



Inspection of  
Youth  
Offending

*Archwilio Rhaglen Troseddwy'r Ifanc*



Criminal Justice  
Joint Inspection

*Arolygiad ar y Cyd Cyfiawnder Troseddol*

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

Report on youth offending  
work in:

**Blaenau Gwent and  
Caerphilly**

ISBN: 978-1-84099-357-8

2010



## Foreword

This Core Case Inspection of youth offending work in Blaenau Gwent and Caerphilly took place as part of the Inspection of Youth Offending programme. We have examined a representative sample of youth offending cases from the area, and have judged how often the Public Protection and the Safeguarding aspects of the work were done to a sufficiently high level of quality.

Over the area as a whole, we judged that the Safeguarding aspects of the work were done well enough 56% of the time. With the Public Protection aspects, work to keep to a minimum each individual's *Risk of Harm to others* was done well enough 54% of the time, and the work to make each individual less likely to reoffend was done well enough 67% of the time. A more detailed analysis of our findings is provided in the main body of this report, and summarised in a table in Appendix 1. These figures can be viewed in the context of our findings from the regions of England inspected so far. To date, the average score for *Safeguarding* work has been 64%, with scores ranging from 38-82%, the average score for *Risk of Harm* work has been 60%, with scores ranging from 36-85%, and the average score for *Likelihood of Reoffending* work has been 66%, with scores ranging from 50-82%.

We found a committed staff team, who demonstrated a range of skills and were able to engage children and young people and their families. The case managers had been well supported by partner agencies, including substance misuse workers, parenting support workers and employment, training and education workers.

Work is needed to improve the quality and timeliness of assessments of *Risk of Harm* and vulnerability, and the production of detailed plans to manage issues that have been identified. Quality assurance methods and the risk management panel had not ensured work had been planned in a consistent way according to the needs of the child or young person.

Overall, we consider this a mixed set of findings.

*Andrew Bridges*

*HM Chief Inspector of Probation*

*September 2010*

## **Acknowledgements**

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

<i>Lead Inspector</i>	<i>Yvonne McGuckian</i>
<i>Practice Assessor</i>	<i>Kerry Robertson</i>
<i>CCI Assessor</i>	<i>David Watkins</i>
<i>Support Staff</i>	<i>Andrew Doyle</i>
<i>Publications Team</i>	<i>Catherine Calton; Kirk Davis; Alex Pentecost; Christopher Reeves</i>
<i>Editor</i>	<i>Alan MacDonald</i>

## Contents

	Page
Acknowledgements	4
Scoring – and Summary Table	6
Recommendations	7
Next steps	7
Service users’ perspective	8
Sharing good practice	9
1. ASSESSMENT AND SENTENCE PLANNING	10
1.1 Risk of Harm to others	10
1.2 Likelihood of Reoffending	12
1.3 Safeguarding	13
2. DELIVERY AND REVIEW OF INTERVENTIONS	16
2.1 Protecting the public by minimising Risk of Harm to others	16
2.2 Reducing the Likelihood of Reoffending	17
2.3 Safeguarding the child or young person	18
3. OUTCOMES	20
3.1 Achievement of outcomes	20
3.2 Sustaining outcomes	21
Appendix 1: Summary	22
Appendix 2: Contextual information	23
Appendix 3a: Inspection data chart	24
Appendix 3b: Inspection data	25
Appendix 4: Role of HMI Probation and Code of Practice	25
Appendix 5: Glossary	26

## Scoring – and Summary Table

This report provides percentage scores for each of the 'practice criteria' essentially indicating how often each aspect of work met the level of quality we were looking for. In these inspections we focus principally on the Public Protection and Safeguarding aspects of the work in each case sample.

Accordingly, we are able to provide a score that represents how often the *Public Protection* and *Safeguarding* aspects of the cases we assessed met the level of quality we were looking for, which we summarise here.

We also provide a headline 'Comment' by each score, to indicate whether we consider that this aspect of work now requires either **MINIMUM**, **MODERATE**, **SUBSTANTIAL** or **DRASTIC** improvement in the immediate future.

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

<b>Public Protection – Risk of Harm score:</b>	
This score indicates the percentage of <i>Risk of Harm</i> work that we judged to have met a sufficiently high level of quality. This score is significant in helping us to decide whether an early further inspection is needed.	
<b>Score:</b> <b>54%</b>	<b>Comment:</b> <b>SUBSTANTIAL improvement required</b>

<b>Public Protection – Likelihood of Reoffending score:</b>	
This score indicates the percentage of <i>Likelihood of Reoffending</i> work that we judged to have met a sufficiently high level of quality.	
<b>Score:</b> <b>67%</b>	<b>Comment:</b> <b>MODERATE improvement required</b>

We advise readers of reports not to attempt close comparisons of scores between individual areas. Such comparisons are not necessarily valid as the sizes of samples vary slightly, as does the profile of cases included in each area's sample. We believe the scoring is best seen as a headline summary of what we have found in an individual area, and providing a focus for future improvement work within that area.

