HM Inspectorate of Probation
Arolygiaeth Prawf EM

Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

Full Joint Inspection of Youth Offending Work in **Powys**

An inspection led by HMI Probation

independent inspection of youth offending work

June 2013

Foreword

This inspection of youth offending work in Powys is one of a small number of full joint inspections that we are undertaking annually with colleagues from the criminal justice, social care, health and learning and skills inspectorates.

The majority of the Youth Offending Teams selected for these inspections are those whose performance – based on Youth Justice Outcome Indicators supported by other information, such as recent inspections – is of significant concern. Periodically, we also include high performing areas to establish a benchmark of good practice.

We chose to inspect in Powys primarily because this was our first full joint inspection in Wales and we wanted to visit a Youth Offending Team that was performing well against Youth Justice Outcome Indicators.

The findings of this inspection should be considered in the context within which Powys Youth Justice Service works. The service covers a large, mostly rural, geographical area but manages a relatively small caseload, which was reflected in the relative size of the inspection case sample from which many of our judgements were drawn. Many of its cases involve young people of 16 and 17 years of age, only a modest proportion of whom have been convicted of violent offences. Powys Youth Justice Service acts as host for a number of children and young people placed in the county by other local authorities, including a number of children from England, which can constitute between 17-20% of its work. As a result, in addition to facilitating transfers to probation services for young people as they become adults, it is also involved in caretaking and transfer processes for children and young people as they move between local authority areas.

Despite this complexity, we were pleased to see that Powys Youth Justice Service was working well with partner agencies to help children and young people complete their sentences and sustain positive changes in their lives. The staff were a strong asset and workers were skilled in building relationships with the children and young people, and the victims of their offences. However, while the Youth Justice Service had introduced improvements since our inspection in 2010, it was disappointing to find that there was still a need to make considerable improvement to processes and systems relating to protecting the public and the child or young person themselves, and to management oversight. Transfer arrangements also needed extensive development. We found that children and young people in our sample, who were looked after by a local authority or transferred between areas or to probation and fell under the responsibility of more than one agency, received a lower standard of service.

The recommendations made in this report are intended to assist Powys Youth Justice Service in its journey of continued improvement by focusing on specific key areas. The service has a history of embracing and driving performance development and we are confident that it will act quickly to introduce them.

Liz Calderbank
HM Chief Inspector of Probation

June 2013

Summary

Reducing the likelihood of reoffending 

Overall, work to reduce reoffending was good. While assessments completed at the time the child or young person started their sentence were of variable quality, they were reviewed appropriately throughout the order. However, there were gaps relating to both the assessment and planning for emotional and mental health. The effective delivery of suitable interventions for children and young people, and their victims, was given equal attention. Caseworkers demonstrated dedication to ensure they were able to access varied and appropriate resources and, as a result, achieve a range of positive outcomes. The Youth Justice Service had developed positive relationships with partner agencies but there were no systems in place to ensure the clear delineation of roles and responsibilities, which had a negative impact, especially on transfer cases. Management oversight had not sufficiently improved the quality of work to reduce the likelihood that a child or young person would reoffend.

Protecting the public 

Overall, work to protect the public and actual or potential victims was unsatisfactory. There was not enough priority given to the risk of harm a child or young person posed to others and management oversight was not sufficiently effective in ensuring that work to protect the public and victims was of good enough quality. Case managers did not always recognise changes in the child or young person's circumstances that should have initiated a review of how the case was being managed, or pay enough attention to managing risks to victims. A Case Planning Forum played an active and effective role in steering direction and action in cases involving children and young people who had been identified as posing a high risk of harm to others. However, in a number of cases, especially those involving a transfer, the Youth Justice Service did not ensure that there was sufficient

joined-up working and communication with partner agencies. We saw some good work around the implementation of interventions, some of which took account of the child or young person's specific, individual needs.

Protecting children and young people 

Overall, work to protect children and young people and reduce their vulnerability was unsatisfactory. The Youth Justice Service had not done enough to keep children and young people safe and we considered that management oversight had not made a sufficient difference to the quality of work in this area. Assessments lacked essential detail and analysis, and the quality of planning was poor, especially, for instance, in relation to emotional and mental health. Case managers were not ensuring they took appropriate action in enough cases to safeguard the child or young person, or to take account of changes in their circumstances. Sometimes referrals to other services were not being made where necessary or there were gaps in effective engagement with other agencies. While the Youth Justice Service and wider county council worked hard to try to resolve these, there were particular issues relating to cases that involved children who were looked after by a local authority or whose cases had been transferred.

Ensuring the sentence is served 

Overall, work to ensure that the sentence was served was very good. The Youth Justice Service engaged well with all service users. Restorative justice was given a high profile and there was an inclusive approach to victims. Case managers built effective relationships with the children and young people and

their parents/carers, which aided progress throughout the sentence. While diversity issues were not always included sufficiently well on plans, case managers had a good understanding of relevant issues and ensured these were taken into account in order to enhance the delivery of interventions. They took appropriate steps to encourage compliance and, with their specialist partners, to sustain positive outcomes achieved during the sentence. Service user views were sought and there was positive action to take these into account.

Governance 

Overall, work relating to governance was unsatisfactory. The Youth Justice Service Management Board was a well represented, cohesive body, which provided a good arena for sharing information and supporting the work of the Youth Justice Service in meeting its national priorities. However, it did not provide a strong enough lead for youth offending. There was little strategic drive from the Management Board to explore and challenge important local issues such as those relating to cases transferred between areas and to probation, the management of risk of harm to others and the protection of children and young people.

There was a multi-agency approach to developing services across Powys, with a focus on meeting the needs of vulnerable children and young people as a holistic group. The Youth Justice Service took positive steps to ensure that children and young people who had offended or were likely to offend were kept high on the county's agenda and that services took account of their needs.

The Youth Justice Service was resourced to provide an effective service and the integrated team had a good understanding of the principles of effective practice.

Recommendations

Post-inspection improvement work should focus particularly on the following:

1. That the Youth Justice Service Management Board proactively drives the strategic agenda for youth justice, identifying local priorities and holding the Youth Justice Service to account for its performance in these areas (Chair, Youth Justice Service Management Board).
2. That improvements are made to strategic policy relating to Looked After Children and transfer cases, and to ensure that safeguarding and risk of harm to others are central to this work (Chair Youth Justice Service Management Board).
3. That initial assessments and their reviews are completed to a sufficient quality with particular reference to the risk of harm the child or young person poses to others and their vulnerability (Youth Justice Service Head of Service).
4. That quality assurance arrangements, including management oversight, ensure that assessments and plans, and their reviews, are of at least sufficient quality (Youth Justice Service Head of Service).
5. That there is a joined-up, comprehensive, appropriately communicated and recorded response to changes in a child or young person's circumstances, with particular regard to safeguarding and the risk of harm the child or young person poses to others (Youth Justice Service Head of Service).

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Theme 1: Reducing the likelihood of reoffending

What we expect to see

As the purpose of the youth justice system is to prevent offending by children and young people we expect youth justice partners to increase the likelihood of successful outcomes by undertaking good quality assessment and planning, deliver appropriate interventions and demonstrate both positive leadership and effective management.

Case assessment score

Within the case assessment, overall 73% of work to reduce reoffending was done well enough.

Key Findings

1. In every case for which a pre-sentence report (PSR) was produced for the court, this was of good quality and local management arrangements were effective in ensuring this.
2. Overall, assessments of whether a child or young person was likely to reoffend were completed to a satisfactory standard in two-thirds of cases. The quality of assessment improved as a case progressed and, in the majority, the likelihood of reoffending was reviewed sufficiently well throughout the sentence.
3. There was enough planning to address issues linked to reoffending, and review of plans, in slightly less than two-thirds of cases.
4. Delivery and review of interventions was an area of strength for Powys YJS. A range of good quality, appropriately balanced and resourced interventions was being delivered and there was evidence that children and young people were making positive progress to reduce the likelihood they would reoffend.
5. Positive partnership working had produced some good outcomes for children and young people. However, it was not sufficiently supported by formal structures and living protocols that would ensure agencies were clear about their responsibilities and roles and could be held to account, especially in cases involving transfers either to probation services or between local authority areas.
6. Management oversight had not made enough positive difference to work being undertaken to reduce the likelihood a child or young person would reoffend.

Explanation of findings

1. Assessment

1.1. Of the 23 cases we inspected, six involved a child or young person looked after by a local authority, four of whom had been placed in Powys from another area. Additionally, ten cases involved a transfer, some to probation but the majority either to or from another local authority area.

1.2. Overall, there was variation in the quality of initial assessments of the likelihood a child or young person would reoffend. Some omitted important information around vulnerability, substance abuse, or emotional and mental health. Many of the assessments of education, training and employment (ETE), lacked the detail needed to ensure learners could gain the most benefit from interventions, for example around levels of attainment in literacy and numeracy or additional learning needs.

1.3. The mental health nurse took a comprehensive approach to assessing the mental health needs of children and young people managed by the YJS. She screened every new case, joining in case

discussions with colleagues. Additionally, every child or young person was invited to complete a standard health questionnaire and a mental health assessment which were used to help assess their needs and capture information they might not wish to share with their case managers.

1.4. All children and young people referred to CAIS[1] were given a triage assessment to determine the seriousness and urgency of their problems; those with more complex needs were given a more comprehensive evaluation, including a risk assessment.

1.5. While the YJS considered it took a joint approach to assessment, there were no formal systems to ensure this happened. Case managers were not always adequately drawing on all the information available to them when undertaking their assessments and we considered that the current process of gathering information from colleagues on an ad hoc, informal basis led to gaps in information about the issues to be addressed in the case.

