Inquiry into the supervision of Peter Williams by Nottingham City Youth Offending Team

2005
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1. INTRODUCTION

1.1 On the 30 September 2003, two men entered a jewellery shop intent on armed robbery. During the course of the robbery the proprietor, Mrs Marian Bates, was shot by one of the robbers and subsequently died.

1.2 The younger of the two men, Peter Williams, was at the time of the offence subject to supervision by Nottingham City YOT under the terms of a DTO licence, with an ISSP and curfew supported by electronic monitoring.

1.3 Following his conviction on 21 March 2005, the YJB asked HMI Probation to give an independent account to Ministers of the work undertaken with him during the course of his licence. The terms of reference for the inquiry were agreed on 29 April 2005 and were as follows:

- to enquire into the supervision of Peter Williams whilst subject to DTO licence
- to enquire into the implementation of relevant policies and procedures
- to enquire into any wider issues relating to the case
- to assess the effectiveness of the governance and supervision of DTO/ISSP cases by the Nottingham City YOT Management Board and YOT
- to consider any implications arising from the case for the development of the ISSP nationally by the YJB
- to identify areas for improvement and make recommendations as appropriate.
2. KEY FINDINGS AND RECOMMENDATIONS

2.1 Our inquiry found that:

- the YOT arranged for additional conditions to be inserted in Peter Williams’ release licence, but did not manage them assiduously enough
- in particular, the case manager should either have instituted breach proceedings in accordance with the national standard or sought the authorisation of the YOT Manager not to do so

**Recommendation:** The YOT should ensure that DTOs are enforced in accordance with national standards, absences are consistently recorded as acceptable or unacceptable and any decision not to proceed to breach after the second unacceptable absence is endorsed by a manager.

- even if the YOT had instituted breach proceedings within the required timescale, the consequent enforcement actions at court and elsewhere would have had to have been completed within 12 working days for Peter Williams to have been in custody on 30 September 2003. An ‘end-to-end’ enforcement target was introduced on 1 April 2005 whereby Community Penalty Breach Proceedings should take an average of 35 working days from the relevant unacceptable failure to comply to resolution of the case and that 50% of all breach proceedings be resolved within 25 working days of the relevant failure to comply. These targets currently relate to adult cases only and discussions are ongoing with the YJB to define the involvement of children and young people.

**Recommendation:** The YJB should:

- clarify the status of the enforcement target with regards to children and young people subject to community penalties
- ensure that the breach of DTO licences is subject to the same processes and scrutiny as community penalties
- issue guidance to YOTs on achievement of the target
- instigate appropriate monitoring arrangements

- Premier, the electronic monitoring company, monitored the curfew requirement and identified several occasions when Peter Williams appeared to be in violation of his curfew, but did not notify the YOT of any of these violations until the morning of 30 September 2003. This was potentially a significant contribution to the YOT’s failure to enforce the order assiduously enough
neither of Premier’s explanations of its understanding of the Home Office’s statement of operational requirements for electronic monitoring were satisfactory. In particular its view, given in writing, that there was no requirement, other than in HDC cases, to inform the supervising officer of ‘negative’ results from ‘random alternative monitoring’, implies that a curfew becomes a meaningless exercise other than in HDC cases

the Home Office’s statement of operational requirements for electronic monitoring did not clearly or adequately define the necessary actions for monitoring curfews in the ‘stand alone mode’

**Recommendation:** The Home Office should ascertain whether Premier’s interpretation of the statement of operational requirements for electronic monitoring is widely held and take action as appropriate.

**Recommendation:** The Home Office should review the statement of operational requirements for electronic monitoring and clarify it, if necessary, to ensure that it is not open to misinterpretation.

the requirements placed on YOTs by the YJB to implement alternative monitoring arrangements until electronic monitoring arrangements were in place, were unclear.

**Recommendation:** The YJB should clarify the expectations placed on YOTs by the YJB’s ISSP electronic monitoring protocol to ensure that the action expected of YOTs is both feasible and reasonable.
3. ADDITIONAL FINDINGS

3.1 Our inquiry also considered that:

- the lack of a range of suitable accommodation that was able to meet Peter Williams’ needs made it much more difficult for him to build his life on a secure base, and for the relevant agencies to work with him effectively

**Recommendation:** The Chair of the Nottingham City YOT Management Board should ensure that a suitable range of provision is available for homeless children and young people who need accommodation that will accept them with a requirement for electronic monitoring.

- the YOT did not appear to have thought through the implications of making Peter Williams subject to all the requirements of an ISSP, given the high demands of the programme and his previous failure to respond positively to other interventions

**Recommendation:** The YJB should issue guidance to YOTs in respect of the suitability and management of ISSP in such cases where there is a history of non-compliance.

- there was insufficient formal induction or training for new staff in the period leading up to the final release of Peter Williams, particularly on the use of assessment tools, recording systems or risk analysis. Although this was recognised by the YOT at the time, efforts to assist staff to perform at a satisfactory level were not successful, leaving some staff ill-equipped to deliver appropriate supervision of children and young people who had offended

**Recommendation:** The YOT Manager should ensure that a training needs analysis, identifying the requirements of all staff, is conducted and regularly updated so that staff are equipped to undertake the roles required of them.

- although the case manager’s work was overseen by both her line manager and a practice manager, her work with Peter Williams was not subject to sufficient oversight

- the need to record all contacts on the main case record was neither well understood by the case manager, nor enforced by management through auditing or supervision.
**Recommendation:** The YOT Manager should ensure that all staff receive regular supervision, during which a sample of their case files is examined to ascertain whether recording practices are sufficient, assessments and supervision plans are in place, policies are consistently implemented and that remedial action is taken where necessary.

**Recommendation:** The YOT Manager should ensure that case files are well organised and contain all relevant information, which is easily accessible to case managers, and that a system for archiving closed files is developed.
4. **THE EVENTS OF 30 SEPTEMBER 2003**

4.1 On the afternoon of 30 September 2003, Peter Williams and an unnamed adult entered a jewellery shop in Nottingham, both wearing crash helmets and intent on armed robbery. In the shop at the time were the proprietors, Mrs Marian Bates, her husband Victor Bates and their daughter Xanthe Kirkland-Bates.

