people completed a questionnaire for the inspection.

- ◆ Nearly all of the children and young people who responded were clear about why they had to attend the YOS, and 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.
- ◆ Three-quarters of children and young people reported that their YOS worker had discussed their referral order contract or supervision plan with them, and 62% had been given a copy of it to keep.
- ◆ Three-quarters of respondents said they had completed a questionnaire about their needs as part of their supervision by the YOS, and 83% said YOS staff had taken action to deal with problems they had raised. Six respondents said that during their time in contact with the YOS there had been things in their life that made them afraid, and in all cases the YOS had helped them.
- ◆ Respondents reported receiving help with a wide range of issues, particularly family and relationships, lifestyles, making better decisions, and understanding their offending.
- ◆ Two-thirds of the children and young people reported a satisfaction level of 70% or more with the service they had received, with one-quarter being completely satisfied. 86% thought they were less likely to offend as a result of their work with the YOS.

### Victims

Five 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. All five were completely satisfied with the service they had received.
- ◆ All respondents felt that the YOS had explained what they could offer, taken into account their particular circumstances, and paid attention to their safety. 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.
- ◆ Three had benefited from reparative work undertaken by the child or young person who had committed the offence.
- ◆ One respondent commented *"Although I personally didn't benefit from any work carried out by the offender, I was asked what work I thought would be suitable. My views were listened to, and acted upon. I thought the whole experience was supportive and cathartic, as I was able to make the offender aware of the repercussions of his actions"*.



## Sharing good practice

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

### Delivery and Review of Interventions

#### General Criterion: 2.1

Matthew was a 14 year old described as being just below the level of a gifted child and this had the potential to create problems in the management of his case. He clearly understood the principles of the assessment of his *RoH*, and challenged his worker over the assessment. The worker delivered a session in which Matthew used the Asset criteria to assess himself, and through discussion and challenge, his self-assessment was very near to that of the worker. As a result he understood the reasons underpinning his intervention plan and he became more willing to work towards its objectives.

### Delivery and Review of Interventions

#### General Criterion: 2.2

Joseph was a black male with a very distinctive appearance who had been moved by police from a major city to the Banbury area. The practitioner recognised that the transition into rural living was likely to have been difficult. He worked with Joseph to manage this, signposting him into local activities and ensuring he was aware of the need to plan for less frequent public transport. The practitioner addressed potentially sensitive issues such as ethnicity and accent with confidence, helping Joseph to gain the skills to challenge discrimination without resorting to aggression.

### Delivery and Review of Interventions

#### General Criterion: 2.2

Connor had received a DTO sentence for possessing Class A drugs. He had undertaken work on substance misuse while in custody and as a result was very reluctant to engage in any form of substance misuse work when released on supervision. However, he agreed to meet the substance misuse worker and they agreed a creative plan of work to encourage his engagement. They studied Bob Marley and his influence on the use of cannabis and popular music, and also looked at the harmful effects of cannabis, the law, chains of dealing, and the wider effects of drugs. As a result, Connor continued to make progress in addressing his offending.

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:**

**59%**

### **Comment:**

***SUBSTANTIAL improvement required***

### **Strengths:**

- (1) An RoSH screening was completed in 54 (87%) of the 62 cases inspected, and we considered the RoSH classification was correct in 85% of the screenings.
- (2) Forty-two cases required an RoSH analysis and these were completed in 86% of them.
- (3) *RoH* assessments drew on all appropriate information including MAPPA, in 70% of cases.
- (4) An RMP was completed in three-quarters of the 37 cases where one was required.
- (5) Five cases in the sample met the criteria for MAPPA, and four had been notified or referred to MAPPA. The initial level (Level 2) was correct in these four cases.

### **Areas for improvement:**

- (1) The initial RoSH screening was completed late in one-third of cases, was inaccurate in nearly one-third, and had not been done at all in a further eight. This was recognised by the YOS through its own quality assurance processes as an area requiring improvement.
- (2) In cases where RoSH assessments were required, they were completed late in one-third, and not completed at all in six cases.
- (3) The 36 RoSH analyses completed were of insufficient quality in 61%. This was due to a number of factors including previous relevant behaviour and *Risk of Harm* to victims not being fully considered. The YOS recognised that some assessments failed to take account of relevant previous behaviour.

