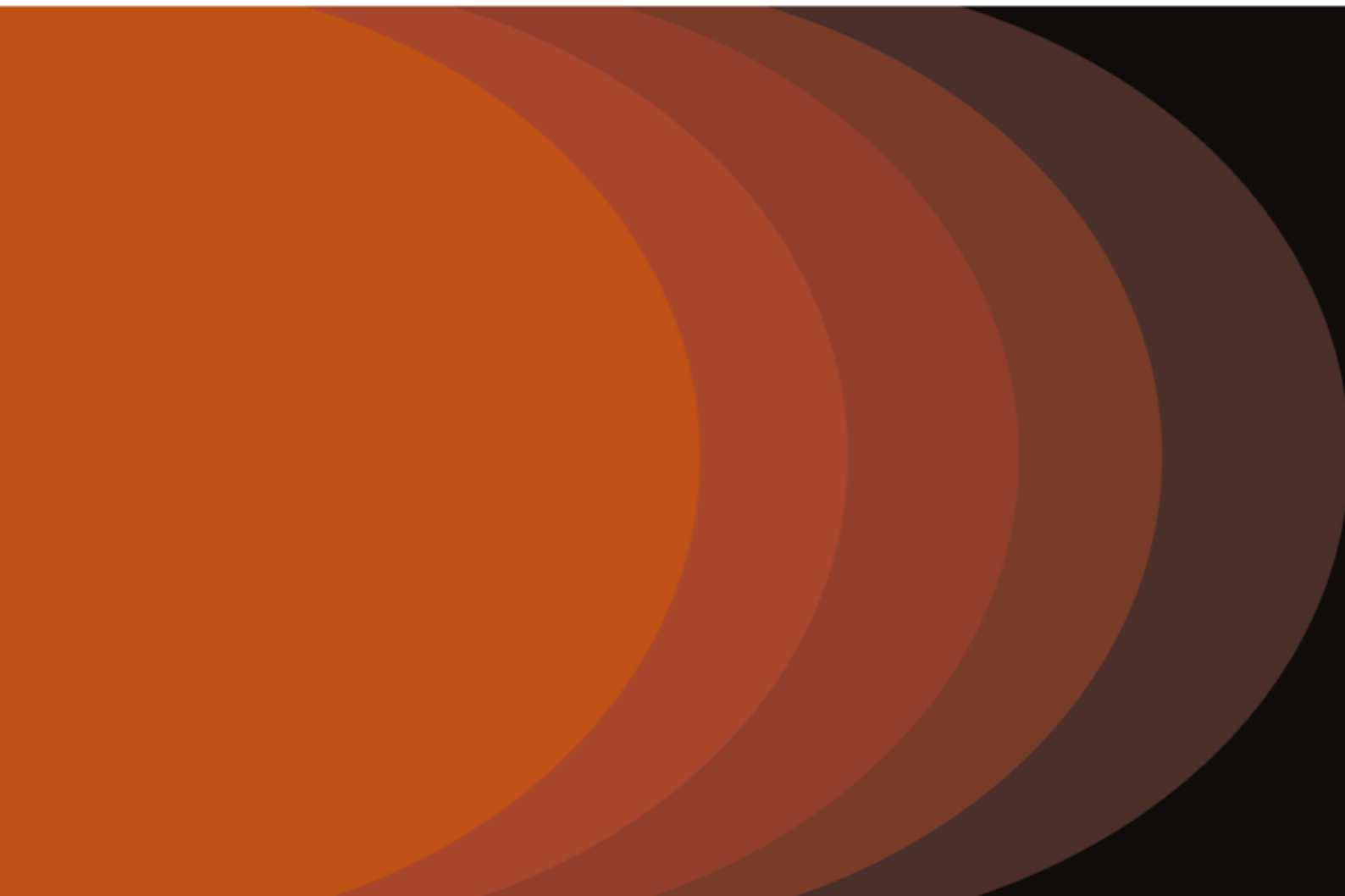
HM Inspectorate of Probation

An inspection of youth justice services in

Reading

HM Inspectorate of Probation, December 2024



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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.

We inspect these services and publish inspection reports. We highlight good and poor practice and use our data and information to encourage high-quality services. We are independent of government and speak independently.