1.6. The YJS had the skills and took care to provide effective services from the outset of some of the more complex cases. Every PSR provided to the court to help inform sentencing decisions was of good quality and there were constructive local management arrangements in place to ensure this happened.

1.7. We were pleased to note the level of understanding by the YJS staff that circumstances in a child or young person's life are liable to quick and unexpected change. In the majority of cases, assessments were reviewed throughout the sentence to take account of these.

2. Planning for interventions

2.1. A number of cases being managed by Powys YJS had had an initial plan completed by another YOT. Two of these were up to date and relevant and we did not expect Powys case managers to make changes to them. Of the 21 remaining cases, planning to reduce reoffending was of sufficient quality in less than two-thirds. It was disappointing to see that a considerable number did not give enough attention to care arrangements or emotional and mental health. On the other hand, substance misuse was clearly high on the agenda and taken into account in most of the cases that merited it.

2.2. In the one custody case inspected, we judged that initial planning had been of satisfactory quality.

2.3. Where assessments were reviewed to take account of changes in the circumstances of the child or young person, plans were not always changed to reflect this. Less than two-thirds of plans were reviewed sufficiently well throughout the sentence.

3. Delivery of interventions

3.1. Interventions implemented in order to reduce the likelihood of reoffending were generally delivered well. Case managers made use of good quality resources to strike an appropriate balance between work to reduce reoffending, manage the risk of harm, and address vulnerability. We found examples of innovative practice, with case managers going to some lengths to help the child or young person access appropriate interventions.

Case illustration

In recognition of the deep emotional health needs of a young person with whom he was working, a case manager used distraction techniques, such as playing draughts or having informal discussions away from the office, to lessen the impact of discussing difficult topics. As a result of the time spent with the YJS, the young man assessed that he was able to "*handle myself better in relationships and be less aggressive*".

1 CAIS is a voluntary sector provider of drug and alcohol services across Wales.

Case illustration

A young person was given a map of his local area and asked to draw on 'hot spots' (good places to be) and 'grot spots' (bad places to be). He seemed to enjoy this and almost without realising it provided his worker with a wealth of information about his interests, activities and how safe he felt in his neighbourhood.

3.2. In the majority of cases, interventions relating to the child or young person's attitude to offending, substance misuse, physical health and ETE were delivered where appropriate. However, there were other areas which were not addressed often enough. These included interventions to address living arrangements, family and personal relationships and, particularly, emotional or mental health. Sometimes this was due to shortcomings in assessment or planning but, more often, there was not enough effort being made by the YJS to ensure the work was done.

3.3. Most of the time, YJS workers gave attention to reinforcing positive factors during the delivery of interventions and to working with both victims and the child or young person to gain the most appropriate benefits from restorative justice.

Case illustration

A young woman with a growing history of repeat offending opted, as indirect reparation, to recite poetry to a group of people who were visually impaired. Affected by this experience and the positive response of her audience, she became a trained nurse.

Case illustration

The YJS was determined to build a relationship with a young man who was reluctant to comply with his order. They arranged for him to carry out his reparation at the Montgomeryshire Wildlife Trust in Welshpool, where he met with the Minister for the Environment and Sustainable Development, and his participation was featured in 'the Otter', the Montgomeryshire Wildlife Trust's newsletter. His attendance was a big step forwards in terms of his engagement with the YJS and, although compliance is still an issue, there has been an improvement since his experience of the reparation.

3.4. Where cases were transferred, there was less assurance that interventions would be of good quality. We found that in six of the ten cases where the child or young person was either moved between areas or to a Probation Trust, joint working was not effective in ensuring that there was continuity in services being delivered to address their likelihood to reoffend. Sometimes this was due to a lack of clear agreement about timing or responsibilities. In one instance, a young person whose case had been transferred to probation services had not been meaningfully involved in discussions and had received too little information to help with the transition.

3.5. In regard to the custody case, we were pleased to find that this was delivered as a single integrated sentence. The young person was involved in a range of interventions, with consistency of workers and interventions both within the custodial setting and through into the community part of the sentence.

4. Initial outcomes

4.1. Many children and young people made good progress in addressing the key factors linked to their likelihood of reoffending, especially in relation to their general attitudes about themselves and offending, but also with regard to their physical health, ETE and substance misuse. However, there

were some key areas linked to the child or young person's emotional or mental health, living, and family and personal arrangements where there had not been sufficient progress.

4.2. We saw examples of good work by YJS workers to sustain positive outcomes following the end of the child or young person's sentence, for instance, case managers testing and reinforcing the strategies learned during the sentence. Additionally, contact with the mental health nurse, Careers or CAIS was offered on an ongoing basis and in one case a young man continued with a long-term project with CAIS to raise awareness around drug misuse.

4.3. The child or young person had reduced the frequency of their offending in nearly two-thirds of the cases inspected and, in more than half of the cases, the seriousness of their offending.

5. Leadership, management and partnership

5.1. We judged that case managers had sufficient understanding of the principles of effective practice to reduce the likelihood that children and young people would reoffend.

5.2. Both the CAIS workers and mental health nurse were supported by their external professional bodies and were able to access the necessary clinical supervision, advice, resources and training to maintain and develop their professional skills. The YJS education workers and seconded probation worker had monthly supervision with YJS managers but did not have the same level of support from their professional bodies and were not offered training alongside fellow professionals to help them develop in their specialist areas.

5.3. At an operational level, YJS workers engaged well with a wide range of partners to extend the learning opportunities for children and young people. They had good links with pupil referral units, work based learning providers and schools to facilitate programmes aimed at reducing offending behaviour, and had had a measure of success – in one school the rate of exclusions had dropped. They had also recently worked effectively with Brecon High School in a project to test if early intervention would be successful. However, at a strategic level, partnerships relating to ETE were underdeveloped; there was a lack of good quality training provision for older children and young people and no assessment of the impact of the reorganisation of Careers Wales. For example, Careers Wales was no longer providing, obtaining and risk assessing work based learning placements.

5.4. The YJS had access to a range of joint funding opportunities, and made good use of these to help enable children and young people to access suitable interventions. Recent examples included workers applying for and obtaining additional funds from the School Effectiveness Grant, the Local Resource Solution Panel and the 14-19 Learning Partnership, to pay for the insurance costs of a young man undertaking a work placement on a farm; another involved securing money from the Diversionary Activities Fund and Domestic Abuse Forum to enable a young person to attend a domestic abuse course.

5.5. Partnership working produced some successful outcomes for children and young people. However, it was not sufficiently underpinned by local, active, working protocols and agreements, which would enable agencies to be clear about their responsibilities and roles, and with which they could hold each other to account.

5.6. There was confusion around the protocol for transfer arrangements for Looked After Children. Although new practice advice is due to be published shortly, the existing Youth Justice Board (YJB) National Protocol for Case Responsibility stated it applied to England only, although we understand that it also applied equally to Wales. This, understandably, was not widely known by relevant agencies in Powys. The document clearly states that the needs of young people are paramount and that their best interests must remain a priority.

5.7. The YJS experienced considerable difficulty in obtaining information, from other local authorities that

were not adhering to this guidance, about children and young people moving into Powys. Supported by the wider county council and local health board, the YJS had made commendable efforts to address issues as they arose on a case by case basis. The YJS was able to discuss issues at the Safe and Stable Care Arrangements sub-group and the Local Safeguarding Children Board (LSCB). Additionally, the heads of relevant Powys County Council departments had tried to resolve concerns at a more senior level. However, they seemed unable to expedite the faster flow of information from other authorities and the YJS had no arrangements or supporting policy in place to undertake their own assessments of children and young people who arrived in Powys without the relevant documentation. We were concerned about the impact of this.

Case illustration

In one case reviewed, the young person's circumstances had resulted in a referral to social services, by health, for an initial assessment. The fact that there had been a referral to social services was reported by other agencies, including the YJS, as providing assurance that potential safeguarding issues had been addressed. However, the young person had refused to engage in the assessment and social services had closed the case. It was unclear if information had been shared with relevant workers. For example, there was intelligence that there was the potential for violence within the home. Other agencies, also, may have held information not known to social services. In this instance, although all agencies recognised the potential vulnerability of the young person, communication between agencies to protect him was not effective.

5.8. There was no agreed Powys-wide protocol to support the transfer of cases to Probation Trusts. Previously, there had been one Local Delivery Unit (LDU) covering the county, and an agreed practice direction for transfers. However, by the time of this inspection, there were two LDUs. One was still adhering to the practice direction; the other had introduced a new transfer framework which it had yet to agree with the YJS. As a consequence, communication issues and delays had led to significant gaps in service provision to young people transferring to this LDU.

Case illustration

In one case, a young man who was reported as presenting a high risk of harm to others, and who had a substance misuse and possible mental health problem, had been placed in Powys in a care home that may not have been meeting his needs. YJS workers had been advised about his violent behaviour and, initially, were reticent to become involved with him until they received appropriate transfer documents. At the time of inspection, he had been in Powys for five months without any direct contact with the YJS or other appropriate services.

