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 **Wrexham**

An inspection led by HMI Probation

independent inspection of youth offending work

January 2014

Foreword

This inspection of youth offending work in Wrexham is one of a small number of full joint inspections that we undertake 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 the three National 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 Wrexham primarily because their reported reoffending rates were higher than in most other areas.

We were pleased to find that Wrexham Youth Justice Service (YJS) had made substantial progress since our previous inspection in 2010. A recent reorganisation aligned the YJS alongside youth services, under a single senior management structure. The way that this had been undertaken meant that the specialist skills of the YJS staff were likely to be maintained and strengthened, as was joint work with those services that would continue to provide support to many children and young people once their involvement with the YJS ended. We found much early prevention activity focused within the YJS, or undertaken jointly, indicating the value of this approach.

Partners worked together well at strategic and operational levels, although the effectiveness of the YJS Management Board was limited by the frequent absence of statutory partners. Much of the case management work was of a high standard and service users spoke very highly of their involvement with the YJS, but there were also some significant areas for improvement. The YJS needed to develop greater consistency in its approach to managing work on risk of harm and to ensure that girls and young women engaged in addressing their offending behaviour.

The recommendations made in this report are intended to assist Wrexham YJS and its partners in their continuing improvement by helping them focus on specific key areas. We were impressed with the commitment of the Chair of the YJS Management Board, the Head of Service and other partners to improving work with those who have offended. We were equally impressed with the quality of staff and their clear focus on achieving positive outcomes for the children and young people with whom they worked. In combination, these provide a solid basis for continuing improvements and give us confidence that the findings from this inspection will be acted upon quickly and effectively.

Liz Calderbank
HM Chief Inspector of Probation

January 2014

Summary

Reducing the likelihood of reoffending 

Overall, work to reduce reoffending was satisfactory. Assessments and plans were good, with plans meaningful to children and young people. In contrast referral order contracts were poor. Plans in custodial cases had an appropriate balance between the needs of the institution and the factors that may reduce reoffending in individual cases. Pre-sentence reports were of high quality and concise. Caseworkers had access to a broad range of interventions, which they delivered well; although sufficient attention was not always given to ensuring that children and young people understood the work. Joint work with the Probation Trust provided effective support to those moving to adult services. Information sharing between Children and Adolescent Mental Health Services and case managers needed improvement. Appropriate action was taken by the YJS to address the needs of those with substance misuse problems or who were not in receipt of education, training or employment.

Protecting the public 

Overall, work to protect the public and actual or potential victims was satisfactory. Individual pieces of work often met the needs of the particular case, although plans would benefit from being much clearer. When the caseworker had planned that something would be done, they delivered it. However, these strengths masked an inconsistent approach to risk of harm work. We noted some tension between public protection work and a focus on the needs of the child or young person – when done well public protection work should also reduce the vulnerability of the child or young person. This work would also benefit from a better understanding of Multi-Agency Public Protection Arrangements (MAPPA). Not enough focus was given to known victims. There was good quality targeted work by Children and Adolescent Mental Health Services and substance misuse workers to address risk of harm to others.

Protecting children and young people 

Overall, work to protect children and young people and reduce their vulnerability was satisfactory. Staff within the YJS were effective advocates for children and young people. Assessment and planning generally met the needs of the cases and the right work was done within the YJS to ensure that children and young people were protected and their vulnerability reduced. Work to address substance misuse was good and the YJS had a positive relationship with Children and Adolescent Mental Health Services. Work was needed to ensure that communication with children's social services was consistently effective, although joint work with the leaving care team was strong. Wrexham YJS worked with a substantial number of children and young people who were looked after and placed in Wrexham from elsewhere. They were proactive in seeking to ensure that the particular difficulties caused by this were recognised and overcome.

Ensuring the sentence is served 

Overall, work to ensure that the sentence was served was good. The YJS reaped significant benefits from having access to a Speech and Language Therapist. This made a substantial difference to work with some children and young people; however, the funding for this is temporary and urgent attention is needed to ensure that the positive impact of this is retained. Case managers built positive relationships with children and young people and their parents/carers. There was accurate assessment and appropriate actions taken to address diversity and other factors that may act as barriers to engagement. The YJS had implemented a positive approach to ensuring that progress was recognised and continued improved behaviour encouraged. Where enforcement action was required this met the needs of the case; however, work was needed to ensure that girls and young women engaged fully with the work of the YJS.

Governance 

Overall, governance was not effective. We found good partnership working in Wrexham and commitment to the work of the YJS. However, the robustness of this work was seriously limited by the poor attendance of some statutory partners at the YJS Management Board. Consequently this critical body could not effectively hold partners to account nor, acting as a partnership, hold the YJS to account. Work was underway to address the effectiveness of the Management Board. We were pleased that reducing reoffending by children and young people was reflected in local priorities and there was good knowledge of the work of the YJS. Insufficient attention was given to promoting use of the Welsh language. The views of service users were not routinely collected and collated in order to inform the development and improvement of services.

Recommendations

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

1. Attendance by statutory partners at the YJS Management Board, including from police, health, probation and within the local authority needs to be regular and stable, so that the Board is in a stronger position to provide a strategic lead for the work of the YJS and to hold partners and the YJS to account (Chair of YJS Management Board).
2. There should be a consistent approach to risk of harm work that is clearly focused on the main objective of protecting the public. In particular, plans should be clear and precise, Multi-Agency Public Protection Arrangements well understood and good attention given to the needs of victims (Head of Service).
3. Workers should ensure that their engagement with children and young people to deliver interventions is undertaken using language that is meaningful for those with whom they work, and ensure that the work has been understood (Head of Service).
4. Work is required to ensure that girls and young women engage with the YJS so that effective work can be undertaken to reduce their likelihood of reoffending (Head of Service).
5. Sufficient attention must be given to promotion of the use of the Welsh language in all aspects of YJS work (Chair of YJS Management Board).
6. The Management Board and key partners, particularly education and health, should ensure that the future of work to address speech and language needs is secured (Chair of YJS Management Board).
7. Information sharing arrangements with Children and Adolescent Mental Health Services should be formalised to ensure that consistent information is available and held on the case record about assessments, progress and outcomes from Children and Adolescent Mental Health Services involvement (Head of Service).
8. All staff should recognise when changes in circumstances are significant enough to require a review of assessments or plans, and act on this accordingly (Head of Service).

Please note: names of individuals in this report have been changed to preserve anonymity.

Contents

Reducing the likelihood of reoffending

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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. Assessments were analytical and of good quality.
2. Pre-sentence Reports (PSRs) were concise and met the needs of the court.
3. Plans were child or young person friendly and reflected the assessed reasons for offending.
4. Custodial plans reflected both elements of the sentence and objectives to reduce offending.
5. Interventions were delivered as planned, using appropriate materials that were well understood by staff.
6. Staff did not always give sufficient attention to ensuring that work was understood by children and young people, and sometimes used vocabulary that was not meaningful to them.
7. Good attention was paid to education, training and employment (ETE) and substance misuse needs.
8. There was a valuable Children and Adolescent Mental Health Service (CAMHS), although the quality of information sharing needed to improve.

Explanation of findings

1. Assessment

1.1. Assessments of the likelihood of reoffending were of good quality, being analytical and including a broad range of evidence to support the judgements made. More than three-quarters of assessments and plans were reviewed as required; although there were some cases where a review had not been undertaken following a significant change in circumstances.

Case illustration

The worker, Jo, engaged with Lee at his pace. The assessment was carried out in 'bite sized chunks'. Jo used child friendly language coupled with affirmation. She frequently checked that Lee was clear about the questions being asked and used different approaches and questions to gather the information she needed. At the end Jo invited Lee to tell in his own words what he thought the session was all about.

1.2. Assessment of ETE needs, and their link to the likelihood of reoffending was strong. The YJS education worker worked well to ensure that the initial assessment contained comprehensive information. This included detailed up to date information on behaviour and attendance, attitudes

to education, attainment and preferred learning styles. All children and young people completed an assessment of their learning style. Staff used the assessment well to make sure they met the identified learning needs throughout the sentence. Assessments also paid good attention to communication difficulties of children and young people.

1.3. Assessment of substance misuse and emotional or mental health were equally detailed, although the links between these and the likelihood of reoffending were not always clearly described. CAMHS and substance misuse staff made use of a range of validated assessment and screening tools.

1.4. More attention could be given to assessment of physical health, which was limited to the screening questions on Asset and a screening undertaken following referral to a substance misuse or CAMHS worker. The information about physical health tended to be brief, indicating that exploration of this was unlikely to have been exhaustive. Case Managers were receiving training to implement the routine use of the Health Information Screening Tool (HIST).

Case illustration

In one case a young person had been placed on a course that involved the use of industrial equipment, which he really enjoyed. However, he had to be rapidly withdrawn when it was realised that he suffered from epilepsy. While this was known, it was not clearly recorded and immediately available to anyone who might need to know it.

1.5. PSRs were of a good standard and were more concise than we often find, concentrating on those aspects of the child or young person's behaviour and needs that were of most value to the court. The YJS had made specific efforts to ensure that irrelevant information and repetition were not included. All PSRs had been subject to local quality assurance arrangements before they were submitted to the court. There was evidence that local sentencers valued the quality of PSRs that they received from Wrexham YJS.