- (4) Nearly half of the 27 RMPs were completed late, and a further ten were not completed at all.
- (5) Completed plans were not of sufficient quality in nearly half of the cases, and lacked effective management oversight. In many plans there was a lack of clarity about roles and responsibilities of those involved with the case, and the planned responses to changes in level of risk were unclear or inadequate.
- (6) Details of the RoSH assessment and management plan were not appropriately communicated to all relevant staff and agencies in more than one-third of 47 relevant cases.
- (7) In 19 cases where there were potential *RoH* issues, but there was no requirement for an RMP, the need for planning to take account of these factors was not recognised in 16 (84%) and not acted upon in all 17 cases where this was required.
- (8) In more than half of the 47 relevant cases management oversight had not ensured that the *RoH* assessment or the RMP was timely or of sufficient quality.
- (9) Custodial and community sentence plans and referral order contracts did not prioritise *RoH* objectives in 41 out of 58 relevant cases (71%).
- (10) Three of the four relevant cases were not notified or referred to MAPPA on time, and a further case was not notified or referred at all.

## 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:***

**66%**

### ***Comment:***

***MODERATE improvement required***

### ***Strengths:***

- (1) An initial assessment of the LoR was completed in 56 cases (90%).
- (2) Where completed, there was active engagement with the child or young person's parents/carers in three-quarters of relevant cases.
- (3) Where appropriate, a large majority of initial assessments were informed by contact with children's social care services; ETE services; and agencies responsible for physical, emotional and mental health, substance misuse, and secure establishments.
- (4) All but one of the 17 custodial cases inspected had a custodial sentence plan, and 15 of these had been completed on time.

- (5) There was a community intervention plan or referral order contract in almost all relevant cases, and this had been completed on time in more than three-quarters. They addressed the factors linked to offending sufficiently in over two-thirds, and where relevant took into account positive factors in the child or young person's life in 73%.
- (6) The large majority of community plans and contracts focused on achievable change; gave a clear shape to the order; set realistic timescales; and reflected the purposes of sentencing and national standards. This was reflected by children and young people completing questionnaires which showed that nearly all respondents were clear about why they were attending the YOS.
- (7) The YOS was actively and meaningfully involved throughout the custodial planning process in 14 out of 17 cases, and plans were reviewed at appropriate intervals in 12 out of 16 relevant cases.
- (8) In three-quarters or more of relevant cases; education and training services; substance misuse and physical, mental and emotional health services; the police; and secure establishments were involved in the planning process throughout the sentence.

***Areas for improvement:***

- (1) In ten cases (18%) the initial assessment of the LoR was completed late, and in a further six cases not completed at all. Overall, 39% of cases inspected lacked an initial assessment of the LoR that was of sufficient quality. This was due to an assessment not being done, or being done late, containing unclear or insufficient evidence or failing to identify factors related to the child or young person's offending.
- (2) There was insufficient evidence of active engagement with the child or young person in the initial assessment in 29% of cases.
- (3) In two-thirds of cases the case manager had not assessed the learning style of the child or young person. A *What do YOU think?* self-assessment questionnaire was not completed by the child or young person in 45% of cases.
- (4) Where appropriate, five out of eight assessments were not informed by contact with or previous assessments from the ASB team, and 10 out of 16 cases by contact with the police.
- (5) Of the 16 custodial sentence plans ten did not sufficiently address factors related to offending. Where relevant, less than two-thirds were integrated with RMPs, and took account of the child or young person's learning needs or style. Less than half took account of Safeguarding needs, positive factors in the child or young person's life, and identified diversity factors.
- (6) Custodial sentence plans were not prioritised according to any *RoH* in 12 cases, and did not include appropriate Safeguarding work in four out of nine relevant cases. They were not sequenced according to the factors linked to offending in 11 cases, and did not take account of victim issues in six cases.