## **Recommendations** (primary responsibility is indicated in brackets)

Changes are necessary to ensure that, in a higher proportion of cases:

- (1) a timely and good quality assessment and plan, using Asset, is completed when the case starts (Chair of Management Board)
- (2) specifically, a timely and good quality assessment of the individual's vulnerability and *Risk of Harm to others* is completed at the start, as appropriate to the specific case, including consideration of all relevant previous behaviours (YOS Manager)
- (3) as a consequence of the assessment, the record of the intervention plan is specific about what will now be done in order to safeguard the child or young person's well-being, to make them less likely to reoffend and to minimise any identified *Risk of Harm to others* (YOS Manager)
- (4) the plan of work with the case is regularly reviewed and correctly recorded in Asset with a frequency consistent with national standards for youth offending services (YOS Manager)
- (5) there is evidence in the file of regular quality assurance by management, especially of screening decisions, as appropriate to the specific case (YOS Manager).

Furthermore:

- (6) assessments are reviewed in the light of significant new information, including the commission of new offences and reports of harmful behaviours (YOS Managers and staff)
- (7) effective plans to manage *Risk of Harm to others* and vulnerability are produced in a timely manner and specify action that needs to be taken, including those required by the YOS (YOS Manager)
- (8) reviews of *Risk of Harm to others* and vulnerability are reassessed when children and young people are taken into custody and reflect any risk posed as a result (YOS Manager).

## **Next steps**

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

## **Note**

*During the course of our normal post-inspection quality assurance process, we found it necessary to disregard the recorded scores for six cases. The scores in this report are, therefore, based on thirty-two cases.*

## Service users' perspective

### Children and young people

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

- ❖ Children and young people were clear about what their order involved and what they needed to do to comply. They felt that staff had taken time to talk to them and explain what would happen to help them prepare for the panel. Most remembered being given a copy of their plan.
- ❖ All but one child or young person felt that staff had listened to them and that they were interested in helping them.
- ❖ During their orders, 11 children and young people felt that something had happened in their lives which had made them feel afraid. Four children and young people stated that the YOS had helped them with this. Three felt that they had not been helped enough.
- ❖ Thirty-four children and young people felt that something in their life had got better as a result of working with the YOS.
- ❖ We asked what things the YOS had helped with and the most common responses included: making better decisions, understanding their offending, help with alcohol misuse and support with education, training and employment.
- ❖ We asked if the work they had done with the YOS had made them less likely to offend in the future. Thirty-three felt that they were a lot less likely to offend, 12 felt they were a bit less likely to offend again and four felt that it had made no difference.
- ❖ Many children and young people felt that their workers had spent lots of time checking out that they really understood what was going on and that the children and young people knew what to expect at sessions with staff.
- ❖ Children and young people were able to describe how they were thinking differently as a result of the work done with the YOS. One young person stated: *'The work I have done with my yot led me to realise what damage I am doing to others when I offend and helped me to decide that it wont happen again'.*

### Victims

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

- ❖ Both victims felt that the YOS had explained what service they could offer and that their needs had been taken into account.
- ❖ The YOS had given them the chance to discuss what had happened to them and that their safety had been properly considered.

## Sharing good practice

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

### Assessment and Sentence Planning

#### General Criterion: 1.2 d

A 16-year-old boy with special needs was coming towards the end of his order and required a referral for specialist support. The YOS worker arranged a multi-agency meeting with all those involved in his case. Time was spent deciding which was the right service to provide ongoing support for the young person and his parents. This resulted in the production of a comprehensive report which included suggestions about the methods of engaging the young person. The YOS worker also offered to write an adapted report specifically for the young person, so that he knew what had been discussed and what the plan for him was.

### Delivery and Review of Interventions

#### General Criterion: 2.2 a

Neil, a 15-year-old boy, had a long history of substance misuse, including alcohol and drugs. His needs had been assessed at the start of his order and work had been undertaken to help him reduce his use of drugs and alcohol and understand how substances affected his behaviour. Towards the end of the order, an aftercare plan was produced to support Neil once he was no longer receiving support from the YOS. The plan was discussed with him and he was able to make links with community-based organisations.

### Outcomes

#### General Criterion: 3.2 a

The YOS had developed a certificate of completion issued to all children and young people who had completed a referral order. On the back of the certificate was information to help them explain to prospective employers the nature of the order and that it had been successfully completed. This initiative reinforced positive behaviour and gave children and young people information that they could refer to when needed.

## 1. ASSESSMENT AND SENTENCE PLANNING

### 1.1 Risk of Harm to others:

**General Criterion:**

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

**Score:**

**49%**

**Comment:**

***SUBSTANTIAL improvement required***

**Strengths:**

- (1) A RoSH screening had been completed in all but one case, with 24 of 31 being completed on time.
- (2) The YOS had access to the Swift system, which provided details of any involvement with children's social care services. Each file contained the details of checks to this system, along with an address check undertaken by the police to make staff aware of any known issues.
- (3) Assessments of victims' needs and wishes had been undertaken quickly and were often available at the beginning of the order.
- (4) A RMP had been completed in 12 of 14 cases where one should have been done.