Case illustration

Jake had significant communication difficulties. He struggled to understand what was happening in court and the implications of what he had done. A speech and language assessment was attached to the PSR that explained his difficulties, the implications of different sentencing options, and provided advice to the sentencing court on how to engage effectively with him. This report was valued by the court and was influential in informing the outcome.

2. Planning for interventions

2.1. There was sufficient planning in place for work to reduce likelihood of reoffending in all except one case. Plans reflected the reasons for offending that had been identified in the assessment. Case managers ensured that plans for youth rehabilitation orders were written in language that was meaningful to the child or young person, often clearly detailing the change that needed to be made and how that could be achieved. Case managers often made specific efforts to ensure that the plan was understandable where learning or communication needs had been identified.

Case illustration

Owen had significant diagnosed difficulties with literacy and understanding what was said to him. At his first review the case manager spent some time ensuring that Owen understood the progress that he had made and the work he needed to do over the next months. She recognised that giving Owen a copy of the review and plan on the standard template would not meet his needs. She typed a simple review and plan, in a large font using straightforward language that was meaningful to Owen. This also reviewed and congratulated him on his progress, encouraged him to maintain it, provided clear and simple objectives and included pictures as visual triggers to help Owen understand the objectives.

2.2. In contrast, the presentation of referral order contracts was poor. There was evidence that panels engaged with the child or young person to ensure that they understood the implications of what they had done and how they needed to change. However, the contracts listed a number of areas of activity, without making the precise objective of each clear. Neither did they explain what the child or young person's specific responsibility to meet each 'objective' was. This meant that when the child or young person signed the contract to agree to it they were not able to make a fully informed decision about what they were signing. Subsequently, case managers completed an intervention plan and got the child or young person to sign it, as they did for other sentences. While this was valuable in ensuring that the child or young person understood what was expected of them, it misunderstood the role of the referral order contract; this being an agreement between the child or young person, their parents/carers and the panel, not a separate agreement between the child or young person and the case manager.

Case illustration

In a referral order case an inspector observed that at the panel the young person had agreed that 'victim empathy work' would be on his contract, but at the next meeting with his case manager when asked if he understood victim empathy he replied *"I don't know, I haven't got a clue"*

2.3. We were particularly pleased to find that the sentence plans in all inspected custodial cases reflected the behavioural management and other needs of the custodial institution, and the work that needed to be undertaken to address the reasons for offending. This provided a clear message, at the start, that it was one integrated sentence. In our experience it is unusual for all custodial sentence plans to meet this standard. Credit for this must go to the case managers who ensured that the outcomes of the assessment were recognised, and to staff at Hindley Young Offenders Institution who produced the agreed plans.

Case illustration

Tom's sentence plan at the start of his custodial sense included offence-focused work to address his consequential thinking. To help make the link between the need to address his offending and the importance of behaving well in custody the objective in his plan about improving his thinking also included a specific target to stay adjudication free.

3. Delivery of interventions

3.1. In more than three-quarters of the cases staff delivered the interventions that they had planned and that the case needed, although formal reviews were not always undertaken when needed. In the great majority of cases, where these were required, interventions had been delivered to address emotional or mental health, substance misuse, self-perception and attitudes to offending. However, not enough attention was given to timely interventions to address physical health and family relationships, in particular when these were linked to the likelihood of reoffending.

3.2. We were pleased to find that records of intervention sessions were well structured, comprehensive and included an element of continuous review. We were able to identify what had been planned, what actually occurred and what the caseworker's assessment was following the session.

3.3. The YJS had access to a broad range of intervention materials and understood where these needed to be extended, although they did not have any immediately available in the Welsh language. They said that if this was required they would get the materials translated. In our view this does not sufficiently address the equal promotion of both languages that should be apparent throughout the YJS.

3.4. The materials and resources used to deliver interventions were of good quality, and were delivered in a way that maintained the integrity of their design. Case managers showed creativity in the way that they used interventions to meet the needs of the children and young people.

Comment from a child or young person

"we done a board game...to show me when I get angry and how to stop myself, I feel like I can control my anger now...I know when to stand back"

3.5. Sufficient attention was given to restorative justice in over three-quarters of the cases where it was appropriate. Restorative justice training had been provided to some staff, who had begun to use these skills to plan conferences. While this is only a start, it is encouraging to hear that these skills are being used.

3.6. We were able to observe a broad range of work being undertaken with children and young people. Workers knew and understood the children and young people well, were engaging and positive in their approach, had a good understanding of the intervention materials they were using, and made good use of affirmation in encouraging desistance.

3.7. Some sessions were delivered to a high standard. However we had two particular concerns. Firstly, the vocabulary, terms and jargon used with children and young people were sometimes those where the meaning was commonly recognised by professionals, but they were not translated into terms likely to be understood by children and young people.

3.8. Secondly, staff sometimes did too much of the talking, meaning that they missed clues worthy of further exploration and provided insufficient opportunity for children and young people to confirm their understanding – for example by summarising back the learning in their own words or explaining what they should now do differently. Sometimes there was insufficient exploration of the meaning of yes or no answers, in particular when confirming understanding.

3.9. The YJS had begun to undertake observations itself. We would encourage the development of this approach, including through the use of peer observation to support sharing and development of practice, rather than solely as a quality assurance tool.

3.10. Substance misuse workers used assessment and intervention (psycho-educational) materials that were appropriate and motivating, resulting in good engagement and successful completion.

3.11. Case managers paid good attention to ETE needs. They liaised well with the YJS education worker and kept her involved at the appropriate points. In one good example, following a meeting to review risk of harm to others good attention was given to planning ahead regarding education plans.

3.12. There was a positive process in place for managing the transition to probation as children and young people reached 18 years old. The focus was on ensuring the young person did not encounter a marked difference in approach as the case was transferred. A clear protocol was in place to support the approach. The frequency of

Comments from inspectors

Inspectors made the following observations:

"...no-one asked him to tell [those present] what he thought he was required to do. . . the language used was often academic or jargon, words such as de-brief, social ownership, conflict management... , all of which could have been replaced with explanations meaningful to him"

"...the case manager introduced the exercise clearly. Appropriate space was given to the young person to answer the questions that were asked. Silence was used well and the session progressed at a pace that the young person could cope with. There was good examination of why the young person expressed things in the meeting and had done [things]..."

appointments arranged initially at probation reflected the intensity that existed in the YJS, further helping ensure that the young person did not experience a sudden drop in the support available to them at a risky stage in their life.

Youth to Adult transition (Y2A)

Young people approaching 18 are considered for inclusion on the adult Integrated Offender Management Scheme, known locally as 8-Ways. The matrix for inclusion on the scheme is applied to all those subject to transfer. Staff from the YJS attend meetings with 8-Ways staff to consider the benefits of inclusion and ensure a smooth handover. Irrespective of whether inclusion in the scheme is appropriate, young people are allocated to the scheme offender manager, who understands the work of the YJS and can therefore provide effective support. Those who are not suitable for longer term inclusion are still managed within it for the first three months, until their transition has been stabilised, and are not removed until their situation has been reviewed. An example of how this joint working can be effective is a case of a young man who was receiving educational support within the YJS. To ensure continuity the YJS worker continued to provide support at probation alongside an ETE specified activity. This continuity proved beneficial both to the young person and to effective information sharing between caseworkers.

3.13. There were four cases where the child or young person had moved into Wrexham during the sentence. In two of these the transfer was not effective in maintaining the continuity of services, due to difficulties in getting the required information from the home YOT, including following escalation to managers. Wrexham YJS was doing what it reasonably could to improve the management of transfers and used a transfer forum to review each case as it was received.

3.14. Records of assessments, interventions and outcomes carried out within CAMHS, following referral by the YJS, were not generally available in the YJS case management systems, other than basic information such as waiting times. As a result, important information was not immediately available to any caseworker who might need it. The CAMHS nurse kept her records in separate files which were housed on a different site. There was no interface between the system used by CAMHS and the YJS, so only the CAMHS worker in the YJS was able to access that information. Concerns about the sharing of information can often be overcome through seeking consent from the individual to make it available to others who may need to know it, supported by an information sharing agreement that defines how that information can be used.

Case illustration

Jack had significant mental health problems. His mother raised concerns that Jack was consuming high levels of energy drinks which exacerbated his sleep problems and may have implications for his medication. The case manager made an immediate referral to the substance misuse worker who visited Jack within two days and worked with him to plan a reduction in his use of the drinks. This was very successful. The case manager also wrote to his General Practitioner to inform her.

3.15. Substance misuse workers recognised the importance of diversionary activities to help reduce substance misuse and offending behaviour. They organised opportunities to attend the gym, and participate in sporting and recreational activities. Their programmes also included opportunities to gain Open College Network (OCN) qualifications, which influenced self-esteem and may help provide motivation to gain other qualifications. These were likely to help reduce substance misuse and offending behaviour.

