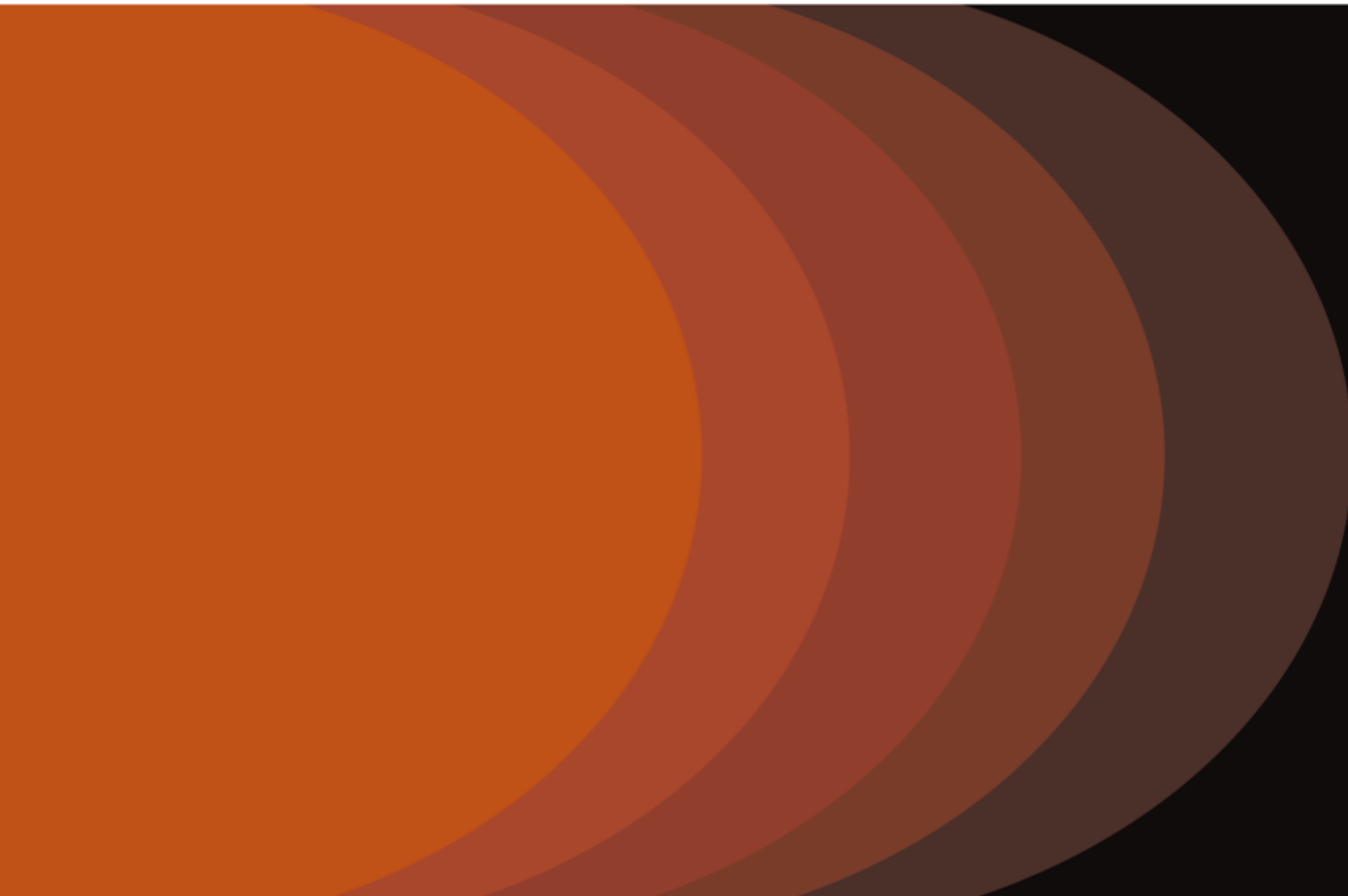
HM Inspectorate of Probation

An inspection of youth justice services in

Slough

HM Inspectorate of Probation, January 2025



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Acknowledgements

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The role of HM Inspectorate of Probation

HM Inspectorate of Probation is the independent inspector of youth justice and probation services in England and Wales. We report on the effectiveness of probation and youth justice service work with adults and children.

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Foreword

This inspection is part of our programme of youth justice service (YJS) inspections. We have inspected and rated Slough YJS across three broad areas: the arrangements for organisational delivery of the service, the quality of work done with children sentenced by the courts, and the quality of out-of-court disposal work.

Overall, Slough YJS was rated as 'Inadequate'. We found that staff, managers, and board members were committed to providing quality services to children and young people, but that there were some significant barriers to achieving this.

Until last year, the work and responsibilities of the YJS had not been prioritised across the partnership and we found there had been a fragile and limited understanding of youth justice practice. The specific needs of the YJS cohort of children were not fully understood by the board or the wider partnership. However, under the direction of the chair of the board, the YJS board has been reconstituted and as a result of the new membership, partners are beginning to understand what their roles and responsibilities are, there is a recognition that there needs to be much better join up strategically to lead and support the service.

The creation of a youth justice plan shows the ambition to support children in a way that recognises and responds to children's complex needs. Slough Children First is committed to improving the YJS. Senior managers have some insight into how ineffective many aspects of the work have been and recognise that the quality of services for children falls well below where it needs to be. Actions taken to redesign the service and to learn from other services are welcome and there are some very early indicators that these are beginning to bring about changes. The service's ability to make progress and achieve its ambition has been hampered by several issues, including, a lack of clarity across the partnership about the role and function of the YJS, and a limited understanding of how services and agencies needed to best work together to support children involved with the YJS. Furthermore, this has been compounded by high turnover and changes in staffing, particularly across management positions, vacancies in some key posts and disconnect strategically and operationally.

Management capacity and current training and development arrangements in the YJS are too limited to bring about the improvement needed to provide effective assessment of children, produce detailed and shared planning, and deliver the range of services that children need, and this is an area that requires urgent attention.

Additionally, we were concerned that there was very little focus on the needs of victims and the service had limited understanding of its public protection responsibilities. A refocus upon this needs to be a priority.

The service has stated it is committed to making improvements and we have made a number of recommendations within this report, which we hope will assist the YJS in making significant changes to improve the strategic oversight and quality of work delivered to children and victims.

