Inspection of Youth Offending Work
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To:	Superintendent Simon Bowden, Chair of Slough YOT Management Board
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From:	Helen Mercer, Assistant Chief Inspector
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Report of Short Quality Screening (SQS) of youth offending work in Slough

The inspection was conducted from 23-25 March 2015 as part of our programme of inspection of youth offending work. This report is published on the HMI Probation website. A copy will be provided to partner inspectorates to inform their inspections, and to the Youth Justice Board (YJB).

Context

The aim of the youth justice system is to prevent offending by children and young people. Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. We examined 14 cases of children and young people who had recently offended and were supervised by Slough Youth Offending Team (YOT). Wherever possible, this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

The published reoffending rate[1] for Slough was 37.3%. This was worse than the previous year and worse than the England and Wales average of 36.1%.

Overall, we found that staff engaged well with children and young people and their parents/carers. Staff worked well to address individual needs to help children and young people to meet the requirements of their sentence. However, it was disappointing to find that, following recommendations from the previous inspection in 2011, there still remained considerable scope for improvement in work to protect the public and safeguard the child or young person. Management oversight needed to be more effective and robust to improve both the quality and consistency of the work.

Commentary on the inspection in Slough:

1. Reducing reoffending

1.1. Pre-sentence reports (PSRs), and referral order panel reports, are the principal means by which the sentencing courts and panels are advised about the causes of offending and the work required to address it. More than two-thirds of PSRs and most panel reports were of a good quality overall. However, some would have benefited from a more

[1] Published January 2015 based on binary reoffending rates after 12 months for the April 2012 – March 2013 cohort. Source: Ministry of Justice

thorough analysis both of the risk of harm the child or young person posed to others, and of safeguarding issues in particular.

1.2. The initial assessment of the child or young person's likelihood of reoffending was done well in the great majority of the cases in the sample. Most were thorough and provided a full picture of the child or young person's circumstances, such as how living arrangements, family and personal circumstances and education might impact on reoffending. There was good engagement with the child or young person, and their parents/carers, to understand the factors in the case in well over three-quarters of the cases inspected. In almost all of the cases, staff worked to identify and understand any barriers to engagement.

1.3. Following on from the assessment, we look to see if there is a plan of work to help reduce the likelihood of reoffending. We found that there was sufficient planning in place for work in the community in most cases. In the large majority of cases, children and young people and their parents/carers were involved in the planning, and plans contained focused objectives which were meaningful to the child or young person. An inspector commented: "*The contract and initial plan addressed identified offending behaviour needs. It was focused and young person centred, with sign up from the young person and parents*."

1.4. Children and young people's lives can change very quickly and, as a result, assessments and plans need to be reviewed in a timely and thorough way. There had been a sufficient review of initial assessments in almost two-thirds of relevant cases in the sample. However, there was sufficient review of plans in only three of the ten relevant cases. Where reviews were insufficient, they lacked quality or were not completed in a timely manner.

1.5. We observed that the level of contact with children and young people was good, and the recording of those contacts was generally thorough and detailed. An inspector noted: "*The recording in this case is very good – easy to follow, clear as to what work has been done with the young person to date, good communication and liaison with other workers involved and the foster carer. Particularly good intervention plan with appropriate objectives, clear and easily understood by the young person, with evidence on file of the young person having agreed and signed it.*"

2. Protecting the public

2.1. The work of the YOT to manage risk of harm to the public needed to be improved. We expect to see a detailed assessment of the risk of harm a child or young person poses to others, covering all relevant information including past offending and behaviour, as well as the impact on victims. Case managers had made sufficient effort to understand and explain the risk of harm to others posed by the child or young person in just over two-thirds of cases in the sample. We found a number of cases where the risk classification was too low, or was reflected inconsistently within case records. Insufficient account was taken of actual or potential victims.

2.2. Having assessed the risks, plans should be put in place to manage them. Planning to manage the risk of harm to others was not good enough in more than half of the cases inspected. Specifically, this was because plans to manage the risk of harm had not been completed, victim issues were not adequately addressed, planned responses were insufficient or unclear, or potential changes in risk of harm had not been anticipated.

2.3. Reviews of assessments and plans to manage risk of harm were not done well enough. This was because reviews had not been undertaken or lacked quality. In a number of cases, reviews were a copy of a previous assessment or plan, with insufficient update.

2.4. Taking account of the needs of victims is crucial in helping to keep them safe. We found that there was enough work undertaken to protect victims in only one out of the nine relevant cases in the sample. This was mostly because the assessment and planning to manage the risk of harm was insufficient.

2.5. Effective management oversight in ensuring the quality of risk of harm work needed to be improved as a priority. We found this to be ineffective in a large majority of relevant cases, where important deficiencies in assessment and planning had not been addressed.

3. Protecting the child or young person

3.1. More work was needed to improve the YOT's approach to protecting the child or young person. While no immediate alerts were raised from the case sample assessed, case managers made sufficient effort to understand and explain vulnerability and safeguarding needs in less than half of the cases in the sample. In two cases, assessments of vulnerability were not undertaken at all. In others, the assessment was of insufficient quality, the vulnerability classification was inaccurate or unclear, or other relevant behaviour was missed, such as potential gang involvement in the neighbourhood, offences involving offensive weapons, or substance misuse. Case managers did not always understand the impact of a child or young person's offending or behaviour on their vulnerability.

3.2. Suitable plans were put in place to manage safeguarding and vulnerability at the start of the sentence in only half of the relevant cases in the sample. In the remainder of those cases, plans were not put in place at all.