Case illustration

Kyle lacked appropriate self-esteem. This was significant in his offending as he did not consider that he was worth anything and saw no reason to change. He 'acted blasé' but had no real confidence. As part of his reparation he worked cleaning out the chicken coop maintained by the YJS. He was scared of getting involved with the birds but did not want to show it. The case manager was able to use the fact that he had overcome his fear as evidence that he was able to change and make a positive contribution. He obtained an OCN certificate in small animal care. In combination, these helped Kyle improve his self-esteem and gave him an alternative way of looking at himself.

4. Initial outcomes

4.1. Outcome measures for the work of CAMHS and substance misuse staff were in a process of development. Some pre and post-intervention measures were taken, reflecting progress in the specialist area of work. No data was currently available on the relationships of (health work) outcomes to the likelihood of reoffending. A research study was, however, examining Asset data and reoffending since 2009. This includes all referrals made to the YJS CAMHS service. It will examine patterns and should reflect the impact of the CAMHS input on reoffending.

4.2. There had been a reduction in the frequency and seriousness of offending, since the start of the current sentence or release from custody in over half of the cases where there was a recent offending history to assess.

4.3. The offending-related areas where improvements were most common were substance misuse, perception of self and others, motivation to change, living arrangements and attitudes to offending. The areas where improvements were less frequent related to lifestyle and ETE. The integration with youth services and move into the Lifelong Learning department is a particular opportunity to improve lifestyles, and to ensure that case managers give more attention to ensuring that positive outcomes are sustainable following the end of the sentence, including through development of a clear exit strategy.

Comments from parents/carers

"his behaviour before coming to the YOT wasn't good... his friends and his views were pretty blinkered but now after working with the YJS he's positive and more focussed".

"it's become good to look back on, because he is a good boy and they've now really brought that out of him".

5. Leadership, management and partnership

5.1. Case managers had access to sufficient resources for work to reduce the likelihood of reoffending. CAMHS staff, a Speech and Language Therapist (SALT), substance misuse workers and an ETE worker were based in and well integrated into the YJS. Case managers reported excellent opportunities for both formal and informal case discussions.

5.2. There were effective referral processes to alert the YJS when children and young people had been dealt with by the police and received a charge or a less formal sanction. This alerted the YJS to the action taken or requested assistance in determining the appropriate outcome. Police officers completed a form called a YOF8, which was submitted securely online. A yellow card scheme was operated by North Wales Police in partnership with other local agencies, where children and young people were informally warned about antisocial behaviour. There was some duplication in the information produced on a yellow card and on the YOF8. This has been recognised and is subject to review to ensure clarity in responsibilities for contacting families.

5.3. One of the fields on the YOF8 form asked whether the victim consents to their details being passed to the YJS to allow them to make contact. The form simply contained a yes/no tick box without any context or explanation as to why this may be beneficial to the victim. It is believed that this had a significant impact on the likelihood of victims accepting contact, with many forms having a 'no' response. It would be helpful if the wording on this form provided more assistance to officers in explaining the benefits of contact with the YJS. In any event it is essential that victims understand the potential benefits of engagement with the YJS before they are asked to answer this question.

5.4. Access to police IT systems from the YJS office was problematic. We understood that this had been like this for a considerable period of time. As a key part of the role is reliant upon access to police systems, in order to assess risks to young people and receive and share intelligence; this requires urgent attention. Inspectors also commented that the performance of the main YJS case management system was much slower and less reliable than is common. We were pleased to find that the YJS now had an experienced champion for the use of the Careworks system, whose role included helping case managers make more effective use of its potential.

5.5. Case managers had a good understanding of the principles of effective practice with children and young people who have offended.

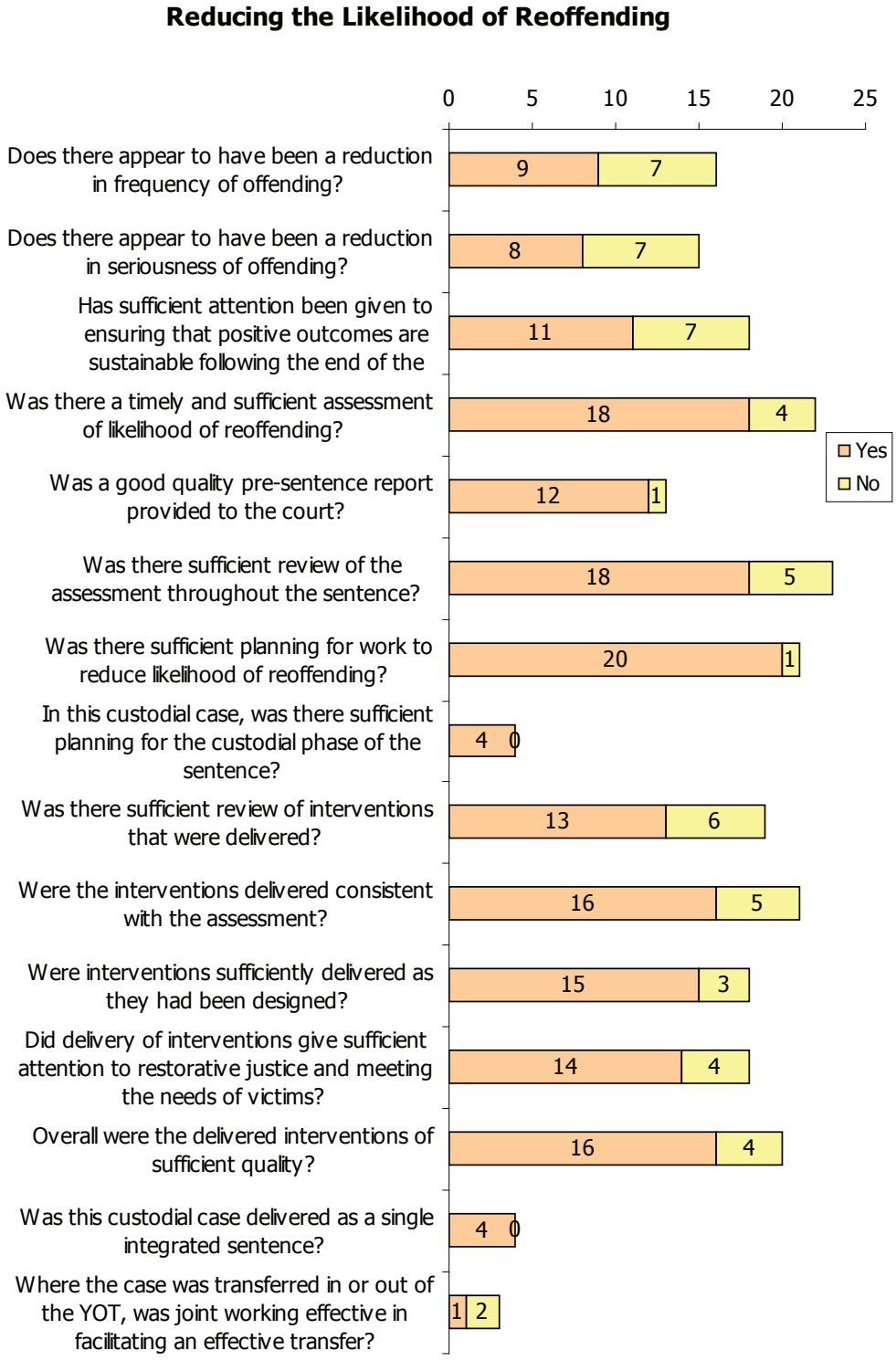
5.6. There was a valuable service from the CAMHS Consultant who worked in the YJS one half day per fortnight; providing supervision, consultancy, and advice to staff as well as assessments and therapy for children and young people. This effectively provided a 'fast track' referral into CAMHS, because even if they were not treated by him, the consultant could refer children and young people directly to colleagues for specialist treatment. In view of the proportion of children and young people who had severe mental health issues, this shows a good response to local need.

Summary

Overall, work to reduce reoffending was satisfactory. Assessments and plans were good, with plans meaningful to children and young people. In contrast referral order contracts were poor. Plans in custodial cases had an appropriate balance between the needs of the institution and the factors that may reduce reoffending in individual cases. PSRs were of high quality and concise. Caseworkers had access to a broad range of interventions, which they delivered well; although sufficient attention was not always given to ensuring that children and young people understood the work. Joint work with the Probation Trust provided effective support to those moving to adult services. Information sharing between CAMHS and case managers needed improvement. Appropriate action was taken by the YJS to address the needs of those with substance misuse problems or who were not in receipt of ETE.

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

2

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 71% of work to protect the public was done well enough.

Key Findings

1. PSRs included an appropriate assessment of risk of harm to others.
2. The approach to public protection work was inconsistent.
3. Multi-Agency Public Protection Arrangements (MAPPA) were not well understood.
4. Planning was sufficient in just under three-quarters of cases, but with substantive areas for improvement.
5. Interventions delivered to manage risk of harm to others were normally consistent with the needs of the case.
6. More attention should to be given to the needs of victims, although victims that became involved with the YJS spoke positively about it.
7. The internal risk management meeting and oversight by managers could be more effective.
8. Reviews were not always undertaken following significant events.
9. There was an opportunity to make wider use of the YJS police officer.