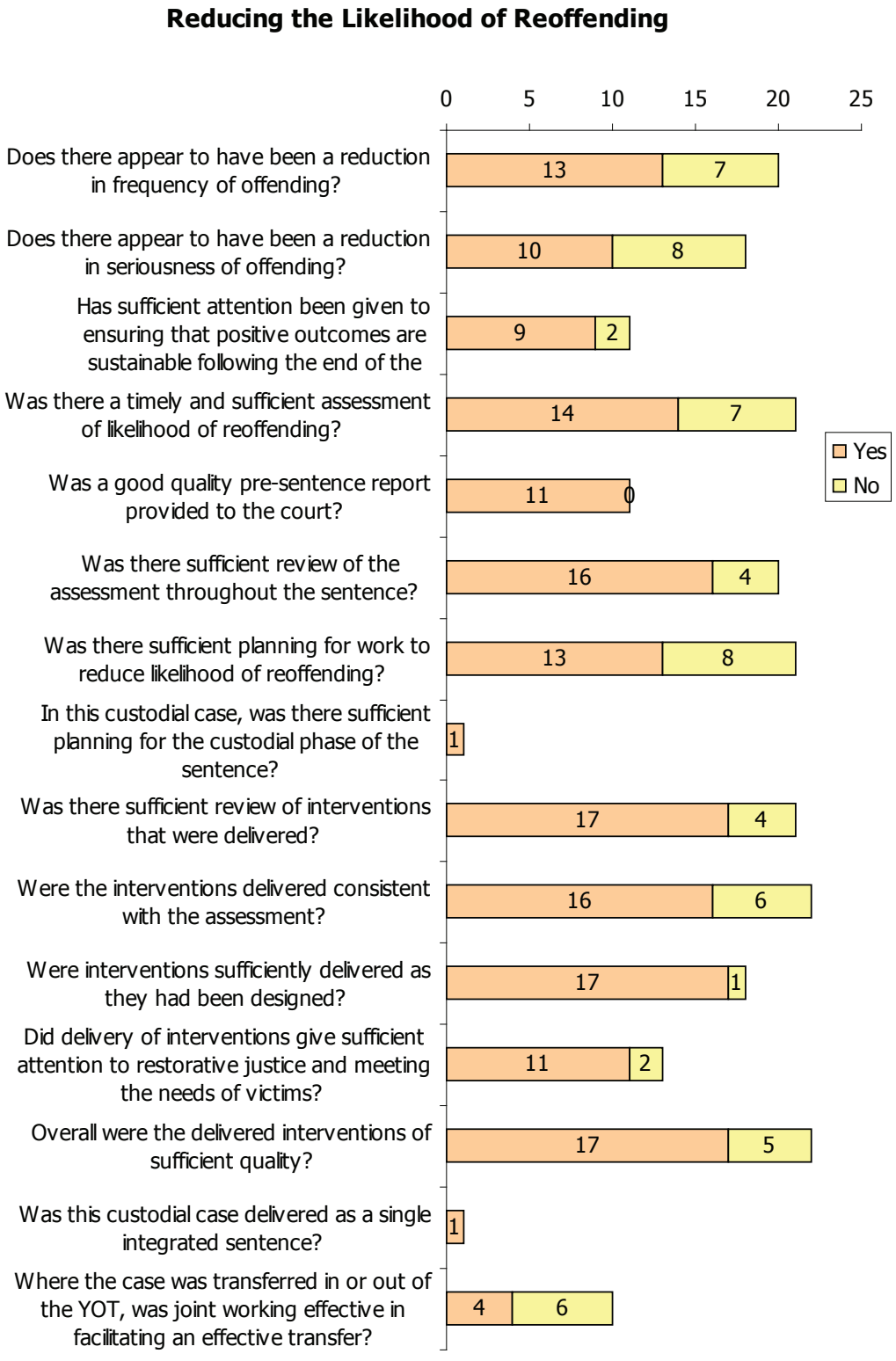
5.9. The staff interviewed during this inspection considered that YJS managers had the skills and knowledge to support them with, and help them to improve the quality of, their work. We did not share their confidence that quality assurance arrangements were working effectively. We found evidence that they had made a positive difference in only 7 out of the 18 cases where management oversight would have been appropriate. This is because whilst the processes were in place to address these issues, the results did not lead to improvements in practice.

Summary

Overall, work to reduce reoffending was good. While assessments completed at the time the child or young person started their sentence were of variable quality, they were reviewed appropriately throughout the order. However, there were gaps relating to both the assessment and planning for emotional and mental health. The effective delivery of suitable interventions for children and young people, and their victims, was given equal attention. Caseworkers demonstrated dedication to ensure they were able to access varied and appropriate resources and, as a result, achieve a range of positive outcomes. The YJS had developed positive relationships with partner agencies but there were no systems in place to ensure the clear delineation of roles and responsibilities, which had a negative impact, especially on transfer cases. Management oversight had not sufficiently improved the quality of work to reduce the likelihood that a child or young person would reoffend.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 23 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Protecting the Public

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Theme 2: Protecting the Public

What we expect to see

Victims, and potential victims, of crime have the right to expect that everything reasonable is done to manage the risk of harm posed by children and young people who have offended. We expect to see good quality assessment and planning with the delivery of appropriate interventions, and positive leadership, effective management and partnership work which reduces the risk of harm to others.

Case assessment score

Within the case assessment, overall 59% of work to protect the public was done well enough.

Key Findings

1. We expected Powys YJS to have undertaken an initial assessment of issues and needs relating to the risk of harm a child or young person posed to others in 21 of the cases we inspected. In over one-third of these, the assessment had not been completed well enough. There were also considerable gaps in the review process, and assessments had been reviewed to a high enough standard in less than half.
2. In about half of the cases we looked at, we identified issues relating to risk of harm to others that needed to be planned for, managed and addressed. We found that planning was sufficient in only half of these and had been reviewed to a high enough standard in even fewer.
3. While the YJS did not always implement the plan, interventions necessary for the effective management of risk of harm to others were delivered in nearly three-quarters of cases. Staff had access to a range of good quality resources.
4. The quality of work to manage the risk of harm to victims was variable.
5. Despite positive efforts to improve systems to manage the risk of harm to others since HMI Probation's last inspection, management oversight was not sufficiently effective in ensuring this work was of good enough quality.
6. There were examples of good partnership working but the lack of agreement around roles and responsibilities left considerable gaps for transfer cases.
7. Overall, risk of harm to others was likely to be considerably better managed in cases which neither involved a transfer or a child or young person who was looked after by a local authority.

Explanation of findings

1. Assessment

1.1. A number of cases being managed by Powys YJS had had an initial assessment completed by another YOT. We considered that two of these needed no further amendment by the Powys team. Of the remaining 21 cases, there was a sufficient assessment of the risk of harm the child or young person posed to others in 13. Where there were gaps in assessment these often related to not taking sufficient account of victims, ignoring relevant behaviour such as past offences, not drawing adequately on information available from other agencies, or not making a good enough assessment of children and young people moving in to the area during their sentence. In three cases, there had been no assessment of the risk of harm to others.

1.2. Bearing in mind the dynamic nature of risk of harm, we expected to see a meaningful review of

risk of harm to others at periodic intervals, or after a significant event in the lives of the children and young people. A review should have taken place in 18 cases; in only eight of these had it been undertaken adequately. In some, the review was a duplicate of the original assessment which had not been updated sufficiently well. We also found instances where there had been no review after a child or young person had showed signs of further offending behaviour.

2. Planning for interventions

2.1. There were ten cases where there were issues of risk of harm to others to be managed. We found sufficient planning to support this in five. In many, no links had been made with the plans held by partner agencies, sometimes because, despite the YJS's efforts, they had been unable to gain access to these. Plans drawn up by YJS case managers did not always relate to their assessment of risk, contain enough detail, or demonstrate that they had tried to anticipate or plan for potential changes in risk of harm. Some risk management plans had not been updated enough after sentence, while others were a commentary about the child or young person rather than a plan. In the custody case, there had been satisfactory planning to address the risk of harm to others during the custodial period.

2.2. There were two cases where Multi-Agency Public Protection Arrangements (MAPPA) should have been put in place. One provided an example of how MAPPA arrangements were working well to make a difference, while the management of the other caused us concern.

Case illustration

An appropriate referral was made to MAPPA in a complex custody case involving a young person who had been convicted of a violent offence and who, it was deemed, could still pose a serious risk to others. All the relevant partner agencies attended numerous MAPPA meetings, following an effective multi-agency approach to protect victims and the public and to ensure measures were in place to reduce the likelihood of reoffending.

In another case, the YJS, on advice from the MAPPA coordinator, made no referral. This case involved a young person who had been placed in Powys by another local authority. His offending had been escalating in seriousness, persistency and level of violence over many years and repeated and unsuccessful attempts had been made to place him in accommodation that would meet his needs. He was assessed as at 'high risk of reoffending and high risk of harm' and met the threshold for a MAPPA Category 3 referral. By the time of the inspection he had been in the area for four months. We understand that the YJS has now taken steps to remedy this.

2.3. There were 14 cases where it would have been appropriate to review the risk of harm to others. In a small number of these there was no review. Where reviews had been undertaken, some were of insufficient quality and some did not lead to any meaningful change being made to the plan.

3. Delivery of interventions

3.1. In the 11 cases where there was a need to deliver interventions to manage risk of harm, the right work was undertaken in eight. In some, case managers had taken particular care to ensure the diversity needs of the child or young person were met in order to enhance outcomes; for example, using the learning styles questionnaire to tailor the delivery of anger management work. In the main, case managers had access to sufficient resources to undertake their work. Where there were gaps these most often related to the provision of specialist emotional or mental health services or interventions relating to family and personal arrangements.

3.2. The size of the Powys YJS caseload limited the range of local programmes that could be run but we saw a number of examples of notable practice, some in partnership with other agencies, in order to deliver appropriate interventions.

