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 **Cwm Taf**

An inspection led by HMI Probation

independent inspection of youth offending work

July 2017

Foreword

This inspection of youth offending work in Cwm Taf 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.

We chose to inspect in Cwm Taf primarily because its component areas had appeared consistently among the poorest performing youth offending services in Wales on a number of national indicators, and because inspectorates wanted to test the effectiveness of its creation through the amalgamation of two previous youth offending services.

Cwm Taf Youth Offending Service (YOS) worked with children and young people with complex needs, where safeguarding and risk of harm issues were common. The YOS engaged well with children and young people and their parents/carers, and was delivering some satisfactory operational work. Restorative justice was well embedded and provided tangible benefits to the local community.

The YOS Management Board did not consistently commission, evaluate and utilise data to identify the needs of children and young people who had offended. This meant that it could not plan and deliver its services effectively enough. Careful attention should be paid to intelligence that is shared from other agencies, particularly around missing children and child sexual exploitation in order to improve outcomes.

The recommendations made in this report are intended to assist Cwm Taf YOS in its continuing improvement by focusing on specific key areas.

Dame Glenys Stacey
HM Chief Inspector of Probation
July 2017

Key judgements

Reducing reoffending	
Protecting the public	
Protecting children and young people	
Making sure the sentence is served	
Governance and partnerships	
Interventions to reduce reoffending	

Summary

Reducing reoffending

Overall work to reduce reoffending was satisfactory. There were clear and thorough assessments of children and young people, to identify the work needed to reduce reoffending. Planning and the review of work did not always reflect this. The YOS's understanding and use of restorative justice was good. Case managers needed to be more investigative, to make sure they had all relevant information about the case. Interventions to reduce reoffending needed to be mapped and successful outcomes evaluated.

Protecting the public

Overall work to protect the public and actual or potential victims was satisfactory. Assessment of the risk of harm to others was good, but planning and review did not always consider the assessment sufficiently. The YOS was not yet making effective use of the new AssetPlus assessment tool to support its work. Multi-Agency Public Protection Arrangements worked well, but the plethora of other multi-agency meetings and protocols needed improvement so that intelligence sharing could be more focused. Oversight by managers was not always effective. Children and young people were able to describe the work undertaken with them to reduce their risk of harm to others.

Protecting children and young people

Overall work to protect children and young people and reduce their vulnerability was satisfactory. There was some good safeguarding work undertaken by case managers. Assessments usually included a coherent analysis of the risk of harm to the child or young person, but planning and review were not consistently good enough and the YOS was not yet making effective use of AssetPlus to support its case management.

The immediate sharing of information between other agencies and the YOS about missing children and young people did not always reach the right case managers.

Making sure the sentence is served

Overall work to make sure the sentence was served was good. The YOS made consistently good efforts to understand and respond to the individual needs of children and young people. Staff built positive relationships to make sure that engagement with children and young people and their parents/carers was good throughout. This meant that compliance work was effective; making sure the sentence was served.

Governance and partnerships

Overall work relating to governance was ineffective. The YOS Management Board provided a good arena for sharing information and supporting the work of the YOS in meeting its priorities. It could not, however, direct strategic planning sufficiently, due to an absence of wider and more sophisticated data. There was no overarching strategy to determine the range and content of provision and to fully understand the needs of the YOS caseload. There was some good partnership working, but the provision of services by Child and Adolescent Mental Health Services was poor. There was insufficient access to suitable and sustainable accommodation for children and young people.

Interventions to reduce reoffending

Overall work on interventions to reduce reoffending was satisfactory. The YOS was unable to assure itself that a suitable range of interventions was available. Interventions had not been mapped and evaluated and, therefore, their impact could not be demonstrated. Assessments were good, but delivery was not always consistent with assessed need. Restorative justice work and work to engage with children and young people was good.

This inspection was led by HM Inspector Caroline Nicklin, supported by a team of inspectors, as well as staff from our operations and research teams. The Assistant Chief Inspector responsible for this inspection programme is Helen Mercer. We would like to thank all those who helped plan and took part in the inspection; without their help and cooperation, the inspection would not have been possible.

Recommendations

Post-inspection improvement work should focus particularly on achieving the following outcomes within 12 months following publication of this report:

1. strategic planning should be informed by the commissioning, and effective evaluation of, a needs analysis to identify the needs of the cohort, the staff and the business needs of the YOS as a whole (YOS Management Board)
2. work should be undertaken to secure suitable and sustainable accommodation for children and young people (YOS Management Board)
3. routine intelligence sharing between the police and the YOS should make sure that case managers receive timely information about all children and young people who are arrested (South Wales Constabulary and YOS manager)
4. joint working with children's services and information sharing at case level should be consistent (YOS manager and Directors of Children's Services)
5. case management practice should be of good quality, driven by thorough investigation by case managers and fully utilising the AssetPlus assessment and planning system (YOS manager)
6. there should be a structured and consistent approach, based on good practice, to the provision and use of interventions intended to reduce offending (YOS manager).

Please note – throughout this report all names referred to in the practice examples have been amended to protect the individual's identity.

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Reducing reoffending

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Theme 1: Reducing 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 67% of work to reduce reoffending was done well enough.

Key Findings

1. Work with the courts was good. Pre-sentence reports (PSRs) were of good quality and presented robust and credible proposals which sentencers had confidence in.
2. Assessment for work to reduce offending was good. Staff understood the complexity of their cases and had a clear focus on understanding the perspective of the child or young person.
3. Priority was given to cases with the highest likelihood of reoffending.
4. Sufficient work was done during the custodial phase of sentences to reduce offending.
5. The menu of recommended interventions available to case managers for work to reduce offending needed to be mapped and successful outcomes evaluated.
6. Understanding and use of restorative justice was good, with examples of positive outcomes.
7. Police made an assured contribution to the work of the YOS, particularly in cases requiring the most intensive input, but information sharing needed to be more accurately directed and pursued.
8. Effective relationships were developed with children and young people and their parents/ carers, which were important to effective work to reduce offending.

Explanation of findings

1. We consider it essential, in order to plan for successful outcomes, that case managers understand from the start of the sentence, why the child or young person offended and what may help reduce that. This was done well enough, with clear explanations of why children and young people had offended, in all except eight of the inspected cases.
2. Case managers worked hard to understand situations from the perspective of the child or young person. Not enough effort was always made, however, to gather information from partners, such as children's social care services and the National Probation Service.

Comments from parents/carers

Parents described Cwm Taf YOS as providing a "*brilliant service"* where staff "*have a real understanding of these young people*".

3. When inspecting in Wales, we expect to see evidence of active and timely screening of the Welsh/English language preference of the child or young person. In the cases we inspected, none of the children or young people had Welsh recorded as their first language, or any preference expressed for use of the Welsh language. We did note that staff answered telephone calls with a Welsh language greeting, before switching to English. Staff were aware of those colleagues who could speak Welsh, to whom relevant enquiries could be passed. There were sufficient Welsh speakers among the staff to enable the YOS to deliver services through the medium of Welsh, if children or young people requested it. This offer could be made more routinely.

4. Some initial documents provided to children and young people were available in Welsh, but the new participation strategy and action plan had no mention of the Welsh language. No members of the YOS management team were Welsh speakers. Staff were not proactive in promoting the value of the Welsh language as an employment skill, or in encouraging children or young people who had been taught Welsh in school to further develop their skill. Assessments did not take full account of children or young people's skills in the Welsh language in order to identify which children and young people could benefit from support to increase their use of the language or to raise their awareness of its value.

5. The new AssetPlus assessment and planning tool had recently been introduced. Despite being trained, not all YOS case managers had developed a full understanding of how to use the tool to support assessment. Further work was being undertaken to make sure that records were comprehensive and that the system's full potential was realised.

6. The initial assessment of the preferred learning styles of children and young people helped case managers to support engagement. Case managers were usually clear about how to use this assessment information to tailor individual activities and to adjust the personal support offered to enable children and young people to engage in activities.

7. PSRs were the main method by which the court was informed about offending and other factors to assist in sentencing. The quality of PSRs and the appropriateness of recommendations is particularly important when considering cases on the threshold of custody and we were concerned to note that six of such inspected PSRs were not good enough. Problems included insufficient analysis, excessive length, insufficient assessment of risk of harm to others and vulnerability.

8. Almost all of the referral order reports were good, providing valuable information to inform discussions at youth offender panels.

9. Planning for work to reduce offending was good enough in just under three-quarters of cases, generally providing a strong basis for future work. Work to address education, training or employment, thinking and behaviour, and attitudes to offending was identified in almost all plans where this was required. More attention needed to be given to planning to address family and personal relationships, emotional or mental health, living arrangements and lifestyle. The role of partner agencies sometimes needed to be clearer. All but one of the children and young people that we interviewed knew that they had some sort of plan, either a referral order contract or an individual sentence plan.