- (7) In relevant community intervention plans and referral order contracts, just over half were not integrated with RMPs, and did not take into account the learning needs and style of the child or young person. Less than half took into account Safeguarding needs, and responded appropriately to identified diversity factors. Relevant goals were not set in 41% of all plans/contracts.
- (8) Community intervention plans were not prioritised according to any *RoH* in 69% of cases, and did not include appropriate Safeguarding work in 37% of relevant cases. They were not sequenced according to the factors linked to offending in 61% of cases, and did not take account of victim issues in 40%. They were not sensitive to diversity issues in half of the relevant cases.
- (9) ASB teams and the police were not sufficiently involved in the planning process throughout the sentence in 5 out of 6, and 19 out of 36 relevant cases respectively. Information received from the police was not always taken into account in assessments and sentence plans. Accommodation services were not sufficiently involved in one-third of relevant cases.
- (10) The LoR was not reviewed at appropriate intervals in 48% of cases, and likewise intervention plans were not reviewed at appropriate intervals in 56%. The child or young person, and their parents/carers, were not actively involved in the planning process in 37% and 57% of cases respectively.

<b>1.3 Safeguarding:</b>	
<b><i>General Criterion:</i></b>	
<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>	
<b><i>Score:</i></b>	<b><i>Comment:</i></b>
<b>66%</b>	<b>MODERATE improvement required</b>

### ***Strengths:***

- (1) A vulnerability screening was completed in 87% of the cases inspected, and Safeguarding needs were reviewed as appropriate in 68%.
- (2) In 9 out of 11 cases of vulnerable children and 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 plans, other than the intervention plan, in seven out of nine cases. There was evidence of a contribution to the CAF and other assessments and plans concerned with Safeguarding, in eight of the ten relevant cases. Copies of other plans (care, pathway, protection, etc) were available on the file in the great majority of applicable cases.

***Areas for improvement:***

- (1) One-third of cases did not have a timely vulnerability screening, and 63% lacked a screening of sufficient quality.
- (2) A VMP was completed in only 56% of cases where one was required and less than half of these were completed on time. Nearly one-fifth were of insufficient 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) VMPs did not contribute to and inform the intervention plan in 45% of cases.
- (4) In 60% of applicable cases the vulnerability assessment had required more effective management oversight.

**OVERALL SCORE for quality of Assessment and Sentence Planning work: 65%**

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

Where screenings or assessments were insufficient, this was generally because they had overlooked some significant issue or behaviour or there was not 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.

Assessment and planning was supported by strong partnership working with other agencies, including regular risk management and DYO Panels. However there was a need to improve recording of joint working with the ASB team and police, in the intervention and risk management planning within Asset.

## 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:**

**61%**

**Comment:**

**MODERATE improvement required**

**Strengths:**

- (1) Effective use was made of MAPPA in three out of four relevant cases, and in all four the decisions taken within MAPPA were clearly recorded, followed through and acted upon. Case managers and other staff contributed effectively to MAPPA in both of the relevant cases that were in custody.
- (2) Case managers and other staff contributed effectively to multi-agency meetings (other than MAPPA) in all but one of the cases in custody, and in all but two of those in the community.
- (3) Purposeful home visits had been carried out throughout the sentence in response to the level of RoH in 67% of cases, and in response to Safeguarding issues in 85%.
- (4) Appropriate resources had been allocated according to the assessed RoH throughout the sentence in 90% of cases.
- (5) Specific interventions to manage RoH were delivered as planned in 64% of cases in the community and in 69% of cases in the custodial phase of sentences.

**Areas for improvement:**

- (1) The RoH had not been thoroughly reviewed in-line with the required timescales in nearly half of applicable cases. Regular reviews had not been undertaken at all in 11 cases, and were late in a further 11, while 5 were of insufficient quality.
- (2) Changes in factors related to the RoH posed by the child or young person had not been anticipated where feasible in 39% of cases.
- (3) The RoH had not been thoroughly reviewed in 20 out of 37 cases following a significant change. In 15 of these cases there had been no review at all, while

five were undertaken late. Some did not fully reflect the change or additional information.