Case illustration

The YJS had made the decision to discontinue with the Phoenix Fire Project as the difficulty in filling places on the course was affecting the success of the programme. Working with the Fire Service to resolve this issue, they agreed that Fire Safe would be delivered on a one-to-one basis with those children and young people who would benefit from this.

3.3. Overall, there was active and effective management of risk of harm throughout the delivery of interventions in only 6 out of the 11 cases where this was needed. The key gaps related not only to deficits in the review process but also to risk of harm not being given sufficient priority. In some cases, the case manager did not recognise and respond to changes in the child or young person's circumstances that could impact on the risk of harm they posed to others.

3.4. The quality of joint working to support the transfer of cases either to probation or between areas will play an important role in ensuring continuity of arrangements to manage risk of harm to others. Of the ten cases which were transferred, there were eight where it was important to ensure the smooth transition of systems to address risk of harm and three in which this happened. In each of those where transfer arrangements did not run smoothly, there had been no agreement between agencies about timing or responsibilities.

4. Initial outcomes

4.1. The management of risk of harm to victims was not always facilitated as well as it should have been. Some of this related to the quality of assessment and planning around victims' needs, but in some instances the YJS did not undertake the work it should have, or that it intended to do.

4.2. Overall, we judged that the YJS had done enough to keep to a minimum the child or young person's risk of harm to others in 7 out of the 11 cases where this was relevant.

5. Leadership, management and partnership

5.1. In the main, case managers had sufficient understanding of local policies and procedures for the management of risk of harm to others. There had been an active effort to improve practices since our last inspection, with the introduction of written guidance, training for staff and a range of quality assurance measures.

5.2. Cases in which the child or young person was deemed to present a high risk of harm to others were referred to the Case Planning Forum (CPF). Meetings were regularly attended by appropriate partner agencies and the CPF was effective in providing practitioners with direction and supporting them in their work. Members, such as the YJS police officer, effectively used the forum to gather and disseminate intelligence.

5.3. Despite these measures, there were still considerable gaps in the management of risk of harm to others. Some were 'easy to fix', relating to the completion of the assessments and plans. Others involved more complicated issues, often involving deficits in partnership communication and working, with the potential for significant issues to be overlooked. The lack of policy regarding whether or not and when to carry out an assessment on children and young people arriving in the county during their sentence was affecting the quality of service in this area.

5.4. At the time of inspection, police and probation services for Powys were intending to adopt Integrated Offender Management (IOM) arrangements in the near future. This scheme provides an overarching framework that allows local agencies to work together to coordinate existing resources and governance in order to manage offenders at high risk of causing serious harm to others or of

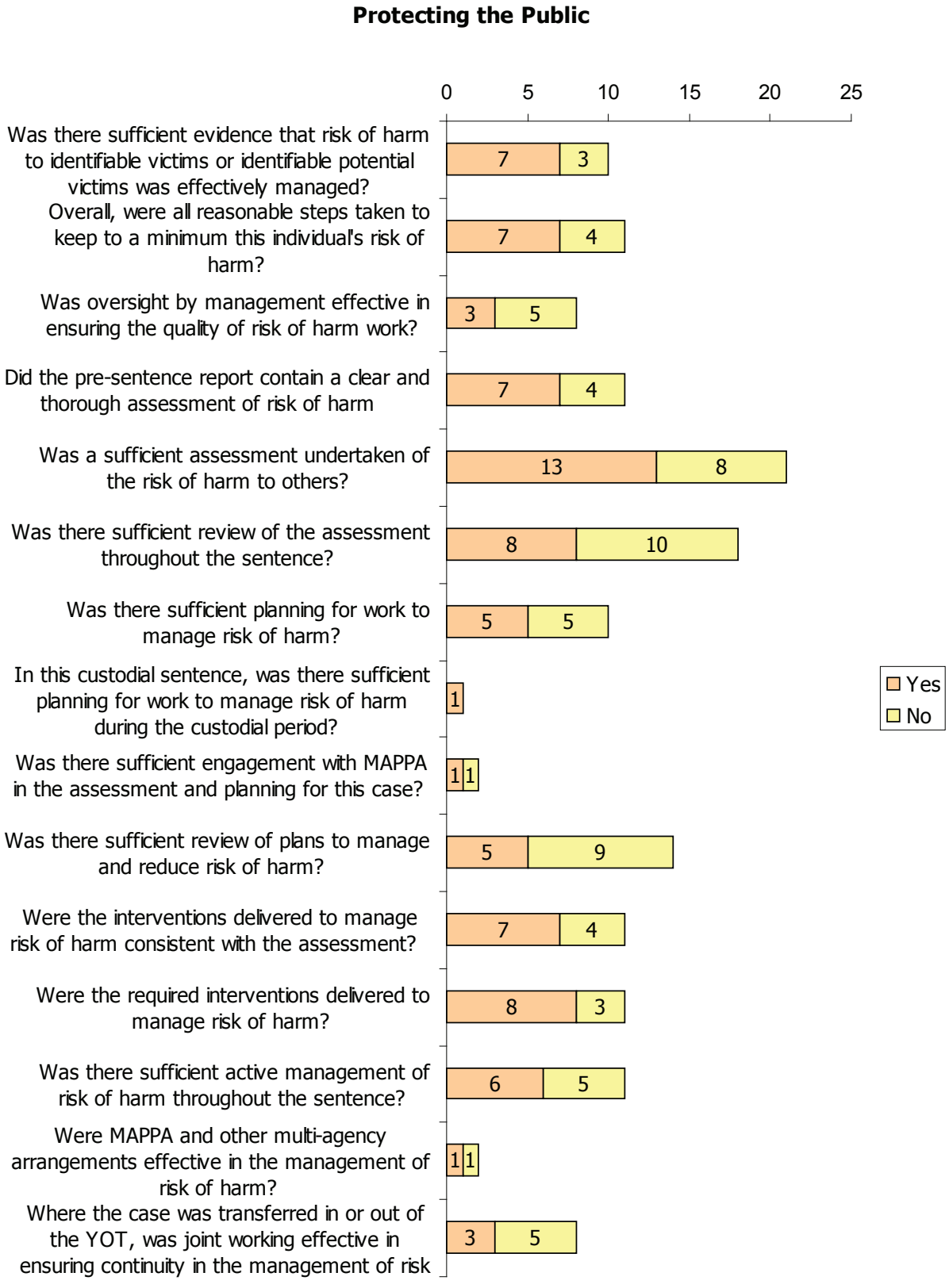
reoffending. The YJS did not envisage referring any of their children and young people who offend to the IOM panel, preferring to manage the factors linked to their offending through the CPF. However, it had made positive links with the process; it had been involved in developing Powys's IOM, and had offered to work with the children of the adults on the scheme to help address factors that may lead them to offend. It will also work to ensure intelligence is shared across all agencies working with the same families. We think it is worth the YJS management team also exploring the risks and benefits of IOM in relation to the young people who are in transition to adult services.

Summary

Overall, work to protect the public and actual or potential victims was unsatisfactory. There was not enough priority given to the risk of harm a child or young person posed to others and management oversight was not sufficiently effective in ensuring that work to protect the public and victims was of good enough quality. Case managers did not always recognise changes in the child or young person's circumstances that should have initiated a review of how the case was being managed, or pay enough attention to managing risks to victims. A CPF played an active and effective role in steering direction and action in cases involving children and young people who had been identified as posing a high risk of harm to others. However, in a number of cases, especially those involving a transfer, the YJS did not ensure that there was sufficient joined-up working and communication with partner agencies. We saw some good work around the implementation of interventions, some of which took account of the child or young person's specific, individual needs.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 23 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Protecting the child or young person

3

Theme 3: Protecting the child or young person

What we expect to see

Whether the vulnerability of children and young people is due to the consequences of their own behaviour or the behaviour of others; we expect to see that they are kept safe and their vulnerability is reduced. This should be through good quality assessment and planning with the delivery of appropriate interventions, positive leadership and management, and an effective contribution to multi-agency child protection arrangements.

Case assessment score

Within the case assessment, overall 53% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. Overall, the YJS had not done enough to keep the child or young person safe.
2. Assessments of the vulnerability of the child or young person, and their safeguarding needs, were more likely to be of good quality in PSRs than those written at the beginning of the sentence.
3. We found considerable gaps in assessments of vulnerability and safeguarding, planning to address these, and the quality of reviews.
4. In most instances, resources were available to help manage vulnerability and safeguarding effectively, but appropriate interventions were delivered in just over half the cases.
5. There was a variety of multi-agency groups, boards and specialist workers dedicated to protect children and young people which had produced a range of positive outcomes. However, in some cases, often those involving very vulnerable children or young people, there had not been enough engagement between agencies and/or specialist workers to ensure effective safeguarding measures were in place.
6. The YJS, wider county council and local health board had worked hard on a case by case basis to improve the flow of information for cases involving children looked after by a local authority, who were transferred between areas. However, we judged that in many instances these children and young people received a reduced quality of service delivery in relation to safeguarding.
7. Management oversight did not effectively ensure the work to manage vulnerability and safeguarding was of high enough quality.

Explanation of findings

1. Assessment

1.1. We found that PSR assessments were more likely to be of good quality than those written at the beginning of the sentence. Overall, there had been sufficient assessment of vulnerability and safeguarding in 12 out of the 21 cases where an assessment should have been undertaken. There were a number of areas needing improvement, including being clear about the level and nature of vulnerability, and the need to draw on information available, either from other agencies or relating to the child or young person's wider behaviour. In three cases, there had been insufficient assessment following a transfer in from another local authority area. While the original authority should have provided an up to date, accurate assessment at the time of transfer, we considered

that, where this had not happened, Powys YJS had a responsibility to ensure that the vulnerability and safeguarding needs of the children and young people with whom they were working had been sufficiently assessed in order to keep them safe.