Comments from a child or young person

"*I got given my contract straight away, after the panel meeting; it covers things like education, and anger and stuff.*"

"*Yeh, I've got a plan, I keep it in the kitchen, I've got to keep my appointments and stay out of trouble.*"

10. For children and young people in custody, their sentence planning should be delivered in an integrated way. It was encouraging that the custodial phase of sentences included planning for work to reduce offending in almost all relevant cases and that the planned work during the custodial period to address reoffending was delivered. Two parents/carers with children in custody reported good support from the YOS staff including help to attend a sentence panning meeting, by collecting them and travelling with them to the secure establishment. Parents/carers confirmed that sentence planning meetings took their child or young person's needs into consideration and the plan met the identified needs.

Comments from parents/carers

"*The YOS has been brilliant, they take me to the meetings and give me feedback on how [my son] is getting on….. I am confident he is getting the help he needs.*"

"*[YOS officer] is doing one-to-one work with him in prison when he visits him because the prison does not have the course, he tells me how he is getting on, but not the details of the work because that is between [my son] and [YOS officer].*"

11. Inspectors form judgements about the priorities that should have applied in each case, and whether sufficient work had been undertaken to address these. We found that where work; living arrangements; education, training and employment; thinking and behaviour; and substance misuse were priorities, sufficient work had been completed in most cases. Where family and personal relationships; lifestyle, emotional and mental health; attitudes to offending; and motivation to change were factors, the work was insufficient in some cases.
12. Case managers sometimes described a reliance on internet searches to find suitable intervention work, rather than them having a coherent set of recommended options available. There was, however, an internal system (the YOS Online Data Archive), which was a useful source of information for staff. The YOS also benefited from being selected as a location for the DRIVE programme (a domestic violence programme from Safer Merthyr Tydfil. This was a research project so not yet available to all, but was the only one in Wales). Staff should be applauded for their creativity in seeking to identify appropriate work to match the individual cases, but this should be grounded in a core set of evidence-based interventions. We found that case managers understood the broad principles of effective practice with children and young people, but they did not always have a good understanding of what interventions would work best, nor how to evaluate their effectiveness.
13. Sufficient attention was given to reinforcing positive factors in work to reduce offending in almost all cases. Such work is important and we found that attention was given to make sure that positive outcomes were sustainable in almost all cases that were close enough to the end of their sentence to be assessed.
14. There was a good understanding of restorative justice in almost all relevant cases and we saw strong examples of this work, although a little more attention could be given to making sure that referral order panels heard and understood the voice of the victim. Children and young people wrote letters of apology and undertook a wide variety of useful reparation activities, which added value in their local community.

Example of notable practice: Illustration of effective restorative work

A large supermarket in one of the town centres was a repeat victim of shop theft. The YOS had an ongoing relationship with this store, and the store facilitated meetings with the children and young people who had offended there. The security manager met with the children and young people and explained the impact of the theft on the store. She explained that children and young people often think it is more acceptable to steal from a large store and she was able to explain to them the effect on staff, profits and costs to the community.

15. The frequency of reoffending since the start of the sentence had reduced in 75% of those cases where there was sufficient evidence to assess this. The seriousness of reoffending had reduced in 69% of relevant cases. Inspectors judged that almost half of the children and young people were less likely to reoffend than they had been at the start of their sentence.

16. We spoke to 11 children and young people from the cases that we inspected.

17. The quality of engagement between case managers and both children and young people and their parents/carers was good. Children and young people valued their relationships with case managers and the interest shown by them. All of the parents/carers we interviewed felt that sentence plans were comprehensive, knew what was in them and had contributed to them.

Comments from children and young people

"*[YOS worker] is proper legend, at first I hated her and I wanted to blow her car up, and I was going to, but now I think she is proper sick, I tell you, I would take a bullet for her.*"

"*My worker was tidy with me, he said, you do what you do, but I will give you advice about what you can do and what will happen, you use your head, he gave me advice, he told me about the consequences.*"

"*He was tidy with me, so I was tidy to him, there's no point in kicking off, you just have to be there longer.*"

18. We saw some effective operational partnerships, in particular those addressing substance misuse. There were strong links with locality services that could provide continuing support when the court order ended.

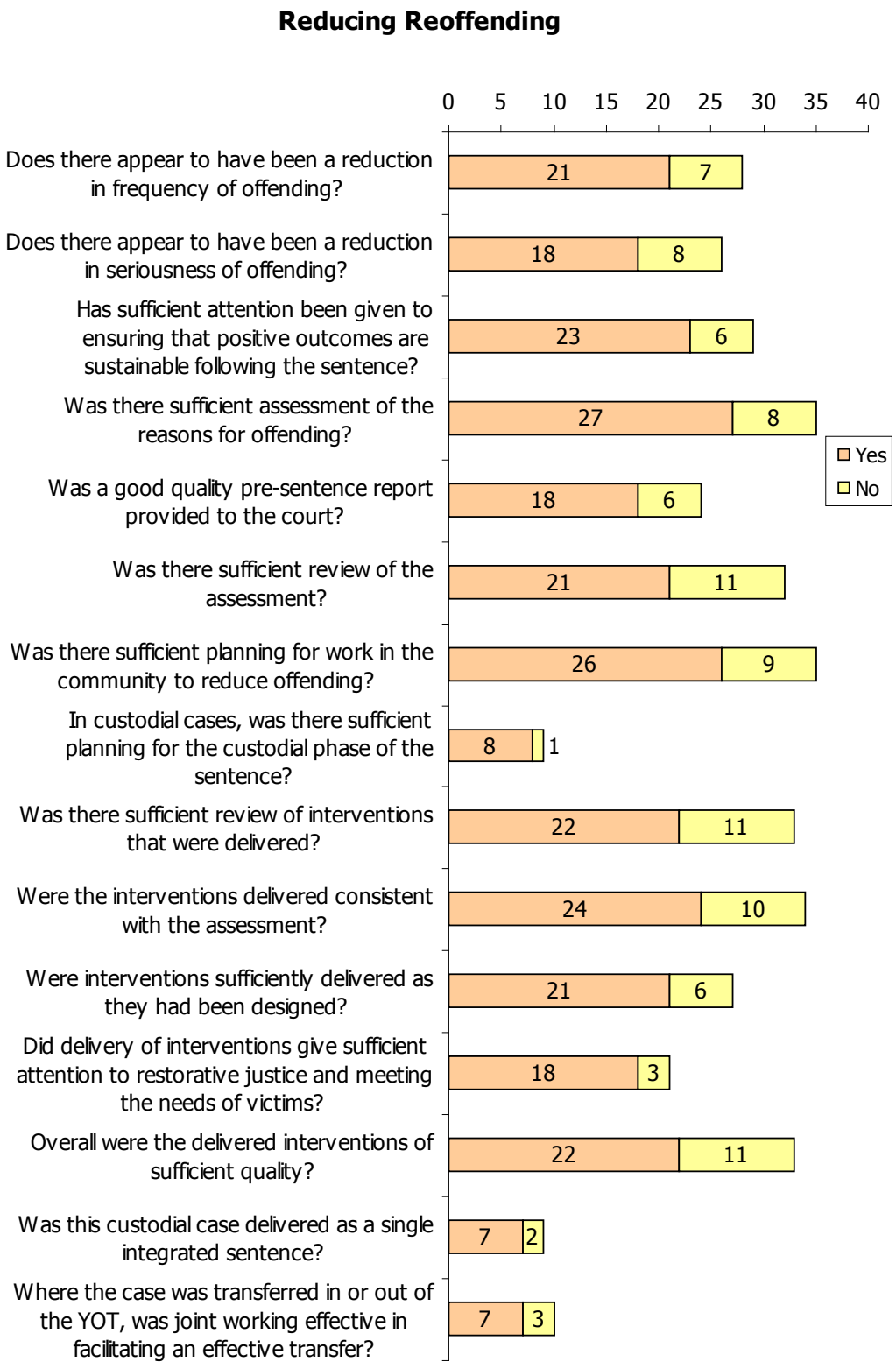
Comments from parents/carers

"*His grandmother wanted me to tell you that [case manager] is the best thing that has ever happened to this family, he has been fantastic.*"

"*The [YOS worker] plays football with my son because he struggles to concentrate and finds it hard to talk, when he clams up [YOS worker] goes outside for a kick about, it's been really good.*"

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 35 cases were inspected. The total answers, however, 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 76% of work to protect the public was done well enough.