- (4) Changes in factors related to the *RoH* posed by the child or young person were not identified or appropriately acted upon in 58% and 66% of cases respectively.
- (5) Decisions taken within MAPPA were not appropriately reviewed in one of two relevant cases, and case managers and other staff had not contributed effectively to MAPPA in one of two relevant cases in the community.
- (6) Insufficient priority was given to the safety of victims in half of relevant cases, and a full assessment of safety was carried out where required in less than half of these cases. This was an area of practice the YOS recognised as requiring improvement.
- (7) Specific interventions to manage *RoH* in the community and in the custodial phase of sentences were reviewed following a significant change in only one-third of cases.
- (8) There was effective management oversight of the *RoH* in only 53% of relevant cases in custody, and only 40% of cases in the community.

<b>2.2 Reducing the Likelihood of Reoffending:</b>	
<p><b><i>General Criterion:</i></b></p> <p><i>The case manager coordinates and facilitates the structured delivery of all elements of the intervention plan.</i></p>	
<p><b><i>Score:</i></b></p> <p><b>77%</b></p>	<p><b><i>Comment:</i></b></p> <p><b><i>MINIMUM improvement required</i></b></p>

***Strengths:***

- (1) Interventions delivered in the community were of good quality in 82% of cases, and were designed to address LoR in 93%. They were delivered in-line with the intervention plan in 72%, were appropriate to the offender's learning style in 63%, and incorporated diversity factors in 67%.
- (2) Fifty-eight cases were subject to the scaled approach, and the initial intervention level was clear and correct in all but two cases. Appropriate resources to address the LoR were allocated to 90% of the cases throughout the sentence.
- (3) The YOS worker had actively motivated and supported the child or young person throughout the sentence in 87% of cases, and had reinforced positive behaviour in 82%. In three-quarters of cases they had actively engaged the parents/carers where appropriate.



- (4) In 15 out of 17 cases in custody YOS staff had been appropriately involved in the review of interventions delivered, and had actively motivated and supported the child or young person throughout the sentence. In nearly all cases they had reinforced positive behaviour, and had actively engaged the parents/carers where appropriate.

**Area for improvement:**

- (1) Interventions delivered in the community were not reviewed appropriately in nearly half the cases, and not sequenced appropriately in 44%.

<b>2.3 Safeguarding the child or young person:</b>	
<p><b>General Criterion:</b></p> <p><i>All reasonable actions have been taken to safeguard and reduce the vulnerability of the child or young person.</i></p>	
<p><b>Score:</b></p> <p><b>79%</b></p>	<p><b>Comment:</b></p> <p><b>MINIMUM improvement required</b></p>

**Strengths:**

- (1) All necessary immediate action was taken to safeguard and protect the child or young person in 80% of cases in custody and in the community. In all except one of the relevant cases immediate action was taken to safeguard and protect any other affected child or young person.
- (2) All necessary referrals to ensure Safeguarding were made to other agencies in all relevant cases in custody, and in most cases in the community.
- (3) YOS staff and those from ETE services; and agencies responsible for physical, emotional and mental health; and secure establishments worked together to promote the Safeguarding and well-being of the child or young person in the community in 67% or more of cases. The figure for such inter-agency working was 88% for children’s social care services, and 97% for substance misuse services, but only 63% for the police.
- (4) For cases in custody, YOS staff worked together with those from other agencies to promote the Safeguarding and well-being of the child or young person in 91% or more of cases.
- (5) In 89% or more of 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 emotional and mental health services where the figure was lower at 60%.

- (6) Specific interventions to promote Safeguarding in the community were identified in 82% of cases and incorporated in the VMP in 10 of the 14 cases where one was present. They were delivered in 76% of applicable cases.
- (7) The well-being of the child or young person was supported and promoted by all relevant staff in most cases in both custody and the community.

***Areas for improvement:***

- (1) Specific interventions to promote Safeguarding for cases in custody were not identified in 4 out of 11 cases, and not incorporated in the VMP in two out of the six cases where one was present. They were not delivered in 5 out of 11 applicable cases, and were not reviewed every three months or following a significant change in five out of nine cases.
- (2) For cases in custody, YOS staff worked together with the police to promote the Safeguarding and well-being of the child or young person in only 40% of relevant cases.
- (3) Specific interventions to promote Safeguarding in the community were not reviewed every three months or following a significant change in 58% cases.
- (4) There had been effective management oversight of Safeguarding and vulnerability needs in only 55% of relevant cases in the community, and only 47% of 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:**

We found good levels of contact between YOS staff and the children and young people. There was positive use of home visiting to support offending related work and 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, and this was reflected in our service user survey.