4.2 Once in the shop, Peter Williams began attacking a display cabinet with a crow bar whilst the adult produced a gun and pointed it in the direction of Victor Bates, shouting the words: “*Back, back*”. At this time Xanthe Kirkland-Bates was on the telephone.

4.3 Seeing Xanthe Kirkland-Bates using the telephone, the adult ordered her to put it down. He pointed the gun in her direction, prompting Mrs Marian Bates to come forward and place herself between her daughter and the gunman. Having done so, she was shot.

4.4 The adult turned the gun back to Victor Bates and fired at him. The gun failed to discharge and the gunman attempted to reload. This delay allowed Xanthe Kirkland-Bates to jump on his back and prevent any further discharge of the weapon.

4.5 Subsequently, a struggle ensued between the adult and Xanthe Kirkland-Bates and Victor Bates. The struggle, however, came to an end when Peter Williams struck Victor Bates across his wrist, head and face with the crow bar, rendering him dazed and stunned. Both men fled the shop.

4.6 The gunshot wound to Mrs Marian Bates proved fatal and she was pronounced dead shortly afterwards.
5. SUMMARY OF THE RESPONSIBILITIES OF THE YOT

5.1 The principal aim of the youth justice system is the prevention of offending. Each local authority with social services and education responsibilities, in conjunction with a range of statutory partners, is required to establish and contribute to the YOT and ensure that services are available for children and young people who offend. The YOT is responsible to a steering group or management board, comprised of appropriate representatives from the various partners.

5.2 The person responsible for the management of a child or young person under the supervision of the YOT is generally known as the case manager or case worker. Assessments of children and young people known to the YOT must be undertaken using the YJB approved tool, Asset, at the commencement of any contact and at regular intervals thereafter.

5.3 The job description for case managers in Nottingham City YOT, at the time of Peter Williams’ supervision, included responsibility for undertaking assessments, translating assessments into supervision plans, delivering programmes of intervention and managing a caseload of children and young people subject to statutory supervision. It also included expectations of liaison, coordination and working with colleagues within the YOT and its partner organisations.

DURING THE CUSTODIAL PART OF THE DTO

5.4 The 2002 national standard required that the YOT allocate a supervising officer to a child or young person within one day of sentence.

5.5 An Asset assessment should be completed at the time of sentence and forwarded to the institution with other papers. The first review meeting must be held within one month of sentence and the YOT must remain in regular contact.

THE SUPERVISION OF DTO LICENCES

5.6 The arrangements for supervision and breach of DTO licences effective at the time, including any additional requirements, were that:

- unexplained missed appointments must be followed up by a YOT staff member within one day
- if there was no acceptable reason for the failure, there must be a formal warning or breach
- the acceptability of any explanation must be noted on the file with copies of any warnings
• breach action must be initiated within ten working days of the most recent failure to comply if the offender receives more than two warnings
• breach action could only be stayed in exceptional circumstances with the authorisation of the YOT manager.

5.7 Where assessed as appropriate by the YOT, it is possible to request that the governor of the discharging institution adds additional requirements to the release licence. In the case of Peter Williams, the licence contained the following additional requirements:
• ‘Comply with the directions of the supervising officer in respect of taking part in ISSP.
• Be at your curfew address between 10.00pm and 7.00am.
• Compliance with the curfew will be monitored by electronic tag.’

5.8 An ISSP is an intensive programme of intervention which offers 25 hours planned contact time per week. Subject to meeting the relevant criteria, it is available to all children and young people supervised by the YOT.

5.9 Peter Williams was also required to abide by a curfew, monitored by means of an electronic monitoring device. In the event of any difficulties with the address given on the licence for monitoring purposes, it was the responsibility of the:
• case manager to arrange for any variations to the address
• electronic monitoring company, once it had received instructions from the prison governor, to inform the case manager of breaches of the curfew.

BREACH OF DTO LICENCES

5.10 The supervising officer from the YOT is responsible for the collation of the evidence of breach from all component parts of the DTO licence, including a curfew.

5.11 Breach of a DTO licence remains a matter for the sentencing court and any alleged breach must be proven in court. The YOT must apply to the court to issue a summons or warrant and for the case to be listed. The time taken to complete this process varies according to the internal processes of the YOT, protocols with the court and the availability of court dates. Nationally, an ‘end-to-end’ enforcement target for community penalties (covering the period between the failure to comply and disposal by the court) has recently been set of 35 working days.

5.12 Individual cases may be prioritised with the agreement of the court, usually on the basis of their assessed risk of harm or the prolific nature of
their offending pattern. At the time of the murder, Peter Williams fell into neither of these categories.

5.13 There are no powers of recall outside of this system.
6. **BACKGROUND INFORMATION ON PETER WILLIAMS**

6.1 The full history of Peter Williams’ development and the efforts of various agencies to intervene in his life are beyond the scope of the inquiry. It would, however, be wrong not to offer some contextual information. Peter Williams’ experiences undoubtedly shaped his developing personality and contributed to his lifestyle, attitude and ultimately the offences for which he was convicted.

6.2 Born in 1985, Peter Williams had no contact with his mother or twin brother from an early age. Records indicate that from the age of four he lived with his father until, after a number of minor offences followed by offences of burglary, he received his first custodial sentence aged 15. Between this time and his arrest in January 2004 in connection with the murder, there were five brief periods when he was not in custody, the longest of which was less than ten weeks.

**SUMMARY OF PREVIOUS CONVICTIONS**

6.3 Peter Williams’ early criminal record was unexceptional. He received two cautions shortly before his 11th birthday and was further cautioned when aged 12, all for offences of theft. He was sentenced to an attendance centre order when he was aged 13, for further thefts from shops and interfering with a motor vehicle. Shortly after his 15th birthday he received two reparation orders for handling stolen goods and thefts. Records indicate he completed the first of these reparation orders, but that he was incarcerated before the second could be commenced.

6.4 At the age of 15, Peter Williams’ offending behaviour escalated rapidly and he was convicted of two counts of dwelling house burglary and a further two offences of theft, dealt with by way of a 12-month DTO. Within two months of his release from this DTO, then aged 16, Peter Williams was convicted of more burglaries and received a further 18-month DTO.