Explanation of findings

1. Assessment

1.1. Just under three-quarters of assessments of the risk of harm to others were good enough. The main area for improvement was that other relevant behaviour was ignored, including behaviour that occurred a couple of years ago but was clearly part of a continuing pattern. Insufficient account was taken of known actual or potential victims.

1.2. Reviews of risk of harm to others were sufficient in just under two-thirds of cases. As with work to reduce the likelihood of reoffending, the most common reason for insufficiency was that significant events were not recognised as being triggers for review. The YJS now operates in a climate where national standards for formal reviews are less frequent. Therefore, it is even more important that the need for a review is recognised following significant events.

1.3. We were pleased to find that all except one inspected PSR included an appropriate assessment of risk of harm to others.

1.4. Overall, we found an inconsistent approach to risk of harm work, with some staff clearly understanding and working to the underlying principles of public protection work; while others

focused too much on guidance, processes or classifications, which were sometimes out of date or unhelpful. We noted some tension between public protection work and a focus on the needs of the child or young person – when done well, public protection work should also reduce the vulnerability of the child or young person.

1.5. When requested, health staff attended meetings and contributed to assessments of risk of harm to others, contributing their expertise on mental health/substance misuse/speech and language.

2. Planning for interventions

2.1. Planning for work to manage risk of harm to others was sufficient in less than three-quarters of cases where this was required. The most common reason for insufficiency was that not enough attention had been given to victims' issues, and sometimes consideration had not been given to the potential for MAPPA to contribute to management of the case.

2.2. Most plans made reference to the required actions. However, their presentation was often formulaic and presented in terms of standard processes that would be undertaken anyway. They did not work effectively as a means of communicating a clear and precise plan to everyone who would need to know it, where everyone would be clear on what part they had to play and when they needed to do it. More consideration needed to be given to ensuring that the contingency part of the plan included precise actions. Almost half of the reviews of plans were insufficient, normally because the review had not been undertaken at the time when it had been decided it would be needed.

2.3. It was evident that detailed working knowledge of MAPPA, a clear understanding of the thresholds for referring Category 3 cases, and understanding of the potential benefits of formal or informal engagement with MAPPA were inconsistent across the YJS. An example was a view sometimes stated that MAPPA thresholds were high; whereas the evidence was that the MAPPA profile in North Wales was not high. The North Wales MAPPA coordinator has offered to provide training to staff of local criminal justice agencies, including YOTs, and some other YOTs in North Wales had already taken up this valuable opportunity.

2.4. The YJS has strengthened its direct work with victims. Whenever contact can be made with a victim the victim worker seeks to undertake an impact assessment of the victim's experience to inform the work of case managers. However, more needs to be done to ensure that risk management planning is fully and consistently informed by victims' concerns.

3. Delivery of interventions

3.1. In over three-quarters of cases the actions actually undertaken to manage risk of harm to others were consistent with the assessment and plan of work in the case. Indeed, in the great majority of cases the work done met the needs of the case, irrespective of whether it had been reflected in the planning.

3.2. Reviews of assessments and plans sometimes did not reflect significant changes in the case. However on a day to day basis the actual actions taken were sufficient in more than three-quarters of the cases. The cases where this was not good enough were sometimes those where risk of harm was escalating. In particular case managers needed to be more aware of the potential of referral to MAPPA later on during the sentence, as circumstances changed.

3.3. Targeted interventions by the CAMHS nurse and substance misuse worker to address specific difficulties, for example anger management or mephedrone[1] use, helped to reduce risk of harm to others.

4. Initial outcomes

4.1. We met three victims of offending by children and young people. All spoke positively about the

1 Mephedrone is a 'legal high' often known by it's nickname 'MCAT'.

support they received from the YJS and said that the victim worker would personally seek to advocate on their behalf with the police, victim support and other agencies to enable them to feel safer.

4.2. However, this appeared to happen because of the direct engagement between the victim worker and the victims, rather than as a result of proper assessment and planning in the case. Overall, the risk of harm to actual or potential victims had been managed sufficiently well in less than half of the cases where this was required, primarily because their needs had not been recognised in the assessment and planning.

4.3. Largely as a consequence of this, and due to other shortcomings in planning and assessment described in previous paragraphs, overall the YJS had not done enough to keep to a minimum the individual's risk of harm to others in almost one-third of cases.

5. Leadership, management and partnership

5.1. None of the inspected cases had required referral to MAPPA at the time of the initial assessment and planning. However, it was reported by the MAPPA coordinator and others that, when the YJS did make a referral to MAPPA, engagement in MAPPA meetings involving children and young people had been good; although the coordinator also stated that while most organisations attended these with a case manager and a member of the Management Team, Wrexham YJS usually brought a larger group of staff. This was considered unnecessary.

5.2. There was no identifiable single point-of-contact for MAPPA issues within the YJS. Other local criminal justice agencies adopt this approach in order to increase the quality of operational management around MAPPA, increase familiarity with the processes and support consistency in attendance at MAPPA meetings. We recommend that the YJS considers a similar approach.

5.3. The deployment of the police officer in the YJS is effective, and broadly in line with current guidance. However, YOTs are encouraged to utilise the specific skills that a police officer brings to the team. One such role can be to provide a point of advice to other staff for cases considered to be higher risk (either of vulnerability, risk of causing harm to others or likelihood of reoffending) to consider what other police resources can be utilised to help deal with that risk. In Wrexham, case managers did not routinely involve the police officer in such cases and the officer was not routinely involved in Risk Management Meetings.

5.4. Another key function is to support breach action, either directly or through liaison with police colleagues and departments, where this is required. While there was evidence of good liaison with local neighbourhood police teams, and other forces to deal with other specific issues, there was no routine referral of breach cases, where the child or young person was subject to warrant, to the YJS police officer to progress.

Case illustration

A warrant issued (without bail) for non-compliance with an order had been in existence for some six weeks before the inspection and yet there was no record of any attempts to try and detain the young person in spite of their probable whereabouts being known. This young person was also vulnerable, which increased the importance of early action.

5.5. The YJS used a Risk Management Meeting forum that sought to provide robust oversight of cases assessed as high Risk of Serious Harm to others. This was an excellent idea. However, while there was some evidence of discussion in this meeting being valuable to the management of the case, overall we did not consider that the forum was working effectively. For example, outcomes from the meeting were often unclear, as was the frequency with which meetings were held – in some cases we found an excessively long gap between meetings. When comments were made about

assessment or risk management plans there was not a robust process in place to ensure that they were addressed. Comments made to us indicated that the discussion sometimes focused too much on the appropriateness of a classification and whether guidance was followed, rather than a more open discussion on whether the right things were being done in the case. We did not consider that the role of this meeting was clearly understood by all staff.

5.6. Overall, management oversight of risk of harm work was not effective in almost half of the cases where this was required. In some cases this was because oversight had not been provided when it should have been, but the main reason was that deficiencies in assessment and planning had not been adequately addressed.

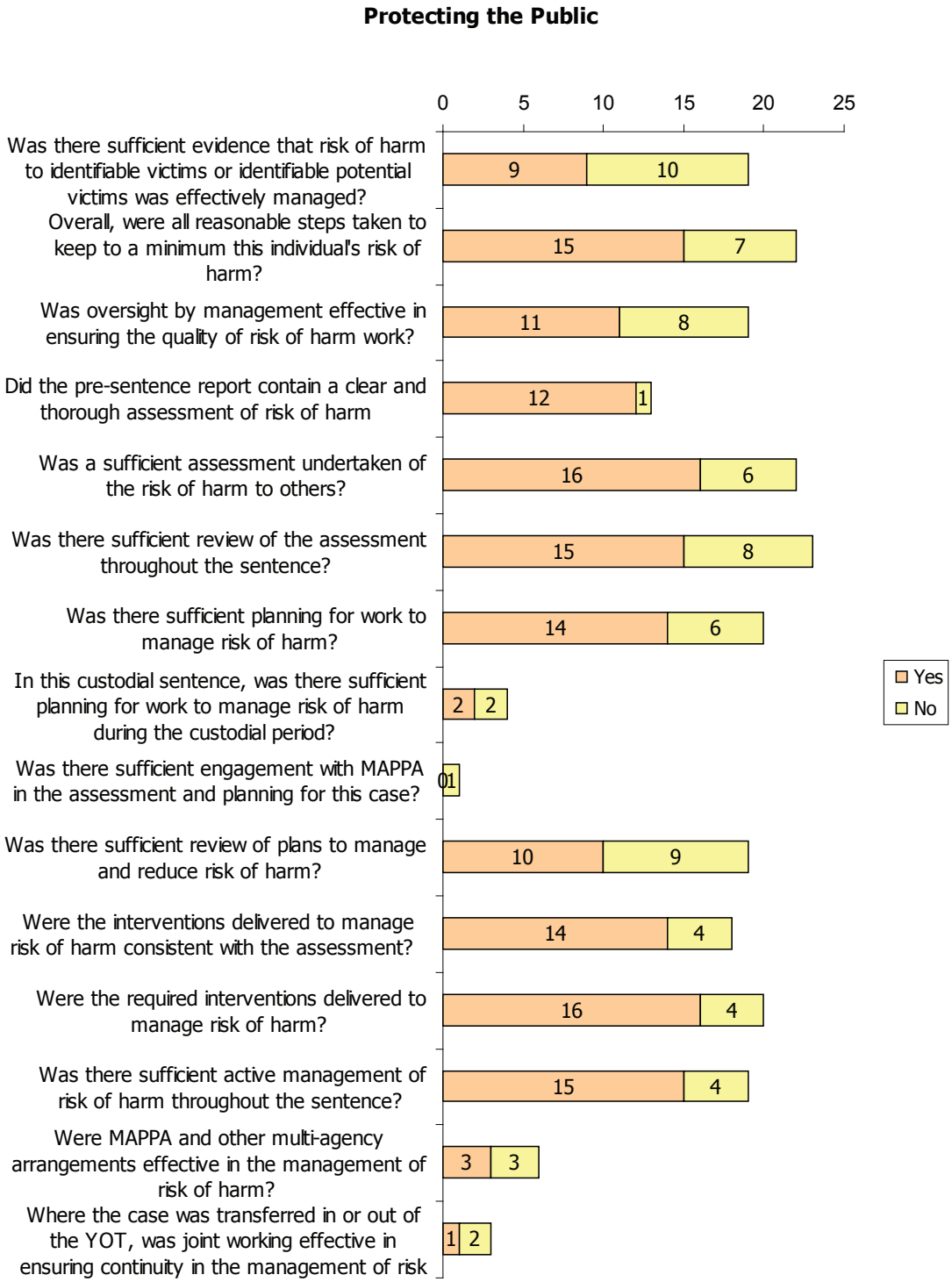
5.7. We were pleased to see that the YJS had a clear policy and procedures for the management of risk of harm to others, which was understood by staff. If implemented robustly this should lead to a rapid improvement in this aspect of work.