1.2. Levels of vulnerability can change quickly, sometimes as a result of new relationships or living arrangements. In too many of the cases we looked at there was no review of vulnerability and safeguarding after such an event. Of the reviews that had been completed, nearly one-third were copies of previous assessments with insufficient update.

Case illustration

One vulnerable young man aged 17 years changed his address to reside with a much older person, who was a known substance misuser. The case manager sought information from the YJS police officer, probation services and social services, about potential risks for the young person. When the results of checks were negative, the case manager accepted this, and took no further action to ensure potential issues relating to safeguarding would be noted, analysed and addressed. They did not review their assessment and plans or seek further information from either the young person or the adult with whom they now resided.

2. Planning for interventions

2.1. We found there was sufficient planning in place to address vulnerability and safeguarding in 7 of the 17 cases that needed it. Vulnerability management plans had not always been drafted where they should have been and, where there was a plan, not enough of these were of good quality. Some overlooked significant areas of vulnerability, included too little detail about what needed to be done and by whom, or gave little thought to anticipating and addressing potential changes and partnership arrangements. In some cases there was insufficient planning relating to the child or young person's care arrangements or emotional and mental health.

2.2. In the custody case, there was sufficient planning in place throughout the custodial period for work to address vulnerability and safeguarding.

2.3. We would expect to see plans, to keep the child or young person safe or to manage areas of vulnerability, being reviewed to reflect new circumstances or, in a more reflective manner, to ensure that current plans are still relevant. We found that only 4 out of the 13 plans that needed it had been reviewed well enough. Although reviews were almost always undertaken, they were not of sufficient quality. Some plans were copies of originals which had not been updated to reflect changes in circumstances, while others had been updated, but only to record progress against objectives.

3. Delivery of interventions

3.1. In our view, the YJS and partner agencies had delivered the right interventions to address vulnerability and safeguarding in just over half the cases (9 out of 17) which merited it. In many of these, YJS workers had not undertaken the work they should have. In some, this was because the case manager had not identified the right needs or had not made referrals, for instance, to children's social care services or for specialist emotional or mental health service input. While, in the main, case managers had access to sufficient resources to address safeguarding needs, we noted that in three cases they were unable to access the appropriate children's social care services or emotional and mental health services.

3.2. Of the ten cases which were transferred, there were eight where it was important to facilitate continuity of services to manage safeguarding and four in which this had not happened. The main issue was that there was no clear agreement between agencies about timing or responsibilities.

In two cases there was a lack of involvement by the child or young person in their transfer arrangements.

3.3. There was active and effective management of safeguarding and vulnerability throughout the delivery of interventions in just over one-third (six) of the cases that merited it. In many, safeguarding work had not been given sufficient priority. There was also a need to engage more effectively with partners delivering other interventions and to work more productively with children's social care services.

4. Initial outcomes

4.1. We judged that the YJS had done enough to keep the child or young person safe, either from themselves or from others, in 8 out of the 17 cases where this had been necessary. There were gaps in assessment and planning. There were also instances when YJS workers had not undertaken the work they should have or had not engaged and coordinated well enough with other agencies and workers.

5. Leadership, management and partnership

5.1. We were pleased to see that, while there was no duty to do this, the LSCB had convened a Safe and Stable Care Arrangements sub-group in recognition of the fact that Powys has a significant number of independent providers and children and young people placed in the county by other local authorities. This sub-group had been extended to focus on the quality of care provided to all Looked After Children in Powys. The YJS was able to use this forum to directly alert the LSCB to safeguarding issues, particularly where there had been a lack of engagement from the responsible authority. Given the profile of out of county placements it was unclear why the YJS had not been more proactive in escalating through this route the safeguarding concerns relating to one of its most challenging and complex cases.

5.2. The LSCB had also been proactive in developing a forum for Vulnerable Children Living Away from Home; this promoted contact with independent providers throughout Powys to encourage better communication regarding the welfare of children and young people placed in Powys by other local authorities.

5.3. Case managers generally had sufficient understanding of local policies and procedures for the management of safeguarding and escalation procedures, and were confident about child in need and child protection thresholds. Safeguarding formed part of the authority's initial induction training and was then provided as part of each member of staff's ongoing development.

5.4. We considered that management oversight within the YJS had not made a difference to the quality of work to manage vulnerability and safeguarding. While we acknowledge that there were systems to quality assure related processes, these did not sufficiently address deficiencies in assessment and planning or ensure that required services and interventions were being delivered by the YJS or others. Not all of the YJS case managers were aware of the Protocol and Procedures between the Youth Offending Service and Childrens Services, and we considered that the current holistic approach to assessing referrals from agencies to social services needed strengthening in order to identify specific YJS issues, to ensure that delineation of responsibilities and thresholds were well embedded.

5.5. Mental health and substance misuse arrangements were supported by effective partnership agreements. Overall, the YJS mental health nurse and substance misuse workers at CAIS provided a timely and appropriate service to children and young people, offering targeted, evidence based interventions to address issues relating to their health and offending behaviour. They worked closely together with other YJS workers, attending the CPF, and had regular case discussions. CAIS workers were co-located with the YJS teams in both the North and South of the county. The mental health nurse, while based with the South team, provided an equal level of service across Powys. However,

we found that this positive and proactive approach did not always manifest itself into effective outcomes and there were gaps in assessment, planning and provision, particularly in relation to emotional and mental health.

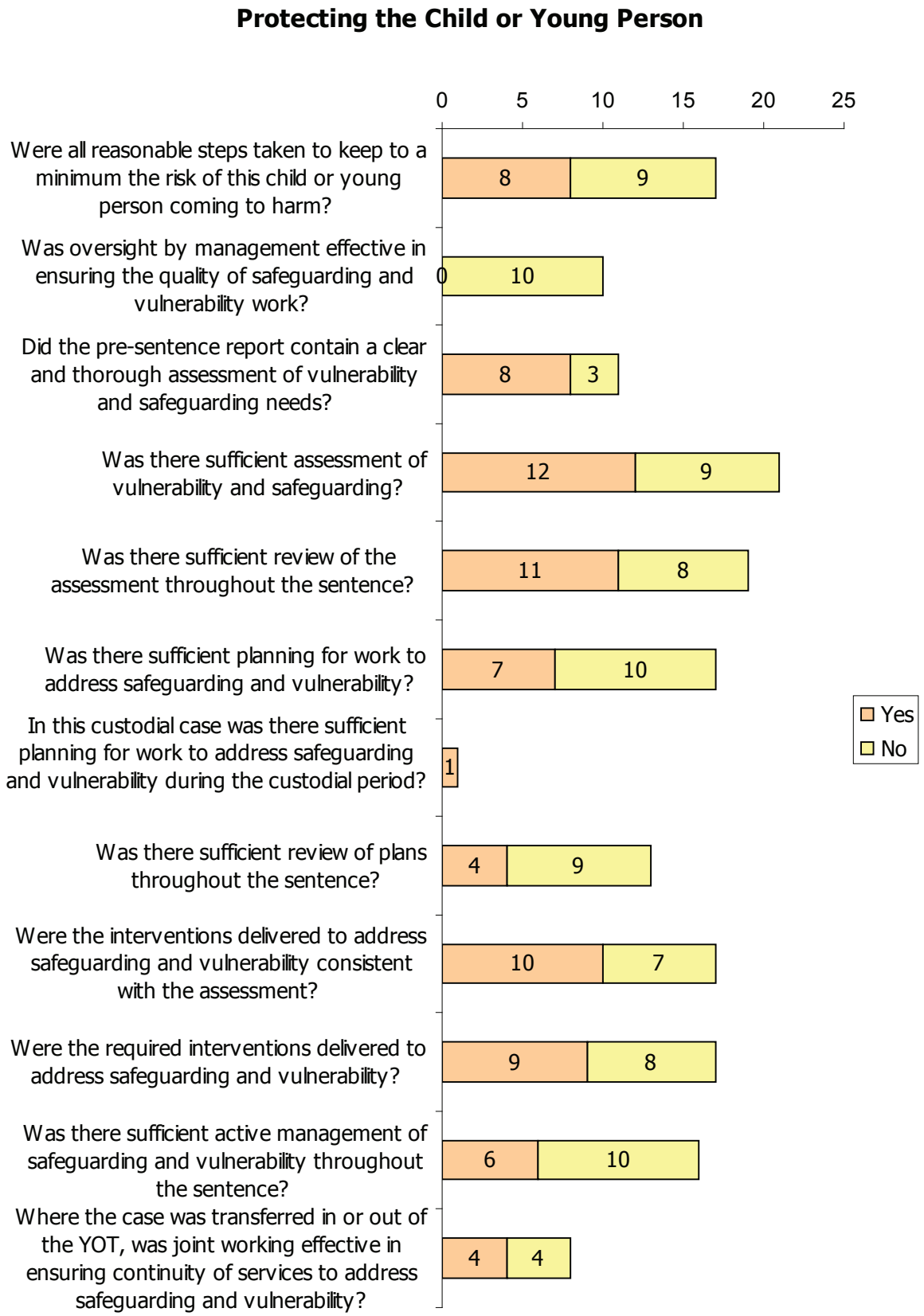
5.6. Good links had been forged with partner agencies and there was evidence of some good outcomes for the children and young people. However, stronger links were needed with some partners, for example, the primary health service. In the main, the effectiveness of joint working relied on good relations and good will rather than systematic arrangements. As a result, there were instances when communication was not as effective as it should have been and some of the most vulnerable children and young people did not have their needs properly recognised and addressed.