6.5 Once again, shortly after release on this DTO licence in March 2002 Peter Williams committed further burglaries. Following a remand in custody, he was sentenced to a supervision order with an ISSP for these matters in July 2002. At this time he was also convicted of an offence of indecent assault which had occurred a year previously.

6.6 These were Peter Williams’ last substantive convictions prior to the murder of Mrs Marian Bates. Six weeks after the imposition of the supervision order with ISSP, he was convicted for a breach of the order. He was sentenced to a 16-month DTO on 12 September 2002.
6.7 He was released on DTO licence with an ISSP and curfew supported by electronic monitoring on 13 May 2003. He breached the licence conditions within a matter of weeks, leading to recall. Following a further three months in custody he was released on 10 September 2003. By the time of the murder of Mrs Marian Bates, 20 days later, Peter Williams was once again in breach of his licence and arrangements had already started to instigate court proceedings. He was eventually summoned to attend court on 29 October 2003, but failed to attend. He was arrested on warrant and appeared before court on 11 November 2003 when he was returned to custody.
7. **EARLY CONTACT WITH THE YOT**

7.1 In order to understand the supervision of Peter Williams whilst subject to DTO licence at the time of the murder, we looked in some detail at the YOT’s earlier contact with him and his response.

**FROM OCTOBER 2000**

7.2 Peter Williams’ first substantial contact with the YOT was in late 2000 when a PSR was written. The PSR did not directly address whether he was considered a risk of serious harm to others, although it did acknowledge that: ‘the rate and seriousness of Peter’s offending has increased in recent months’. Although Peter’s father was described as caring, he was said to be: ‘at the end of his tether and finding it increasingly difficult to deal with him’. Peter Williams himself, was described as: ‘an immature boy with a blasé attitude to his offending...He appears not to be bothered about what happens to him’. The PSR author proposed a 12-month supervision order.

7.3 Despite the proposal for a community penalty, the sentencing court took the view that custody was appropriate and Peter Williams was sentenced to a 12-month DTO in October 2000. There was no record of the use of the Asset assessment tool at this stage, although the PSR did include an assessment of his motivation to offend that included the desire to obtain cash to purchase cannabis.

7.4 From shortly after the imposition of the DTO it became clear that his father was seriously ill and Peter Williams was allowed compassionate leave to visit him in hospital. After his father died on 15 November 2000, Peter Williams was recognised as being at risk of self-harm from this point onwards. Due to fears over his vulnerability, he was placed on ‘suicide watch’ and transferred to a secure unit.

7.5 Any positive attempt to engage Peter Williams during this first custodial sentence was overshadowed by the death of his father. A consequence of which was he had no obvious release address, no ‘family home’, or other significant positive family influences from the age of 15. When not in custody he lived at various addresses, including a children’s home, semi-independent supported lodgings and with friends. He was allocated a social worker from the Assessment Team on 22 November 2000. From this point onwards, the City of Nottingham Social Services Department had responsibilities towards his care, although there appears to have been minimal contact with him prior to his release. His case was allocated to two social workers from the social services Assessment Team before being transferred to the Leaving Care Team 15 months later.
7.6 There was evidence of joint working between the YOT and social workers from City of Nottingham Social Services Department, but communication between the Assessment Team and the Leaving Care Team did not appear to be extensive. The Leaving Care Team had little information about Peter Williams’ time as a Looked After Child. There was also evidence of potentially useful information not being communicated to the YOT.

7.7 The YOT case manager was accompanied by a social worker from the Assessment Team on at least one visit to Peter Williams in custody. Attempts were made to place Peter Williams with a family friend. A release plan was formulated, but ultimately failed as the offer of the family friend was withdrawn after he was suspected of stealing from her. A place was found for him at a local authority children’s home and on his release, on 25 April 2001, he was taken to the home by the YOT case manager.

7.8 Within a short time of his release on licence, Peter Williams came to the notice of the police in connection with two offences of burglary on 11 and 13 June 2001 and being on enclosed premises on 16 June 2001. Following his arrest, now aged 16, he was bailed for a further PSR.

FROM JULY 2001

7.9 An Asset assessment was completed at this stage, the earliest that could be located by the inquiry. Of the 13 sections assessing need, several were poorly completed. However, the section on indicators of serious harm to others was fully filled out, with all questions answered ‘no’. On the basis of what was known at the time, this was a reasonable conclusion to this critical section. No contextual information had been given in the section, although it would have been good practice to record any additional information on risk of harm, or absence of it, as part of the assessment.

7.10 The Asset tool gives an indication of the likelihood of further offending. Those completed by the YOT on Peter Williams were consistently of a poor quality. The first assessment on family and personal relationships concluded that this area of his life had no association with the likelihood of further offending, and other data on the assessment forms were partial or, in some cases, inaccurate. The overall score in the case of Peter Williams was 25 (from a maximum of 48) indicating a high probability of reoffending.

7.11 The PSR described the burglaries as involving a greater level of planning than his previous convictions. The offence analysis concludes that there was: ‘a [sic] increase in the seriousness of his offending behaviour’. Although the PSR proposed an 18-month supervision order, Peter Williams was sentenced to a further 18-month DTO.

7.12 There was evidence of some work being undertaken with Peter Williams by the institution in partnership with the YOT and Leaving Care Team. With
the assistance of social services, he discovered his mothers’ whereabouts and established contact with her for the first time since he was four years old.

7.13 On his release, now less than two months prior to his 17th birthday, a temporary place was found for him in semi-independent accommodation for homeless young people. He was released to this address on 2 April 2002. Within a short time he had moved to other shared accommodation. Despite some support from the Leaving Care Team, Peter Williams was unable to cope and was evicted. Although he returned to the semi-independent accommodation, he also spent some time living with his mother. Unfortunately, these arrangements were short-lived and did not provide him with the emotional or practical stability he needed. Following this contact he expressed negative thoughts about his mother in what was effectively a suicide note.

FROM JULY 2002

7.14 Within six weeks of his release, Peter Williams had been arrested in connection with two burglaries. In addition, he was also convicted of an indecent assault against a female resident of the children’s home where he had previously stayed. This offence had occurred nearly a year before. He was remanded in custody for a PSR.