Summary

Overall, work to protect the public and actual or potential victims was satisfactory. Individual pieces of work often met the needs of the particular case, although plans would benefit from being much clearer. When the case worker had planned that something would be done, they delivered it. However these strengths masked an inconsistent approach to risk of harm work. We noted some tension between public protection work and a focus on the needs of the child or young person – when done well public protection work should also reduce the vulnerability of the child or young person. This work would also benefit from a better understanding of MAPPA. Not enough focus was given to known victims. There was good quality targeted work by CAMHS and substance misuse workers to address risk of harm to others.

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 78% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. Assessments were good but reviews needed to be undertaken more often following significant changes.
2. The use of the Speech and Language Therapist is excellent, but more needs to be done to assess intellectual functioning.
3. Planning and the delivery of interventions met the needs of the cases.
4. Insufficient consideration is given to physical health.
5. There are well established relationships with children's social care services but more needs to be done to ensure that joint working is better recorded and roles understood.
6. Resettlement and Transfer panels are positive initiatives.
7. Oversight by managers could be more effective.
8. There is a clear and consistent focus on the needs of the child or young person.

Explanation of findings

1. Assessment

1.1. Over three-quarters of assessments of vulnerability were good enough, although on occasions the assessment had not recognised and pulled together the breadth of vulnerability factors that existed in a case. However, reviews of assessments and plans were sometimes not undertaken as required - often the case manager had not recognised the need to do this following a significant change in circumstances.

1.2. The great majority of PSRs included a clear and thorough assessment of vulnerability and safeguarding needs. This clarity had been helped by the emphasis on making PSRs more concise and removing unnecessary elements of the child or young person's history.

1.3. No cases were seen in which an assessment of intellectual functioning had been undertaken. Information in some cases suggested that there might well have been an unidentified learning disability. Children and young people at Wrexham YJS have the advantage of a SALT to assess their comprehension, but this does not equate to a full assessment of intellectual functioning including

reasoning ability and memory. Such factors are of crucial importance in relation to vulnerability and to inform work to reduce the likelihood of reoffending. We suggest that assessment should include consideration of whether there might be an unidentified learning disability. A protocol should then be adopted for staff to refer such cases to the SALT for an assessment and then, if appropriate, to CAMHS for an assessment by the Learning Disabilities Team.

2. Planning for interventions

2.1. Planning in the YJS for work to address safeguarding needs and to reduce the vulnerability of the child or young person was good enough in almost all cases, although plans could often be clearer and more precise. However, in one-third of relevant cases plans gave insufficient consideration to physical health needs.

2.2. Generally we found there was a well established working relationship between the YJS and departments within children's social services and particularly so between the YJS and the Leaving Care Team. We saw that if any issues arose these were usually resolved informally without recourse to escalation. Staff reported that they were confident regarding their ability to constructively challenge each other and if necessary could escalate issues where there were professional disagreements about a case or case decision such as a threshold dispute or case closure. Relationships are such that these issues appeared to be mainly resolved between social workers and case managers or at team manager level.

Close working relationships with the Leaving Care Team

Staff interviewed highlighted particularly close working relationships between the YJS and the Leaving Care Team. Staff were confident that their respective roles were understood and interventions were coordinated. As an example of this: in one case the pathway plan addressed the leaving care arrangements but also explicitly incorporated objectives that reflected the work being undertaken by the YJS to reduce reoffending.

2.3. It was not always possible to evidence the effectiveness of communication between the YJS and other teams, as it was not well reflected in the recording of the YJS or the Social Services assessments, plans or diary records. Issues included: lack of comprehensive chronologies which meant it was not easy to identify what progress had been made in the case; insufficient evidence on case files in both services that shared assessments and plans were aligned to meet the holistic needs of the child or young person rather than those related to the individual 'process' needs of services drawing up the document; and lack of clarity about whether or not assessments were appropriately shared once completed. Similarly, we could not always identify the contribution made by the YJS to core assessments although we were aware that changes to the core assessment template to make contributions from partners more explicit were underway.

2.4. The joint approach to resettlement planning (making arrangements for leaving care and/or release from custody) taken by the YJS and the Leaving Care Team seemed to be a positive approach to dealing with some of the most challenging work faced by both teams. Similarly, the Transfer Panel that addressed difficulties associated with children and young people being placed in Wrexham by other authorities was both a pragmatic and a positive initiative. We saw this panel as a clear attempt to manage the risks and complexity of need presented by many of these children and young people.

3. Delivery of interventions

3.1. In the great majority of cases the YJS had delivered the required interventions throughout the sentence to address safeguarding needs and reduce vulnerability. In three-quarters of cases the interventions that were delivered were consistent with the assessment and plan – where they weren't it was due to shortcomings in the assessment or planning.

Case illustration

Poor parenting and drug use meant that Charlie did not get the support he needed to attend CAMHS appointments at the hospital. The case manager took Charlie to his appointments and waited outside for him, and then arranged YJS appointments nearer his home as his mother would not provide bus fares.

3.2. We noted that closing summaries were completed by children's social services at the end of their involvement in a case, including those where the YJS was involved, and that audits were undertaken by children's social services managers at the point of closure. However, these would benefit from more detail regarding why the decision to close involvement had been made, alongside more clarity about outstanding issues and expectations agreed with partner agencies, such as the YJS, that were continuing to work with the family.

3.3. Health staff worked closely with others, particularly case managers, to protect children and young people and reduce their vulnerability. The ease of access resulting from their co-location and their good working relationships facilitated communication on a day-by-day basis.

4. Initial outcomes

4.1. Overall, management of safeguarding and vulnerability needs by the case manager was sufficiently active and effective throughout the delivery of interventions in the great majority of cases that we inspected.

4.2. Oversight by managers was effective in just over half the cases where it was required. Where it was not effective there was a mixture of reasons – in particular deficiencies in assessment and planning not being addressed and in a few cases oversight had not been provided when it was required. In these cases, effective use of IT systems could have alerted the manager to the need to provide oversight.

4.3. In all cases, we considered that the case manager had sufficient access to the resources that they needed work to address safeguarding needs and reduce vulnerability.

5. Leadership, management and partnership

5.1. General partnership working by the YJS with the police was a strength, with good involvement at local strategic partnership level with the Head of Service, and active involvement at operational management level in sub-groups. There was particularly active involvement in groups on domestic abuse, dealing with sexual violence and child sexual exploitation (CSE). YJS staff were aware of the local process for referring any concerns about CSE.

5.2. There was a shared positive ethos that all services for children and young people were 'as one' and that the focus was always on improving outcomes for children and young people. We found that all staff demonstrated a focus on the child or young person and services were put in place to maintain the safety of children and young people.

5.3. When issues were raised with managers, the outcome was not always reflected in the file and the justification for decisions was not always recorded. Professional challenge is constructive and

Comments from parent/carer

"my daughter had slipped through the net, only when she offended was she finally getting the help she needed, but it's too late now...she has offended...we'd been told there was nothing wrong when she was younger...but she can't even tell the time, or read and write...the YJS finally gave me the voice I needed, CAMHS was pushed forward, she was finally diagnosed and she received help".

promotes rigour in decision-making but it is important that the decisions are recorded and that staff are provided with clear feedback if good working relationships are to be maintained between teams.

5.4. Children and young people have quicker access to CAMHS specialist services if they are referred through the CAMHS consultant or nurse who work within the YJS team. It was brought to our attention that some children or young people with significant mental health issues were unable to access CAMHS, due to their waiting list, until they offended. Cases were seen where referrals had previously been made through education or children's social services staff and several months had elapsed without them receiving an initial appointment.