Key Findings

1. Assessment of risk of harm to others was not always sufficient; staff needed to be more investigative.
2. Planning for work to manage or reduce risk of harm required some improvement.
3. Multi-Agency Public Protection Arrangements (MAPPA) were understood and worked well.
4. Other risk management meetings were not always effective. The relationship with and sharing of intelligence by the police was good, but the YOS's system did not make sure that information was consistently shared with case managers, or that actions were followed up effectively.
5. Local protocols around missing children were not clearly communicated or understood.
6. Oversight by managers was not effective in enough cases.
7. Good attention was given to the needs of victims.
8. Children and young people understood and described work being undertaken with them that was intended to reduce their risk of harm to others.

Explanation of findings

1. To protect victims and the public, it is important that planned work is informed by good assessment including the situations the child or young person may become involved in, how that may occur and how that behaviour may begin. This was not done well enough in almost one-third of cases.
2. Case managers should create a clear plan designed to prevent the risky circumstances happening. Plans should also explain what actions need to be taken if any harm does occur. One-third of cases did not have a sufficient plan in place at or near the start of the sentence to manage risk of harm posed to others. Usually this was because the case manager had not recognised the need to plan to manage risk of harm. Case managers did not yet understand how to produce risk management plans in AssetPlus with the clarity, comprehensiveness and precision that was needed. In all of the custodial cases that we examined, a comprehensive risk management plan was in place.
3. All the children and young people that we spoke to were aware that an assessment had been completed which assessed their risk of offending and their risk of harm to the public. Some children and young people were also aware that they had been assessed as presenting a high risk of harm to the public and that they had additional requirements in their intervention plan. 4. YOS case managers had a clear understanding of MAPPA and about how and when to engage with them. MAPPA involvement in the initial assessment and planning met the needs of the relevant cases.

Comments from children and young people

"*They have put in a thing with me not to bother anyone under the age of 16, there has to be either my parents there or their parents there, I can't be alone with anyone under 16, I have had two child abduction warning notices given to me. I've had three girlfriends, one of them was 13, and two of them were 14, in the past I have spent more time at the police station than the police officers themselves, and I know if I breach my order I can go to prison.*"

"*I've got a CBO [criminal behaviour order], I can't go into Ponty [Pontypridd], it's because I used to get into loads of trouble there.*"

4. YOS case managers had a clear understanding of MAPPA and about how and when to engage with them. MAPPA involvement in the initial assessment and planning met the needs of the relevant cases.
5. In joint working with local children's services, the assessment and management of risk of harm to others was given an appropriately high priority. The involvement of children and young people was given active consideration as appropriate. Sound judgment and decision-making was evident in relation to Child Protection during discussions with social workers and YOS representatives.
6. Other multi-agency arrangements, protocols and meetings to manage risk of harm to others were not as effective. YOS staff themselves were concerned that they did not always receive clear actions from the Cwm Taf Multi-Agency High Risk Panels and Cwm Taf YOS Multi-Agency Risk Panel (MARP) meetings; there was little evidence produced that actions were consistently followed up and challenged, where necessary, in subsequent meetings. A recent Critical Learning Review also stated that the "*Young person is also managed under the Risky Behaviour Protocol, although it is not clear from the recordings how this is coordinated or disseminated to all involved in the case*".
7. We observed some of these meetings and considered that, while the sharing of information and perspectives that occurred was positive and valuable, not enough structure or focus was given to make sure that the risks of harm children and young people posed to others were clearly identified, agreed and recorded. Actions were not SMART (specific, measurable, achievable, relevant and timely) or consistently communicated to the relevant case manager. Insufficient attention was given to putting in place robust but proportionate plans to address these risks and to contingency planning.
8. Reviews of assessments and plans for work to manage risk of harm to others were not always undertaken or done well enough. Sometimes this was because the progress made, or any changes, had not been included. The YOS had clear and appropriate local standards for reviews, which staff did not always follow.
9. In order to reduce the risk of harm to others, interventions delivered with children and young people must be consistent with both the assessed need and the plan. This was not achieved in only a very small number of cases. The main issue was that required interventions had sometimes not been delivered to meet identified needs, and it was unclear why that had been the case.
10. In about one-third of cases the right balance had not been struck between a reduction in offending, managing risk of harm to others and addressing vulnerability. The most common reason was insufficient attention being given to interventions to manage vulnerability or risk of harm.
11. Sufficient attention was given to managing the risk of harm to known or potential victims in the majority of relevant cases. Where this had not been the case, the main cause was gaps in planning related to known victims and case managers were not focused on the needs of known victims. All victims we spoke to felt supported by the YOS, were kept informed and, where appropriate, were able to make a contribution to the consideration of licence conditions.

Example of notable practice: Positive victim contact

There was evidence of good restorative work being used and services being offered to victims. In one case the victim of the offence was a family member and the offence had severely damaged family relationships. The parents of the victim took part in a restorative conference. The victim's mother reported that she wanted to participate, because she wanted the offender to know the significant damage his offending had caused the family, but she also wanted him to know that, as extended family, they still wanted to support him. The conference took place at the weekend, so that the father of the victim could attend as he worked full-time. The victim's family felt prepared for the meeting and there had been ongoing support for them since the conference.

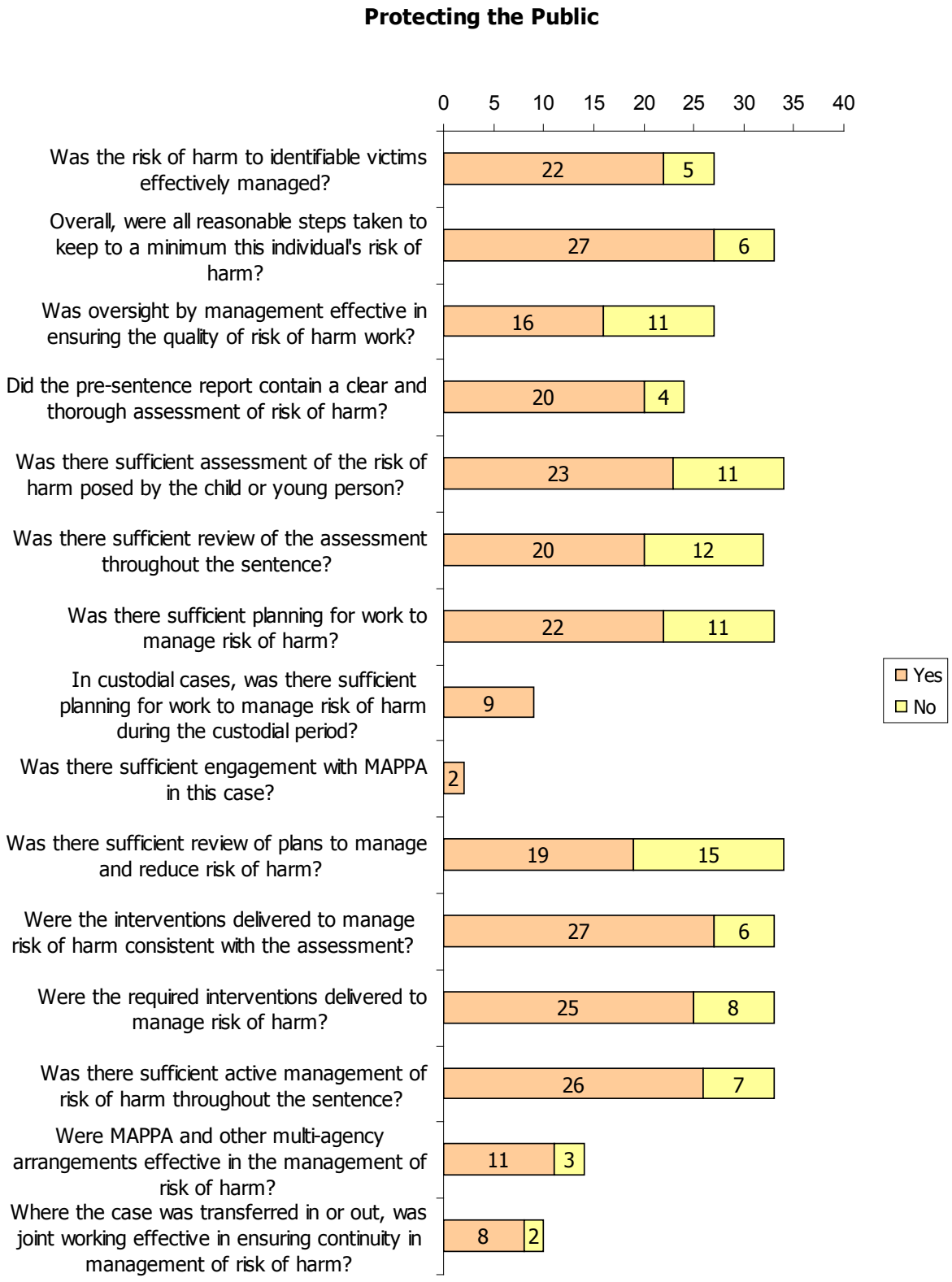
12. Oversight by case managers of risk of harm work had been effective in 59% of the relevant cases. Where oversight was ineffective, this was because no action had been taken where assessments and reviews were not updated after new information was found.
13. An important function of a police officer in a YOS is intelligence sharing. There was a system in place for the police officers to identify when children or young people known to the YOS came to police attention. The YOS police officers had access to the appropriate IT systems at both YOS offices. Intelligence sharing could be formal (via email) or merely verbal.
14. The Youth Engagement Project was a project working with children and young people across Cwm Taf, using a restorative approach to tackle local issues. The multi-agency team conducted outreach work on a weekday evening in crime and antisocial behaviour hot spots. Children and young people at risk of harm to themselves from their activities were identified and invited to work with the YOS, including voluntary participation in educational sessions focusing on alcohol and substance misuse, self-care, victim awareness and health. Information gathered from those evenings was shared via email, inter-agency. This project was delivering effectively.
15. Many of the children and young people we met did not specifically recognise elements of their intervention as relating to protection of the public. When they described the work that had been undertaken, however, it was apparent that this was often intended to address their risk of harm to others. Other children and young people were aware of plans in place to protect the public. They understood them and explained how they were complying with restrictions.