Martin Jones CBE
HM Chief Inspector of Probation

Ratings

Slough Youth Justice Service Fieldwork started September 2024		**Score**	**3/36**
Overall rating		**Inadequate**	
1.	**Organisational delivery**		
1.1	Governance and leadership	**Requires improvement**	
1.2	Staff	**Inadequate**	
1.3	Partnerships and services	**Requires improvement**	
1.4	Information and facilities	**Requires improvement**	
2.	**Court disposals**		
2.1	Assessment	**Inadequate**	
2.2	Planning	**Inadequate**	
2.3	Implementation and delivery	**Inadequate**	
2.4	Reviewing	**Inadequate**	
3.	**Out-of-court disposals**		
3.1	Assessment	**Inadequate**	
3.2	Planning	**Inadequate**	
3.3	Implementation and delivery	**Inadequate**	
3.4	Out-of-court disposal policy and provision	**Inadequate**	
4.	**Resettlement**[1]		
4.1	Resettlement policy and provision	Not rated	

[1] The rating for resettlement does not influence the overall YJS rating.

Recommendations

As a result of our inspection findings, we have made 10 recommendations that we believe, if implemented, will have a positive impact on the quality of youth justice services in Slough. This will improve the lives of the children in contact with youth justice services, and better protect the public.

The Slough Youth Justice Service should:

1. ensure that quality assurance arrangements, oversight of practice and supervision arrangements consistently support the development of staff and volunteers
2. ensure assessment activity identifies children's desistance needs and always considers how best to keep the child and the community safe
3. ensure planning activity is comprehensive and that it aligns effectively with activity undertaken by other services, including activity to keep children and other people safe
4. ensure staff consistently liaise with all relevant services and understand the role of partnership agencies
5. provide sufficient resources, knowledge and focus on services for victims, including the use of restorative justice.

The Slough Youth Justice Board should:

6. ensure that the YJS is both sufficiently resourced and structured to facilitate the delivery of high-quality interventions for complex children and the victims of crime
7. review the local implementation of the out-of-court disposal scheme to provide clarity about the scheme and the service offer, to ensure that there is a consistent decision-making and a suitable offer of help and support for children
8. review the training offer for staff, volunteers and partners to provide knowledge and skills that are specific to youth justice work
9. increase the knowledge and understanding of youth justice work and responsibilities at strategic and operational level.

National Probation Service should:

10. ensure there is effective information-sharing with the YJS to support public protection and the safety of victims.

Background

We conducted fieldwork in Slough YJS over a period of a week, beginning 23 September 2024. We inspected cases where the sentence or licence began between 21 August 2023 and 14 June 2024 and out-of-court disposals that were delivered between 21 August 2023 and 14 June 2024. We also conducted interviews with case managers.

Slough is one of six unitary authority areas within Berkshire, in Thames Valley. We last inspected the YJS in March 2015.

Slough is a highly diverse borough, with 74 per cent of the youth population coming from a Black, Asian or minority ethnic background compared with an average of 19.5 per cent[2] in the South East and 26.1 per cent in England and Wales.

There is a larger than average youth population in Slough, at 12.7 per cent compared with 9.7 per cent for England and Wales. There is a higher-than-average percentage of girls in Slough's youth justice population, at 21 per cent compared with 13 per cent in England and Wales and 15 per cent in the South East. The reasons for this are unknown.

Children's social care statutory functions, including youth justice, have been delegated to Slough Children First (SCF), a private limited company wholly owned by Slough Borough Council (SBC). Slough and Sunderland local authorities are the only two arrangements of this type in England and Wales. SBC issued a section 114 notice to the government, demonstrating significant financial pressures. The notice stops all but essential spending, making sure the council can continue to provide essential services to its most vulnerable residents.

SCF came into Slough in response to the sustained poor performance of children's services, which had been rated 'Inadequate' by Ofsted for a number of years. Ofsted undertook its last full inspection in 2023, when the overall judgement was 'Requires improvement', and the impact of leaders on social work was rated 'Inadequate'. A follow-up short focused visit was carried out at the end of April 2024, where improvements to the stability of the workforce were noted. The current contract for SCF to run services ends in August 2026.

The YJS has been subject to significant changes, having had gone through three iterations in as many years. At the time of the inspection, YJS staff were involved in a formal consultation process about the proposal to create an adolescent support service, which is intended to include the YJS, an exploitation team, edge of care support team and detached youth work.

Staffing levels and management arrangements have had little stability. There have been three operational managers in three years and two heads of service. Some key roles have been vacant for over 12 months, including that of probation officer, victim restorative justice worker and reparation worker.

The proportion of children aged 17 and over who are not in education, employment or training (NEET) is 58 per cent and there is no real alternative provision other than colleges for these children.

[2] The figures for the South East have been calculated by HM Inspectorate of Probation using data from the Office of National Statistics.

Domain one: Organisational delivery

To inspect organisational delivery, we reviewed written evidence submitted in advance by the YJS and conducted 12 meetings, including with staff, volunteers, managers, board members, and partnership staff and their managers.

Key findings about organisational delivery were as follows.

1.1. Governance and leadership

The governance and leadership of the YJS supports and promotes the delivery of a high-quality, personalised and responsive service for all children.	Requires improvement

Strengths:

- The youth justice management board chair has been proactive in reviewing the role and effectiveness of the board. The board includes representatives of sufficient seniority, which has not always been the case. Board members have attended induction and training so that they understand their roles and responsibilities. The board chair has set clear and high expectations about the contributions expected from members.
- In the last 12 months there have been significant changes to the membership and focus of the board. This has led to the development of a clear vision for the service. Board members recognised that they are still learning how to fulfil their responsibilities.
- The YJS plan sets out an ambition to move to a child-first model and to develop a restorative justice approach. There was consultation with a range of stakeholders to develop the plan.
- The chair of the board commissioned a peer review of the YJS. This has been influential in shaping the direction of service delivery and has provided valuable insight.
- The chair of the board has proactively sought opportunities to learn from other YJSs and is using this knowledge in developing the board.
- Board members are developing their understanding of the function of youth justice services and how they should be directing their own services to support desistance, and achieve safety of children and the community.
- The health representative understands the needs of children who are supported by the YJS and supports these through a strong health offer. The representative of community groups provides a valuable link to the community.
- There has been some effort to involve children and staff in board meetings. The board has found their insights helpful.

Areas for improvement:

- Until last year, the work and responsibilities of the YJS have not been prioritised across the partnership. There is a fragile and limited understanding of youth

justice practice. The specific needs of this cohort of children, and the service that is trying to support them, are not fully understood at board level.