**Areas for improvement:**

- (1) RoSH screenings were accurate in only 8 of the 32 cases; they often did not reflect previous convictions and risky behaviours. The previous convictions provided by the police included a section for incidents that had led to No Further Action. This section listed a range of potential harmful behaviours. In no case did we find that this information had been followed up to aid the assessment of *RoH*.
- (2) Full RoSH assessments had been undertaken in 16 of the 19 applicable cases. Of these, 12 had been done in a timely manner. Only four of these assessments were considered to be of sufficient quality. Often, previous relevant behaviour was not considered and the classification of risk levels recorded on the screening, full assessment and RMP did not always match. Many of the assessments were not well evidenced, with little information or analysis of *RoH to others*, including victims and the public.

- (3) Only half of the relevant cases had drawn adequately on other assessments. We noted that the information obtained about victims and the outcomes of investigations by children's social services had not always been used to inform assessments.
- (4) Twelve RMPs had been completed; of these, only three had been completed on time and one completed to a sufficient standard. There was no single reason why RMPs were insufficient, and we noted a range of factors, including victim safety, roles and responsibilities being unclear and a lack of planned response. Some of the RMPs had been completed very late into the order. In a few cases, there was no record of what action the YOS staff were going to take.
- (5) The risk management panel often missed relevant information and factors, and there was little evidence to suggest that they accessed source information. We judged that, in the relevant cases, there had been no effective management oversight of the RMPs.
- (6) There was a lack of quality assurance to ensure that plans were completed when needed. We noted that, in a few cases, the RMP was to be completed in supervision. However, this had not always been followed up.
- (7) Classifications of RoSH levels were accurate in 66% of the initial assessments. However, there were wide variations in assessed levels, within a short period of time, dependent on who had undertaken the assessment. There appeared to be little consistency between the three teams undertaking assessments.
- (8) When a child or young person received custody, risk levels were automatically changed to medium risk from the previously assessed level. This did not always accurately reflect the situation. Little consideration was given to the potential for risk whilst in custody; an example being children and young people who were known to bully others.
- (9) There were a number of cases that did not require a RMP but which indicated potentially harmful behaviour that needed to be addressed. Planning of specific interventions for this purpose had occurred in 8 of the 13 relevant cases.
- (10) Management oversight of *RoH* had been ineffective in all but one of the relevant cases. The YOS risk policy stated that all cases needed to be given a risk level but we found a few cases where the risk level was recorded as not applicable.

## 1.2 Likelihood of Reoffending:

### **General Criterion:**

*The assessment of the LoR is comprehensive, accurate and timely and uses Asset and other relevant assessment tools. Plans are in place to reduce LoR.*

### **Score:**

**65%**

### **Comment:**

**MODERATE improvement required**

### **Strengths:**

- (1) Initial assessments of the LoR had been completed in all cases in the sample and 75% of these had been completed on time. Case managers were good at reflecting positive influences within Asset.
- (2) There had been an active engagement with the child or young person in 75% of the sample, and with parents/carers in 84% of relevant cases. This had been supported by the work of the parenting officer, who offered every parent support as needed.
- (3) Assessments usually drew on information held by other relevant agencies, including children's social care (84%), ETE providers (69%), police (89%) and substance misuse (67%). Case managers sought advice and information from colleagues from these agencies when making their assessment although the recording of the outcomes of the discussions was not always clear.
- (4) Within the intervention plans, case managers had paid due attention to substance misuse, ETE and lifestyle issues.
- (5) 90% of intervention plans had been completed on time; most plans reflected the purposes of sentencing, focused on achievable change and adherence to national standards.
- (6) 71% of plans had taken into account Safeguarding needs.
- (7) Children's social care had been actively and meaningfully involved in planning processes in 84% of relevant cases, including those involving Looked After Children, with community and custody sentences.

### **Areas for improvement:**

- (1) 53% of initial assessments had been completed to a sufficient standard. However, we found assessments with unclear or insufficient evidence, some undertaken late, a few that failed to identify all factors that had contributed to offending and some that failed to identify vulnerability issues.
- (2) The system in the YOS was that a member of the court and assessment team would undertake an assessment at the PSR stage and, following sentence, a member of the community team would undertake the next assessment. We found that, in many cases, there were vast differences in how the

assessments were undertaken, often resulting in very different scores despite there being very little evidence of significant changes.

- (3) In under half of the cases had case managers assessed the learning style of the child or young person and, where such assessments were undertaken, practice on how this had been done had varied.
- (4) The intervention plans had been integrated with RMPs in 38% of cases but there was a lack of focus within plans on motivation to change, emotional/mental health and family and personal relationships.
- (5) In only 37% of cases did the intervention plan give a clear shape to the order, 47% had relevant goals and 55% incorporated the child or young person's learning style.
- (6) In most cases, there was little evidence of prioritisation or sequencing of interventions according to *RoH* (36%). Plans had been sequenced according to offender-related need in 40% of cases.
- (7) Only 33% of plans took into account the needs of victims.
- (8) Just over half of intervention plans were sensitive to diversity needs.
- (9) Whilst 55% of the initial assessments had been reviewed, new information had not always been added, nor had case managers used the review assessment to fully analyse any changes.
- (10) Assessments had been informed by the *What do YOU think?* questionnaire in 9 of the 32 cases.
- (11) The child or young person had been involved in the planning process in 58% of cases and parents/carers in 50%. In our judgement too many plans were completed as a separate process to the actual work being done with individuals.