Summary

Overall, work to protect children and young people and reduce their vulnerability was unsatisfactory. The YJS had not done enough to keep children and young people safe and we considered that management oversight had not made a sufficient difference to the quality of work in this area. Assessments lacked essential detail and analysis, and the quality of planning was poor, especially, for instance, in relation to emotional and mental health. Case managers were not ensuring they took appropriate action in enough cases to safeguard the child or young person, or to take account of changes in their circumstances. Sometimes referrals to other services were not being made where necessary or there were gaps in effective engagement with other agencies. While the YJS and wider county council worked hard to try to resolve these, there were particular issues relating to cases that involved children who were looked after by a local authority or whose cases had been transferred.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 23 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case].



Ensuring that the sentence is served

4

Theme 4: Ensuring that the sentence is served

What we expect to see

Children and young people should serve their sentences as the court intends. We expect that the YOT will maximise the likelihood of successful outcomes by effective engagement with them and their families, responding to relevant diversity factors including paying attention to their health and well-being, and taking appropriate action if they do not comply.

Case assessment score

Within the case assessment, overall 83% of work to ensure the sentence was served was done well enough.

Key Findings

1. In most cases, the YJS engaged well with the child or young person and their parents/carers throughout the sentence. They built constructive relationships to the benefit of all parties involved in the case, including victims.
2. Overall, the YJS gave enough attention to identifying and responding to the child or young person's individual needs and potential barriers to engagement.
3. Restorative justice is a priority area for the YJS and this has produced positive, sustainable results.
4. The YJS gave sufficient attention to compliance and enforcement, visiting the children and young people in their homes when appropriate, and responding well to non-compliance, in most instances.
5. Service user views were captured, effectively, and the YJS responded positively to feedback.

Explanation of findings

1. Assessment

1.1. There was sufficient assessment, especially in PSRs, of diversity factors and of reasons why a child or young person might find it difficult to work with the YJS in order to meet the requirements of their sentence, i.e. barriers to engagement.

1.2. There was clear evidence that the YJS was committed to building relationships and case managers nearly always involved the child or young person and their parents/carers or significant others in the assessment of issues and needs of the case.

2. Planning for interventions

2.1. Some areas of diversity and barriers to engagement were not given enough attention in planning processes or included on plans. These included disability, race or ethnicity, girls or young women, factors linked to being a child or young person looked after by a local authority, and speech, language and communication needs.

2.2. In the majority of cases, we were pleased to see that the child or young person and their parent/carer or significant other was involved in the planning process.

3. Delivery of interventions

3.1. Again, in the majority of cases, the child or young person and their parent, carer or significant other was meaningfully engaged throughout the delivery of the sentence.

Case illustration

There had been effective joint working with a learning disabilities worker to introduce use of the 'Pegasus' scheme into a case. This scheme enabled children and young people with special needs, particularly affecting their communication, to carry a card with a password that linked the police into an information system and helped them access additional support.

3.2. Overall, the YJS gave sufficient attention to the health and well-being outcomes for the child or young person in just under three-quarters of cases. In some cases where this had not happened, the necessary referrals had not been made or agencies had not co-ordinated their work well.

Comment from a parent/carer

"They have helped him get his life back in the right direction, even though it was a small change it has really helped".

3.3. In just under half of the cases that were transferred, joint working to facilitate the continuity of services to ensure the sentence would be served was effective.

4. Initial outcomes

4.1. Overall, the YJS gave enough attention to identifying and responding to diversity factors and actual or potential barriers to engagement. Language needs were met in most instances and interpreters had been enlisted to assist discussions in, for example, Polish, Latvian, and Nepalese.

Comment from a parent/carer

"They really helped to resolve the problems that we were having and supported my son. A few months ago I never thought this would have been possible".

4.2. We were pleased to see how well YJS workers respected the values of the children and young people with whom they worked. They often demonstrated a sound understanding of the issues faced by their children and young people. They worked hard to build constructive relationships, helped by a high level of appropriate home visits, in order to keep them engaged and support them through their sentences.

4.3. The majority of children and young people complied with their sentences, with just under one-third doing so after some initial setbacks. The YJS took appropriate and effective action where necessary to improve compliance in all but one case.

Comment from a parent/carer

"They really went out of their way to help him, they were always there to give advice and support"

4.4. There were arrangements in place to help children and young people build on or sustain positive outcomes. In several cases, they continued to work with, for example, Careers or CAIS after completion of their order.

5. Leadership, management and partnership

5.1. All the case managers interviewed had sufficient understanding of local policies and procedures for supporting effective engagement and responding when a child or young person's compliance in meeting the requirements of their sentence declined.

5.2. We found that the Welsh language had a low profile and case managers were not aware if this was

given any priority by senior managers. The YJS's administration team ensured that a locally devised induction template was available in every file. This posed the question of whether or not the child or young person had a preference to use the Welsh language. In the majority of instances, case managers had given enough attention to exploring the answer to this, but in some, the form was not completed. It was heartening to note that the court induction form now included a prompt for language preference.

5.3. Work relating to restorative justice had a high profile in the YJS. Staff had been trained to support its effective delivery and the YJS produced a newsletter, Reparation Times, which reported on local reparation activities and featured the community organisations with whom they worked. There were also locally devised leaflets explaining the restorative justice process. These presented, clearly, relevant information about this service but we were disappointed to see that they were aimed at the more literate audience and were only readily available in English.

5.4. The YJS and early intervention services, such as the 16 plus team, sought to positively engage with young people and to promote their wishes and feelings. However, there was not always an appropriate balance between the views of the young person and the professional assessment of their potential vulnerability and how best to address this. In a small number of cases there appeared to be an over reliance on the young person's resilience and ability to protect themselves.

5.5. The YJS had processes in place to harness the views of their service users through a range of surveys and requests for feedback. It had recently been inspected as part of its bid to be awarded a Kitemark for user participation. Evidence of this commitment included the recent change of name to the 'Youth Justice Service' in response to the negative views of children and young people about being labelled as offenders.

5.6. We received positive feedback from the children and young people, their parents/carers, and victims about the commitment of YJS workers to their role. They suggested one or two areas for improvement, voicing concern about cancelled appointments in some instances, the influence that some children and young people wrought on others during their attendance at the YJS office and about the slowness of the YJS to resolve issues relating to the lack of transport to help young people meet their unpaid work requirements. However, service users also showed their appreciation of the YJS, praising the way case managers built relationships, earned their trust, communicated with and helped them, and the changes this had brought to the children and young people's lives. Victims felt supported and informed, and effectively involved in the restorative justice process.

Comment from a victim

One victim expressed the following praise for the YJS: "The two things that the youth offending service have done well while working with me is communicating and showing compassion. They really kept me involved in the whole process of restorative justice and really supported me as a victim".

Summary

Overall, work to ensure that the sentence was served was very good. The YJS engaged well with all service users. Restorative justice was given a high profile and there was an inclusive approach to victims. Case managers built effective relationships with the children and young people and their parents/carers, which aided progress throughout the sentence. While diversity issues were not always included sufficiently well on plans, case managers had a good understanding of relevant issues and ensured these were taken into account in order to enhance the delivery of interventions. They took appropriate steps to encourage compliance and, with their specialist partners, to sustain positive outcomes achieved during the sentence. Service user views were sought and there was positive action to take these into account.

Data Summary

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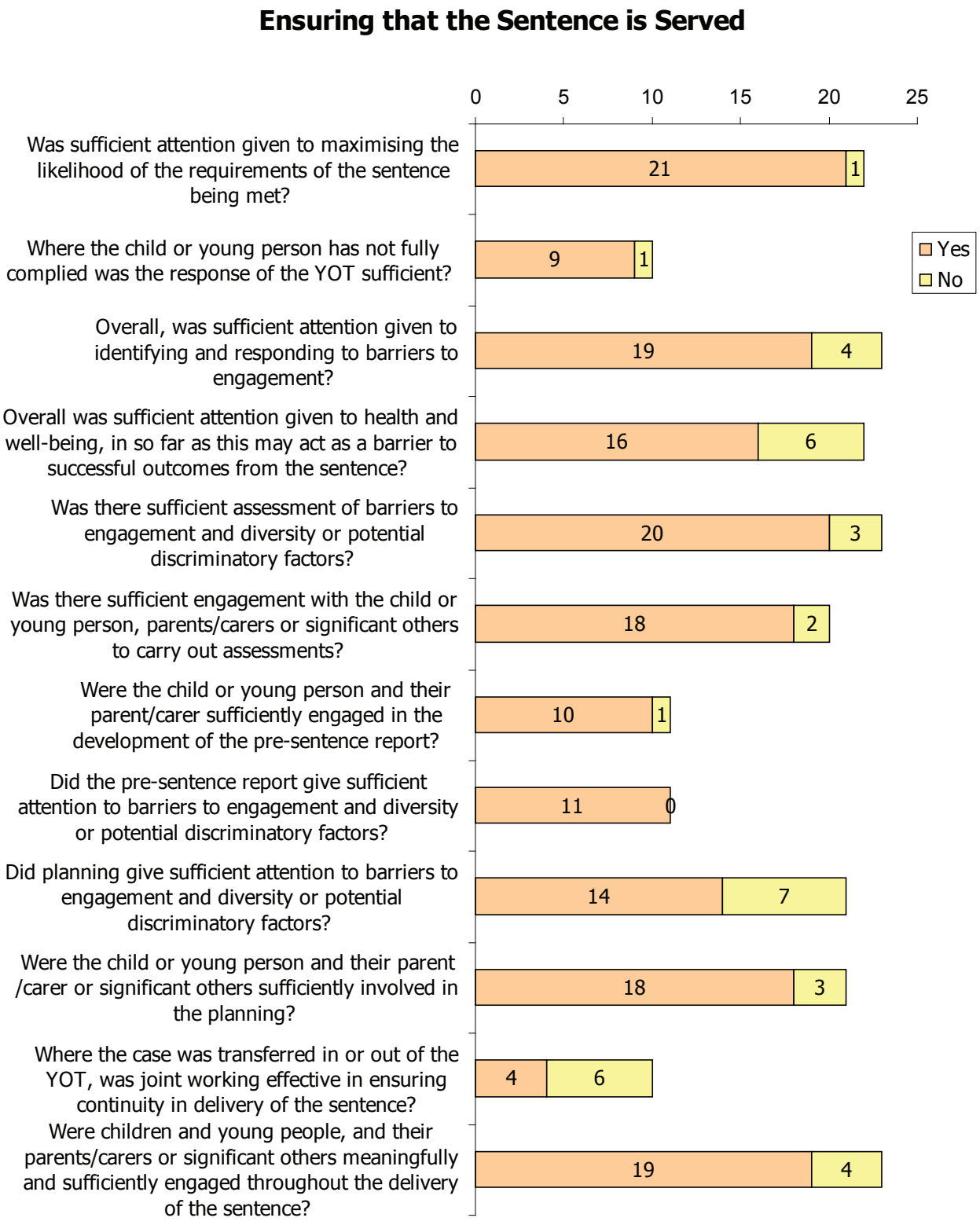