5.5. The substance misuse workers were well trained to keep abreast of emerging synthetic drugs and were part of In2change, the Wrexham young person's drug and alcohol team.

Summary

Overall, work to protect children and young people and reduce their vulnerability was satisfactory. Staff within the YJS were effective advocates for children and young people. Assessment and planning generally met the needs of the cases and the right work was done within the YJS to ensure that children and young people were protected and their vulnerability reduced. Work to address substance misuse was good and the YJS had a positive relationship with CAMHS. Work was needed to ensure that communication with children's social services was consistently effective, although joint work with the leaving care team was strong. Wrexham YJS worked with a substantial number of children and young people who were looked after and placed in Wrexham from elsewhere. They were proactive in seeking to ensure that the particular difficulties caused by this were recognised and overcome.

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. Assessment of diversity factors and barriers to engagement was good, with plans put in place and delivered to address these.
2. The SALT provided an excellent service that was valued by both staff and partners.
3. Children and young people and their parents/carers spoke positively about their engagement with the YJS.
4. Children and young people and their parents/carers were involved in the development of assessments, PSRs and plans.
5. There was a particular difficulty getting girls and young women motivated to engage with the YJS, without which the YJS did not have the opportunity to address their offending.
6. Partnership work with ETE providers was good.
7. Appropriate decisions were made when enforcement action was required, but the compliance panel was not effective.
8. The Review and Congratulate Panel was an excellent way of affirming progress and encouraging improved behaviours to continue.

Explanation of findings

1. Assessment

1.1. Assessment of diversity factors and barriers to engagement was good enough in the great majority of cases.

1.2. There was sufficient engagement with children and young people and their parents/carers to carry out the initial assessment in well over three-quarters of cases. The views of children and young people and their parents/carers were apparent in many of the assessments that we inspected. However, there were a few cases where insufficient attempts had been made to engage with the parent/carers.

1.3. The child or young person and their parent/carer were sufficiently engaged in the great majority of PSRs.

1.4. PSRs gave sufficient attention to relevant diversity factors and potential barriers to engagement. In one PSR there was a thorough assessment of a young person's learning needs. This included a comprehensive report of a speech and language assessment. This identified strategies for the court to use to help the young person understand the court process.

1.5. The child or young person had been asked for their preference about whether they wished to work using Welsh or English in every case that we inspected.

1.6. The YJS had access to a half-time SALT. This was a very valuable service. The SALT worked closely with staff and others, providing assessments and advice on how to engage children and young people in a way that ensured good comprehension. Staff made a referral if there were concerns about levels of understanding. The SALT conducted a thorough assessment and produced a detailed report and recommendations about assisting with communication and understanding. For one young person working with the YJS, the SALT worked closely with staff in a children's home, in others she provided training and resources to education staff.

2. Planning for interventions

2.1. Planning gave sufficient attention to diversity factors and barriers to engagement in all except two cases. In some good examples, YJS workers adapted plans to meet the learning needs of children and young people.

2.2. The child or young person and their parent/carer had been sufficiently involved in the planning in the great majority of cases, so that the plan also reflected their views on priorities for where change needed to be made.

2.3. When asking children and young people to sign their intervention plans, case managers would read them out and ensure that they were understood. The child or young person would then sign to confirm that the plan had been read to them and that they understood it.

2.4. The SALT developed helpful coping strategies for the children and young people themselves and also made recommendations to other professionals to help ensure their working methods would be successful. Where appropriate these were reflected in plans.

3. Delivery of interventions

3.1. In two out of the four inspected cases that were transferred in from other areas, joint work was not effective in ensuring a smooth transfer and continuity of delivery of the sentence. However, this was due to shortcomings in the information provided to the YJS. The YJS had done all that was reasonable to address these difficulties, including by escalating it within the child or young person's home YOT.

3.2. Overall, the child or young person and their parent/carer or significant others had been meaningfully and effectively engaged throughout the delivery of the sentence in well over three-quarters of cases. However, there were a few cases of girls or young women where there was insufficient evidence of sufficient work being done to motivate them to comply.

3.3. The YJS worked well with ETE providers to make sure that children and young people, who wanted to, could receive their education through the medium of Welsh. For example, where home tutoring was arranged, the local authority would allocate Welsh speaking tutors.

Case illustration

Lee was unable to return to his previous school because of the nature of his offending, but was keen to take his exams. The YJS and local authority worked together to find him a suitable Welsh medium school in a neighbouring authority as there were no other suitable schools in Wrexham.

3.4. 3The YJS also worked actively with a wide range of ETE providers to ensure that children and young people in the YJS achieved their full potential. Partners valued the help and support they received in helping them to manage any potential risks posed by the children and young people attending their provision.

3.5. There was very good partnership working with the local college to increase the number of young people with offending backgrounds who accessed college provision. The college received good advice and support on how to carry out risk assessments on young people who presented a raised risk of harm to others. A few YJS young people have progressed from the college to full time employment.

Comments from child or young person

"I just want them to hurry up and get me back to school...the [temporary provision] is 's!&' and they haven't got a clue there, so I just can't be bothered going there anymore".*

3.6. Other providers used a stepped approach to engage with children and young people and get them ready for work.

3.7. The YJS worked effectively with Careers Wales to secure ETE places. In one good example, the careers officer and the YJS supported a young person through points of transition into, through and out of custody. The close partnership work ensured a smooth transition out of custody into a training place.

3.8. In a very few cases, children and young people did not receive the education they were entitled to. They received only a few hours each week and this did not always meet their educational needs. The local authority had been too slow in arranging suitable alternative provision. Plans to manage the return to education of reluctant pupils were not always robust enough. For example, in one case where the YJS staff had worked hard to re-motivate a child or young person and where significant progress had been made, this was being put at risk by delays in reintegrating him.

Comments from parent/carer

"if they send a letter to him then I can't open it and I don't know what's going on and I want to be more involved".

3.9. Administrative support staff supported the work of case managers by sending a text message to all children and young people and, where requested, also their parents/ carers, reminding them of their appointments at the YJS. One young person said to us "*yeah, the texts never let you have an excuse for forgetting you've got an appointment*".

3.10. We met seven children and young people and three parents/carers. All spoke very positively about the quality of relationship between the child or young person and their case manager. The children and young people felt that case managers tried to listen to them and understand them.

4. Initial outcomes

4.1. The YJS had given sufficient overall attention to health and well-being, in particular as these may act as a barrier to effective outcomes, in the great majority of cases.

Review and Congratulate Panels

These were chaired by a YJS manager and included the case manager, child or young person, parent/ carer and a magistrate from the local youth bench. Their purpose was to congratulate the child or young person for the progress they had made and affirm a baseline for their future behaviour. The case manager explained what work had been done and what progress the young person had made. The magistrate then focused on the offence, victims and the need to maintain progress. The meeting ended with a handshake with all present at the meeting. It was followed up by a letter from the Chair confirming what had been said. This was valued by parents/carers and children and young people, who were not used to receiving praise.

4.2. Sufficient attention had been given, throughout the sentence, to identifying and responding to diversity factors and barriers to engagement in well over three-quarters of cases. There were a small

number of cases where the impact of the child or young person's vulnerability on the outcomes from the case had not been sufficiently recognised and addressed.

4.3. In the great majority of cases enough attention had been given to ensuring that the child or young person engaged with the YJS and met the requirements of the sentence. However, there were a number of cases of girls and young women where more should have been done. Unless they engaged with the work of the YJS, there was no opportunity to address the causes of their offending behaviour.

4.4. Over half of the children and young people did not comply fully with the requirements of the sentence. The decisions made following non-compliance were appropriate in all except one of these cases. However, if more had been done to ensure that some girls and women complied with their sentence they may not have needed to be returned to court following its breach.

Comments from parent/carer

One Parent provided a helpful reminder that YJS staff also had responsibilities to model good behaviour with children and young people - *"if they do not turn up on time [to take him to reparation] how can they expect the child to?"*

4.5. The YJS used a Compliance Panel to seek to engage with children and young people to understand the reasons for their non-compliance and to put in place strategies to address any barriers to future engagement. This was an excellent idea, however panels were not always used effectively. Not enough was always done to ensure that both the child or young person and their parent/carer attended the panel. They needed to be clearer on the decisions and actions that arose from them, with precise action plans which were confirmed, preferably in writing, with the child or young person and their parent/carer.

4.6. Review and Congratulate Panels were used as a positive approach to affirming and reinforcing progress. Whilst these worked well (see example above) sometimes more opportunity could be given to the child or young person to explain what they thought they had done well.

4.7. While physical health was not systematically assessed, substance misuse workers and the CAMHS nurse did their own general health screening and signposted children and young people to appropriate services, for example the Information Shop in Wrexham which provided confidential sexual health and other advice. Substance misuse workers provided advice on all aspects of health. They were starting a substance analysis service; so that children and young people could have substances analysed and find out about likely side effects.

5. Leadership, management and partnership

5.1. The SALT made a significant contribution to ensuring that staff in the YJS and externally (for example, in education settings and care homes) were trained to recognise and respond appropriately to language and communication issues; so that the significant proportion of children and young people with these difficulties received an assessment of their needs and appropriate strategies were put in place to manage them. Partners and staff all spoke very positively of the SALT service.