7.15 We were unable to locate an Asset assessment from this period, however, there was a PSR that repeated the earlier assessment. The PSR concluded that custody: ‘has failed to have any impact on him and is unlikely to have any positive effect third time around’ and proposed an 18-month supervision order with ISSP and curfew. The PSR and ISSP report gave an indication of the work to be undertaken, including a ‘life skills programme, reparation work, victim awareness, offence-focused work’. The order was made on 4 July 2002.

7.16 Peter Williams’ response to this disposal was poor. The curfew arrangements were never effectively begun due to two changes of his address within a short period. He attended only two office appointments and was in breach of his order within a short while. Efforts were made to return him to court, although he failed to answer to his bail. A warrant without bail was sought and he was eventually arrested on 23 August 2002.

FROM SEPTEMBER 2002

7.17 A further PSR was requested and produced, that detailed Peter Williams’ failure to engage with the constructive options offered to him. It made the assessment that: ‘until Peter is willing to engage with services that are trying to assist him, he is likely to spend more time in custody and reoffend on release’.
7.18 An Asset assessment was undertaken at this time, although only five of the 12 pages could be produced for the inquiry, the others having been lost. The overall score was not available.

7.19 No community-based proposal was made and on 12 September 2002. Peter Williams was sentenced to a 16-month DTO for breach of the supervision order.
8. THE SUPERVISION OF PETER WILLIAMS ON THE DTO IMPOSED ON 12 SEPTEMBER 2002

DURING THE CUSTODIAL ELEMENT

8.1 Peter Williams’ YOT case manager at the time of his sentence was also his first case manager during the custodial part of the sentence. He was therefore effectively allocated a case manager in accordance with the national standard.

8.2 The first review meeting was held within one month of Peter Williams’ sentence, again in accordance with the national standard. There were further review meetings in November 2002 and January 2003.

8.3 Although there were initially some signs of positive engagement with the custodial regimes, this deteriorated over time. At the January meeting, three months prior to his release, Peter Williams was described as withdrawn, spending most of his time in his cell, disengaged from education classes and with little in the way of social skills to interact with other inmates. Records describe him as sleeping all day and being awake at night, and being watched for self-harm. He was said to be working with a psychiatrist to assist with his assertiveness, although the outcome of this work does not feature in the YOT record. By the time of his release, he was considered as incapable of following even the most basic rules, lacking the social skills to interact with other inmates and withdrawn.

8.4 There were regular contacts from both the YOT and the Leaving Care Team, although the YOT records do not detail a final pre-release review. A further Asset assessment was done at the time of release. The assessment included a rudimentary supervision plan which was of poor quality, setting no realistic plan of intervention.

8.5 Although it was acknowledged that Peter Williams was likely to have great difficulty complying with the additional requirements, in order to provide him with additional support and structure a decision was taken by the YOT to ask the Governor of the institution to include a condition of attendance at an ISSP on release and a curfew monitored by an electronic tag.

8.6 One of the main problems that the case manager and other professionals were faced with was finding suitable accommodation for Peter Williams. Despite his vulnerability and status as a care leaver, there were limited opportunities in the Nottingham area. Peter Williams’ accommodation problems were further compounded by his status as a sex offender, his previous behaviour in semi-independent accommodation and the requirement for an address that would accept him with the electronic
monitoring device. The absence of a range of local facilities that were able to meet his needs made it more difficult to establish a stable base for him from which he could be worked with successfully.

8.7 Ultimately, accommodation was found for Peter Williams in Alexandra Court, a block of flats in which young people could live independently, but were provided with on-site support.

8.8 Under legislation current at the time, as a convicted sex offender Peter Williams was required to sign the sex offenders’ register within 14 days of his release from custody.

**ON RELEASE ON DTO LICENCE FROM 13 MAY 2003**

8.9 Peter Williams was released on 13 May 2003 with additional conditions on his licence. The fact of his release was not noted on the main YOT record of contact and there were no records of any contacts between Premier, the electronic monitoring company, and the YOT. He was given an address where he initially resided. It was clear that he was not happy with the accommodation as the YOT case record indicated that: ‘he was depressed about being in Alexandra Court and felt let down by social services’.

8.10 The YOT record clearly indicated that he was seen on several occasions. These contacts by YOT staff focused appropriately on the very practical issues of accommodation, clothing and financial support which needed to be addressed before further work could be undertaken on his offending behaviour. He also missed a number of appointments.

8.11 On Monday 19 May 2003 he reported that he had been attacked at the accommodation and wished to reside elsewhere with a friend. This was not acceptable to the YOT as the proposed arrangements were vague and any potential address would have needed to be checked for suitability. Although he did report to the office without an appointment on Wednesday 21 May 2003, he missed a range of appointments and on 23 May 2003, ten days after his release, the case manager decided to instigate breach proceedings.

8.12 Peter Williams then did not appear to have been seen by YOT staff until 3 June 2003, when he attended without an appointment. On 5 June 2003, a date was provided for the breach hearing on 25 June 2003. There were further unscheduled visits to the YOT office on 6 and 9 June 2003, when Peter Williams was seen briefly.

8.13 On 11 June 2003, Peter Williams was arrested and taken to court for failing to sign the sex offenders’ register. The alleged breach of DTO licence was put to him and he was recalled to custody for three months.
THE PERIOD OF CUSTODY FOLLOWING THE RECALL ON 11 JUNE 2003

8.14 A DTO planning meeting was convened on 17 June 2003, although there was no record of the contents of the meeting on the YOT record of contact. It was, however, clear that Peter Williams was moved from the initial institution he was placed in, after less than a month as: ‘his behaviour has become unmanageable. He is still on suicide watch’. After two days in a second institution he was moved to a third. Despite the case manager enquiring about the transfer, there does not appear to be any information as to the reason.

8.15 The case manager attended one further review meeting four weeks prior to Peter Williams’ re-release. At this stage he was described as continuing to have a poor attitude, there were concerns about his behaviour and he was generally difficult to engage.

ON RELEASE ON DTO LICENCE FROM 10 SEPTEMBER 2003

8.16 Peter Williams was released from custody on the 10 September 2003. This was his second release from custody on licence for the DTO originally imposed on 12 September 2002.