Example of notable practice: Illustration of effective risk management

One young person we met reported that he was visited monthly by the police and they undertook a search of his property to check he had no guns or knives. He stated that they did this because he had Attention Deficit Hyperactivity Disorder and could not be trusted not to hurt anyone if he did have a weapon. He had been persuaded that these checks were for his own safety and he willingly consented to them.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 35 cases were inspected. The total answers, however, may not equal this, since some questions may not have been applicable to every case]



Protecting the child or young person

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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 71% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. Good work was often carried out by the YOS to safeguard children and young people.
2. Staff developed positive relationships with children and young people, which were valuable in helping keep children and young people safe.
3. Planning required improvement, although planning in custodial cases was good.
4. There was insufficient review of safeguarding and vulnerability factors.
5. There were examples of good joint work with children's social care to keep children and young people safe.
6. Information sharing and communication between the YOS and other agencies was not sufficiently consistent.

Explanation of findings

1. We saw some good work carried out intended to safeguard or reduce the vulnerability of children and young people. Sufficient effort had been made to understand, analyse and explain the safeguarding and vulnerability needs that applied in just over three-quarters of cases. Assessments normally gave sufficient attention to all areas (apart from care arrangements), in so far as these related to the vulnerability of the child or young person.

Comments from children and young people

"*I used to go missing loads when I was in a children's home, and there used to be meetings about me with loads of people there, I didn't go, because I didn't want to sit there and listen to people talking s**t about me, but I like it where I am now, so I stay here all the time.*"

"*The school have a plan that if I am off the premises for more than 20 minutes I am reported missing, but I think its stupid, because I am just going off and getting sweets and things, I'm not doing anything.*"

2. There were good arrangements in place for gathering information from local authorities about children and young people's school attendance, behaviour and attainment when they first became involved with the YOS. Some assessment outcomes, however, were not recent enough or detailed enough to be useful in planning children or young people's progression. One member of staff did have access to local authority management information systems that enabled her to gather assessment outcomes. While staff were thorough in trying to gain information about children and young people from schools, a small number of schools, who dealt with the most vulnerable learners, did not respond effectively to requests for information. In a few cases, the information was incomplete.
3. In other cases, gaps in information sharing required case managers to be more investigative in requests for information. Children's social care services were not sufficiently aware of the importance of the YOS having relevant information, and did not share this routinely. For example, where a child or young person was either at risk of or vulnerable to child sexual exploitation the exact nature of that risk was not always known to case managers. Consequently, assessments and plans were sometimes limited.
4. There was a lack of clarity about the use of child sexual exploitation screening, for example when offending may have been an indicator of child sexual exploitation. YOS staff had not realised their responsibilities with regard to the All Wales Protocol - Missing Children, regarding children and young people who go missing. YOS staff and managers acknowledged that there was no automatic system in place to make sure that they received details from all return-home interviews. Good information was brought to the MARP from the police, who took responsibility for completing return-home interviews and collecting information from children and young people. The YOS accepted that circulation of the information and actions shared in the MARP should be directed at specific case managers, to be utilised as part of the assessments and reviews.
5. Almost all PSRs included a clear and sufficient explanation of the safeguarding and vulnerability needs that applied in the case. We observed good work in the local youth court.

Example of notable practice:

A 16 year old male was facing an expected custodial sentence following his guilty plea to a charge of burglary of a non-dwelling. The case manager was present in court and had provided a comprehensive PSR, which clearly outlined the factors contributing to the young person's continued offending but also explained the positive steps towards change that he had taken since he had committed the offence. These included reducing his substance misuse and securing a place on a local training course. The report also conveyed a detailed proposal for sentence to a youth rehabilitation order (YRO) with Intensive Supervision and Surveillance (ISS). The proposal clearly outlined the rigorous requirements of this order, how the proposed activities would specifically reduce the likelihood of his reoffending and how closely he would be monitored throughout the order. As a result, the court was positively influenced to give the young person "a chance" and imposed the YRO and ISS. The work of the YOS was influential in helping make sure that the young person had the opportunity to continue his change in the community.

6. There was insufficient review of safeguarding and vulnerability. Some reviews were a copy of a previous assessment, even though relevant additional information was known. The need for review following a significant change was not always recognised. The YOS had produced helpful guidance about the additional circumstances in which reviews would be required. It was disappointing to find that this was not always followed.
7. Planning for work in the community to address safeguarding and vulnerability needs was poor, with almost half of plans being inadequate. Case managers did not understand how to use the new AssetPlus tools effectively when planning. More positively, eight of the nine cases in custody included sufficient planning to address safeguarding and vulnerability.

8. Once the required intervention to address safeguarding or vulnerability needs had been identified, it was then delivered in three-quarters of cases. Overall, the YOS had done enough to keep the child or young person safe in two-thirds of the cases. While there were deficits in assessment and planning, no child or young person had been left unsafe as a direct result of these.

9. Management oversight of safeguarding and vulnerability work was sufficient in just over half of the relevant cases. This was primarily due to deficiencies in assessment and planning, of which the supervising manager should have been aware, not being addressed. Sometimes assessments and plans had been countersigned without sufficient consideration given to their quality. This was in spite of a clear policy being in place for management oversight.

10. When a child or young person reaches the age of 18 years old, it is for the YOS to decide whether the case should be transferred to the management of one of the adult probation services. This transfer should be prepared for carefully, with robust information sharing between the case manager and adult probation services to make sure the well-being of the child or young person is maintained. Joint working of this kind was found to be effective in 80% of relevant cases.

11. YOS staff understood the importance of children and young people having someone they could trust and speak to. The quality of those relationships helped children and young people understand how they would be helped and kept safe. There was universal positive feedback from the children and young people on the engagement and support provided by their YOS case manager. All clearly related well to their case manager, even when they had to be breached on their orders. Children and young people we spoke to were aware of work being undertaken to help address risk of harm to others.