Case illustration

Luis had lived in different parts of the world before coming to the United Kingdom. He was referred to the SALT due to his difficulty understanding and expressing himself in English. The SALT was concerned in case his difficulties were about language acquisition. Therefore, she undertook a further assessment jointly with a specialist in English as an additional language, compared the results and was able to confirm that the difficulties were not related to language acquisition. This was valuable in helping case managers understand how to work with him.

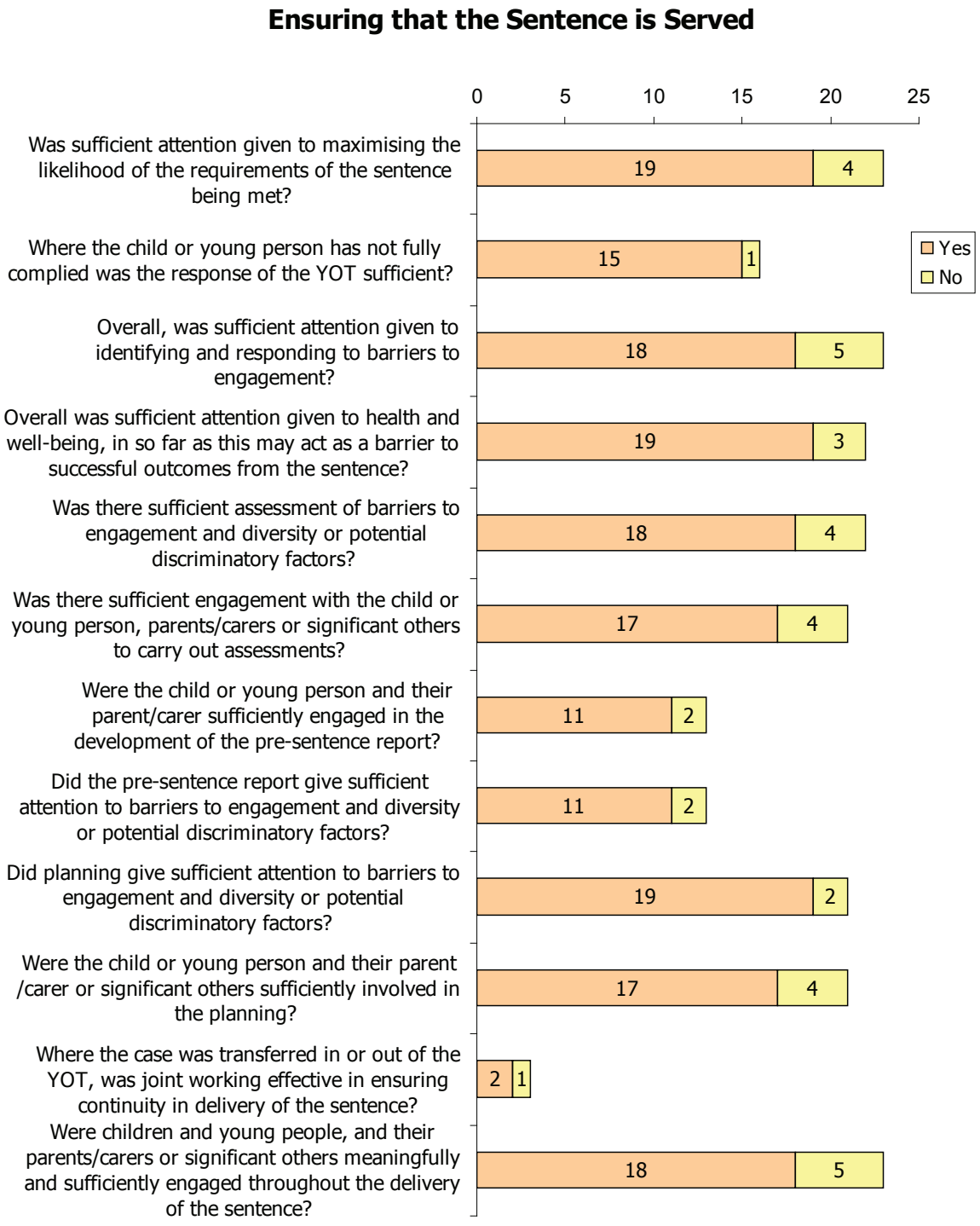
5.2. One example of how the improved links with youth services were being used effectively was use of their premises for reparation work. This provided increased ownership of the reparation, as it was done at facilities that were valued by the local community, but it also helped get children and young people used to engaging with the facilities that were likely to become part of their future support networks.

Summary

Overall, work to ensure that the sentence was served was good. The YJS reaped significant benefits from having access to a SALT. This made a substantial difference to work with some children and young people, however the funding for this was temporary and urgent attention was needed to ensure that the positive impact of this is retained. Case managers built positive relationships with children and young people and their parents/carers. There was accurate assessment and appropriate actions taken to address diversity and other factors that may act as barriers to engagement. The YJS had implemented a positive approach to ensuring that progress was recognised and continued improved behaviour encouraged. Where enforcement action was required this met the needs of the case, however work was needed to ensure that girls and young women engaged fully with the work of the YJS.

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]



Governance

5

Theme 5: Governance and partnerships

What we expect to see

Effective governance, partnership and management arrangements are in place. In particular the YOT partnership and Management Board provide effective governance to ensure that national and local criminal justice objectives are met, and positive outcomes are achieved for children and young people who offend or who are likely to offend, their victims and the local community. Equality of opportunity and wider diversity factors are prioritised throughout. Partnerships are in place which work together well to ensure effective outcomes. Workforce management arrangements are in place within the YOT that enable staff to deliver quality engagement and achieve effective outcomes. The YOT is a learning organisation that continually reviews and evaluates the quality and effectiveness of its services in order to improve and sustain positive outcomes.

Key Findings

1. Attendance by statutory partners at the YJS Management Board was poor; as a result the board was unable to fulfil its functions effectively. Steps were being taken to improve the work of the Management Board.
2. The funding for the valuable SALT was not secure beyond the current financial year.
3. Strategic and other managers within the local authority worked together well.
4. The YJS was well represented on the Local Safeguarding Children Board (LSCB).
5. Insufficient priority was given to the Welsh language.
6. Communication at a case manager level between the YJS and children's social services needed to be improved, building on work already underway.
7. Training and development opportunities and supervision were valued highly by staff.
8. Improvements being made in performance information supplied to the board should assist it in undertaking its scrutiny role effectively.
9. The views of service users are not routinely used to inform and improve services.

Explanation of findings

1. Leadership and governance – criminal justice and related objectives are met

1.1. Following the change of location of the YJS into the Life Long Learning Department from Social Services the authority has ensured that arrangements are in place at a senior officer and managerial level to promote communication across the two directorates. Managers in the local authority worked together well, including through cross-representation on each others management teams.

1.2. We were disappointed that the role of the YJS Management Board did not appear to be well understood by all its members or a significant driver for promoting the work of the YJS in delivering the shared aims of preventing offending, protecting the public and keeping children and young people safe.

1.3. Police attendance at the Board needed to be at strategic level but had been poor to date, with only two out of the last four meetings being attended at all, but by two different police inspectors. Attendance by health and probation representatives had also been poor recently and a key local authority officer was unable to attend due to a clash of meeting times. Whilst there were specific

reasons in each case, lack of attendance by statutory partners has a significant impact on the effectiveness of the YJS Management Board.

1.4. The YJS Management Board included some elected members of Wrexham Council. They were well informed about the work of the YJS, committed to its work to reduce reoffending and active in challenging performance. It was positive that, although not a member of the Management Board, the statutory Director for Social Services received minutes of the meeting and was in tune with the YJS agenda.

1.5. New terms of reference for the work of the Management Board had recently been agreed, and there were plans in place for the Board to undertake a self-assessment and development exercise. However, the effectiveness of this would be dependent on attendance by a sufficient number of partner representatives.

1.6. Lack of active engagement at a senior level had resulted in a lack of scrutiny of qualitative and quantitative performance data for health work in the YJS.

1.7. The YJS was well represented on the executive and development group of the LSCB (a shared board with Flintshire). We noted the positive work begun in the YJS, now being taken forward by the LSCB, in relation to developing closer working relationships and a protocol with independent providers in the authority to manage the complex issue of children and young people placed in the authority from out of county. It is important that the LSCB and the Management Board develop such shared information streams and performance systems.

2. Effective partnerships make a positive difference

2.1. As a result of integration of the YJS into the Lifelong Learning Directorate, the Head of Department for Lifelong Learning was better informed about the education of children and young people under its supervision. He was taking an increasingly robust line and using his statutory powers with secondary head teachers if they did not do everything reasonable to maintain children and young people in school or reintegrate them.

2.2. Another result of the local authority's restructure was that there was a central parenting team allowing a more joined up response to work with parents at the YJS.

2.3. At a strategic level, the YJS Management Board was too slow to respond to the lack of good quality training provision for older children and young people. It did not always focus well enough on the difficulties that young people who attended the YJS experienced when trying to find jobs or work placements.