The YOS had a range of good quality interventions, and the delivery of interventions was effective, notwithstanding the deficiencies in intervention plans and their reviews. The work of the YOS was supported by strong partnership working, particularly in relation to children's social care services, but there was a need to improve joint working with the ASB team and police in the delivery of work to address Safeguarding.

### 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:**

**55%**

**Comment:**

***SUBSTANTIAL improvement required***

**Strengths:**

- (1) There had been a reduction in the frequency of offending in 42% of cases and in the seriousness of offending in 48%.
- (2) All reasonable action had been taken to keep the child or young person safe in 84% of the relevant cases.
- (3) Where Asset scores had reduced, the most predominant areas in which there had been improvement in the child or young person's situation (both in absolute numbers and the proportion that had improved) were motivation to change (31%); attitudes to offending (30%); ETE (29%); substance misuse (24%); and thinking and behaviour (24%).
- (4) We considered that good overall progress had been made in relation to the most significant factors identified as making the individual more likely to reoffend in 16% of cases, and some progress against other significant factors in a further 38%.

**Areas for improvement:**

- (1) The *RoH* was not effectively managed in 56% of relevant cases. This was mainly due to insufficient assessment and planning by case managers, and reflected insufficient oversight of this area of work by managers. The failure to incorporate information from the DYO and ASB process mentioned earlier also contributed to this.

- (2) There had been no reduction in risk factors linked to Safeguarding in 54% of relevant cases.
- (3) The child or young person had not complied with all the requirements of the sentence in 49% of cases. The enforcement action taken by the YOS was not sufficient in 40% of these cases.
- (4) There had been no overall reduction in the Asset score in 66% of cases.

3.2 Sustaining outcomes:	
<p><b>General Criterion:</b></p> <p><i>Outcomes are sustained in relation to RoH, LoR and Safeguarding.</i></p>	
<p><b>Score:</b></p> <p><b>72%</b></p>	<p><b>Comment:</b></p> <p><b>MODERATE improvement required</b></p>

**Strengths:**

- (1) Full attention had been given to community integration issues in 76% of cases in the community and in 65% of cases in custody.
- (1) Where applicable, action had been taken or plans were in place to ensure that positive outcomes were sustainable in 73% of cases in the community and in 60% of cases in custody.

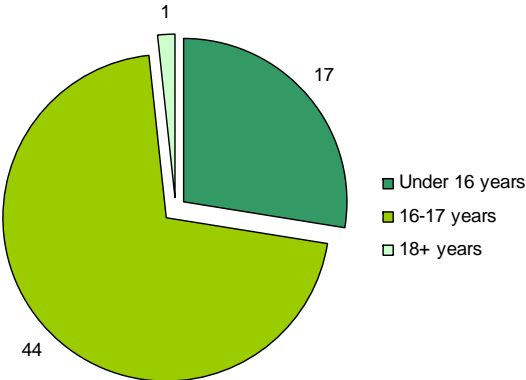
**OVERALL SCORE for quality of Outcomes work: 60%**

**COMMENTARY on Outcomes as a whole:**

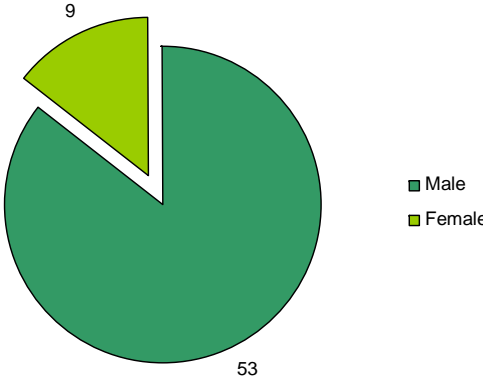
There was a good return rate in the victim survey in this inspection and victims reported a high level of satisfaction with the service they had received.