Governance

5

Theme 5: Governance

What we expect to see

The YJS partnership and YJS Management Board, provides sufficient governance to meet national and local criminal justice objectives, and delivers effective outcomes for children and young people who offend or who are likely to offend and the local community. Equality of opportunity and wider diversity issues are prioritised throughout. The YJS has developed partnerships, which work together to ensure effective outcomes for children and young people who offend or who are likely to offend and the local community. The YJS has in place workforce management that enables staff to deliver quality engagement and effective. The YJS is continuingly reviewing and evaluating the delivery of its service.

Key Findings

1. The YJS Management Board did not provide a strong enough strategic lead for the YJS. The YJS was the key strategic driver for service development relating to children and young people who offend or are likely to offend.
2. The YJS Management Board worked cohesively to support the YJS in meeting national priorities and to link with cross-cutting initiatives, especially those relating to the preventative agenda. However, there was too little focus on identifying and addressing local priorities, such as transfer and caretaking issues, and risk of harm to others and vulnerability had too low a strategic profile.
3. A key asset of the YJS was its staff where there was clear evidence of investment. The service was resourced in order to meet the geography of the county, to develop both its strategic influence and involvement, and the skills of the team.
4. The YJS and partner agencies took an inclusive approach strategically, ensuring that the diverse needs of children and young people who offend or are likely to do so were included in plans and policies across the piece. However, there was no evidence that the Welsh language had high strategic priority.

Explanation of findings

1. National and local criminal justice objectives are met

1.1. The location of the YJS within the children's services management team had enabled it to have a significant profile in the authority. The YJS manager was able to influence the wider children's agenda and was highly respected by colleagues and other agencies.

Comment from a partner agency

"The YJS has single-handedly kept the young person's agenda at the top of the community safety priorities for years. The YJS in Powys is incredibly innovative".

1.2. Whilst the Board was seen by members as a safe environment in which to challenge partners, in reality there was little challenge. The YJS, rather than the Board, was considered to be the key driver for deciding the strategic agenda, with the Board agreeing and supporting the proposals from the YJS. We felt that leadership of the Board could be stronger, with the Board leading from the front to set strategic direction.

1.3. All relevant partners were represented on the YJS Management Board. However, not all agencies gave the Board the same amount of priority. Although meetings were normally well attended, representation was not always at the right level and there was a lack of consistency in representation relating to housing, schools, probation and the police. Few of the agencies raised

their strategic profile through the Board. However, the health and YJS members were seen as notably effective at Board meetings and worked through the Board to improve resources and service delivery.

2. Effective partnerships make a difference

2.1. Most members of the Board sat on other groups and Boards with cross-cutting agendas, and were able to bring relevant information to Board meetings. The YJS, working hard to ensure the needs of its children and young people were highlighted in all arenas, was represented at an appropriate level on all relevant multi-agency meetings and had a positive approach to sharing intelligence with other agencies.

2.2. However, in our view, there was too much overlap of strategic groups, panels and boards. These included the Children and Young People Partnership, the LSCB, Community Safety Partnership, YJS Management Board, and their related sub-groups. In addition, there was a range of groups dedicated to the provision of resources. Although this representation enabled the YJS to influence both the strategic agenda and service development, the number of groups meant that there was a significant impact on managers' time. There was also potential for duplication. It was unclear how cross-cutting issues were managed between the partnerships given their different focus and statutory responsibilities. We were pleased to note that Powys was implementing a programme of partnership rationalisation in recognition that there was duplication and replication of representation and work across a range of strategic and operational cross sector group. We anticipate that this should result in a more streamlined and effective use of time and impact for all concerned.

Case illustration

The YJS was actively involved in the antisocial behaviour (ASB) process and was one of the first points of contact for the ASB coordinator, for referrals of a child or young person, to establish what is known about them. The YJS was also involved in the Stage 3 multi-agency meetings to discuss health, education, mediation and diversionary needs and conduct joint visits with police to deliver antisocial behaviour contracts.

3. Effective workforce leadership and management supports quality service delivery

3.1. The YJS was resourced to meet its role effectively, and its work was split between two teams – one in the South and one in the North. The teams had been carefully structured to cover the expanse of the county, with an Operations Manager on each of the two sites. The mental health and police workers were based in the South but there was evidence that they had worked hard to ensure that this had not resulted in an inequitable service.

3.2. There was evidence that the operations managers were approachable, and readily available, to support their staff. They facilitated regular supervision sessions with case managers and are to be commended for ensuring they proactively sought discussion not only about the more complex, high risk cases, but relating to cases across the board. Team and staff meetings were held in order to update staff and involve them in the development of services, and a reflective practice group had recently been set up for the team in the South.

3.3. Powys's integrated workforce board provides a multi-agency approach to training and the YJS staff had the opportunity to attend any course offered on the integrated training brochure. There had been a variety of team training opportunities covering areas such as restorative justice, motivational interviewing, cognitive behaviour, speech and communication, solution-focused interventions and working with diverse communities, such as travellers. Lucy Faithfull[1] training, to raise awareness around child protection, had also been delivered. Staff applications for training to fulfil individual aspirations were often met favourably.

1 Lucy Faithfull is a UK-wide child protection charity dedicated to reducing the risk of children and young people being sexually abused.

4. Positive outcomes are achieved and sustained

4.1. Overall, performance management and the use of local performance data to improve services were underdeveloped. The YJS Management Board's priorities were driven, mainly, by the national agenda. Performance data were provided to the Board and analysed in order to identify and address areas of lower performance against YJB indicators. The Board had yet to identify additional local indicators or to explore and challenge important local issues relating to, for instance, cases transferred between areas and to probation. Safeguarding was evidently a priority across Powys, with the LCSB taking the lead for this. However, the degree of engagement that the Management Board had with related issues and how this translated into strategic leadership was unclear. There was also no evidence that the Management Board drove improvement in relation to the management of the risk of harm to others. Thus, we judged that the strategic profile of the management of risk of harm to others and the protection of children and young people was far too low.

4.2. The focus and direction of the YJS was supported by a Youth Justice Plan, which anticipated future priorities. This informed the YJS's Business Action Plan, progress against which was reviewed on a regular basis. This plan, however, contained too little detail and context and, although it touched on restorative justice, it did not encourage review or development of YJS services relating to safeguarding and risk of harm to others.

4.3. Comprehensive performance reports were presented to the Board by the YJS, mental health nurse, CAIS and the Youth Inclusion Support Panel. However, there was no clear picture of how well children and young people involved with the YJS were progressing with their education, despite this being an objective on the YJS's Action Plan. There was no measure of attainment or achievement, and little evidence on which to base provision. We were pleased to note that this will be taken into account in the Estyn action plan being developed through education services.

4.4. The YJS should be commended for its efforts to understand local offending trends. Instigated through the YJS Management Board, it had undertaken research to identify the links between exclusion from education and offending, and extended this piece of work to identify other effective methods of helping to prevent children and young people from entering the criminal justice system. Additionally, while the YJS had not completed its own recent needs assessment, it contributed to, advised and drew on the needs assessment undertaken by the local Community Safety Partnership.

4.5. The county placed a strong emphasis on meeting the individual needs of all vulnerable people in Powys and, in an effort not to stigmatise children and young people who offend, took a fully integrated approach to the provision of services. Generally, sufficient attention was given to diversity issues although in some arenas there was complacency around the use of the Welsh language.

Summary

Overall, work relating to governance was unsatisfactory. The YJS Management Board was a well represented, cohesive body, which provided a good arena for sharing information and supporting the work of the YJS in meeting its national priorities. However, it did not provide a strong enough lead for youth offending. There was little strategic drive from the Management Board to explore and challenge important local issues such as those relating to cases transferred between areas and to probation, the management of risk of harm to others and the protection of children and young people.