Please note that throughout the report the names in the practice examples have been changed to protect the individual's identity.

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Foreword

This inspection is part of our programme of youth justice service (YJS) inspections. We have inspected and rated Reading 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, Reading YJS was rated as 'Inadequate'. We also inspected the quality of resettlement policy and provision, which was not rated because there were no resettlement cases within the timescale covered by the inspection.

Significant progress has been made in Reading in the last 12 months. This has coincided with the appointments of the independent management board chair and service manager, who have been proactive in making positive changes. They are developing a 'child-first' vision and have energised the partnership. We saw some aspects of effective practice beginning to emerge; healthcare provision is having a positive impact, there is evidence that the voice of the child is being heard more effectively, and support for the parents of exploited children is impressive.

However, despite the recent progress, too little attention has been given to youth justice work in Reading since our last inspection and there has been an underestimation of the impact that this has had. Our inspection saw disappointing results on the ground, and that the needs of this vulnerable and complex cohort of children have been neglected or overlooked by the partnership. Barriers, such as access to, and engagement with, education providers have not been previously addressed sufficiently and children identified as having substance misuse concerns were not always provided with access to appropriate interventions or support. Where concerns outside of the home were identified for children, the response and approach to address these were not always effective.

YJS managers and practitioners are motivated and diligent. They work hard to develop relationships with children and families and attempts to facilitate identity shift by focusing on their strengths are admirable. However, this approach is not sufficiently aligned with an effective understanding of how to achieve safety for both children and the community. Important factors related to harm reduction are often either not considered or missed. In addition, the needs of victims are not being sufficiently met.

As a consequence of these issues, we identified numerous shortcomings with assessment activity, which then impacted on the quality of planning activity and the coordination of collaborative activity to deliver high-quality interventions with children.

If the recommendations made in this report are accepted and addressed, however, we have no doubt that the delivery of youth justice services will develop positively.

Martin Jones CBE
HM Chief Inspector of Probation

Ratings

Reading Youth Justice Service Fieldwork started September 2024		**Score**	**5/36**
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	**Requires improvement**	
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	**Requires improvement**	
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 eight recommendations that we believe, if implemented, will have a positive impact on the quality of youth justice services in Reading. This will improve the lives of the children in contact with youth justice services, and better protect the public.

The Reading Youth Justice Service manager should:

1. ensure that quality assurance arrangements, oversight of practice, and supervision arrangements consistently support staff and volunteer development
2. ensure that assessing activity always considers how best to achieve safety for the child and the community
3. ensure that planning activity is comprehensive and that it aligns effectively with activity undertaken by other services, including the consideration of appropriate contingency arrangements
4. ensure that staff consistently liaise with all relevant services when delivering interventions
5. ensure that commensurate focus is given to the needs of victims.

The Reading Youth Justice Management Board should:

6. ensure that the YJS is both sufficiently resourced and structured to facilitate the delivery of high-quality interventions for children and the victims of crime
7. assure itself that the disproportionality action plan is being used effectively across the partnership to enhance equity, inclusion, and diversity arrangements
8. work together to ensure that children have access to, and can engage with, high-quality, aspirational education, training, and employment opportunities.

Background

We conducted fieldwork in Reading YJS over a period of a week, beginning 09 September 2024. We inspected cases where the sentence or licence began between 11 September 2023and 05 July 2024and out-of-court disposals that were delivered between 11 September 2023 and 05 July 2023. We also conducted interviews with 17 case managers and the line manager of one case manager.

Reading is one of six unitary authority areas within Berkshire, in Thames Valley. Our last inspection of Reading took place in 2016. The 10–17-year-old population of the town sits at 37,929, 23,973 of whom are of school age. Sixty-three per cent of children open to the YJS at the point of the inspection announcement had a Black, Asian, and minority ethnic heritage, around 20 per cent more than the general 10–17-year-old population.

Around 14 per cent of children in the overall 10-17 population live in absolute low-income families. There is a geographical demarcation within the town's indices of deprivation profile, with some areas, such as Whitley, experiencing greater need than other areas, such as Caversham. The YJS cohort reflects these geographical differences, with more children coming from the more deprived areas.