8.17 Again, the YOT decided to ask the Governor of the releasing institution to include additional requirements in Peter Williams’ licence. These included the fitting of an electronic tag to monitor a curfew and intensive contact with the YOT through ISSP. Although the reasons for this decision were not adequately recorded, staff interviewed expressed the view that it was their intention to use the additional contact to encourage and compel him to accept the services they were able to offer. Whilst this decision had its merits in principle, it committed Peter Williams to a higher level of contact than he had previously been able to achieve and hence was a major challenge for him. It, therefore, required a clearly thought out approach to managing such a programme by the YOT if it were to have any chance of success.

8.18 However, an Asset assessment was not completed prior to Peter Williams’ release, although one was completed two weeks after his release.

8.19 Furthermore, there was no explicit supervision plan or clearly expressed objectives of supervision. The schedule of interventions intended for Peter Williams was said by the case manager to be contained within a ‘timetable’ generated by the ISSP computerised recording system. Unfortunately, there were no paper records of this timetable, and no evidence of it within the archive of the computer system could be produced for the inquiry. It was, therefore, not possible to scrutinise this timetable.
ELEMENTS OF PETER WILLIAMS’ SUPERVISION

8.20 Despite the absence of a clear supervision plan or timetable, we could deduce what the expected contacts were by analysing various sources of information from the electronic and paper records held by the YOT. It was the role of the case manager to oversee and orchestrate these interlocking interventions and enforce any failures to comply that were statutory requirements of the licence. These included:

- contacts between the YOT, its partners and Peter Williams, such as meetings with his case manager, Connexions worker and reparations staff
- reporting to the police station at the weekend
- receiving ‘tracking visits’ – these required him to be at his given address at certain times (separate from the curfew arrangements below) and to meet with YOT staff
- compliance with a curfew, monitored by means of an electronic monitoring device.

8.21 Other arrangements were made for Peter Williams that, although desirable, were not required under the terms of his supervision. These included appointments with:

- a drug counsellor
- the Leaving Care Team
- the housing department
- regard to his claims for benefits.

8.22 Peter Williams reported to this case manager on 10 September 2003, the day of his release. He was required to reside at a particular accommodation that was prepared to accept him with the electronic tag. This was problematic as there were few places that provided such accommodation in the area, other than Alexandra Court which Peter Williams was reluctant to consider as an option. In the event, the YOT information system recorded that: ‘he had presented himself as instructed, but Alexandra Court not happy to have him’.

8.23 The full reasons why Alexandra Court refused Peter Williams accommodation were not recorded. The failure to reside at Alexandra Court was potentially Peter Williams’ first example of non-compliance with the conditions of his licence, although it was not recorded as such. If it had been judged that the situation was not of Peter Williams’ making, it could be designated an acceptable reason for non-compliance and not count towards any breach action. Although the failure to record this decision about acceptability or unacceptability was an omission, our interpretation
is that, *de facto*, the YOT accepted the reason for non-compliance and it was, therefore, not the first failure to comply with the licence.

8.24 Information was received from the housing department of an address given by Peter Williams on 11 September 2003. The case manager and YOT police officer visited the address and, although there was no indication that Peter Williams had spent the night there, the resident indicated that he would be welcome. The YOT informed Premier, the electronic monitoring company, that the original address was not valid and that it would confirm a new address in due course. Premier could not, therefore, fit the tag and start monitoring the curfew at this stage.

8.25 The YJB’s ISSP electronic monitoring protocol (2002) stated that: ‘it is the responsibility of the supervising officer to implement alternative monitoring arrangements as appropriate until the electronic monitoring arrangements are in place’. Other than through random visits to the address during the curfew period, when the child or young person may well be asleep, YOTs had no mechanism to meet this requirement in the absence of a technical solution and it was unclear how they could discharge this responsibility.

8.26 Later that day, 11 September 2003, the case manager and other members of the YOT staff saw Peter Williams. However, he was not at the address he had given for the evening tracking visit. The YOT cited this failure as the first evidence of breach.

8.27 There were no records of any contacts required or kept on 12 and 13 September 2003 in the main YOT recording system, although the YOT gave a failure to attend on 12 September 2003 as the second breach in subsequent warning letters.

8.28 Peter Williams was required to ‘sign in’ at the police station on 14 September 2003 as a requirement of his supervision, but failed to do so. This was cited as the third failure.

8.29 According to the national standard for the enforcement of DTO licences, these failures should have triggered breach proceedings ‘unless stayed in exceptional circumstances with the authorisation of the YOT manager’. There was no evidence that such authorisation was sought or received.

8.30 However, even if the YOT had instigated breach proceedings at this first opportunity, i.e. four days after Peter Williams’ release, it would have to have been completed in less than half the time set by the national ’end-to-end’ enforcement target, for the case to have been dealt with by the court prior to the date on which Mrs Marian Bates was murdered.

8.31 On 15 September 2003, Peter Williams failed to attend the YOT office as instructed and a first warning was issued, (presumably by post) to cover the failures of 11, 12 and 14 September 2003.
8.32 On 16 September 2003, Peter Williams failed to attend one appointment with a drugs worker, but was seen by his case manager during a second appointment at the address he had given. This was the last recorded meeting between the case manager and Peter Williams. The case manager accepted the new address and on 17 September 2003 contacted the YOI to have the licence amended to enable electronic monitoring to start.

8.33 Peter Williams failed another appointment on 17 September 2003, this time with one of the YOT’s education staff. There were no entries on the main YOT information system for 18 September 2003, although a failure to attend on 18 September 2003 was later given in a warning letter.

8.34 In the late evening of 18 September 2003, Premier staff made a first attempt to fit the electronic equipment at the given address. They were unable to do so as they could not gain access. The YOT was not informed of this failure.

8.35 On 19 September 2003 a tracking visit was planned, although there was no record of it taking place. The YOT record indicated that Peter Williams received a further warning for failure to attend on 17 and 18 September 2003 (even though the record does not make it clear that he was offered an appointment on this date).

8.36 The YOT was informed by fax, in the early hours of the 20 September 2003, that Premier had successfully inducted Peter Williams in ‘stand alone mode’ at his address the previous evening. Under the terms of the statement of operational requirements for electronic monitoring, Premier was then expected to contact the YOT to report failures to comply only.