There was a multi-agency approach to developing services for children and young people across Powys, with a focus on meeting the needs of vulnerable children as a holistic group. The YJS took positive steps to ensure that children and young people who had offended or were likely to offend were kept high on the county's agenda and that services took account of their needs.

The YJS was resourced to provide an effective service and the integrated team had a good understanding of the principles of effective practice.

Appendices

Appendix 1

Contextual information about the area inspected

Powys had a population of 133,000 as measured in the Census 2011. The youth population (those aged between 10 and 17 years old) accounted for 10.0% of the population. This was higher than the average for England/Wales as a whole, which was 9.4%.

The percentage of the youth population with a black and minority ethnic heritage was 3.1% (ONS, mid-year estimate 10-17 year olds, black and minority ethnic 2009). This was lower than the average for England/Wales, which was 14.1%.

Reported offences for which children and young people aged 10-17 years received a pre-court disposal or a court disposal in 2010/2011, at 24 per 1,000, were lower than the average for England/Wales of 33 (Youth Justice Board 2010-2011).

Youth Justice Board indicators

The Youth Justice Board indicators are national measures of YOT work and performance:

Reoffending measures:

(i) Of those children and young people who received a reprimand, final warning, court conviction or who were released from custody or tested positive for a Class A drug on arrest, the proportion who reoffend within a 12 month reporting period. The reoffending proportion for Powys was 34%, better than the 35.8% for England/Wales as a whole.

(ii) Of those children and young people who received a reprimand, final warning, court conviction or who were released from custody or tested positive for a Class A drug on arrest, the average number of reoffences within 12 months, per 100 such children and young people. For Powys, there were 0.77 offences per child or young person who reoffends, better than the 1.03 for England and Wales as a whole.

(Data based on April 2010 - Mar 2011 cohort).

First time entrants measure:

The number of children and young people who received their first reprimand, final warning or court conviction (and thus entered the youth justice system) in a 12 month period, as a proportion per 100,000 10-17 year olds in the general local population. The figure for Powys is 641, compared to 595 for England and Wales as a whole.

(Data based on October 2011 - September 2012 cohort).

Appendix 2

Contextual information about the inspected case sample

In the first fieldwork week we looked at a representative sample of 23 individual cases up to 12 months old, some current, others terminated. These were made up of first tier cases (referral orders and reparation orders), youth rehabilitation orders (mainly those with supervision requirements), and one detention and training order.

The sample sought to reflect the make up of the whole caseload and included a number of those who are a high risk of harm to others, are particularly vulnerable, are young women or are black and minority ethnic children & young people.

Appendix 3

Acknowledgements

Lead Inspector	Vivienne Clarke, *HMI Probation*
Deputy Lead Inspector	Helen Davies, *HMI Probation*
Inspection Team	Mark Bishop, *Local Assessor*
	Rob Bowles, *HMI Constabulary*
	Mary Browning, *Healthcare Inspectorate Wales*
	Rachael Bubalo, *Estyn*
	Zoe Jenkins, *User Engagement Officer*
	Iolo Madoc-Jones, *HMI Probation*
	Katy Young, *Care and Social Services Inspectorate Wales*
HMI Probation Support Services	Lynne Osborn, *Support Services Officer*
	Oliver Kenton, *Assistant Research Officer*
	Alex Pentecost, *Publications Manager*
	Christopher Reeves, *Proof Reader*
	Rob Turner, *Support Service Manager*
Assistant Chief Inspector	Julie Fox, *Reducing the likelihood of reoffending*

Appendix 4

Inspection arrangements

The Full Joint Inspection (FJI) programme inspects youth offending work in a small number of local authority areas each year. It focuses predominantly on the quality of work in statutory community and custodial cases during the sentence up to the date of inspection. Its objective is to seek assurance that work is being done well enough to achieve the right outcomes. The four core themes for this inspection are:

- reducing the likelihood of reoffending
- protecting the public
- protecting the child or young person
- ensuring the sentence is served.

Methodology

Fieldwork for this inspection was undertaken during the weeks commencing:

25 February 2013 and 11 March 2013.

YOTs are informed 11 working days prior to the inspection taking place. The primary focus is the quality of work undertaken with children and young people who have offended, whoever is delivering it. Cases are assessed by a team of inspection staff with local assessors (peer assessors from another YOT). They examine these with case managers, who are invited to discuss their work in depth, are asked to explain their thinking and to identify supporting evidence in the record.

Prior to, or during, this first week we receive copies of relevant local documents. During the week in between, the data from the case assessments are collated and a picture about the quality of the work of the YOT emerges.

The second fieldwork week is the joint element of the inspection – HMI Probation are joined by colleague inspectors from the police, health, social care and education to explore in greater detail the themes which have emerged from the case assessments. In particular, the leadership, management and partnership elements of the inspection are explored, insofar as they contribute, or otherwise, to the quality of the work delivered.

During this week we also gather the views of others, including strategic managers, staff and service users – children and young people, parents/carers and victims, and where possible observe work taking place. From April 2013 we will also gather the views of children and young people through a questionnaire.

At the end of the second fieldwork week we present our findings to local strategic managers, the YOT Management Team and other interested parties.

Publication arrangements

A draft report is sent to the YOT for comment three weeks after the inspection, with publication approximately six weeks later. In addition, a copy goes to the relevant Ministers, other inspectorates, the Ministry of Justice Policy Group and the YJB. Copies are made available to the press and placed on our website.

FJI reports in Wales are published in both Welsh and English.

Further details about how these inspections are conducted can be found on our website in the document 'Framework for FJI Inspection Programme' at:

http://www.justice.gov.uk/about/hmi-probation/inspection-programmes-youth/full-joint-inspection-fji-of-youth-offending-work

Appendix 5

Scoring approach

This describes the methodology for assigning scores to each of the core themes:

- Reducing the likelihood of reoffending.
- Protecting the public.
- Protecting the child or young person.
- Ensuring that the sentence is served.

Inspection staff examine how well the work was done across the case - from assessment and planning to interventions and outcomes, focusing on how often each aspect of the work was done well enough. This brings together performance on related elements of practice from all inspected cases.

Each scoring question in the inspection tool contributes to the score for the relevant section in the report. In this way the core themes focus on the key outcomes.

This approach enables us to say how often each aspect of work was done well enough, and provides the inspected YOT with a clear focus for their improvement activities. Each core theme is assigned a percentage (quantitative) score which, along with a descriptor, is then given a provisional star rating.

Case assessment score	Descriptor	Star rating
80% +	Very good	
65% - 79%	Good	
50-64%	Unsatisfactory	
< 50%	Poor	

Each of these themes contains elements of leadership, management and partnership which cannot be evidenced through the scoring system for individual cases, and which are a particular focus of the work of partner inspectorates. A moderation process then takes account of these elements to determine the final descriptor.

Additional modules are scored on a similar basis.

If there are serious and unaddressed shortcomings, in individual cases, relating to the risk of the child or young person suffering or inflicting harm that leaves someone at risk, then this may constitute a limiting factor to the star rating.

Further details of this process can be found on our website.

http://www.justice.gov.uk/about/hmi-probation/inspection-programmes-youth/full-joint-inspection-fji-of-youth-offending-work

Appendix 6

Criteria

The aspects of youth offending work that are covered in the core themes in this inspection are defined in the Inspection Criteria for Full Joint Inspection. A copy of the inspection criteria is available on the HMI Probation website at the following address:

www.justice.gov.uk/about/hmi-probation/inspection-programmes-youth/full-joint-inspection-fji-of-youth-offending-work

Separate criteria are published for each additional module inspected, which are available from the same address.

Appendix 8

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 child or young person's offence, personal circumstances, attitudes and beliefs which have contributed to their offending behaviour
CAIS	CAIS is a voluntary sector provider of drug and alcohol services across Wales
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
CJS	Criminal justice system. Involves any or all of the agencies involved in upholding and implementing the law – police, courts, Youth Offending Teams, probation and prisons
CPF	Case Planning Forum: the vehicle by which Powys YJS seeks to provide effective risk management plans for children and young people assessed to be at high risk of reoffending and/or present a risk of serious harm to others and/or are deemed to be vulnerable. Multi-agency CPF panels are convened to facilitate the process.
CSSIW	Care and Social Services Inspectorate Wales
Estyn	HM Inspectorate for Education and Training in Wales
ETE	Education, training and employment: work to improve an individual's learning, and to increase their employment prospects
FTE	Full-time equivalent
HIW	Healthcare Inspectorate Wales
HM	Her Majesty's
HMI Probation	HM Inspectorate of Probation
IOM	Integrated Offender Management: provides a framework for agencies to take a coordinated approach to the management of offenders at high risk of causing serious harm to others or of reoffending.
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 the 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
Likelihood of reoffending	See also *constructive* Interventions

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
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, for example health, social care or educational
PSR	Pre-sentence report: for a court
RMM/VMM	Risk Management Meeting/Vulnerability Management Meeting
Risk of harm to others	See also *restrictive* Interventions
'Risk of harm to others 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
Scaled Approach	The means by which Youth Offending Teams determine the frequency of contact with a child or young person, based on their RoSH and likelihood of reoffending
YJB	Youth Justice Board for England and Wales
YOI	Young Offenders Institution: a Prison Service institution for children and 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
YOS/YOT/YJS	Youth Offending Service/Youth Offending Team/Youth Justice Service. These are common titles for the bodies commonly referred to as YOTs
YRO	The youth rehabilitation order is a generic community sentence used with children and young people who offend

Appendix 8

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:

www.justice.gov.uk/about/hmi-probation

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

HM Chief Inspector of Probation
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Criminal Justice Joint Inspection

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ISBN: 978-1-84099-600-5