### 1.3 Safeguarding:

**General Criterion:**

*The assessment of Safeguarding needs is comprehensive, accurate and timely and uses Asset and other relevant assessment tools. Plans are in place to manage Safeguarding and reduce vulnerability.*

**Score:**

**59%**

**Comment:**

**MODERATE improvement required**

**Strengths:**

- (1) A vulnerability screening was undertaken in all cases and 81% of these had been completed on time.

- (2) Where the need to take action to reduce vulnerability had been recognised, there was an associated intervention in nine of the ten cases. However, this was not always included on the VMP.

### ***Areas for improvement:***

- (1) Vulnerability screenings were accurate in only 31% of cases and tended only to focus on any risks of self-harm due to suicide or driving offences and not on the risks posed by other people, including parents/carers and partners. Case managers did not record the impact of a range of factors that could contribute to a child or young person's vulnerability including, but not exclusively, being a Looked After Child, domestic abuse within the home and the levels of drug and alcohol use. Case managers were often aware of these issues but had not recognised their impact on the child or young person's vulnerability.
- (2) The inspection team considered that there should have been a VMP in 21 of the cases in the sample. However, there were only eight, with only two having been completed on time. Some of the vulnerability management plans had been produced very late on into the order.
- (3) Four of the completed VMPs were of a sufficient quality, the others lacked a planned response and some just listed what other agencies should do, with little evidence of joint planning.
- (4) Just less than half of the relevant cases had been reviewed as needed and opportunities to reassess vulnerability had not been taken at some critical times, including release from custody and at the conclusion of social services' contact.
- (5) Only some information had been shared with the custodial establishment; again, this was often about risk of suicide or self-harm which, although critical, was not the full range of known vulnerabilities.
- (6) Joint work with children's services varied but we saw a timely response and evidence of joint work. However, in other cases, referrals had been missed or the YOS had worked in isolation from children's services. In a few cases, repeated referrals had been made to children's services with little impact. An escalation process had just been introduced to raise these cases with both authorities, as the need arose.

**OVERALL SCORE for quality of Assessment and Sentence Planning work: 61%**

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

The quality of the assessment and sentence planning had been affected by a number of key issues, including a lack of clear and consistent expectations that staff should operate to and ineffective management oversight. Staff had good assessment skills and often knew what work they needed to do to address the factors that led children and young people to offend. However, this knowledge and understanding had not always translated into robust plans. The lack of timeliness had produced difficulties throughout the assessment and planning stages, leaving some cases without plans to manage risk and vulnerability for long periods of the order. There needs to be a change so that plans and ongoing dynamic assessments are seen as central to the management of the order.

## 2. DELIVERY AND REVIEW OF INTERVENTIONS

### 2.1 Protecting the public by minimising Risk of Harm to others:

**General Criterion:**

*All reasonable actions have been taken to protect the public by keeping to a minimum the child or young person's RoH to others.*

**Score:**

**66%**

**Comment:**

**MODERATE improvement required**

**Strengths:**

- (1) There were no cases identified within the sample where a referral to multi-agency public protection agencies was required; we agreed with these decisions.
- (2) Purposeful home visits had been carried out throughout the course of the sentence in accordance with the level of *RoH* posed in 91% of cases and 84% of cases where there were Safeguarding issues.
- (3) Victim awareness work had been undertaken with many of the children and young people; this had been done on a one-to-one basis and through specific interventions, including a number of car crime initiatives.
- (4) Case managers had effectively contributed to multi-agency meetings in 89% of custody and 67% of community cases. There was evidence that information about the child or young person's attitudes and behaviour whilst in custody had been sought in order to make judgements about *RoH*.

**Areas for improvement:**

- (1) There was evidence of timely *RoSH* reviews in 55% of the cases. In a third of cases, the case manager had identified a significant change which should have triggered a review of the *RoH* posed. Case managers had missed the opportunity to anticipate changes in *RoH*.
- (2) In 69% of cases, appropriate resources had been allocated according to the *YOS* assessment of *RoH*.

## 2.2 Reducing the Likelihood of Reoffending:

### **General Criterion:**

*The case manager coordinates and facilitates the structured delivery of all elements of the intervention plan.*

### **Score:**

**76%**

### **Comment:**

**MINIMUM improvement required**

### **Strengths:**

- (1) Partner agencies provided a range of interventions which were aimed at reducing the LoR. Substance misuse, ETE and parenting being most commonly noted. The education worker had made effective links with mainstream and alternative education provision, and had facilitated children and young people's return to education. Many interventions had been delivered by YOS support officers, and we found evidence that they had undertaken work on a number of offending-related areas, including consequential thinking.
- (2) Interventions had been delivered in line with the intervention plan in 74% of cases but less than half had been appropriately sequenced.
- (3) The majority of interventions had been designed to reduce the LoR and many were appropriate to the learning style of children and young people. The YOS has a range of car crime interventions, each one targeting different levels of offending.
- (4) Substance misuse at Tiers one and two were available within the YOS. However, some of the physical health needs had not been covered due to a vacancy within the YOS.
- (5) We looked at ten cases where the child or young person had been in custody. In eight of these, there had been an effective use of visits to review interventions and to prepare for release.
- (6) Good attention had been paid to lifestyles, with referrals made to the youth service in relevant cases, to provide opportunities for purposeful activities.
- (7) It was evident from discussions with case managers and from case records that children and young people had been actively supported and motivated throughout the sentence. Equally, we found that positive behaviour had been recognised and reinforced.
- (8) Parents/carers had been actively engaged throughout the sentence in over 80% of custody and 94% of community cases.