Reading is one of the three top crime-generating community safety partnership areas in the Thames Valley. Offending rates in Reading (6.8 offences per 1,000 of the 10–17-year-old population) are higher than the south-east regional and national averages, which sit at 5.6 and 6.0 per 1,000 of the 10–17-year-old population, respectively.2 Violence against the person is the highest volume crime type, mostly within the context of the night-time economy. Rates of serious youth violence are the second highest in the Thames Valley.

The needs of children open to the YJS are complex and many have experiences of trauma. The most recent local data shows that the percentage of YJS children experiencing two to three adverse childhood experiences (ACEs) rose from 46 per cent in 2020/2021 to 54 per cent in 2022/2023, and those experiencing four or more ACEs rose from 11 per cent to 30 per cent.

The YJS is part of the Brighter Futures for Children portfolio, a not-for-profit company, wholly owned by, but independent of, Reading Borough Council. The company operates as an alternative delivery model for children's services and took over responsibility for the delivery of Reading's children's social care, education, and early help and prevention services in December 2018.

The YJS service manager service has been in post since February 2024. His portfolio includes extrafamilial harm, and he has oversight of the Reconnect, and Missing and Exploited services. He reports to the head of service for family help and partnerships.

The YJS shares police, probation, and local criminal justice board areas with the eight other Thames Valley YJSs, and this has led to a collaborative approach to youth justice overall in the area. The local youth court is in Reading.

[2] The rate of offences is NOT published and is calculated by HM Inspectorate of Probation using data from: Youth Justice Board. (January 2024). *Youth Justice annual statistics: 2022 to 2023,* and Office for National Statistics. (November 2023)*. UK Population estimates, mid-2022.*

Domain one: Organisational delivery

To inspect organisational delivery, we reviewed written evidence submitted in advance by the YJS and conducted 13 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 and service manager have worked hard over the last 12 months to develop a coherent child-first vision for the service. There is an aspirational philosophy intended to improve outcomes for children.
- Attendees at the management board are proactive participants at other local and relevant strategic forums, such as the community safety partnership and the safeguarding children's partnership.
- The independent board chair is demonstrably 'hands on'. He is knowledgeable and well respected in the sector. He has the skills and experience required to drive forward the improvements needed across the partnership.
- The board has been reinvigorated in recent months. New members have joined. Attendance is stabilising, participation and engagement has improved and diversity of membership increased.
- There is a renewed and genuine desire to listen to the voice of children and their parents or carers at the board, and we saw evidence of impact. There appear to be real opportunities to align this activity with community safety's 'Young Voices' programme and develop activity further.
- The YJS service manager is an experienced and competent individual. He has made a positive impact in the short time that he has been in post. He is aware of inherited deficits in strategic and operational delivery.

Areas for improvement:

- In previous years, youth justice has not been prioritised across the partnership. While there have been clear signs of development in the last 12 months, the previous lack of strategic engagement has had an impact on current outcomes. The management board needs to commit to embedding the changes it has started to make and continue the progress made.
- Performance reports submitted to the board are detailed and provide a narrative. However, critical areas of focus are not always covered, meaning that board members may not always be aware of either good practice or

challenges. Victims, mental health, and substance misuse were areas which have not been scrutinised sufficiently in the last 12 months, for example.

- Board members need to ensure that there is a clear focus on youth justice children in the work that they do at the board and the data that they bring for scrutiny.
- There have been positive recent attempts to listen to the voice of the child but the challenge for the partnership now is to ensure that this qualitative feedback is always reflective of the picture painted within performance reports presented to the board and at other strategic forums.
- Board members have attempted to advocate for the work of the YJS, but the impact is inconsistent. We did not consistently see evidence of joint activity between services taking place.
- There is an audit schedule in place and reports are fed into the board. Outcomes from review of these audits are inconsistent. We saw genuine progress at an operational level following a stop and search audit but a lack of awareness of outcomes within the partnership following a reoffending audit.
- The board has endorsed a comprehensive multi-agency racial disproportionality action plan. None of the partnership staff we spoke to were aware of its contents.
- The voice of the victim is not heard at the board. Overall, there is little, if any, understanding of the challenges that the YJS faces in delivering support for victims.
- The YJS management team has further work to do to fully operationalise the child-first vision and fully communicating it with staff. We saw aspects of satisfactory work to build relationships and work with children, but the service is failing to align this with an approach that achieves safety for either the child or the community.
- The board has been unsuccessful in tackling structural barriers impacting upon youth justice children. For example, we saw and heard of numerous examples of children being unable to access suitable education provision, a key factor in promoting desistance.
- The partnership's understanding of risks to the service is underdeveloped. While risks are monitored, there is not a universal understanding of priority within the partnership.
- While there has been recognition of the need to improve practice, those at a strategic level have underestimated the work that is required to improve this, and the impact this has on delivering the youth justice plan effectively.