# Appendix 1: Summary

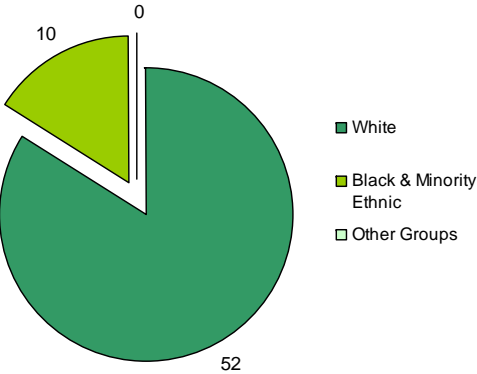
Case Sample: Age at start of Sentence



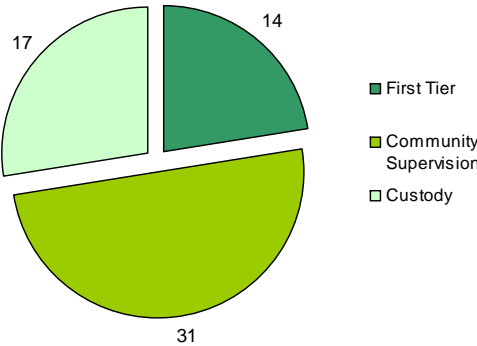
Case Sample: Gender



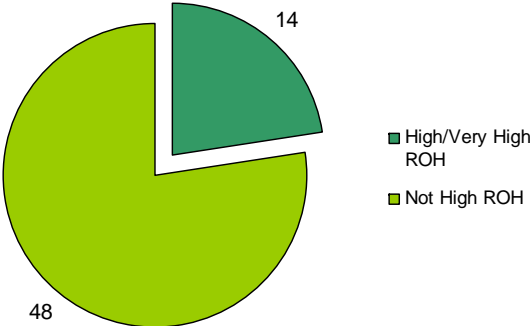
Case Sample: Ethnicity



Case Sample: Sentence Type



Case Sample: Risk of Harm



## Appendix 2: Contextual information

### Area

Oxfordshire YOS was located in the South East region of England.

The area had a population of 605,488 as measured in the Census 2001, 9.8% of which were aged 10 to 17 years old. This was slightly lower than the average for England/Wales, which was 10.4%.

The population of Oxfordshire was predominantly white British (95.1%). The population with a black and minority ethnic heritage (4.9%) 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 20 per 1,000, were better than the average for England/Wales of 38.

### YOS

The YOS boundaries were within those of the Thames Valley police area. The Thames Valley Probation Trust and the Oxfordshire Primary Care Trust covered the area.

The YOS was located within the Oxfordshire County Council Directorate of Children, Education and Families, within the Young People and Access to Education in the Integrated Youth Support Service. It was managed by the Strategic lead, Youth.

The YOS Management Board was chaired by the Head of Service, Young People and Access to Education.

The YOS Headquarters was in the county town of Oxford. The operational work of the YOS was based in Banbury and Oxford. ISS was provided in-house.

### Youth Justice Outcome Indicators 2011/2012 onwards (to replace YJB National Indicator Performance Judgements)

The national youth justice indicators for England have been replaced by three outcome indicators. These indicators will also be used in Wales.

**1. The reoffending measure** is a count of the number of 10 to 17 year olds who reoffend within 12 months of their conviction.

**2. The first time entrants measure** counts the number of young people given their first pre-court or court disposal and thus entering the youth justice system within each year.