Comment from a child or young person

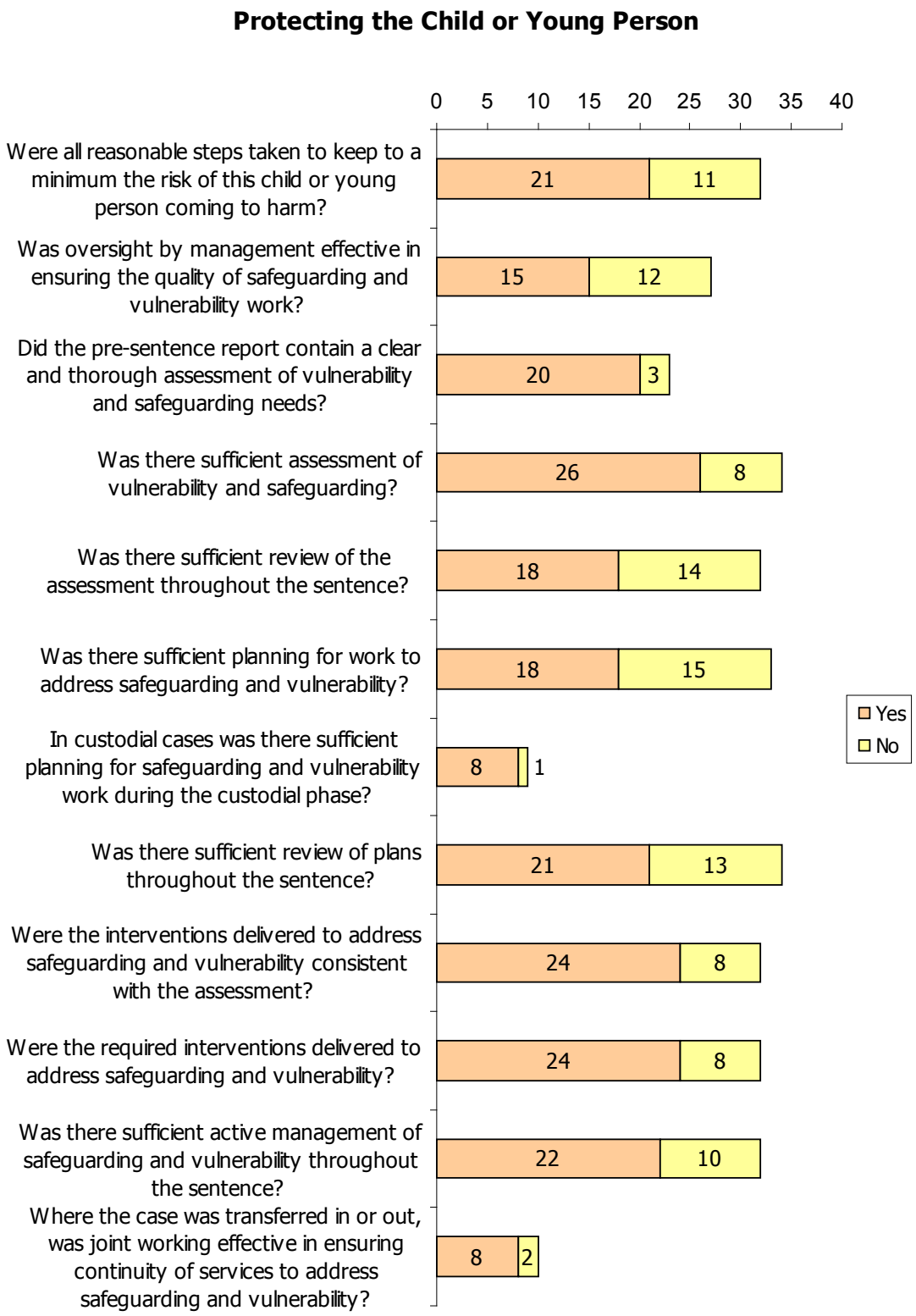
"*She did breach me, yeh, but that just doing the job, you've got to get on with it haven't you?*"

12. Staff understood the negative impact of custody and took action to try and lessen this. They planned well for work in custody to address safeguarding and vulnerability in almost all custodial cases.

13. YOS staff attended Looked After Children reviews and shared information appropriately. Relationships between the YOS and staff in children's services were generally described as good, and there were clear examples where the positive working relationships between individuals in these teams had resulted in beneficial outcomes for children and young people. Recent examples of this included joint visits to a Looked After Child while in custody, and an in-house residential placement being kept open while the young person was in custody.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 35 cases were inspected. The total answers, however, may not equal this, since some questions may not have been applicable to every case]



Making sure the sentence is served

4

Theme 4: Making sure 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 YOS 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 85% of work to make sure the sentence was served was done well enough.

Key Findings

1. Good attention was given to diversity factors and to responding to the individual needs of children and young people throughout the work of the YOS.
2. Children and young people and their parents/carers were involved in the development of both assessments and PSRs.
3. Staff built positive relationships with children and young people.
4. Attention was given to making sure children and young people met the requirements of their sentence.
5. When children and young people did not comply with their sentence, the response of the YOS was appropriate.

Explanation of findings

1. Considering and responding to the individual needs of children and young people was a considerable strength of Cwm Taf YOS. The individual needs and circumstances of children and young people and their families, including diversity factors and other barriers to engagement, were usually assessed and understood well. All the children and young people we met told us that any diversity needs that they had were met.
2. Children and young people, and their parents/carers were usually well engaged in the development of assessments. This meant that assessments reflected their experiences, as these had been presented to the case manager.
3. It is particularly important that children or young people and their parents/carers understand what will be said about them in PSRs, since this can have an impact on the progress of the sentence, once it is underway. In Cwm Taf, the child or young person and their parents/carers had been sufficiently involved in the preparation of the PSR in almost every relevant case that we inspected.
4. Almost all PSRs gave sufficient attention to diversity factors and potential barriers to engagement. Attention to this during planning was also good enough in the great majority of cases. The child or young person and their parents/carers or significant others had been sufficiently involved in the planning in 82% of cases.
5. Staff were tenacious and skilled in building positive relationships with children and young people, and recognised that sometimes this took time. Their actions gave clear messages to children and young people that they mattered. We saw numerous positive examples of how case managers showed their understanding of children and young people's circumstances.

Comments from children and young people

"*We have talked about the consequences and stuff, the main person I think that I've affected is my Mum, my Mum is the reason why I want to stay out of trouble.*"

"*We talk about the consequences of my behaviour, I really like [YOS manager] he explains things in a way I can really understand.*"

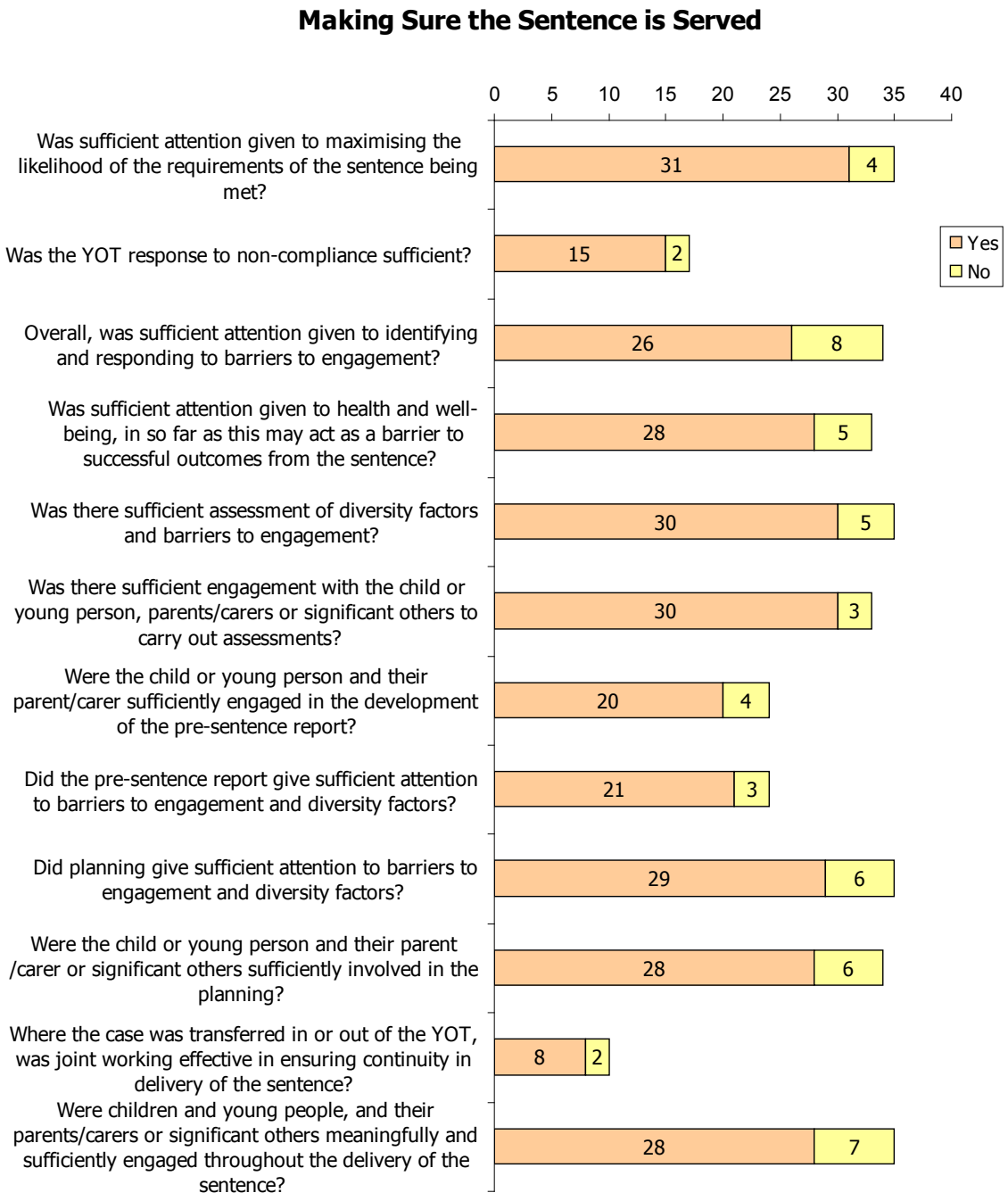
6. We noted as good practice the YOS's commitment to maintaining ownership of cases where the child or young person had gone to live in a different area, perhaps through being moved to another Looked After Child placement. Good work by case managers made sure that all relevant parties continued to be involved and informed and the child or young person was not lost or forgotten.
7. Sufficient attention was given to making sure that the child or young person engaged with the YOS and that the requirements of the sentence were met in almost all cases. Parents/carers explained how the YOS kept them informed about meetings, which helped them to support the work of the YOS. All the children and young people and parents/carers we spoke to reported that the YOS was flexible in their approach to arranging appointments; they would make appointments outside school or employment hours, and be responsive to the needs of children and young people. For example, one young person liked a fixed time and date for his appointments and this was arranged, while another said he responded better in the afternoons and, therefore, he was not given morning appointments.
8. The geography and limited public transport links in Cwm Taf meant that case managers completed regular home visits. Visiting the family home helped their understanding of children and young people's circumstances and how those may change over time. It is also important, however, that children and young people take responsibility for their own compliance, where appropriate. This is particularly the case with older children and young people, for whom this can be used as an opportunity to help develop the self-discipline they will need when starting work or engaging with adult services. Case managers did not always strike the right balance. This view was also expressed by some parents/carers who considered their children and young people should be encouraged by the YOS to take greater responsibility.
9. There were seven cases in our sample where the child or young person had not complied fully with the requirements of their sentence. The response of the YOS to this was appropriate in the great majority of these. The YOS operated a compliance panel process, which focused on understanding and putting actions into place. This meant that problems could be addressed to enable work to reduce offending and protect the public to continue, rather than immediately returning cases to court. Case managers understood the YOS approach to supporting effective engagement and responding to non-compliance.