3.3. The safeguarding needs of children and young people change over time and need to be kept under review. Case managers completed satisfactory reviews of safeguarding and vulnerability assessments in only 3 out of 11 relevant cases in the sample, and reviewed plans well enough in less than one-quarter of cases.

3.4. The effectiveness of management oversight, in ensuring the quality of work undertaken in relation to safeguarding and vulnerability work, needed to be far more robust. We found it to be effective in less than one-third of the relevant cases in the sample. This was mostly because deficiencies in assessment and planning had not been addressed. Most case managers interviewed felt they had sufficient knowledge of local policies and procedures for the management of safeguarding, though we did not always see this demonstrated in their work, and this imbalance needed to be addressed.

3.5. Pleasingly, case managers have had training in recognising risks associated with child sexual exploitation and an example of practice reflected this. An inspector noted: "*The case manager recognised child sexual exploitation risks because of the young person's involvement with older males, alcohol, and frequent episodes of going missing. A child sexual exploitation panel was held and there was multi-agency action involving the police, social care and YOT, which resulted in an adult male being arrested, spending a period in custody and an injunction put in place.*"

4. Ensuring that the sentence is served

4.1. This is the strongest area of work we found in the YOT. We expect to see that the YOT is doing what it can to help children and young people to complete their sentences successfully. This includes engaging with them and their parents/carers in the assessment and planning processes, identifying and addressing barriers to engagement, and putting measures in place to ensure they comply with the requirements of their sentence. We found a very good level of engagement in the great majority of cases between case managers, children and young people and their parents/carers. It was particularly

pleasing to note they were engaged in the development of all six of the PSRs in the sample.

4.2. Case managers gave appropriate attention to barriers to engagement and other diversity factors at the start of sentences in almost all of the cases.

4.3. Case managers also gave sufficient attention to the health and well-being outcomes for the child or young person, insofar as this may act as a barrier to successful outcomes from the sentence, in the large majority of cases. It was pleasing to hear that training in recognising speech, language and communication needs had commenced and was ongoing.

4.4. We found that children and young people complied with the requirements of their sentence in just over half of the cases in the sample, some after initial difficulties. Where children and young people did not comply, the response of the YOT was robust in most cases, such as issuing warning letters as appropriate, or returning them to court. We saw examples of where case managers were persistent in trying to engage with children and young people who were not complying with their sentence requirements. An inspector commented: "*There was evidence of good liaison with other professionals and efforts to engage the young person and give him every opportunity to engage*."

Operational management

We also found that most of the seven case managers we interviewed had sufficient understanding of local policies for the management of risk of harm to the public, and safeguarding. However, this was not always reflected in practice. Some staff spoke positively about their manager's knowledge and skills to support them in their work, while others were unsure. Some staff commented that they would like more effective supervision, and would welcome challenge and support to help them improve their work. Case managers reported a mixed picture in relation to the effectiveness of the countersigning and management oversight of risk of harm and safeguarding work. We found little evidence that staff supervision or other quality assurance arrangements had made a positive difference to the cases in the sample.

All of the case managers interviewed considered that their training and skills development needs were met to do their current job, and all felt they had received sufficient training to recognise and respond to diversity factors or potential discriminatory factors. It was positive to hear that staff had received training in recognising risk factors which may indicate child sexual exploitation.

Key strengths

- Children and young people and their parents/carers were engaged well in the initial assessment and planning processes.
- Initial plans to reduce the likelihood of reoffending had focused objectives which were meaningful to the child or young person, and reflected the factors linked to the risks of reoffending identified in the initial assessment process.
- Good effort was made by case managers to identify and understand diversity factors and barriers to engagement. They also gave attention to health and well-being outcomes for children and young people, insofar as this may act as a barrier to successful outcomes from the sentence.

Areas requiring improvement

- Case managers should review plans to help reduce the likelihood of reoffending in a more thorough and timely manner, so that they remain accurate and up to date.

- Assessments and plans to manage risk of harm posed by the child or young person to the public need to take account of all relevant information, the actual or potential harm to victims, and should anticipate potential changes in risk of harm, so that the public are protected.
- Case managers should ensure that assessments and plans to manage safeguarding and vulnerability take account of all relevant information, including risks to the child or young person through their own offending or behaviour, so that children and young people are protected.
- More account should be taken of the needs of victims in order to ensure that appropriate action can be taken to manage the risk of harm to them.
- Management oversight should be more consistent and more robust, including active management and sign off of relevant assessments and plans, and there should be processes in place to ensure these remain current and are of good quality.

We are grateful for the support that we received from staff in the YOT to facilitate and engage with this inspection. Please pass on our thanks, and ensure that they are made fully aware of these inspection findings.

If you have any further questions about the inspection please contact the lead inspector, who was Sue McGrath. She can be contacted at susan.mcgrath@hmiprobation.gsi.gov.uk or on 07557 848458.

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Chair of Youth Court Bench	*Shabana Glynn*
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Care Quality Commission	*Fergus Currie*
HM Inspectorate of Constabulary	*Paul Eveleigh*

Note 1: As an independent inspectorate, HMI Probation provides assurance to Ministers and the public on the effectiveness of work with those who have offended or are likely to offend, promotes continuous improvement by the organisations that we inspect and contributes to the effectiveness of the criminal justice system.

Note 2: We gather evidence against the SQS criteria, which are available on the HMI Probation website - http://www.justiceinspectorates.gov.uk/hmiprobation.

Note 3: To request a paper copy of this report, please contact HMI Probation Communications at communications@hmiprobation.gsi.gov.uk or on 0161 240 5336.