- There is limited evidence of how board members advocate for YJS children and limited understanding of the YJS's role and what its workers do. Where there is clarity, this is because of individual relationships rather than systemic and embedded knowledge.
- There is insufficient understanding of the specialist nature of youth justice work. The board chair and heads of service have been visiting other youth justice services to gain knowledge and understanding. However, put simply, board members do not currently know or understand the gaps in their knowledge, and this is a critical business risk.
- Board members need to ensure there is a detailed analysis and needs assessment of the YJS cohort, including trends, children's desistance needs, types of offending, use of violence, and safety and wellbeing needs. Recent developments, although welcome, have not yet had an impact on current outcomes or service delivery.
- YJS managers and staff have been disempowered by a lack of wider effective provision. Safety planning is based on what the YJS can do, rather than what the whole partnership should be contributing. The gaps in victim work are a systemic weakness and have had an impact on many of the inspection standards.
- The board has made recent attempts to listen to the views of children and this is contributing to a partnership-wide participation strategy. However, it is not yet clear how the specific voice of children in the YJS will be heard or utilised. Feedback from children to case managers is that some children feel that they are being racially profiled, but this perception has not reached the board.
- The board has anecdotal evidence of some[3] positive outcomes for children, including the outcomes of Operation Cuba. However, there are no consistent methods to identify effective practice or risks to service delivery. Board members need to ensure they are better sighted on the quality of operational work and their understanding of risks to the service. The board does not have a formal risk register.
- Case assessment outcomes confirmed the need for the roles and responsibilities of different teams to be made clearer. This includes the social care team, the criminal and sexual exploitation teams, and the serious youth violence team. Clarity of different roles and responsibilities needs strengthening, both strategically and operationally. We saw limited evidence of effective joint working between services, or of this being addressed at board level.
- The service is in the early stages of introducing a child-first approach. YJS staff have given presentations on this to strategic partners. A critical aspect of the vision is to develop restorative approaches. However, no staff are currently trained in restorative justice and there is a vacancy for this specific role. The service is actively recruiting to this role. This means there are risks to implementing the approach successfully. The board needs to ensure it is sighted on these issues and is supporting a solution.

[3] Operation Cuba was a partnership response to respond to concerns about children at risk of being involved in serious youth violence.

- The board has not yet been able to reduce the structural barriers that affect children who work with the YJS. Board members are aware of the significant difficulties that older children face in accessing suitable post-16 education, training and employment provision. They understand that this is a key factor in helping children to desist from offending. The appointment of the head of the pupil referral unit (PRU) as deputy chair is positive. However, the current board arrangements are too new to have had an impact and significant further work is required.
- The YJS has experienced the impact of instability and change in the management of the service. Despite efforts to support staff to attend the YJS management board, there is a disconnect between the perceptions of YJS staff and those of senior leaders.
- The board had heard some feedback about the quality of work undertaken by the YJS, and recognised that this was likely to be variable. However, board members had significantly underestimated the work required to improve service delivery.

1.2. Staff

Staff within the YJS are empowered to deliver a high-quality, personalised and responsive service for all children.	Inadequate

Strengths:

- Staff are motivated and committed to working with children. They develop good relationships and have a good knowledge of individuals, often better than what was written in the case recordings. It is to the staff team's credit that motivation is high, as the service has faced numerous challenges in the last few years.
- Although there were mixed views about work and caseloads, staff said that workloads were currently manageable. There are arrangements to allocate work and tasks to cover leave.
- Health, parenting and education staff seconded to the YJS are positively regarded and feel welcomed and integrated in the team.
- Staff and volunteers are representative of the community within which they work. They have good local knowledge and provide links to community organisations that are of benefit to children and families.
- YJS managers provide good welfare support to staff and their response is appreciated by the team.

Areas for improvement:

- The design of the service and frequent changes in management have meant that staff are working in a highly changeable working environment. The service is consulting on a service redesign. This will be the third iteration in just under three years. As a result, staff have found it difficult to understand what is expected of them and how to achieve effective service delivery.
- Staffing arrangements are not sufficient, with vacancies in key roles. The victim worker post has been unfilled for around 10 months. Attempts to recruit to this post have been unsuccessful. Restorative justice and reparation posts have also been vacant for around a year.
- Assistant team manager and other specialist staff vacancies have resulted in the head of operation and a remaining assistant team manager covering a range of tasks, including court duties and writing pre-sentence reports. This detracts from their ability to provide effective management oversight.
- There is confusion about the assessment, planning and response to keep children and the community safe. While work to support desistance was the strongest area of practice, there was a lack of consistency in delivery. The training the team has received has not translated into quality practice.
- Case managers have a range of qualifications, but the specific skills needed to assess and plan for risk of harm are too varied across the team. In the absence of sufficient targeted and consistent role-specific training, some staff have been left in a difficult position, without a clear understanding of what constitutes high quality work. Staff were trying to do their best to overcome gaps, but casework practice was judged insufficient in many of our inspected cases. In addition,

there is no consistent understanding of what constitutes good youth justice practice at a strategic level, and senior managers' understanding of this area of work was fragile.

- Understanding of risk to others and the safety of victims was particularly underdeveloped. A culture has developed where there was little focus on this area of work, in part due to misconception in some areas of the partnership about the role and responsibility of youth justice workers, who were sometimes referred to as 'youth workers'. The levels of risk YJS workers were holding in their work were underestimated, and their work was not understood well enough strategically and operationally.
- There was no probation officer seconded to the YJS, and no mitigation in place to share information or to link with adult probation services.
- None of the case managers had received training in restorative approaches. We found some work to bring restorative justice into case management, but this was sporadic and not fundamental to service delivery. The YJS did not take a clear restorative justice approach to working with children in care, or with children who were at risk of losing placements in residential provision or in schools.
- Support for volunteers was poor. Referral Order panels ran with only a single panel member being present on some occasions. The number of volunteers has decreased and is insufficient for delivering work effectively.
- We found inconsistency in management oversight. Often, guidance was superficial, ineffective, or incorrect. Actions requested were not always followed up.
- Workforce training plans are in place, but they are based on a staff survey rather than a skills audit. The YJS relied too much on self-directed learning. We found it concerning that the Youth Justice Board (YJB) effective practice certificate was viewed mainly as a tool to get promotion, rather than for establishing baseline training. There was a lack of clarity about the arrangements for funding critical and relevant case manager training.
- Equity, diversity, and inclusion in relation to race and ethnicity are discussed with children in most cases, but there are some gaps in knowledge, including in how to work with girls. We also found some unhelpful assumptions being made about children and families from the Gypsy, Roma and traveller communities.