1.2. Staff

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

Strengths:

- Practitioners are motivated and want to do a good job. Morale in the office is high. Everyone described the atmosphere as 'like being part of a family'.
- Despite vacancies within the team, workloads remain manageable, albeit within the context that additional work is sometimes shared between managers and practitioners.
- Sickness rates are low and have not affected service delivery.
- There is a pool of enthusiastic and committed volunteers. The recent addition of a lived experience volunteer is positive.
- Parenting support is comprehensive and has facilitated some positive outcomes for parents of children open to the YJS.
- Staff and volunteers are representative of the community within which they work.
- Staff receive reward and recognition when good practice is undertaken. One practitioner has received an award from Brighter Futures for Children (BFfC).
- Managers engage staff well. Minutes from team meetings indicate a collegiate approach to discussions and sharing information.

Areas for improvement:

- The very poor outcomes seen in domain two and domain three indicate that staffing arrangements have not been conducive to the delivery of high-quality interventions.
- Recommendations to develop management oversight and staff training, made in our last inspection, eight years ago, have not been followed up effectively. We saw inconsistency in management oversight. Guidance was often ineffective or incorrect. Middle managers need more support to ensure that appropriate guidance is delivered consistently.
- Staffing levels are not sufficient. A recruitment freeze within the trust has previously impacted the YJS, although we note there are plans to fill vacancies. The case manager and victim worker vacancies have affected service delivery.
- The absence of case managers with professional qualifications or a full understanding of harm reduction best practice is hampering both team development and service delivery. We saw an inconsistent and, at times, unsophisticated understanding of how to manage risks – both to and from the child – and how to facilitate desistance. Practitioners need more support to help them deliver interventions more effectively.

- The team has not had a probation officer for several years. Service delivery has been impacted by the lack of technical understanding that a seconded probation officer can bring to a YJS. The importance of this role has been recognised by the service manager and partnership and a 'transitions worker' role has recently been advertised. This appears to be a sensible workaround to address this gap.
- There has been insufficient attention given to delivering an effective offer of restorative justice and victim support. Current arrangements are not appropriate or sustainable.
- One-to-one supervision is delivered regularly; however, it is having minimal impact upon staff development. Group supervision arrangements are in place but are not sufficiently structured and potentially perpetuate ineffective practice. Volunteers receive no systematic ongoing support once they have been inducted.
- Workforce development plans are underdeveloped; there is not a clear understanding of priority areas for the development of staff.
- While there are arrangements in place for managing poor performance, the lack of a consistent understanding of what constitutes good practice hampers these.
- The service urgently needs to revisit Asset Plus training for staff. We saw some examples of an overly rigid approach to risk assessment emanating from previous training activity.
- Equity, inclusion, and diversion training has been delivered, but its effectiveness needs to be evaluated. Basic errors in practice, such as not using interpreters, suggest that it has not been fully embedded.

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:

- All partners have a sufficient high-level understanding of the needs of the YJS cohort of children, and they are committed to working collaboratively to achieve best outcomes.
- There is evidence that some data has been analysed well by partners, and action taken. For example, there is a mature understanding of serious youth violence trends, and this has led to the commissioning of targeted support to aid interventions in the town.
- The Young Voices strategy, coordinated by the community safety manager, provides an effective means to ensure that children's voices are considered when activity is developed, although the feedback provided is not always sourced specifically from YJS children.
- Staff feel that there is sufficient access to services for the children they work with.
- The Reconnect team is co-located with the YJS. This is a multidisciplinary team working with children experiencing harm outside the home. The offer of support is impressive. Staff from this team assist with formulations.
- There is a strong health offer available to YJS children. We saw children routinely being screened by the 'health and justice' team, and interventions provided.
- There are good links with the third sector. Reading Football Club delivers an effective intervention, for example.
- The 'New Meanings Training College' provides a good level of support for post-16 children who have not thrived in mainstream education.
- The 'parents exploitation peer support group' provides an effective way to listen to and address the needs of parents, whose voices can then be fed into wider partnership activity to develop services.
- Multi-agency case planning forums facilitated by the YJS are arranged for all children assessed to pose a high risk. Children and parents actively participate in these meetings.