### **Areas for improvement:**

- (1) Interventions had been reviewed appropriately in only 38% of the cases. This had resulted in case managers assessing the impact of interventions on an ad hoc, rather than systematic, basis. This had then impacted on the ability of support staff to sequence interventions appropriately.
- (2) ISSP plans did not integrate with the sentence plan, and work done by this team could, on occasion, be separate to case management.

2.3 Safeguarding the child or young person:	
<b>General Criterion:</b> <i>All reasonable actions have been taken to safeguard and reduce the vulnerability of the child or young person.</i>	
<b>Score:</b> <b>57%</b>	<b>Comment:</b> <b><i>SUBSTANTIAL improvement required</i></b>

### **Strengths:**

- (1) Necessary referrals, to ensure Safeguarding, had been made in the relevant custody case.
- (2) We found evidence of prompt joint work with other agencies to promote Safeguarding. Most notable was the work with substance misuse, ETE and the police and, to a lesser degree, children's services, accommodation services and emotional and mental health.
- (3) For children and young people who had moved from custody back into the community, we evidenced some good continuity of interventions in relation to ETE, accommodation services and children's social care.
- (4) Interventions in the community, promoting Safeguarding, were evident in 65% of relevant cases, but incorporated into just over half of the VMPs that had been produced.

### **Areas for improvement:**

- (1) We expect to find that all necessary action is taken to immediately protect children and young people. We found that this had happened in only one of four custody cases and three of ten community cases. Factors contributing to this judgement included referrals not being made and, for those children and young people in custody, all information about their immediate vulnerability

needs had not been forwarded to the secure establishment. We found that referrals had been made to other agencies to ensure Safeguarding in half of the relevant community cases.

- (2) Case managers and other relevant staff had supported and promoted the well-being of the child or young person throughout the course of the sentence in 50% of custody and 63% of community cases.
- (3) We found effective management oversight of Safeguarding and vulnerability needs in only one of six custody cases and four of 21 community cases.
- (4) Interventions in custody, to promote Safeguarding, were evident in 71% of relevant cases of which only half had been reviewed following a significant change. None of this work had been incorporated into the VMPs.

**OVERALL SCORE for quality of Delivery and Review of Interventions work: 66%**

**COMMENTARY on Delivery and Review of Interventions as a whole:**

Performance in delivery and review of interventions (LoR and RoH) was stronger than in assessment and planning. We noted that case managers were undertaking work which did not specifically feature on the plan. The joint work between case managers and other agencies remained a generally positive feature. A lack of formal reviewing of interventions for RoH and for Safeguarding made it difficult at times for staff to track progress and identify what worked with children and young people. We noted that children and young people were seen by a range of staff during the course of the order; case managers, therefore, need to ensure that they fully coordinate and assess the progress and effectiveness of work. Victims' needs had been assessed and responded to in about 70% of all cases.

### 3. OUTCOMES

#### 3.1 Achievement of outcomes:

**General Criterion:**

*Outcomes are achieved in relation to RoH, LoR and Safeguarding.*

**Score:**

**43%**

**Comment:**

***SUBSTANTIAL improvement required***

**Strengths:**

- (1) In 71% of cases where it had been needed, enforcement action was taken sufficiently well.
- (2) The factors that had contributed most to reducing offending behaviour included ETE, substance misuse and lifestyle.

**Areas for improvement:**

- (1) RoH had been effectively managed in 36% of cases.
- (2) There had been an overall reduction in the Asset score in 41% of the cases in the sample. The factors that had reduced the most were substance misuse, ETE, lifestyle and motivation to change. Reduction in factors linked to Safeguarding was evident in 29% of relevant cases.
- (3) In 63% of the sample, all reasonable action had been taken to keep the child or young person safe.
- (4) Factors linked to offending that had reduced the least included physical health, emotional and mental health and family and personal relationships.
- (5) In 11 of the 32 cases the child or young person had not fully complied with the requirements of the sentence.

### 3.2 Sustaining outcomes:

**General Criterion:**

*Outcomes are sustained in relation to RoH, LoR and Safeguarding.*

**Score:**

**75%**

**Comment:**

**MODERATE improvement required**

**Strengths:**

- (1) Full attention had been given to community integration issues in 78% of community orders and 80% of custody cases.
- (2) In 75% of community orders, there had been plans in place, or action taken, to ensure that positive outcomes achieved were sustained.