Comments from a child or young person

"*I've had a couple of warnings, it was at the beginning, because of my attitude, I know them better now, so I don't kick off any more.*"

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 35 cases were inspected. The total answers, however, may not equal this, since some questions may not have been applicable to every case]



Governance and partnerships

5

Theme 5: Governance and partnerships

What we expect to see

Effective governance, partnership and management arrangements are in place. These enable the YOS to meet national and local criminal justice and related objectives, and to deliver and maintain good quality services.

Key Findings

1. There was good commitment to the work of the YOS within the local authority and there were some strong partnership arrangements.
2. Roles and responsibilities within the YOS management team were not clear enough, across both delivery areas.
3. The YOS and employment, training and education (ETE) partners had not been effective in meeting targets for the involvement of children and young people in ETE.
4. The YOS Management Board lacked sophisticated data to inform strategy and planning. There was not a sufficient analysis of the needs of children and young people.
5. YOS staff and managers worked well together operationally.
6. There was a significant lack of Child and Adolescent Mental Health Services (CAMHS) provision.

Explanation of findings

1. Leadership and governance – offending is reduced and other criminal justice and related objectives are met

1.1. In Cwm Taf, reoffending and the use of custody have all reduced over the last two years[1].

1.2. The YOS had a high degree of visibility and attracted a commitment from the local authority, including at Lead Member and Chief Executive level. Cwm Taf YOS and the YOS Management Board had high expectations for the services they provided, and were ambitious to further improve these. There was a clear overall purpose for the YOS expressed by the Board, along with good partnership working. The local authority had a focus on prevention and diversion and this had been reflected in the YOS, which had developed a strong and innovative approach to preventative work. This reflected the policy of the Welsh Government that children and young people should be seen as children first and as offenders second. Its success had led in part to a reduced, but proportionately more serious, caseload of statutory work in the YOS.

1.3. The YOS had been focused on the creation of a single service from two previous delivery areas; seeking to draw the two offices together into a single YOS, and considerable work had been undertaken. While the range and nature of interventions provided by or available to the YOS appeared to be broadly appropriate, there was no clear strategic approach to the development and delivery of interventions to reduce offending. Instead, it was largely practitioner led, in response to the presenting needs and issues of case managers' caseloads, rather than as part of an informed plan.

1 Latest 12 month data published January 2017 is: Binary [43.4%] with the April 2014–March 2015 cohort, against an England and Wales average of 37.9%: Frequency 1.40, against an England and Wales average of 1.25. Use of custody in the year to June 2016 was 0.34 episodes per 1000 in 10-17 population, compared to the England & Wales average of 0.36 per 1000. First time entrants rates were also better than average. Source: Ministry of Justice.

1.4. The Board received a range of performance information, but this was not sufficiently sophisticated, and was unable to support the Board to make decisions and drive change. The Board did not regularly commission and utilise in depth qualitative data to support the area-wide commissioning, evaluation and delivery of services. The Board had not conducted regular in-depth analysis of, for instance, the impact of training or education on specific groups or the needs of the YOS as a whole. We did see two examples where the YOS had sought additional information, but oversight of this critical area had not been consistently effective and the Board had not influenced other partners to widen provision where needed. Strategic planning was, therefore, weakened.

1.5. Without this information, the Board and the YOS were identifying development priorities, for example in the latest youth justice plan; but they did not sufficiently understand changing local needs and risks to the service. There was no joint strategic needs assessment or analysis in place. Actions from meetings were not SMART (specific, measurable, achievable, realistic and timely) and we saw little evidence that they were followed up sufficiently every time.

1.6. There was no strategy to measure the impact of interventions and no evaluation of the effectiveness of the service.

1.7. There was good attendance at Board meetings and a strong commitment to the partnership by South Wales Police. There was also evidence of good Health Board (this was the wider Cwm Taf organisation that provided the health provision for all the members of the general public that live in the locality) and YOS collaborative working, such as the new development service[2]. This initiative had a positive impact in terms of reducing waiting times for children and young people to access health services.

1.8. The Health Management Board was an internal forum that considered the specific health care needs of children and young people within the YOS. A number of reports were presented to the YOS Health Management Board, but it was unclear how these meetings added value. For example, information provided to the inspection indicated that between 01 April 2016-31 December 2016 a total of 326 children and young people were in the YOS system, but not enough of these had an internal YOS health referral and subsequent assessment. It had been recognised that a number of the children and young people may have had contact with other community health professionals, but this could not be evidenced. This level of detailed information had not been provided to the Health Board, and a significant majority of children and young people had not had a healthcare assessment.

1.9. Other information provided to the Health Management Board was of value and an example of this was the 'health quarterly report' for quarter three, which reflected a significant number of children and young people had 'emotional health' needs. The Health Management Board, however, did not have a clear strategy in place to address this.

1.10. We found that case managers gave children and young people good support if they identified that their basic skills were poor. The YOS, however, did not have a clear strategy for improving children and young people's literacy or numeracy skills. Not enough attention was given to systematically assessing children and young people's skills at the start of their order to inform the planning, delivery or evaluation of support.

2. Partnerships – effective partnerships make a positive difference

2.1. The YOS were highly regarded by partners, and some effective partnerships were in place.

2 The initiative was announced in 2015 and was funded by the Welsh Government to reduce waiting times in specialist CAMHS.

2.2. The police representative on the Board was a Superintendent, with responsibility for partnerships, Multi-Agency Safeguarding Hub, Public Protection Unit, Integrated Offender Management (IOM), Youth Justice and Community Safety. Youth Justice Data and Police Crime data from the police national computer was shared at Board level; however, there was recognition that this data could be too historic and could distort local data and current understanding. We heard about the commissioning of some work to spot anomalies in the data and seek greater granularity to provide a more up to date picture.

2.3. There were two police officers seconded into the YOS who were managed by a Detective Inspector who had a portfolio covering the YOS, IOM, the Wales Integrated Serious and Dangerous Offender Management Project, and dangerous and sexual offenders. These line management arrangements demonstrated a comprehensive understanding of offender management and a clear steer towards partnership working and risk management.

2.4. The YOS police officers were co-located in each of the YOS offices and we saw effective working relationships between the two officers. Co-location was seen as good practice, as the value and skills that the police officers could bring, extended further than just the supply of intelligence. The YOS officers were enthusiastic, committed and well regarded by the case managers.