8.37 There were no entries on the YOT system for 20 September 2003. On 21 September 2003 Peter Williams failed to sign in at the police station as required and on 22 September 2003 failed to attend the YOT.

8.38 Once again Peter Williams had not to keep appointments with the YOT. His case manager believed that she had given him as much latitude as possible to comply with the terms of his order and could no longer justify not initiating breach proceedings. On 23 September 2003, when Peter Williams phoned the YOT, he was informed that breach action would be taken.

8.39 The case manager initiated action to start the breach process by completing a draft witness statement on 23 September 2003, however, the breach papers were not actually checked and signed until 7 October 2003. There was no explanation for this delay other than the relevant YOT staff did not pursue the matter assiduously enough. This caused an unnecessary hold up of two weeks.

8.40 Although Peter Williams had a number of appointments to keep after this date, the only contact with him was when a message was left at the office
on 29 September 2003 to inform the YOT that his electronic monitoring device had come off in a fight.

8.41 As the YOT had received no information from the Premier to this date that Peter Williams had failed to comply with the curfew, it was reasonable of the staff to assume that he had complied with the terms of the curfew between 20 and 29 September 2003. This matter is referred to below.

8.42 Unknown to the YOT and other authorities, on the 30 September 2003, Peter Williams was involved in the murder of Marian Bates.

8.43 On 7 October 2003, the witness statement and application for a summons in connection with the breach was completed and sent to court. On the 13 October 2003 a summons was sent to Peter Williams requiring him to attend court on the first available date, two weeks later on 29 October 2003.

8.44 On 29 October 2003 Peter Williams failed to attend court, a warrant without bail was issued. He was arrested on a warrant and returned to custody on 11 November 2003.
9. **THE ROLE OF PREMIER, THE ELECTRONIC MONITORING COMPANY**

9.1 In order to monitor a curfew electronically, a dedicated telephone land-line has to be installed by British Telecom to send a ‘live’ compliance report to the electronic company’s monitoring centre.

9.2 At the time, there were two interim measures which could be used, one based on mobile telephone technology and the other a stand alone unit. In the ‘stand alone mode’, the electronic tag was fitted on the offender and the monitoring equipment installed in their home, but not connected to a telephone line. The monitoring equipment recorded the presence or absence of the electronic tag, although it could not send the information to the monitoring centre. In the case of Peter Williams, Premier fitted a stand alone monitoring unit.

9.3 There were requirements in the contract between the NPD (acting on behalf of the Home Office) and the electronic monitoring company to deal with these circumstances, which were not unusual. The contract required company personnel to visit the address (at least two hours apart) each curfew period and check for the presence of the tagged individual. This process was done by means of a hand-held device that detected the presence of the electronic tag and is known as ‘random alternative monitoring’.

9.4 There was a detailed schedule of actions required by the electronic monitoring company in the event of failures to comply with the curfew. These were classed as level one or level two violations. According to the statement of operational requirements for electronic monitoring, in the case of DTOs the company was required to report any level one or level two violations to the supervising officer by 5.00pm on the day of the violation, or 10.00am the next day, when the violation occurs after 4.30pm.

9.5 A level one violation is defined as: ‘being absent for one entire curfew period during any 24 hours, including HDC cases where a curfewee, if subject to random monitoring, and at both visits to the curfewee’s address during the curfew period, the curfewee is registered as being absent and does not respond to an attempt to verify his presence’.

9.6 A level two violation is constituted by: ‘being absent for a total of two hours or more of the curfew period during any period of 24 hours’.

9.7 These requirements were open to misinterpretation. Premier initially told the inquiry that if the tagged individual was absent for both visits, this would be treated as a level one violation and the YOT would be informed.
If the individual was present for one, but not for the other visit, this would not be treated as a level two violation and the YOT would not be informed.

9.8 Subsequently, Premier told the inquiry in a letter dated 28 June 2005 that: ‘only when an individual is subject to a HDC is there a requirement to report negative random monitoring visits’.

PREMIER’S CONTACT WITH PETER WILLIAMS

9.9 We had access to the paper records retained by Premier. These records were not fully comprehensive, lacking some of the original field monitoring officer reports from certain key periods. Elements of the reports were also poorly completed.

FROM 10 SEPTEMBER 2003

9.10 Premier was unable to fit the electronic tag or monitoring equipment until they had received authorisation from the YOI Governor to proceed at the new address. The Governor could not issue such authorisation until in receipt of a valid address, which could only be supplied by the case manager. The case manager attempted to verify each of the two potential addresses she had for Peter Williams, but due to his failure to maintain contact and keep her informed of his whereabouts, this took her until the evening of the 16 September 2003. She contacted the YOI the next morning, 17 September 2003. On 18 September 2003, Premier received the required instructions.

FROM 18 SEPTEMBER 2003

9.11 Premier staff attempted to fit the electronic tag and monitoring equipment during the curfew, late on 18 September 2003, however they were unsuccessful as Peter Williams was not at the given address. The YOT was not notified of this failure, in accordance with the requirements placed on the company.

9.12 The next evening, 19 September 2003, a further attempt to fit the tag and equipment was made, this time successfully. The YOT was informed of the commencement of monitoring on 5.40am on 20 September 2003.

9.13 This was the last information received by the YOT until 6.56am on 30 September 2003. The following evidence was not therefore available to the YOT to inform the supervision of Peter Williams.

9.14 Details of the contact between Peter Williams and Premier from 20 September 2003 to 29 September 2003 are shown in the following table.
<table>
<thead>
<tr>
<th>Date</th>
<th>Details of contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.09.03</td>
<td>Peter Williams was present at the curfew address for both random alternative monitoring visits. As a consequence there was no action required by Premier.</td>
</tr>
<tr>
<td>21.09.03</td>
<td>Premier visited the curfew address on only one occasion and the hand held device was unable to detect the electronic tag. A second visit was not conducted (in contravention to the requirements of the contract). There was no contact with the YOT. There was evidence, obtained on 10 October 2003, when the stand alone monitoring device was removed from the address, that Peter Williams was actually at the curfew address on this occasion.</td>
</tr>
<tr>
<td>22.09.03</td>
<td>Peter Williams was present on two occasions during the curfew period.</td>
</tr>
<tr>
<td>23.09.03</td>
<td>There was no evidence of the presence of the tag from the stand alone monitoring unit after the commencement of the curfew period on 23 September. Clearly the electronic tag was removed at some time after this point.</td>
</tr>
<tr>
<td>24.09.03</td>
<td>No visits were carried out.</td>
</tr>
<tr>
<td>25.09.03</td>
<td>Premier was unable to detect the presence of the electronic tag.</td>
</tr>
<tr>
<td>26.09.03</td>
<td>Premier was unable to detect the presence of the electronic tag.</td>
</tr>
<tr>
<td>27.09.03</td>
<td>Premier was unable to detect the presence of the electronic tag.</td>
</tr>
<tr>
<td>28.09.03</td>
<td>Premier was unable to detect the presence of the electronic tag. The YOT was not informed of any of these violations of curfew.</td>
</tr>
</tbody>
</table>