**Area for improvement:**

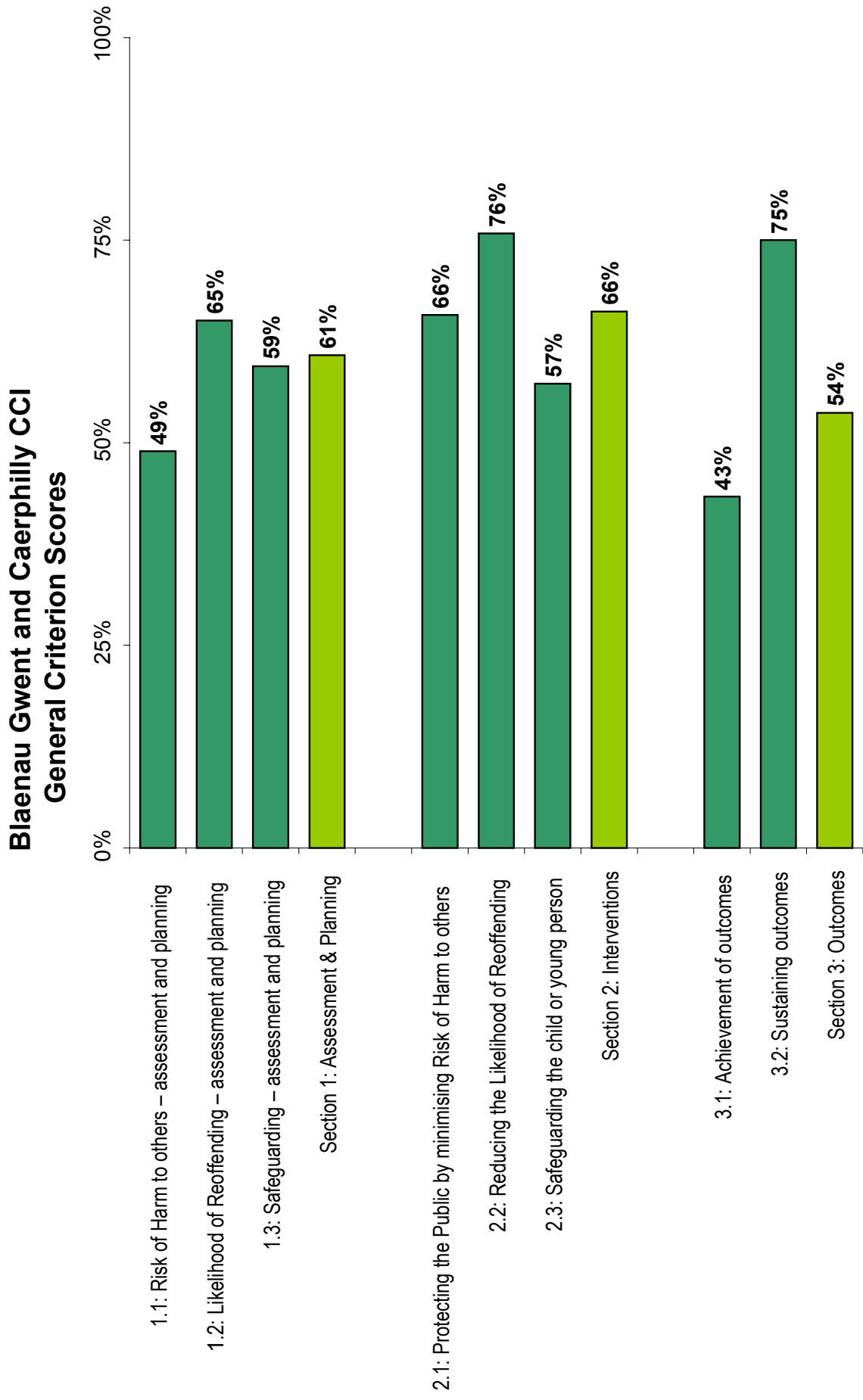
- (1) In 60% of custody cases, there had been plans in place, or action taken, to ensure that positive outcomes achieved were sustained.

**OVERALL SCORE for quality of Outcomes work: 54%**

**COMMENTARY on Outcomes as a whole:**

The ability to track changes to Asset scores during the order was hampered by the wide range in the Asset scores. This had depended on which member of the YOS was assessing the child or young person. A more consistent approach to scoring Asset across the teams would provide a clear base line in which achievements could be measured. The lack of some reviews also meant that the organisation missed the opportunity to identify the impact of interventions.

## Appendix 1: Summary



## **Appendix 2: Contextual information**

### **Area**

Blaenau Gwent and Caerphilly YOS was located in the Gwent region of Wales.

The area of Caerphilly had a population of 169,519 and the area of Blaenau Gwent had a population of 70,064 as measured in the Census 2001, 11.3% of which were aged 10 to 17 years old for Caerphilly and 11.5% for Blaenau Gwent. This was higher than the average for Wales, which was 10.6%. The comparable figure for England and Wales was 10.4%.

The population of Blaenau Gwent and Caerphilly was predominantly white British (99.1% Caerphilly; 99.2% Blaenau Gwent). The population with a black and minority ethnic heritage (0.9% Caerphilly; 0.8% Blaenau Gwent) was below the average for Wales of 2.1%. The comparable figure for England and Wales is 8.7%.

Reported offences for which children and young people aged 10 to 17 years old received a pre-court disposal or a court disposal in 2008/2009, at 45 per 1,000, were below the average for England/Wales of 46.

### **YOS**

The YOS boundaries were within those of the Gwent police area and Wales Probation Trust (with effect from April 2010).

The YOS Management Board was chaired by the Director of Social Services for Caerphilly. All statutory partners attended regularly.