1.3. Partnerships and services

A comprehensive range of high-quality services is in place, enabling personalised and responsive provision for all children.	Requires improvement

Strengths:

- There is a strong health offer in place and delivered to YJS children. All children are assessed by the health and justice worker. Assessments, such as for autism and neurodiversity, are carried out quickly and there is routine screening for speech, language and communication needs. A nurse practitioner is also in post and children's physical health needs are identified and supported.
- There is an offer for joint professional supervision for the YJS practitioners by the health and justice worker. There is also an opportunity to carry out case formulations to help practitioners to understand children's underlying needs and behaviours more fully.
- We saw some positive examples of interventions to support children involved with weapons offences and serious youth violence. These involved some joint work across the partnership and collaboration with parents. Outcomes for children appeared to be positive.
- Board members are more aware of the contribution they need to make as a partnership to ensure the right services are in place to improve outcomes for children working with the YJS.
- There are some good individual relationships between the YJS and partnership staff, where these were established and roles were clearly defined, we saw evidence that some effective work was being delivered.
- The YJS is developing links with the community and voluntary sector. It has clear plans to use these to support children working with the YJS.
- The 'Act Now' project, aimed at providing an immediate response to children arrested for possession of an offensive weapon, shows promise in intervening early. The approach needs to be linked effectively with the work of the YJS.
- The parenting and education, training and employment (ETE) workers embedded in the YJS are valued by the staff team. There is some evidence of joint approaches to prevent exclusions.
- The ETE worker attends a range of meetings and reviews all cases to identify what support the child may need. They provide case managers with information on the child's learning needs, exclusions, and attendance levels at school. The ETE worker then makes referrals to the educational psychology services. The YJS is working with schools and colleges to help them understand why children open to the YJS may need adaptation to help them attend. However, as yet there is not enough information or data to check if exclusions or NEET rates are improving for this cohort of children.
- Our rules and guidance indicate that usually 'Inadequate' ratings in 2.3 and 3.3 implementation and delivery would result in an 'Inadequate' rating. However, we considered there was enough qualitative evidence to warrant a rating of 'Requires improvement' for partnerships and services.

Areas for improvement:

- There was not enough understanding at strategic or operational level of the YJS's distinct role and function, or the profile of children's needs and risks. Therefore, it is unclear if the appropriate services are available to meet children's needs. Roles and responsibilities across the partnership are unclear. However, this is developing, and partners have made a commitment to improve their understanding and identify appropriate services that will improve outcomes for children.
- The YJS's role in public protection is not sufficiently understood or prioritised. Activity to assess and plan to keep others safe was consistently insufficient for both statutory and out-of-court disposals. Assessment, planning and support in relation to victims' safety requires considerable improvement. Links to partnership systems, including multi-agency public protection arrangements and integrated offender management, require strengthening.
- The service offered to victims requires significant development and a prioritised strategic response. There is a lack of focus across the partnership to support the victims of crime. The two posts that cover victim, restorative justice and reparation work have been vacant for almost a year, with no effective mitigations in place.
- There are no effective operational links with probation to support critical information-sharing, risk management and transitions planning. The YJS does not fully understand or recognise the additional value that having a seconded probation officer brings.
- There is an insufficient response to domestic abuse, and links with multi-agency risk assessment conferences are not clear or used when needed. This was evident in some of the case assessments, where a limited focus on domestic abuse led to some risks being unmanaged.
- We found significant shortcomings in the quality of work being delivered to keep children safe and support their wellbeing. This was exacerbated by limited joint or partnership working. We saw examples where concerns for children's safety and wellbeing had increased, but the partnership had not responded appropriately and the necessary referrals for support were not made.
- While partners have committed to work to reduce disproportionality, the action plan has not yet been embedded and tangible outcomes have not been identified. There are no specific guidance, training or interventions for work with girls and the understanding of the Gypsy, Roma and traveller communities is underdeveloped.
- We found no evidence that children on statutory orders who had substance misuse needs were being supported, despite organisational data indicating that 20 per cent of children working with the YJS had these needs.
- There is no alternative provision for children aged over 16 who do not attend college, despite the evidence that ETE are key factors for desistance.

1.4. Information and facilities

Timely and relevant information is available and appropriate facilities are in place to support a high-quality, personalised and responsive approach for all children.	Requires improvement

Strengths:

- The partnership is using a range of methods to review and learn about youth justice services. For example, it has used the Local Government Association peer review to formulate plans for the future operation of the YJS and has reviewed serious incidents. Members of the leadership team have visited high-performing services to identify how well-functioning boards operate.
- The co-location of the YJS with children's services is a positive move. It should embed more effective communication, understanding of roles and responsibilities and better joined-up working.
- The use of the children's social care building provides a single room for children to be seen. Case managers use other venues and home visits to see children safely when they are unwilling to come to the main building.
- Reparation placements are limited, but those available are appropriate.
- ICT provision enables staff to record and share information on the case management system. Equipment is available for hybrid working and when staff are working in community locations. Staff have been trained in how to better access information from children's social care.
- There is a useful disproportionality statement and action plan. The service is clear about the work it needs to undertake to better understand the reasons why certain groups are over- or under-represented in the youth justice service.

Areas for improvement:

- Some policies, for example the resettlement policy, do not provide sufficient guidance for staff, or reflect the actions that they actually take. We found limited examples of managers evaluating whether polices are being implemented consistently. We found wide variation in practice, which suggested that staff were not adhering to national and local policy, including transitions and victim codes of practice.
- YJS policies are not specific about the approach to equity, diversity and inclusion. There are no systems in place to support work with girls or the Gypsy, Roma and traveller community.
- The YJS office base is in an accessible location, but little consideration has been given to keeping everyone safe. Staff expressed legitimate concerns about safety mapping for children who could cause harm if they met. Although YJS staff had coordinated appointments to avoid this, other partners had not. Therefore, it was possible that children could have unintentional contact when visiting social workers or other partnership staff. A senior manager is considering the suitability of the building; however, mitigations are needed in the interim.

- Not having a probation officer, nor effective links with probation, results in gaps in checking probation records to support risk and safety management. This leaves some worrying shortfalls, especially where close family members or domestic abuse perpetrators are under probation supervision.
- Information-sharing with partner agencies is variable. Even when information is gathered, it is not used often enough to inform risk and safety assessments and planning activity.
- The YJS would benefit from additional resource to assist with data analysis. This would provide greater assurance about data integrity and greater sophistication when analysing information.
- The quality assurance processes are not providing an accurate line of sight to frontline practice. YJS managers need to focus more closely on this to ensure high-quality work in relation to safety and wellbeing and risk of harm.
- Participation of children and families in sharing their experience of services is not undertaken routinely. The current strategy does not ensure that all groups are represented.
- Learning from serious incidents or practice reviews is not passed on to staff throughout the service well. A more systematic approach is needed to ensure all partners and YJS staff are aware of findings and recommendations.

Involvement of children and their parents or carers

The YJS contacted, on our behalf, children who had open cases at the time of the inspection, to gain their consent for a text survey, no children replied to this. We were only able to speak to one of the two children who consented to be spoken to.

The YJS management board are committed to including children in service design and have had one child speak to them about their experience of being supported by the service. Board members had found the child's views informative and extremely helpful.

Case managers were able to have detailed discussions with children and were able to talk to them about their experiences of growing up in Slough.

Children's services are developing a participation strategy, and the views of children working with the YJS will be incorporated as part of the new arrangements.