9.15 On the morning of 29 September 2003, the YOT received information that the electronic tag had been removed and informed the electronic monitoring company of this. In response, Premier staff attended the curfew address in the curfew period with the intention of re-fitting the tag. Peter Williams was not present and the visit was unsuccessful.

9.16 On 30 September 2003, the YOT received two faxes from Premier; the first of these informed them that electronic tag had not been refitted due to Peter Williams not being present when their staff called. This was the first indication the YOT received to suggest that there had been any breaches of the curfew requirement, despite our finding of at least six occasions when there was clearly evidence of breach available that should have been passed to the YOT.

9.17 The second fax, received three hours later, informed the YOT that Peter Williams ‘had a dedicated BT line installed for monitoring purposes on 29th. The site will now be monitored live’. This was interpreted by the YOT as meaning that from that point Peter Williams was being monitored. In reality the installation of the telephone line by British Telecom, without the monitoring equipment being connected to the line by Premier and the
refitting of the electronic tag, did not actually give the Premier the ability to monitor the curfew.

9.18 On 7 October 2003, the YOT was informed of failures to gain access to fit the equipment on 3, 5 and 6 October 2003. Our interpretation is that by this point Peter Williams had been in constant breach of the curfew requirement for two weeks.

9.19 Premier staff continued in their attempts to fit the electronic tag and equipment until 11 October 2003 when they visited and found Peter Williams at the curfew address. Monitoring continued from this point with multiple failures to comply. The YOT was informed of only one of these failures, on the night of the 25 October 2003. The equipment was removed on 26 October 2003 following information that Peter Williams was in police custody.

9.20 Although Peter Williams appears to have been in custody at this time, he was subsequently released. It was not clear to us whether the police informed Premier of the release. No attempts were made to re-start tagging, although he should have continued to be electronically monitored whilst still subject to theDTO curfew. This requirement could only be rescinded by the court if he was convicted of the breach. He failed to surrender to his bail on 29 October 2003 and was eventually arrested on 10 November 2003.

COMMUNICATION BETWEEN PREMIER AND THE YOT

9.21 Premier did not notify the YOT of the many apparent violations in the first ten days that the curfew was monitored, in accordance with their own interpretation of the contract. The majority of failures to comply were only communicated to the YOT several days after the event, following information being sent from the YOT to Premier.
10. YOT MANAGEMENT AND GOVERNANCE

RECORD KEEPING WITHIN THE YOT

10.1 The main source of documentary evidence for the inquiry was the YOT information system, where all appointments, contacts, interventions and assessments should be logged. During the period that Peter Williams was known to the YOT, the practical arrangements for recording information in Nottingham City YOT changed. The electronic information system initially used by the YOT had proven inadequate and another system was purchased and instituted. Also, the Asset assessment tool was initially completed by hand, with an electronic version introduced later.

10.2 As a person subject to an ISSP, Peter Williams should have been provided with a detailed timetable to cover 25 hours activity a week. Although there were references to ISSP timetables in the main file, no actual record of the relevant timetables could be produced. We are prepared to accept assurances that such timetables were used, however the inability of the YOT to produce any of the timetables renders them beyond scrutiny.

10.3 The YOT was unable to produce all relevant paper files for the inquiry at the start of the fieldwork. This was despite the fact that the case had been inactive for over a year, had been the subject of an internal review and of interest to the police in terms of the murder investigation. Additional papers were produced during the fieldwork, leading to the impression that YOT was unable to marshal the information available, even after the event.

10.4 We asked to look at other cases from the same time period as Peter Williams’ supervision for the purposes of comparison and this confirmed our impression that case records were generally not well organised. All of the files provided were extensive, some containing as many as 16 sub-files and folders in addition to the electronic records. It, therefore, was not feasible for us to examine these files in any depth within the timeframe originally agreed for this inquiry, and we questioned whether YOT practitioners would have found them useful.

10.5 It was clear that at the time of Peter Williams’ supervision, the need to record all contacts on the main case record was neither well understood by the case manager, nor required by the line manager for auditing or supervision purposes. There were several entries on the system for which there were no logical explanation other than human error, such as the recording of failures to attend office appointments when Peter Williams was, in fact, in custody and a second warning being issued on the day of release for failures to attend despite evidence of attendance.
Although it proved possible through cross referencing to deduce the dates on which certain factual events occurred, other significant events and appointments were not recorded at all. From the records kept, it was clear that there was a failure of management oversight in relation to the case of Peter Williams.

THE CASE MANAGER

The case manager allocated the responsibility for Peter Williams was relatively inexperienced; she had no formal qualifications in youth work, social work or probation, although she had worked with disadvantaged children before joining the YOT and undertaken voluntary work for the probation service. She was initially employed via an agency to work within the YOT in the summer of 2002.

The case manager's perception of her initial time in the YOT was that, as an agency member of staff, she was expected to understand the job she had been employed to do. She received no formal induction or training at this time. The main method of learning was to accompany other staff and observe their practice. When the opportunity arose to join the YOT as an ISSP case manager and a permanent member of staff, she was keen to apply and was successful.

Having joined the YOT permanent staff there was still no formal induction. Initially she observed and shadowed Peter Williams’ previous case manager, formally assuming responsibility immediately prior to his release.

OPERATIONAL AND LINE MANAGEMENT

Arrangements for the management of staff in 2003 were that case managers had both a practice manager, responsible for day-to-day case work supervision and a line manager responsible for training and development.

