Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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Report of Short Quality Screening (SQS) of youth offending work in Windsor & Maidenhead

This report outlines the findings of the recent SQS inspection, conducted during 4th-6th March. We carried this out as part of our programme of inspection of youth offending work. This report will be 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

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.

Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. The purpose of the SQS inspection is to assess the quality and effectiveness of casework with children and young people who have offended, at the start of a sample of 12 recent cases supervised by the Youth Offending Team. Wherever possible this is undertaken in conjunction with the allocated case manager, thereby increasing the effectiveness as a learning opportunity for staff.

We gather evidence against the SQS criteria, which are available on the HMI Probation website - http://www.justice.gov.uk/about/hmi-probation.

Summary

Windsor & Maidenhead has a relatively small YOT reflecting both the size of the Royal Borough and the relatively low proportion of children and young people involved in crime. As a consequence, there were fewer cases within the sample specification than we would usually inspect.

Overall, we found that almost all the assessments of, and plans for work with children and young people was undertaken by the YOT to a good standard. This was particularly the case in relation to working with the court, reducing the likelihood of reoffending and ensuring the sentence was served. Case managers had a detailed knowledge of the young people they supervised and had adopted an investigative approach that challenged children and young people appropriately whilst offering support.

Commentary on the inspection in The Royal Borough of Windsor & Maidenhead:

1. Reducing the likelihood of reoffending

1.1. There was a timely and sufficient assessment of the factors that were associated with why the child or young person had committed the offence in all but one case. Initial assessments were usually thorough, although in some cases included too much historical information.

1.2. In each of the seven cases where a pre-sentence report had been requested, a high quality report was provided for the court. Management oversight of the quality of reports was effective. In cases where a report had not been requested, there was evidence of the YOT providing information in the form of breach reports or verbal updates. One file contained feedback from magistrates regarding the pre-sentence report which commented that *'the quality of the report and its proposal swayed our decision away from custody'*.

1.3. There was a good quality review of the likelihood of reoffending in 10 of the11 relevant cases.

1.4. Planning for work to reduce the likelihood of reoffending had been done well in both of the cases in the sample that had received custodial sentences. For those in the community, all but two were of a good quality.

1.5. In 10 out of 11 cases where it was required, there had been a sufficient review of the plan to reduce the likelihood of reoffending.

1.6. Overall, we found that case managers had a good understanding of what was likely to be effective in working with children and young people, assisting them to lead crime free lives and improve their overall life chances.

2. Protecting the public

2.1. There was a sufficient assessment of the risk of harm to others posed by the child or young person in 10 out of the 12 cases we inspected. A comment from an inspector was that *'the assessment of risk of harm was thorough with all significant information included and evidence that all relevant factors had been considered in reaching decisions. There is evidence that a range of sources of information contributed to the assessment of the young person and that this information has been analysed by the YOT in determining risk levels'*. In the two cases that we judged insufficient, other relevant behaviour had not been given enough consideration.

2.2. Where required, there had been good quality reviews of the risk of harm to others in 9 of the 11 cases. In the remaining two cases there were reviews, but these were copies of earlier assessments that had not been updated to reflect changes.

2.3. The planning to manage the risk of harm to others was of a good quality in 10 out of 12 cases. In the two cases we judged as insufficient, victims' issues had not been addressed sufficiently, or potential changes in risk of harm had not been anticipated. Management oversight had not identified these deficiencies.

2.4. Planning to manage the risk of harm to others was of a good quality in both of the custodial cases inspected.

2.5. Two cases in the sample were eligible to be considered under Multi-Agency Public Protection Arrangements. We found that procedures had been correctly followed in these cases and that case managers had a good understanding of the relevant requirements.

2.6. All staff understood local policies and procedures for the management of risk of harm and how this would be undertaken in partnership, where necessary.

3. Protecting the child or young person

3.1. Where written, all pre-sentence reports included a thorough assessment of vulnerability and safeguarding needs.

3.2. There was a sufficient initial assessment of vulnerability and safeguarding issues in 11 out of 12 cases, each of these 11 were all reviewed appropriately.

3.3. In nearly three-quarters of relevant cases, including the two custodial sentences, there was a good quality plan in place to manage the vulnerability of the child or young person. In some cases there was a lack of consistency between the vulnerability management plan and the sentence plan.

3.4. Reviews of plans to address safeguarding and vulnerability issues had been undertaken to a good standard in two-thirds of relevant cases. Where the reviews of plans were insufficient, this had not been identified by management oversight.

3.5. All staff understood local policies and procedures for the management of safeguarding issues. There was liaison with children's social care services in appropriate cases.

3.6. Although the YOT had liaised with children's social care services, we found two cases involving vulnerable children and young people where it appeared that YOT requests for detailed information on care plans and core assessments had been ignored. In one case children's social care services staff had not attended several 'team around the child' meetings, called by the YOT when vulnerability issues were increasing. We were pleased to note that the YOT was escalating these issues as they were dissatisfied with the responses received from children's social care services, particularly where vulnerability was a significant issue.

4. Ensuring that the sentence is served

4.1. There was a high quality assessment of diversity factors and barriers to engagement with the YOT in all cases that had an initial assessment.

4.2. There was a culture in the YOT of engaging well with the child or young person and their parents/carers to inform the initial assessment. This was evident in all of the pre-sentence reports written and nearly all the cases inspected, with attention paid to diversity factors and barriers to engagement.

4.3. Children and young people and their parents/carers were nearly always fully engaged in the sentence planning process. In one case we noted that *'the child or young person is fully engaged in the order and progress is being made, the YOT have developed good relationships with him and his family. The young person's level of risk had reduced recently as a consequence of the work being undertaken'*. There was, however, room for improvement in the way the plans were written and communicated to children and young people. They were sometimes not written in child-friendly language and often lacked simply stated objectives with clear outcomes.

4.4. Where there where issues connected to the health and well-being of the children and young people, staff were able to identify these and incorporate them into the plans to address them.

4.5. Half of the children and young people in the sample had fulfilled the requirements of the sentence without difficulty. In two cases, there had been specific action to ensure compliance that had led to the child or young person successfully completing the order of

the court. In four cases, the child or young person had failed to comply, and in three of these they were returned to court, usually with the result that the breach was noted and the order was allowed to continue. We found that staff had a good understanding of local policies on supporting effective engagement and responding to non-compliance.

Operational management

We found that case supervision and other quality assurance measures had made a positive contribution in eight out of the ten relevant cases inspected.

Case managers themselves were confident in the abilities of their managers to both assess their work and assist with helping to improve it. All said that they received appropriate supervision and thought that management oversight was effective. All believed that Windsor & Maidenhead YOT had a culture that actively promoted learning and development. They were all clear about the organisational priorities they operated within, and this was supported by the evidence we saw.

Area requiring improvement

The most significant area requiring improvement was:

i. Sentence plans should be written with a greater emphasis on securing ownership by the child or young person by the use of simple language and achievable objectives.

We strongly recommend that you focus your post-inspection improvement work on this particular aspect of practice.

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 Mark Bother. He can be contacted on 07771 527326 or by email at mark.boother@hmiprobation.gsi.gov.uk.

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