The child who agreed to speak to us new why he was working with the YJS and felt that his worker had the right skills and knowledge to support him. It was clear that he had been working with his case manager to help him understand the dangers of carrying and possessing weapons.

The young person had developed a good relationship with the case manager, having made the decision to keep working with her when he moved away from the area.

He said that:

> *"They are quite understanding, they make sure I understand, don't rush me, do what they are meant to".*

He also felt that the work he had completed with the YJS would help him make better decisions in the future.

Diversity

- Slough is a diverse borough with a young population. It is one of the most ethnically diverse towns in the UK: 56 per cent of residents were born outside the UK and the EU; 20.2 per cent have been resident in the UK for less than 10 years; and 46.7 per cent identify as Asian, Asian British or Asian Welsh.
- YJS staff have diverse backgrounds and reflect the community they serve. We saw examples of staff using a variety of languages to communicate with children.
- Some staff have excellent links with the local community and use these to support their work with children.
- A disproportionality statement and action plan are in place. The board recognises the need to do more to understand patterns and trends in disproportionality.
- In our court disposal casework, we found that assessments and plans had a clear focus on diversity. Children's protected characteristics were routinely identified (73 per cent) and planned for (64 per cent). This led to the delivery of services that were adapted to and reflected children's needs (82 per cent). We saw real efforts to understand the diverse needs of children and talk to them about their experiences of discrimination.
- It was a surprise to find that, despite staff having these skills, the assessment, planning and delivery of interventions in out-of-court disposals addressed these issues in far too few cases. Assessment of diverse needs was sufficient in one of the 15 cases, planning in three cases and delivery in two cases. This may have been affected by the assessment tool that was being used (Identify), which is limited in scope. Staff have not yet had training on the use of the YJB prevention and diversion assessment tool. The YJS needs to set clear expectations for staff to use the assessment and planning tools, specifically to include diverse needs.
- The needs of girls and the Gypsy, Roma and traveller communities are not always understood or recognised.
- Age and maturity are not included in assessments. Children who received court orders tended to be older (16 to 17 years old), while children on out-of-court disposals were much younger (13 to 14 years old). The interventions available are not designed to consider the differences age may make.
- Staff understood the impact that neurodiversity has on children. The ETE worker provided some good support to children to keep them in school and to find alternative provision for them.
- Autism assessments could be started and completed by the psychologist from the health and justice team. This mitigated delays in accessing mainstream services.
- We were told that there were no delays in starting education, health and care plan assessments for YJS children. These were completed within the statutory timescales of 24 weeks.
- The use of interpreters was not consistent and on occasion children had to translate for their parents.

- The work of the health and justice team and the speech and language therapy worker was helping the YJS to better understand children's needs. The comprehensive formulations undertaken with children provided a good foundation on which staff could base engagement strategies.
- The staff survey showed that staff thought that, in the main, their diversity needs had been met very well or quite well.

Domain two: Court disposals

We took a detailed look at 11 community sentences managed by the YJS.

2.1. Assessment

Assessment is well-informed, analytical and personalised, actively involving the child and their parents or carers.	Inadequate

Our rating[4] for assessment is based on the following key questions:

Does assessment sufficiently analyse:	% 'Yes'
how to support the child's desistance?	64%
how to keep the child safe?	**36%**
how to keep other people safe?	**36%**

There was a strong focus on assessing children's desistance needs. But assessment focused on keeping children and victims safe was too narrow and did not explore all known areas of concern.

Assessments to analyse how best to support the child's desistance routinely focused on the child's level of maturity, willingness to engage with the service and personal circumstances. The youth justice assessments were supplemented by case formulations undertaken by a health and justice worker. Staff found these formulations to be invaluable in helping them understand how trauma or adverse experiences had contributed to the child's offending. These assessments also outlined how best to work with the child to overcome any barriers.

In the cases where assessment was sufficient, we found good attention to a range of diverse needs. Through discussions with children, and using information from partner agencies, case managers explored neurodiversity alongside the children's educational experiences. Children were able to raise their experiences of discrimination with case managers.

However, case managers did not consistently consider how to keep the child and other people safe.

Although proportionate classifications about children's safety and wellbeing were made, the underpinning analysis was too often narrowly focused. Most children had multiple issues that compromised their safety. Assessments needed to include all factors and then draw out the implications of each, to give a comprehensive basis for understanding the child. Assessments did not always include the risk children faced from being exploited, the reasons that had led to children being on child protection or child in need plans and risks they faced living in households were there was domestic abuse.

Information from other agencies had been used in just under half of the assessments including concerns such as the child was being criminally exploited.

[4] The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. A more detailed explanation is available in the data annexe.

When children's behaviour had the potential to pose a risk to other people, the case manager had produced an accurate and full analysis in just under half of the cases we inspected. Case managers did not always identify who the actual and potential victims might be or the circumstances in which harmful behaviour might present itself. This included where siblings could be victims of violence and risks to staff. Most notably where children under supervision were parents, the potential effects on their own children due to offending or use of violence were not sufficiently considered. As a result, there were missed opportunities to provide early support to provide parenting support.

2.2. Planning

Planning is well-informed, holistic and personalised, actively involving the child and their parents or carers.	Inadequate

Our rating[5] for planning is based on the following key questions:

Does planning focus sufficiently on:	% 'Yes'
supporting the child's desistance?	55%
keeping the child safe?	45%
keeping other people safe?	**27%**

Planning to support children was not as robust or explicit as it needed to be. We were concerned about the very limited focus on victims. Planning rarely set out the steps that the YJS and other partners needed to take to keep others safe.

Planning for desistance needs was proportionate and identified relevant services for the child in most cases. It frequently built on the children's existing strengths, motivation to change and maturity levels. Case managers routinely planned how to keep children in ETE, with support from the ETE worker. Case managers understood the importance of providing children with opportunities to learn and have structure in their lives. We saw positive developments in the YJS's relationships with schools and the PRU.

When children's safety is compromised, we expect planning to be in place to reduce and manage the risks. In one case, a child had completed a booklet called 'Me', which had helped him to explain some of the difficulties he had faced, where he felt unsafe. His views were then taken into account and planning focused on how he could avoid and manage some of the risks his behaviours resulted in. However, work such as this was not consistently undertaken well.

Many children who are contact with the YJS were involved with or at risk of exploitation, and we found too few examples of effective joint planning with the exploitation team. Similarly, where children's social care were involved, we found that planning was mostly undertaken in isolation and there was no coordination between actions planned by social care and those planned by the YJS. This created gaps; for example, in three cases, YJS staff did not know the details of the social care team's plans for children, and YJS activity was not effectively coordinated or joined up with these plans.