The YOS headquarters was in the town of Blackwood in Caerphilly. The operational work of the YOS was based here. ISSP was provided by the YOS.

### **YJB performance data**

The YJB summary of national indicators available at the time of the inspection was for the period April 2008 to March 2009.

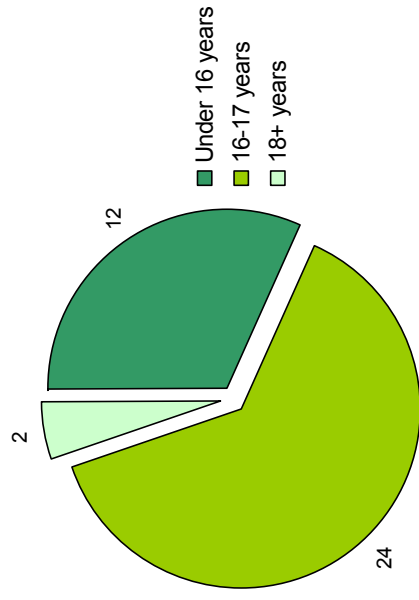
Blaenau Gwent and Caerphilly's performance on ensuring children and young people known to the YOS were in suitable education, training or employment was 57.9%. This was a decline on the previous year, and below the Wales average of 69.0%.

Performance on ensuring suitable accommodation by the end of the sentence was 98.1%. This was a slight improvement on the previous year and better than the Wales average of 96.1%.

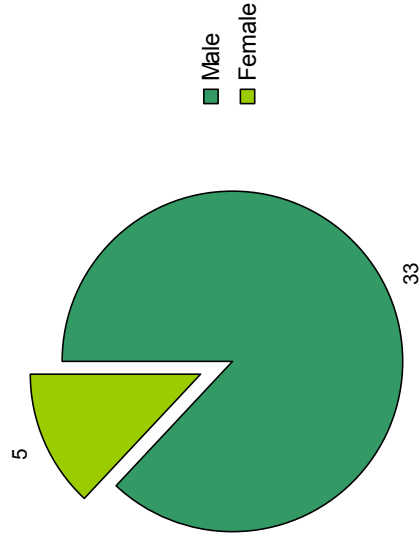
The "Reoffending rate after 9 months" was 90%, worse than the Wales average of 74% (See Glossary).

## Appendix 3a: Inspection data chart

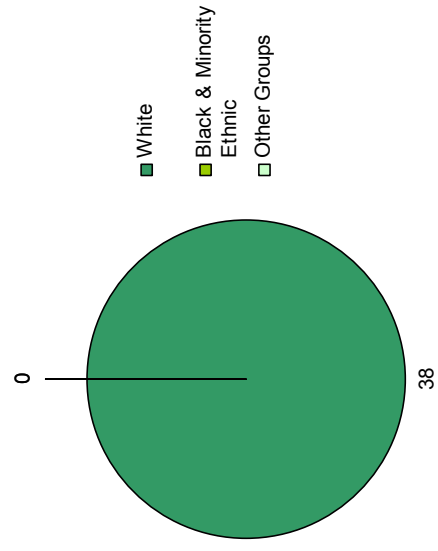
Case Sample: Age at start of Sentence



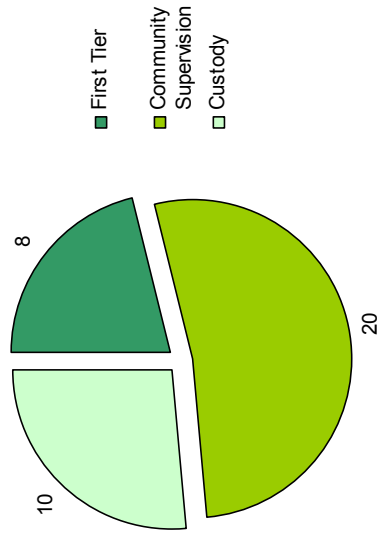
Case Sample: Gender



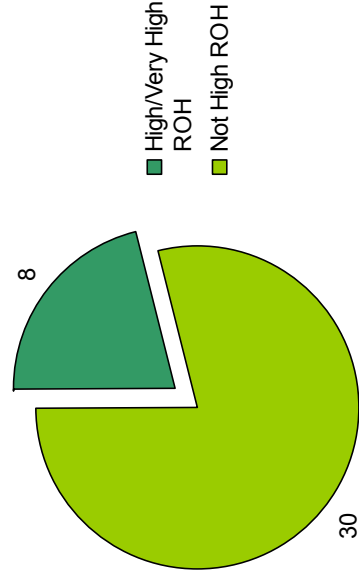
Case Sample: Ethnicity



Case Sample: Sentence Type



Case Sample: Risk of Harm



## **Appendix 3b: Inspection data**

Fieldwork for this inspection was undertaken in April 2010.

The inspection consisted of:

- ◊ examination of practice in a sample of cases, normally in conjunction with the case manager or other representative
- ◊ evidence in advance
- ◊ questionnaire responses from children and young people, and victims.

We have also seen YJB performance data and assessments relating to this YOS.