2.5. The YOS police officers completed a number of core functions. They completed joint home visits and visits to secure establishments with case managers, and also attended the youth court. The officers had delivered various briefings, talks and presentations with neighbourhood policing teams, particularly around preventative activity such as street disposals. The officers had also spoken in schools about sexting, bullying and antisocial behaviour. We recognised all of this work as good practice and evidence of proactive work to reduce risk of harm and vulnerability.

2.6. An important function of a police officer in any YOS is intelligence sharing. The police invested considerable time in preparing intelligence records for Bureau[3] meetings in particular, and we were satisfied that they were regularly accessing custody records every morning and sharing intelligence about arrests with case managers. This was not, however, a consistent process and there was no obvious flagging system in place for the police officer to identify when a child or young person on the YOS caseload came to the attention of the police.

2.7. We also found evidence of disparity between the level of information provided by Gwent Police when children and young people had moved to the Gwent area but were still being managed by Cwm Taf YOS. Both police forces were using the same police systems, but application of the system was varied and could make accessing information more difficult.

2.8. South Wales Police had invested considerable resources to safeguard children and young people, including missing person teams within each basic command unit, a Multi-Agency Safeguarding Hub, and a proactive public protection team, all of which were seen as key players in protecting children and young people and the public.

2.9. Police officers had a good knowledge of the warning signs of child sexual exploitation and had attended a number of training courses. Both officers regularly attend High Risk Panel meetings and MARP meetings. While it was recognised that these risk meetings were valuable, the level of intelligence being shared outside of these meetings was insufficient.

2.10. Similarly, while there was a clear process in place for police officers from the missing person's team to complete return-home interviews, the level to which this information was shared with case officers was on an as and when it was requested basis. There needed to be a more consistent communications channel from the police to the case managers.

3 The Bureau is a local multi-agency project that works with children and young people who have been arrested, to divert them from antisocial or criminal behaviour before their activities lead them to receive a criminal conviction.

2.11. We found that there were positive and constructive working relationships between the IOM[4] and the YOS, with a particular emphasis on the transition of cases from child to adult and a multi-agency approach towards these individuals. There was a referral process for 17 ½ year olds by case managers. These individuals went to a 'Multi-Agency Selection Panel' and were co-managed for a six month period, after which time they were IOM scored.

2.12. Children and young people who fitted the MAPPA criteria were, by their very nature, likely to pose significant risk of harm to both themselves and others. From the cases we inspected, there appeared to be appropriate referrals into MAPPA and case managers had received the four pillar training. Police officers working in the YOS, however, should also have received MAPPA training.

2.13. The health staff within the YOS consisted of two health visitors. A number of cases had mental health issues, but there was no psychiatric expertise within the YOS to address these.

2.14. Separate sets of children and young people's notes were being maintained by the health visitors and substance misuse workers based within the YOS. The health visitors completed two sets of notes, one paper and one electronic and, along with the AssetPlus notes, this meant that each child or young person had three sets of notes.

2.15. There was a lack of documented involvement of a number of key individuals including the health visitors and substance misuse workers. Health and substance misuse workers were not inputting information into the AssetPlus assessment and, therefore, were not included in making the assessment. YOS staff were, therefore, often inappropriately left undertaking assessments of health care needs.

2.16. The initiative of a Speech and Language Therapist being available within the YOS was a positive one. This resource, however, was limited to one day a month, which was taken up with assessment, meaning that there was no time to deliver any therapeutic input.

Comments from a parent/carer

One young person's parent identified that their child had mental health problems and she reported that the YOS advocated for the family to receive mental health support, which was something they had been asking for over some time, but was only put in place following intervention from the YOS.

"*They contacted CAMHS for us, the psychiatrist had cancelled lots of appointments, because she was ill or on holiday, it was only when [YOS officer] got involved that we were seen.*"

2.17. The lack of access to CAMHS was a significant issue despite the tenacious efforts of YOS staff. The transition of children and young people from youth to adult services was problematic and we saw limited involvement from CAMHS. YOS staff did report that the service was better for children and young people known to the YOS who had a dual diagnosis.

2.18. All of the children and young people we interviewed aged 16 years old and under were in some kind of educational provision, which was a mixture of mainstream education, college placements or 'Educated Other Attending School' (EOTAS), the main alternative provision. Some of these children and young people were on reduced timetables, and some were not attending as required, but there was provision available for most of them.

2.19. This provision was supported by the work that the YOS did for EOTAS. The YOS police officer attended the EOTAS team meetings and the YOS had provided training to EOTAS staff on the

4 IOM brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together.

principles and use of restorative justice. YOS staff often had their meetings with children and young people at the premises. This provider felt that they had good support from the YOS.

2.20. Most children and young people who engaged with the YOS improved their levels of engagement with ETE. Those children and young people supervised by the YOS who were of statutory school age improved their engagement by 57% and those above school age improved their engagement by 38%[5]. Despite this improvement, too many children and young people of statutory school age did not receive their entitlement to full-time education. For those attending pupil referral unit provision, there was insufficient monitoring of and reporting on the number of hours of education they received. This limited the YOS's ability to influence education provision.

2.21. There was one probation officer seconded from the National Probation Service, who had a good understanding of her role. She lacked, however, appropriate three-way supervision and did not have access to adult services' IT systems and recording. There was a need to clarify the YOS probation officer role to make sure that the transition process was focused on the needs of the child or young person. We saw little evidence of YOS liaison with the Wales Community Rehabilitation Company to which some of the YOS's children and young people would eventually be transferred.

2.22. There is a lack of appropriate housing available to vulnerable children and young people in Cwm Taf. This has resulted in inappropriate placements being made in bed and breakfast accommodation, particularly in the Rhondda Cynon Taf area. Senior managers were aware of this and were planning an accommodation strategy with accompanying additional resources, but the YOS Board could not satisfy itself that it had sufficiently rigorous measures in place to prevent the inappropriate placement of children and young people. The YOS did not have an accommodation worker.

2.23. Restorative justice was a strength of the YOS. We saw some excellent restorative justice interventions, which were appropriate, well developed, meaningful and valued by victims. The good work supporting this activity was informed by a Monthly Restorative Justice Action Group meeting, which was aimed at sharing updates on victim work, victim focus referrals, police work, reparation, volunteers and prevention activity. Updates were received in relation to planned restorative justice conferences, Bureau interventions, reparation work, police restorative justice card disposals and volunteer activity. This was a significant area of expertise that the YOS had developed and for which it should be commended.

Comments from children and young people

"*I have done 36 hours reparation, this was in a local school, and it was helping me, I learnt practical things, and it helped me not lose my temper, because I couldn't lose my temper there.*"

"*I did community work because I had broken the law, the workers were tidy, we talked about all sorts of things, and I learnt practical stuff, like painting and stuff, it was good.*"

2.24. Links with schools were good. YOS staff worked well with teaching staff and school pastoral staff to make sure that the support children and young people received complemented the school's support. In one case, the school commented on the marked difference in a young person's behaviour after YOS case managers had undertaken an intervention to improve his emotional literacy.

2.25. Case managers gave children and young people careers advice and helped them to make informed choices about their progression. The YOS had actively supported 50 children and young people in the last two years to work towards gaining a Construction Skills Certificate Scheme (CSCS) to improve their employability.

5 Data provided by Estyn.

Comments from children and young people

"*YOS referred me to the YFF [Young Fire Fighters] course, I really liked it, I got loads of certificates, I liked how they talked to you, I got my CSCS card, which would have cost me hundreds of pounds if I had to pay for it, it will help me get a job soon.*"

"*I got my CSCS card, which was really good, I'm doing cleaning now, but I'll use it when I'm 18 and it will help me get a better paid job.*"

2.26. Links with Careers Wales were variable. There was no Careers Wales representative on the YOS Management Board. One local authority had created very good, close partnership working. Through this, a multi-disciplinary panel, including a Careers Wales representative, provided tailored progression support to enable partners to respond quickly to emerging crises, and improving children and young people's ability to succeed in their chosen career plans. In Rhondda Cynon Taf, links with Careers Wales were less strong and did not make sure that children and young people had access to appropriate advice, guidance and progression support. In this area, the local authority had developed transition workers to support children and young people, but YOS case managers were not aware of this support or how to help children and young people to access it.

3. Workforce management – effective workforce management supports quality service delivery

3.1. The YOS had procedures in place, including local standards for practice delivery and processes to support quality assurance and oversight. The cases that we inspected did not always meet the local standards. The YOS's current quality assurance systems were largely process driven. While this provided a level of reassurance to senior managers, it was not effective in improving practice in planning and review.

3.2. Case managers spoke positively about their senior managers. It was apparent that YOS staff and managers worked together well. Staff considered that managers were skilled at assessing their work; supporting them and helping them improve. All YOS staff said that they received effective and appropriate supervision.