The YJS staff were managing a wide range of risks to other people. When risks to others were identified in the assessment, planning to address and manage these was then not sufficiently detailed to cover all known issues. Planning did sometimes include victim awareness work, but this relied on the child developing an understanding of the impact of their behaviour on others and then changing that behaviour, rather than a focus alongside this of what else was needed to keep actual and potential victims safe. We found examples where orders had been applied to give additional powers to agencies to step in if risks and offending increased, such as criminal behaviour orders,

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exclusion zones and restraining orders. However, the details of these were not always known or fully considered in planning activity.

There were no effective links between the YJS and probation services. This meant that joint planning was not carried out when children transitioned to adult services.

We also noted that case managers had not planned for some key actions to keep people safe where the risk was within the family and intimate relationships. We saw examples where the risk to siblings and young children was not planned for with children's social care, and two cases where the YJS had not notified children's social care of the risks posed to very young children.

2.3. Implementation and delivery

High-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child.	Inadequate

Our rating[6] for implementation and delivery is based on the following key questions:

Does the implementation and delivery of services:	% 'Yes'
effectively support the child's desistance?	82%
effectively support the safety of the child?	55%
effectively support the safety of other people?	**45%**

This is the service's strongest area of practice, with more effective work being undertaken to prevent reoffending and support children to make better decisions, away from offending activities.

The support provided by the health and justice worker and ETE worker were evident in service delivery. The case formulations undertaken with each child gave case managers a detailed understanding of how best to work with the child, how to develop meaningful relationships with them and how to help them access key services.

Case managers helped children to understand the details and implications of EHCPs and it was positive to find examples where the health and justice team had undertaken assessments to identify neurodiversity, so that children did not have to wait for these.

Staff understood the positive effect of children being in ETE, and prioritised this, supported by the ETE worker. Children received practical support to access education. For example, one YJS worker took a child who was particularly anxious for a tour of a college. Another child was taken to visit an educational placement that had been found out of the area. Children were supported to engage with the virtual school and undertake AQA qualifications, which were linked with their employment aspirations or circumstances.

It was evident that case managers were creating relationships and a culture where children could have open and honest discussions. The voice of the child was often heard and responded to. Delivery was personalised, with case managers considering where and when to see children, and working around work and family commitments. An important part of work on identity is understanding children's life experiences. It was positive to find that children were having open and honest conversations about their experiences of living in Slough, their experiences of discrimination and their interactions with the police. Where children had negative perceptions of the police, case managers helped children to understand the role of the police and their rights and responsibilities if they were stopped and searched.

The delivery of services to keep children safe was mixed. There were some examples of effective responses and joint work, including responding to keep a child safe when he was afraid of reprisals following the murder of a peer. Case workers attended some

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child in need and core group meetings to provide support with joint approaches. They also worked well with child and adolescent mental health services to support children's emotional and mental health.

Joint work with the exploitation and serious youth violence teams was limited. There were interim cover arrangements for the vacant post of serious violence worker, and some missed opportunities to work with children who were being criminally exploited. This included one child where, in our view, a national referral mechanism referral should have been made. As services develop in line with strategic plans, and the multi-agency child exploitation arrangements are reviewed, there is an opportunity to align the work of these teams more closely.

Actions to manage and mitigate risk of harm to others were not always taken to provide assurance that victim safety was a part of the delivery of services. Interventions and responses did not match the severity of risk or use of violence, even if the case had been discussed at the risk management panel. In particular, case managers did not contact other areas when victims moved, even when there was an ongoing and increasing risk. We were concerned about the lack of clarity to confirm what action had been taken to inform another local authority to ensure effective risk management for a vulnerable child and adult in their area following a serious domestic violence incident.

2.4. Reviewing

Reviewing of progress is well-informed, analytical and personalised, actively involving the child and their parents or carers.	Inadequate

Our rating[7] for reviewing is based on the following key questions:

Does reviewing focus sufficiently on:	% 'Yes'
supporting the child's desistance?	36%
keeping the child safe?	27%
keeping other people safe?	**18%**

Reviewing of progress was not used effectively to make changes to support desistance, or to keep the child or other people safe. This area of work needs significant improvement.

The lack of action to follow up on new information was concerning. In three of the 11 cases, children presented with injuries that indicated that they may have been harmed by others. These incidents were not given sufficient consideration or analysis, and it was difficult to identify if the information had been shared with social care. This meant that children's social care was not being given the option to assess the child, explore concerns and take action where appropriate. There was a lack of follow-up when changing circumstances were identified such as known issues with domestic abuse and concerns about a child being exploited.

Reviewing was not effective in preparing children for adulthood, or for the changes they would face moving to probation supervision. It did not provide them with information to help them successfully access adult services. Additionally, in some cases, reviews happened after the child's order had finished. Whilst this provided the service with updated information following the completion of work, it did little to influence or benefit the activity undertaken with the child.

An example of this was for a child with neurodiverse needs. The inspector noted:

> *"There are opportunities to revise approaches to working with this child. There is clear evidence from ETE worker, speech and language therapist and within educational psychologist reports that the child is functioning at a much lower level than his actual age and has difficulties processing information. The child also shares he is feeling overwhelmed with the number of professionals he is expected to maintain contact with. The response, however, is through warnings and statements to him that he needs to demonstrate engagement before interventions can be reduced. There is a missed opportunity to take an approach that listens to what is known about the neurodiversity needs and to sequence and prioritise rather than use enforcement or demands for the child to change before considering the adaptation of interventions."*

Reviewing new information that indicated that the potential harm to others was increasing was not given the attention it warranted or sufficiently checked out or shared with other agencies. As a result, this limited the responses and meant that risk

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management planning was not amended when needed. We found examples of children who were suspected of committing serious offences, who had been arrested and where there were ongoing investigations but the implications of these had not been reviewed, including the indications that the seriousness of offences had increased.

Domain three: Out-of-court disposals

We inspected 15 cases managed by the YJS that had received an out-of-court disposal. These consisted of three youth conditional cautions and 12 community resolutions. We interviewed the case managers in 10 cases.

3.1. Assessment

Assessment is well-informed, analytical and personalised, actively involving the child and their parents or carers.	Inadequate

Our rating[8] for assessment is based on the following key questions:

Does assessment sufficiently analyse:	% 'Yes'
how to support the child's desistance?	**20%**
how to keep the child safe?	33%
how to keep other people safe?	**20%**

Assessment of children who received out-of-court disposals did not provide a clear analysis of the reasons that had contributed to the child's offending. The child's level of maturity, attitude to behaviour and acknowledgement of what they had done were not considered often enough. The views of children, and their parents or carers, had been included in just over half of the cases.

The wishes and needs of victims were rarely known or recorded, despite children sometimes living near identified victims or being at school with them. Diversity and identity were not considered well enough for children on out-of-court disposals. This meant that assessment activity was not personalised or tailored to each child.