## **Appendix 4: Role of HMI Probation and Code of Practice**

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

**<http://www.justice.gov.uk/inspectors/hmi-probation>**

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

*HM Chief Inspector of Probation  
2nd Floor, Ashley House  
2 Monck Street  
London, SW1P 2BQ*

Data charts in this report are available electronically upon request.

## Appendix 5: Glossary

ASB/ASBO	Antisocial behaviour/Antisocial Behaviour Order
Asset	A structured assessment tool based on research and developed by the Youth Justice Board looking at the young person's offence, personal circumstances, attitudes and beliefs which have contributed to their offending behaviour
CAF	Common Assessment Framework: a standardised assessment of a child or young person's needs and of how those needs can be met. It is undertaken by the lead professional in a case, with contributions from all others involved with that individual
CAMHS	Child and Adolescent Mental Health Services: part of the National Health Service, providing specialist mental health and behavioural services to children and young people up to at least 16 years of age
Careworks	One of the two electronic case management systems for youth offending work currently in use in England and Wales. See also YOIS+
CRB	Criminal Records Bureau
DTO	Detention and Training Order: a custodial sentence for the young
Estyn	HM Inspectorate for Education and Training in Wales
ETE	Employment, training and education: work to improve an individual's learning, and to increase their employment prospects
FTE	Full-time equivalent
HM	Her Majesty's
HMIC	HM Inspectorate of Constabulary
HMI Prisons	HM Inspectorate of Prisons
HMI Probation	HM Inspectorate of Probation
Interventions; <i>constructive</i> and <i>restrictive</i> interventions	<p>Work with an individual that is designed to change their offending behaviour and/or to support public protection.</p> <p>A <i>constructive</i> intervention is where the primary purpose is to reduce Likelihood of Reoffending.</p> <p>A <i>restrictive</i> intervention is where the primary purpose is to keep to a minimum the individual's <i>Risk of Harm to others</i>. Example: with a sex offender, a <i>constructive intervention</i> might be to put them through an accredited sex offender programme; a <i>restrictive intervention</i> (to minimise their <i>Risk of Harm</i>) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case. NB. Both types of intervention are important</p>
ISSP	Intensive Supervision and Surveillance Programme: this intervention is attached to the start of some orders and licences and provides initially at least 25 hours programme contact including a substantial proportion of employment, training and education
LoR	Likelihood of Reoffending. See also <i>constructive</i> Interventions
LSC	Learning and Skills Council
LSCB	Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality.

MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher <i>Risk of Harm to others</i>
Ofsted	Office for Standards in Education, Children's Services and Skills: the Inspectorate for those services in England (not Wales, for which see Estyn)
PCT	Primary Care Trust
PPO	Prolific and other Priority Offender: designated offenders, adult or young, who receive extra attention from the Criminal Justice System agencies
Pre-CAF	This is a simple 'Request for Service' in those instances when a Common Assessment Framework may not be required. It can be used for requesting one or two additional services, e.g. health, social care or educational
PSR	Pre-sentence report: for a court
'Reoffending rate after 9 months'	A measure used by the Youth Justice Board. It indicates how many further offences are recorded as having been committed in a nine-month period by individuals under current supervision of the relevant YOS, and it can be either more or less than 100%. '110%' would therefore mean that exactly 110 further offences have been counted as having been committed 'per 100 individuals under supervision' in that period. The quoted national average rate for Wales in early 2009 was 74%
RMP	Risk management plan: a plan to minimise the individual's <i>Risk of Harm</i>
RoH	<i>Risk of Harm to others</i> . See also <i>restrictive Interventions</i>
'RoH work', or 'Risk of Harm work'	This is the term generally used by HMI Probation to describe work to protect the public, primarily using <i>restrictive interventions</i> , to keep to a minimum the individual's opportunity to behave in a way that is a <i>Risk of Harm to others</i>
RoSH	Risk of Serious Harm: a term used in Asset. HMI Probation prefers not to use this term as it does not help to clarify the distinction between the <i>probability</i> of an event occurring and the <i>impact/severity</i> of the event. The term <i>Risk of Serious Harm</i> only incorporates 'serious' impact, whereas using ' <i>Risk of Harm</i> ' enables the necessary attention to be given to those offenders for whom lower <i>impact/severity</i> harmful behaviour is <i>probable</i>
Safeguarding	The ability to demonstrate that all reasonable action has been taken to keep to a minimum the risk of a child or young person coming to harm.
SIFA	Screening Interview for Adolescents: Youth Justice Board approved mental health screening tool for specialist workers
SQIFA	Screening Questionnaire Interview for Adolescents: Youth Justice Board approved mental health screening tool for YOS workers
VMP	Vulnerability management plan: a plan to safeguard the well-being of the individual under supervision
YJB	Youth Justice Board for England and Wales
YOI	Young Offenders Institution: a Prison Service institution for young people remanded in custody or sentenced to custody
YOIS+	Youth Offending Information System: one of the two electronic case management systems for youth offending work currently in use in England and Wales. See also Careworks
YOS/T	Youth Offending Service/Team

© Crown Copyright

HM Inspectorate of Probation  
6th Floor Trafford House  
Chester Road  
Stretford  
Manchester  
M32 0RS  
Telephone - 0161 869 1300

Alternative formats are available upon request

ISBN 978-1-84099-357-8