At the time of Peter Williams’ release his allocated case manager was relatively inexperienced. The practice manager was a trained probation officer with significant practice, although not management experience. There was evidence of regular case discussion meetings between the case manager and the practice manager. The contents of these meetings were recorded, although not in great detail. The agenda of the meetings was largely set by the case manager and there was no evidence that the electronic or paper case file was scrutinised. There were no entries on the file from the practice manager to indicate that the file had been read or decisions endorsed. The notes of the meetings indicated that they were reflective of decisions already taken rather than forward looking.
The line manager was relatively new to the ISSP, although experienced in the YOT. She had been asked to take on responsibility for the ISSP when the previous manager left. Her primary focus was on negotiating with the partners to the ISSP, ensuring that it was possible to achieve the 25 hours contact time for each child or young person under supervision and dealing with a range of issues in connection with the development and financing of the ISSP, which was still in an early phase of development.

The line manager had responsibility for supervising the case manager on a monthly basis. Her remit did not include discussion of cases, which was the responsibility of the practice manager. She did, however, recall that Peter Williams presented behavioural problems, but was not seen by the YOT as potentially dangerous.

Although the training needs of the case manager were eventually recognised and met, the absence of a holistic approach to supervision, with no manager apparently reading the case files and monitoring the quality of the interventions was a significant weakness.

The YOT did have in place a document titled *Policy, Practice Guidelines and Procedures for Identification, Assessment and Management of Risk of Harm*, dated March 2000. This indicates an awareness of the importance of issues of harm at the time of Peter Williams’ contact with the YOT. The document outlines the general principles of risk assessment, definitions of types and levels of risk, and procedures for completing the Asset assessment tool.

Although this document demonstrated a level of management awareness of the issues, the absence of a thorough induction process for new staff and close oversight of files reduced the likelihood of the policy being understood and followed.

**THE MANAGEMENT OF THE ISSP IN THE CONTEXT OF THE YOT**

The ISSP was one of eight sub-teams within the YOT, reporting to the YOT Manager and the Management Board.

In common with other YOTs, the expansion of programmes to deal with children and young people who had offended had lead to a shortage of suitably qualified YOT workers. This led to the recruitment of inexperienced staff who were assessed as having the capacity to learn.

Having recruited inexperienced staff, Nottingham City YOT did not immediately provide them with sufficient induction, guidance, training or oversight to ensure adequate service delivery. The YOT had become aware of the absence of clear guidance to staff on national standards and enforcement by 2003. Guidance, in the form of a *Checklist for Case Managers* was issued in June 2003. This was further extended in
December 2003 in a more detailed paper titled *Guidance on National Standards and Enforcement*.

**THE ROLE OF THE MANAGEMENT BOARD**

10.20 Responsibility for the governance of a YOT lies with the management board or steering group. Membership of the Nottingham City YOT Management Board consisted of partners from various statutory agencies such as the police and probation services, health, social services and education departments. The YOT Manager was held to account by the Management Board, keeping the Board informed of the functioning and operation of the YOT.

10.21 Nottingham City YOT experienced significant strategic difficulties from 2002 onwards. Two particular problems were evident. Nottingham City Council had, since the establishment of the YOT, provided some services to children and young people resident in Nottinghamshire, notice was given in 2002 of the county’s intention to terminate this arrangement. This had significant funding implications that were the main focus of the then steering group discussions in 2002. In addition, the information system purchased by the YOT was deemed unsatisfactory. This also caused significant problems at both a strategic and practical level.

10.22 There was evidence of the Management Board focusing on a range of strategic, financial and performance issues during 2003. In common with other strategic boards, the Management Board did not routinely discuss issues of practice or operational policy within the YOT.
11. CONCLUDING COMMENTS

11.1 Our inquiry has focused on the supervision of Peter Williams under the terms of a DTO, imposed in 2002, with the critical incidents taking place in September 2003. Since this time, the national standards for the supervision of children and young people by YOTs have been revised and further national guidance issued. In addition, Nottingham City YOT has evolved and developed more comprehensive policies and procedures.

11.2 We found several areas of concern about the practice of the YOT in 2003. Performance at this time in respect of recording practices, the implementation of national standards, assessment and supervision planning, and management oversight all required attention.

11.3 The weaknesses that were apparent at this time are not unique to the Nottingham City YOT, and in some respects reflect the difficulties that many YOTs experienced in the early stages of their development.

11.4 We accept that there are indications that the YOT has subsequently made progress in addressing these issues. Guidance for staff has been developed and induction and training provided. However, we have reported here what we found to be the case in 2003, and the wider issues raised during this inquiry that relate to the YOT will be comprehensively examined in the forthcoming round of YOT inspections.

11.5 The YJB is currently drafting revised guidance to YOTs on the management of ISSP.

11.6 With regard to electronic monitoring, there have also been further technological, procedural and contractual developments. However, we have found significant inconsistencies in the interpretation of the operational requirements for electronic monitoring, and the establishment and implementation of the monitoring arrangements which need to be addressed. There is currently no plan for an independent inspection of electronic monitoring.
12. INQUIRY METHODOLOGY

12.1 The inquiry was managed by Liz Calderbank, Assistant Chief Inspector HMI Probation, with responsibility for the YOT inspection programme. Fieldwork consisting of two visits to Nottingham City YOT, each of one and a half days was carried out by Mark Boother HM Inspector of Probation and Vivienne O’Neale, an independent social work consultant.

12.2 Interviews were undertaken with the former YOT manager, now Assistant Director of Community Safety, the current YOT Manager, the ISSP Coordinator from 2003, a senior practitioner based in the ISSP team at the relevant time and the police officer seconded to the ISSP team. The YOT case manager directly responsible for Peter Williams’ supervision was also interviewed, as was the social worker from the Leaving Care Team responsible for Peter Williams’ case.

12.3 The inquiry also had access to the internal Serious Incident Review, the YOT’s electronic information system and paper files, and relevant policy documents.

12.4 The inquiry also interviewed the Assistant Director, Operations Support from Premier monitoring, the company responsible for the electronic monitoring of Peter Williams, and had access to the retained paper records held by the company.

12.5 In order to assess the performance of the YOT at the relevant time, three other DTO cases with ISSP and curfew requirements were also reviewed.