The YJB's prevention and diversion assessment tool had been introduced in Slough, however, staff had received limited support in implementing it. This was due in part to shortages in management capacity. Management oversight had been provided on all of the cases we assessed, but the quality was variable, and actions identified were not always followed up. Inspectors viewed management oversight as effective in just two of the 15 cases.

Children's safety and wellbeing were affected by a range of issues, some within the family, including neglect and domestic abuse, and some due to external factors, including exploitation and the influence of peers. Assessment tended to focus on one area of risk or trauma rather than how a range of safety issues could affect the child. Although we found a few examples where information held by other agencies had been used effectively, there were more examples where information held by social care, the police, probation or exploitation services was either not known about or not used effectively to assess and fully understand children's safety.

Any assessment of risks to other people should, where possible, specify who is at risk and what the risks may be. We noted there was an identifiable victim in all of the 15

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cases we looked at. The service identified victims in 12 cases. Five victims had consented to contact from the YJS; however, the purpose of victim identification is wider than ongoing contact. We expect that the YJS use this information to assess, plan to mitigate any ongoing behaviour that may cause harm to others. However, we found a sufficient assessment in just two. In some cases, information about the full breadth of the child's behaviour was not taken into account. This meant that assessment focused too narrowly on a single aspect of the child's behaviour, rather than fully considering all relevant information available.

3.2. Planning

Planning is well-informed, analytical and personalised, actively involving the child and their parents or carers.	Inadequate

Our rating[9] for planning is based on the following key questions:

Does planning focus on:	% 'Yes'
supporting the child's desistance?	**20%**
keeping the child safe?	33%
keeping other people safe?	27%

Planning that set out the actions to support desistance, and keep children and others safe, was either not in place, or was not sufficiently detailed to direct work. We saw the shortcomings in assessment then feed into poor quality planning activity. There was minimal recording of the panel discussions and the rationales for the out-of-court disposal outcomes. As most decisions were made solely by the police, there was also very little detail about what the panel identified in terms of intended work.

We found no planning to support desistance in some cases. Less than a third of plans considered the child's diversity needs, personal circumstances and motivation to change and engage. Much of the work and engagement is undertaken on a voluntary basis, which meant that failing to plan for the child's motivation or make arrangements to meet their individual needs reduced the chances of the child cooperating with and getting the best from interventions and services.

Planning did not provide a clear focus for the work that should be done, in what order or how parents and other professionals could contribute. In one case, the child received a community resolution with voluntary engagement. Only one objective was set in relation to addressing emotional regulation. Based on the information available, we identified concerns in relation to temper control, discriminatory attitudes linked to the offence, drug misuse, negative peer influences and issues related to bereavement. Factors that had been relevant or contributing to the child's offending and needed to have been considered in planning.

Some of the YJS planning contained some very general objectives, whether or not they related to the child's needs. The objectives set for children tended to be based on the interventions that were available rather than setting out the actions that suited the child's situation and circumstances.

The views of children, parents and carers had been taken into account in 40 percent of plans. In a few cases, children acted as translators for their parents, so it was not possible to identify whether the parents had an independent voice and their views had been appropriately considered or included.

We saw very little individualised planning that tailored approaches, and we saw examples where younger children, girls, and children who spoke English as a second

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language were overlooked and planning that sis not consider the child's experience of trauma or family dynamics.

Children who were known to or working with other agencies did not always receive services that were coordinated to maximise support. There was a lack of professional curiosity in some instances about what was contained in child protection or child in need plans. In other cases, the lack of a recorded YJS plan meant that there was no evidence of what was planned or the supporting actions that could or should have been taken while the child was on the disposal. This included children who had clear safety and wellbeing needs, and where domestic abuse and exploitation were ongoing issues. Some actions were not recorded clearly, so it was not possible to identify whether referrals to other agencies had been made or accepted, or the outcomes of these. In only one case did we find sufficient planning with partner agencies to manage the risks from the child. This was particularly evident for children who remained at school with the victims of offences. Given the seriousness of some of the children's behaviour, including repeatedly carrying knives, the lack of clear, joined up planning, such as with the school, police and the YJS was concerning.

There was very little planning to manage the instances where children remained in contact with victims, including neighbours, siblings, parents and peers. It was concerning to find that, when new information came to light, including allegations of harmful sexual behaviour and further use of violence, there was little adaptation of planning or contingency planning. Even when information about the child was shared with other agencies, the YJS did not respond with clear and robust actions.

Planning to respond to children who demonstrated harmful sexual behaviour was not evident in the cases where it was needed. Planning did not focus on how victims would be kept safe.

3.3. Implementation and delivery

High-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child.	Inadequate

Our rating[10] for implementation and delivery is based on the following key questions:

Does service delivery effectively support:	% 'Yes'
the child's desistance?	40%
the safety of the child?	**27%**
the safety of other people?	40%

The delivery of services to children who receive out-of-court disposals needs a fundamental review, to ensure that the right services are delivered at the right time. The current arrangements do not adequately match children's desistance needs, are not sufficiently personalised and do not help to keep children and other people safe.

However, there was a good and consistent focus on developing relationships to engage children, parents and carers. Case managers worked with persistence to see children where it suited them and utilised home visits effectively. They had also taken steps to make sure children could engage with services. This included introducing the health workers to children so that they could carry out communication needs screenings. They also arranged contact with the nurse.

Health and justice workers provided some effective consultation and work with children. This led to a better understanding of children and any difficulties they may have with engaging with services. However, where we identified some effective service delivery, this was often due to individual workers, rather than the use of coordinated and effective services.

We found the main intervention being delivered on out-of-court disposals was a nine-week group-based programme covering issues such as consequential thinking, weapons awareness, conflict resolution, and victim awareness. This was often delivered without being adapted to take account of the nature of the child's offence, age, gender or issues arising from neurodiversity.

Some children did not receive services within a reasonable time, and we found some unnecessary delays in children. In one example there was a significant delay in delivering any interventions, with two months between a decision being made and the child's case being allocated It then took a further six weeks for the case manager to make contact with the child and see them for the first time. As a conditional caution this meant that only two weeks were available for interventions to be delivered before it was due to cease. The delays made it difficult for the case manager to form a relationship with the child, and the benefits of the intervention for the child were limited. We also found instances where minimal work was undertaken and interventions that had been planned were not delivered.

[10] The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. A more detailed explanation is available in the data annexe.

The roles of other workers were not clear, and we found this potentially undermined some of the more positive work that could have been undertaken. One child had been working well with a youth worker assigned through early help, but the case was closed when the YJS become involved. Both the child and parent asked that the youth worker remained working with the child, as they had developed trust over time. In this instance, the youth worker could have provided the voluntary intervention under the direction of the YJS, but this did not occur. At the end of the community resolution, the child's mother asked for this support to be reinstated, but it was unclear from the records if this had happened.