3.3. Regular supervision took place between health visitors and their managers and between substance misuse workers and their managers. Both the health visitors and substance misuse workers felt well supported and trained on a number of key areas that were relevant to their role.

3.4. The ability of the YOS to work effectively was heavily dependent upon reliable IT systems. Effective use of the new AssetPlus system for assessment, planning and recording is key to making sure that YOS staff know the risks and needs in individual cases. It is also vital for effective communication with other agencies, for example to help keep victims or children and young people safe. The YOS had arranged training according to national guidelines, and the YOS should continue with the ongoing refresher training so valued by staff.

3.5. IT systems were entirely desktop-based. This meant that time was often wasted between remote appointments and staff had difficulty accessing information when they were away from the office. A more efficient solution may be for staff to have access to laptops, to facilitate remote working.

3.6. Rurality led to challenges around staff safety. The YOS had a lone working and buddy system, and the YOS police staff would check address markers on request and undertake joint visits, but most visits were undertaken by single members of staff. The system did not make sure that the marker check was completed automatically whenever a new case was created. Staff expressed concern that due to the rural nature of the area, it would be difficult for them to access support quickly.

4. Learning organisation – learning and improvement leads to positive outcomes

4.1. There were good training links with the Cwm Taf Safeguarding Children Board, promoting opportunities for effective joint learning. Case managers mostly considered that their immediate development needs were met by the YOS, although they would welcome more training to meet their future development. In order to achieve this, the YOS management team first need to identify their future business priorities.

4.2. Volunteers on referral order panels understood their roles well. They valued the support and training available to them. Further work to support them in engaging well with children and young people would be helpful. Referral order panel meetings were always held on a Tuesday at the YOS office and sometimes in working hours which meant that some parents/carers were unable to attend. There was no evidence of the use of community venues for panel meetings. Referral orders were designed to reintegrate children and young people back into their community by the use of community volunteers, and should take place in community venues.

4.3. We were pleased to find that a Participation Group had been implemented to develop new and interesting ways to engage with children and young people to help improve services. We encourage the development of this work.

4.4. We observed a mutually beneficial partnership between the YOS and the University of South Wales. The partnership examined 15 cases of children and young people with complex needs who were at a higher risk of harm or offending. This allowed the YOS to identify commonalities and lessons to inform future practice.

4.5. The YOS had recently asked the researchers to explore how AssetPlus was being used, to help the YOS better understand its role in helping children and young people to change, and to help understand the links to reducing offending. This work was underway and was due to report initially in summer 2017. This has the potential to drive a number of significant developments for the YOS and demonstrated the YOS's commitment to learning.

Interventions to reduce reoffending

6

Theme 6: Interventions to reduce reoffending

What we expect to see

There should be a broad range of quality interventions being delivered well and as their design intended. We expect to see that these are based on assessed needs with appropriate planning to maximise the likelihood of sustainable outcomes being achieved. Where children and young people are working with more than one agency, partnership working should be integrated.

Case assessment score

Within the case assessment, overall 71% of work on interventions to reduce reoffending was done well enough.

Key Findings

1. Assessments of the suitability of children and young people for specific interventions had been considered well enough in most cases.
2. Restorative justice was particularly good.
3. The delivery of interventions by case managers within the YOS or between the YOS and partner agencies was not always joined-up or consistent with assessed needs.
4. The effectiveness of interventions was not evaluated.

Explanation of findings

1. The YOS did not know the interventions available to children and young people and had, therefore, commissioned a senior manager to identify these, prior to our inspection. We observed some excellent interventions, delivered either by YOS staff or partner agencies. These included one-to-one supervision; work in the youth court; reparation; a Family Group Conference DVD; the Youth Engagement Programme Briefing; the Girl's Group; referral order panels; the Restorative Justice Action Group and the Parent's Drop-In. Most were delivered by YOS case managers, not all of whom had received training on delivery. Case managers selected aspects of interventions to deliver on a one-to-one basis with children and young people, to suit their needs. There were a limited, but well-targeted range of accredited learning programmes that staff supported children and young people to undertake. In a minority of cases, children and young people's work was not accredited.

Comment from a child or young person

"*Because I set fire to the children's home I had to do work with the Fire Brigade, I had to talk to them and watch some videos, it helped me understand the risk of fires.*"

2. Sometimes a court can impose a YRO with ISS when it is dealing with an offence which is punishable with imprisonment, but wishes to use an alternative to custody. A YRO with ISS should include an extended rehabilitation activity requirement for which the court may specify the number of days in the order, with a supervision requirement, a curfew requirement and, where appropriate, an electronic monitoring requirement. It can include a range of activities including reparative activities, restoring

the costs of crime and reintegrating children and young people back into the community. Such orders are usually delivered jointly with YOS police officers. Three of the children and young people we interviewed were either currently, or had previously been subject to ISS. None of these children and young people appeared to be aware of the role of the police in the surveillance element of their ISS, and none reported regular meetings with either the YOS police officers, IOM police officers, or the neighbourhood teams.

Comment from a child or young person

"*The ISS is nothing to do with the police, I just see the YOS team, and I have to keep YOS appointments*."

3. Staff paid good attention to developing children and young people's 'soft skills' but this was not measured well. There was no systematic monitoring of progress made by children and young people while in ETE. Records about this were sometimes limited. Neither was there a mechanism to analyse the impact of specific ETE activities on reoffending rates.
4. Activities to help children and young people develop creative writing skills and deliver powerful pieces of drama achieved valuable therapeutic outcomes. YOS staff gave good attention to developing soft skills including confidence, self-esteem and ability to form relationships with others. There were, however, no effective systems in place to assess progress in developing these.
5. Assessments of the suitability of children and young people for specific interventions had been considered well enough in just over half of the cases and planning to reduce reoffending was sufficient in three-quarters of cases. There were gaps in reviews and in the delivery of interventions and there was no clear link between planning and the delivery of interventions.
6. In sessions, children and young people engaged well with YOS staff and responded well to the trust that staff built up.
7. There was little evidence of interventions being quality assured. It was not clear how the YOS evaluated the quality of delivery or effectiveness of interventions. When we spoke to children and young people and their parents/carers, however, they were very clear on the value of the work of the YOS.

Comment from a parent/carer

One mother had experienced long-term difficulties in parenting her son and had attended the Parent Drop In to receive support for the past five years. She described her decision to attend as "*the best thing I ever did*" and said that the YOS staff were "*appropriate and professional and go above and beyond their jobs. You can pick up the phone anytime you have a problem and coming to this group has literally changed my life".*

Appendices

Appendix 1 - Background to the inspection

Inspection arrangements

The Full Joint Inspection (FJI) programme inspects youth offending work, predominantly in statutory community and custodial cases, in a small number of local authority areas each year.

The majority of the Youth Offending Teams selected for these inspections are those whose performance – based on reoffending rates, National Youth Justice Outcome Indicators and 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.

The published reoffending rate for Cwm Taf was 43.4% (with an average number of previous offences per offender of 1.40), and 37.9% for all England and Wales (average number of previous offences of 1.25).

The primary purpose of the youth justice system is to reduce offending. This is the main theme of the inspection. The other core themes are protecting the public, protecting the child or young person, making sure the sentence is served and governance and partnerships.

Criteria

A copy of the inspection criteria is available on the HMI Probation website:

http://www.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/

Methodology

YOTs are informed approximately 11 working days prior to the inspection taking place.

Fieldwork for this inspection was undertaken on the weeks commencing:

13 March 2017 and 27 March 2017.

In the first fieldwork week we looked at a representative sample of 35 individual cases up to 12 months old, some current, others terminated. The sample 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 and young people. Cases were assessed by a team of inspection staff. They examined these wherever possible with case managers, who were invited to discuss their work in depth, explain their thinking and identify supporting evidence in the record.

We also received copies of relevant local documents.

During the week in between, the data from the case inspections was collated and a picture about the quality of the work of the YOS developed.

The second fieldwork week is the joint element of the inspection. HMI Probation was joined by colleague inspectors from police, health, social care and education. We explored the lines of enquiry which emerged from the case inspections. The leadership, management and partnership elements of the inspection were assessed, with a particular focus on reducing offending.

We also gathered the views of others, including strategic managers, staff and service users, children and young people, parents/carers and victims, and observed work taking place.

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

Scoring Approach

Details of how our inspection judgements are made can be found on our website.

http://www.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/

Publication arrangements

A draft report is sent to the YOS 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.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/

Role of HMI Probation and Code of Practice

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

www.justiceinspectorates.gov.uk/hmiprobation

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:

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Criminal Justice Joint Inspection

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