2.4. The YJS did not yet have effective systems in place to measure the impact of interventions on the educational outcomes for children and young people. ETE outcomes were not routinely reported to the Board and the Youth Justice Board (YJB) indicators that were reported did not provide an effective enough way of measuring educational performance. The local authority and the YJS have recognised this and are working to align the different local authority IT systems to improve monitoring and reporting of performance in this area.

2.5. The previously full-time resource offered by the SALT has been reduced by half. The post is only funded until the end of the current financial year. Although the Head of Service is preparing a paper in support of continued funding (from Health), the YJS Management Board does not appear to be actively engaged in this issue, for example by identifying whether pooled resources may help to secure this effective work. We are concerned that an extremely valuable service that meets a clear and significant need within the YJS is potentially at risk.

2.6. The services of the YJS must be able to be delivered through both the Welsh and English languages, at the choice of the service user. It was apparent from observation of the YJS premises that some notices were only provided in English and, whilst there was a wealth of advice materials available to service users they were displayed in English only. Where they were bilingual, the Welsh information

faced inwards towards the wall, with only the English information visible. Neither was there evidence that the YJS Management Board had recently sought to promote the use of Welsh as a norm, nor satisfy itself that its obligations in this regard were being met.

3. Effective workforce management supports quality service delivery

3.1. Staff and operational managers across both children's social services and the YJS were unclear regarding YJS access permissions to the social services electronic system, known as RAISE. As a result, they were not always aware of what information was already available to them in relation to shared cases, nor the current status of the case in social services. In one case it appeared the YJS did not to know that a case had been closed to children's social services following assessment, despite social services reliance on the YJS to deliver the plan. We were aware that social services have a system whereby closure letters were routinely sent out to agencies at the point of closure but it did not happen on this occasion.

3.2. The need to ensure consistent access to RAISE had already been identified by the Head of Service. Discussions were ongoing in relation to developing access protocols. YJS staff access to RAISE needs to be clarified and protocols put in place as soon as possible with the express purpose of expediting clearer communication between departments in respect of the management of risk and vulnerability and the delivery of timely information to court. While access to RAISE would support better communication, it should not be viewed as a substitute for direct contact between staff from both services. Workers should be proactive in seeking any clarification or information they need regarding any shared case.

3.3. The recent development of audit workshops involving managers from both the YJS and children's social services was a positive development. This initiative had the potential to create a greater understanding of shared issues across the departments; operational staff would benefit from similar opportunities. It is important that learning from these workshops is effectively disseminated.

3.4. We noted recent opportunities for joint staff training in the use of risk assessment tools and that plans for shadowing roles across departments were being progressed. Staff from both services told us that they welcomed opportunities to better understand the respective roles and responsibilities of their colleagues.

3.5. From our interviews we found that managers appreciated the regular opportunities in place for information sharing. For example, the Head of Integrated Youth Services attended the Head of Prevention & Children's Social Care departmental management team meetings on a regular basis and met with the other Heads of Service. Team managers from across children's social services and the YJS also met at monthly operational management meetings.

3.6. The YJS clearly valued training and development for all groups of staff within it. Staff spoke highly of the opportunities provided to them to undertake their current roles better, for their ongoing development and to enable them to deliver interventions effectively as their designs intended. They considered that the culture of the YJS actively promoted learning and development. While there were processes by which personal and corporate training needs were taken forward, the YJS did not maintain its own training plan.

3.7. Staff felt they understood and were committed to the recent reorganisations, both internal within the YJS and the greater integration with youth services. They said that they had been well involved as these changes had been planned and made. The move to Lifelong Learning was viewed positively as promoting flexibility and potential access to a wider range of services with a strong focus on prevention.

3.8. Staff, including health, substance misuse and education workers, spoke positively about their managers and, specifically, about the quality of supervision and support they received, considering that this was effective and appropriate. They were able to recognise circumstances where managers would clearly satisfy themselves about the quality of a piece of work before they were prepared to countersign it.

4. Learning and improvement increases the likelihood that positive outcomes are achieved and sustained

4.1. The Management Board and YJS had been keen to receive consultancy input offered by the YJB to help them understand the causes of local reoffending rates and identify strategies to address this. They had engaged positively with this work, which was drawing to its close.

4.2. The quality of performance information provided to the Management Board had improved considerably. It now focused on localised and recent data in addition to national indicators. There were plans to develop this further. This should prove valuable in enabling the Board to provide more effective oversight and challenge.

4.3. We were pleased to find that the current YJS operational delivery plan included a range of actions arising from self-assessment against the findings from recent thematic inspection reports, in addition to actions arising from the involvement of the YJB and ongoing YJS development plans.

4.4. The YJS does not routinely survey service users (victims, children and young people, parents/ carers), to understand their views on the services they have received, in order to inform improvements to the services provided by the YJS.

4.5. Managers in the YJS articulated the importance of using evidence from research to inform and direct the way that they worked. One said "*...if research is telling us it works then we will do it that way...*". An example of the application of this approach was the commissioning of a university to help understand the reasons why children and young people reached the stage where they had to be breached.

Summary

Overall, governance was not effective. We found good partnership working in Wrexham and commitment to the work of the YJS. However, the robustness of this work was seriously limited by the poor attendance of some statutory partners at the YJS Management Board. The consequence was that this critical body could not effectively hold partners to account, nor, acting as a partnership, hold the YJS to account. Work was underway to address the effectiveness of the management board. We were pleased that reducing reoffending by children and young people was reflected in local priorities and there was good knowledge of the work of the YJS. Insufficient attention was given to promoting use of the Welsh language. The views of service users were not routinely collected and collated in order to inform the development and improvement of services.

Appendices

Appendix 1

Contextual information about the area inspected

Wrexham had a population of 134,844 as measured in the Census 2011. The youth population (those aged between 10 and 17 years old) accounted for 9.3% of the population. This was lower than the average for England and Wales as a whole, which was 9.5%.

The percentage of the youth population with a black and minority ethnic heritage was 3.6% (Census 2011). This was lower than the average for England/Wales, which was 18.3%.

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 37 per 1,000, were higher than the average for England and Wales of 26 (Youth Justice Board 2011-2012).

There is no data available for the proportion of young people in Wrexham aged 16-18 who were not in education, training or employment. The average for England is estimated at 5.7% (Department for Education 2012).

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. This reoffending proportion for Wrexham was 45.4 %, worse than the 35.8% for England and 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 Wrexham, there were 1.45 offences per child or young person who reoffends, worse than the 1.03 for England and Wales as a whole.

(Data based on April 2010 to March 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 Wrexham is 990, compared to 595 for England and Wales as a whole.

(Data based on October 2011 to September 2012 cohort)

Use of Custody measure:

The number of children and young people receiving a conviction in court who are sentenced to custody in a 12 month period, as a proportion per 1,000 10-17 year olds in the general local population. There is no data available for Wrexham. The figure for England and Wales as a whole is 0.72.

(Data based on January 2012 to December 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), detention and training orders and other custodial sentences.

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 and young people.

Appendix 3

Acknowledgements

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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 on the weeks commencing:

16 September 2013 and 30 September 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.

At the end of the second fieldwork week we present our findings to local strategic managers, the YOT Management Team, YOT staff 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 Youth Justice Board. 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% +	Good	
65% - 79%	Satisfactory	
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 7

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
CAF	Common Assessment Framework: a standardised assessment of a child or young person's needs and of how those needs can be met. It is undertaken by the lead professional in a case, with contributions from all others involved with that individual
CAMHS	Child and Adolescent Mental Health Services: part of the National Health Service, providing specialist mental health and behavioural services to children and young people up to at least 16 years of age
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
DTO	Detention and training order: a custodial sentence for the young
Estyn	HM Inspectorate for Education and Training in Wales
ETE	Education, training and employment: work to improve an individual's learning, and to increase their employment prospects
FTE	Full-time equivalent
HIW	Healthcare Inspectorate Wales
HM	Her Majesty's
HMI Probation	HM Inspectorate of Probation
Interventions; *constructive* and *restrictive* interventions	Work with an individual that is designed to change their offending behaviour and/or to support public protection. A *constructive* intervention is where the primary purpose is to reduce 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
ISS	Intensive Surveillance and Supervision: this intervention is attached to the start of some orders and licences and provides initially at least 25 hours programme contact including a substantial proportion of employment, training and education
Likelihood of reoffending	See also *constructive* Interventions
LSC	Learning and Skills Council

LSCB	Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others
Ofsted	Office for Standards in Education, Children's Services and Skills: the inspectorate for those services in England (not Wales, for which see Estyn)
PCT	Primary Care Trust
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
RMP	Risk management plan: a plan to minimise the individual's risk of harm
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*
SALT	Speech and Language Therapist
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
SIFA	Screening Interview for Adolescents: Youth Justice Board approved mental health screening tool for specialist workers
SQIFA	Screening Questionnaire Interview for Adolescents: Youth Justice Board approved mental health screening tool for Youth Offending Team workers
VMP	Vulnerability management plan: a plan to safeguard the well-being of the individual under supervision
YJB	Youth Justice Board for England and Wales
YOI	Young Offenders Institution: a Prison Service institution for 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:

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