We saw very little effective partnership work to keep children safe, even when information was shared.

We saw very little delivery of services to keep other people safe, even when there was evidence of repeated instances of harmful behaviour. Victim work undertaken as part of the group programme was generic in nature rather than tailored to the specific child or potential victims. Planning nor delivery was not adapted or reviewed when children's risk to others continued or changed, at school or in the community. Work continued despite indications that it was not addressing risks effectively. There was very little effective oversight of risk management. In one example, a girl had received a community resolution following an assault on a neighbour. The child then stated she had been involved in a further altercation with two family members. There was no evidence that the case manager had tried to understand who these family members were or who the victim of the index offence was, or had any discussions with the child about victim safety.

3.4. Out-of-court disposal policy and provision

There is a high-quality, evidence-based out-of-court disposal service in place that promotes diversion and supports sustainable desistance.	Inadequate

We also inspected the quality of policy and provision in place for out-of-court disposals, using evidence from documents, meetings and interviews. Our key findings were as follows.

Strengths:

- Out-of-court policy and provision has been reviewed and new processes introduced in the past year. The police are using more appropriate child-first guidance. This was created with input from regional YJSs, and Slough has been part of these changes. The introduction of a joint decision-making panel (JDMP) is positive, and the ability of the YJS to influence decisions for children in out-of-court disposals is developing.
- The responsibility for prevention work has recently moved to the targeted youth service. This has provided additional capacity for YJS staff to undertake out-of-court disposal work.
- Turnaround funding has been used to provide a parenting worker. This has strengthened the service's capacity to offer support to parents and improve relationships within the family home.
- Children receiving out-of-court disposals benefit from the work of the health professionals, as well as the ETE and parenting workers.

Areas for improvement:

- The JDMP arrangements have not yet improved outcomes for children. Assessments for this panel were of a low quality. The panel did not record attendees or rationales for decision-making, which made it difficult to assess how effective the new arrangements were.
- Decision-making was not undertaken jointly. In 12 cases out of our sample of 15, the decision was made solely by the police. Only three cases had been agreed jointly. Other than providing information or allocating assessments, it was not clear what role the YJS had in these panels.
- The out-of-court processes are confusing and not easy to understand or follow. There are many opportunities for deviation from the process, not many of which were based on the needs of the child.
- Social care staff did not routinely attend the panels. Social workers could be invited, but there was a limited understanding of what they or early help professionals might be able to add or contribute to the process.
- Improvements in the timeliness of decision-making, assessment activity, and the delivery of interventions are required. Some children attended interventions that were not linked to the reasons they had received an out-of-court disposal.

- All areas of out-of-court disposal activity, including assessment, planning and delivery, require significant improvement, particularly in relation to work to keep children and other people safe.
- Children who receive an out-of-court disposal can access a wide range of support. However, we found examples where referral and access to this support were inconsistent.
- The YJS's analysis of out-of-court disposal data is underdeveloped. Staff have a limited understanding of the outcomes or effectiveness of each type of disposal. They do not recognise disproportionality for the children receiving disposals, or how to segment and analyse data on children's protected characteristics.
- Children have not been consulted on the review of policy and provision.
- Scrutiny arrangements for out-of-court disposals have been paused since April 2024. There is a lack of strategic scrutiny, beyond basic data on key performance indicators. The lack of internal strategic knowledge means that out-of-court disposal provision is not being overseen effectively.
- We could not be assured that decision-making was appropriate in all cases. We found a few cases where the child might have been diverted to prevention work, given the situation and the child's age. There was no clear explanation about how discretion would be used or about the safeguarding in place to ensure that children were not inadvertently brought into YJS services.
- There is very little focus on victims, and opportunities to use restorative approaches are limited.
- The YJS has not analysed the effectiveness of the various outcomes. The reoffending data for children who received out-of-court disposals needs to be examined to understand the narrative.

4.1. Resettlement

4.1. Resettlement policy and provision

There is a high-quality, evidence-based resettlement service for children leaving custody.	Not rated

We inspected the quality of policy and provision in place for resettlement work, using evidence from documents, meetings and interviews. There were no resettlement cases for us to inspect. Our key findings were as follows.

Strengths:

- The resettlement policy is evidence-based and provides the key elements needed to resettle children into the community from custody.
- Work undertaken from the examples of resettlement work we were given and the expectations of resettlement work from managers are more in depth than the policy outlines.
- Resettlement work is overseen by a manager with experience of work in the youth custodial estate. This helps staff to navigate the systems and processes.
- The leaving care team has developed a specific tool to identify suitable accommodation for children. The YJS will use the 'Find my home' tool for future releases.
- The YJS manager has proposed to the senior leadership team that children remanded should keep their looked-after status to provide an additional safeguard. This is a child-focused approach.
- Health services will work alongside custody staff to share information, support assessment activity and plan for release.

Areas for improvement:

- Given that the YJS's role is not understood or given sufficient priority across the partnership, we have little confidence that partners would work with the YJS to support children preparing for or being released from custody.
- Given the lack of focus on public protection and victim safety, we are not assured that the service understands what actions and restrictions may be required for robust safety planning in resettlement activity.
- There is too little knowledge across the partnership and within the service to support effective resettlement work. There are no strategic methods in place to hold partners to account for providing services to children on release.
- The development of the resettlement policy has not involved other agencies or been to the board. It does not specify how key partner agencies should be involved in resettlement planning. The policy does not specify the roles of education, social care or accommodation providers.
- The policy does not include the response to victims and responsibilities under the victim code.

- There are no arrangements for the board to review custodial episodes, and gather any learning or understanding in relation to local resettlement needs.
- There is no reference to equality, diversity and inclusion in the policy.
- Very few staff have received training in resettlement. One of the four staff who completed the survey said that they had received training in this area.
- The use of release on temporary licence (ROTL) and opportunities to support children on temporary release were not fully understood. Partners would need to understand their role in ROTL periods and applications.
- Staff are inexperienced in court work and have required support from managers to mitigate this to ensure that remand and custodial sentences are appropriate. With no recent training in court, bail, remand and resettlement, we are not assured that custody is only used when absolutely necessary. We told about instances where children had been promised ETE services on release but these had not been delivered. Within the current availability of ETE in Slough, a child aged over 16 coming out of custody would have to wait up to a year to access college.
- If the child had substance misuse issues, the only available support is through a voluntary sector provider.
- Given the levels of risk associated with custodial sentences, current arrangements are not sufficiently robust.

Further information

The following can be found on our website:

- inspection data, including methodology and contextual facts about the YJS
- a glossary of terms used in this report.