**3. The use of custody** for young people aged 10 to 17 years.

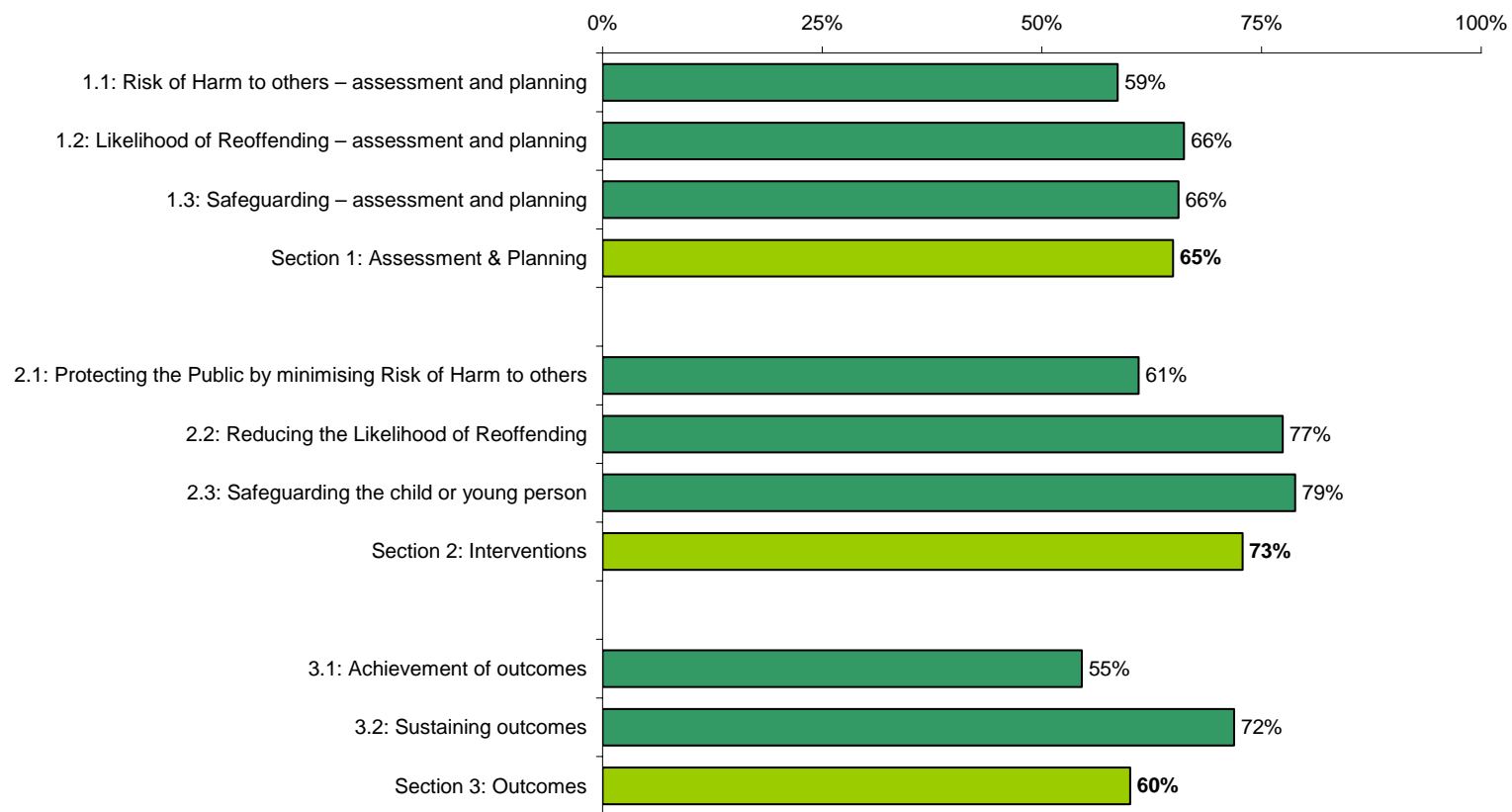
Data will be made available progressively through 2011, broken down by Local Authority area.

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

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

## Appendix 3a: Inspection data chart

### Oxfordshire CCI General Criterion Scores



## Appendix 3b: Inspection data

Fieldwork for this inspection was undertaken in February and March 2011

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

## 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
DYO (Panel)	Deter Young Offender: a strand within the multi-agency crime reduction arrangements
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>
Ofsted	Office for Standards in Education, Children's Services and Skills: the Inspectorate for those services in England (not Wales, for which see Estyn)
PCT	Primary Care Trust
PPO	Prolific and other Priority Offender: designated offenders, adult or young, who receive extra attention from the Criminal Justice System agencies
Pre-CAF	This is a simple 'Request for Service' in those instances when a Common Assessment Framework may not be required. It can be used for requesting one or two additional services, e.g. health, social care or educational
PSR	Pre-sentence report: for a court
RMP	Risk management plan: a plan to minimise the individual's <i>Risk of Harm</i>
RoH	<i>Risk of Harm to others</i> . See also <i>restrictive</i> 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 <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