Areas for improvement:

- The intervention and delivery standard in both domain two and three was rated 'Inadequate'. Despite the breadth of interventions available, arrangements have not been successful in ensuring that children can access them in all instances.
- There is a wealth of data and information about YJS children available, but it is not always shared effectively. There are genuine attempts to scrutinise trends within the YJS cohort, but approaches are underdeveloped, given the

relatively small numbers of children involved. Consequently, a lot of the good work we saw during our fieldwork was reactive in nature, when there should have been scope for a more proactive, earlier intervention from partners.

- A more sophisticated understanding of resourcing is required. For example, a more detailed health needs assessment of YJS children would help promote a better understanding of resource sufficiency. Greater speech and language therapy (SALT) capacity and provision is needed, for example, given the level of need identified within the YJS cohort of children.
- Partners understand the need to tackle potential disproportionality, but we did not always see a joined-up approach to tackling concerns. Work with girls was being undertaken but lacked coordination.
- Children who experienced harm outside the home did not always receive a consistent response from children's social care services, and we did not always see effective challenge of decision-making by the YJS.
- The partnership needs to strengthen its approach to ensuring that intervention for children upstream is undertaken at 'reachable' moments. The violence reduction unit-funded 'Act Now' project, starting imminently, is a good example of how to achieve this.
- Half of the YJS caseload at the point of inspection had a recognised substance misuse need, but we saw minimal intervention to support these needs within the cases we inspected.
- Information sharing with probation services is not effective. We did not see liaison taking place consistently when family members were known to probation services.
- Work is being undertaken to improve education provision for excluded children. However, we saw a number of examples of insufficient provision facilitated by the pupil referral unit.
- Consideration needs to be given to the appropriateness of the police station as a child-friendly location for the seconded police officer to deliver some interventions.

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:

- Policies and procedures for all areas of activity are accessible to staff via an internal SharePoint drive. There is evidence that staff have been consulted when some of these policies have been developed, and of discussion at team meetings.
- The service manager has prioritised the updating and review of policies and procedures since his arrival. A number of documents needed review before he was in post, and he agrees that there is a need to make sure that a systematic review schedule is put into place to ensure consistency.
- The service operates from a modern, spacious, and accessible building. It has ample capacity for the delivery of one-to-one or group activities. Staff assist children in accessing the building if they have transport difficulties or are wary about visiting because of postcode rivalries.
- The YJS has a sensory room which can be used for children with neurodiversity or who become over-emotional and need to de-escalate.
- Reparation placements are appropriate and there is assurance that all receive a sufficient health and safety assessment.
- Information and communications technology provision enables staff to record information on the case management system and share it. Equipment is available for staff working away from the office and supports a hybrid approach to working.
- The service has recently become involved in the Area Leader Programme pilot, facilitated by the Youth Endowment Fund. This presents a great opportunity to access external resource to review systems and leadership in the authority.

Areas for improvement:

- Not all policies facilitate effective operational delivery currently. For example, the volunteer policy was last reviewed in 2011, and the lack of urgency to update this is reflected by the limited offer of ongoing support we saw afforded to volunteers.
- Not all the YJS policies are explicit enough in their consideration of equity, diversion, and inclusion.
- Although the YJS building provides a child-friendly space for delivering interventions, the service must ensure that this is maintained effectively, and the environment is appropriately welcoming.
- The absence of a probation officer means that nDelius records are rarely interrogated. There is also an overreliance on staff reading information on

social care's Mosaic system and not following up with effective dialogue between services. This impacts on the quality of information sharing practice.

- Additional resource to assist with data analysis would be beneficial. This would ensure better assurance about data integrity and greater sophistication when analysing information.
- While there is a comprehensive quality assurance framework in place, the poor practice identified in domains two and three indicate that its application needs to be strengthened.
- The Young Voices project provides an effective way to source children's feedback, but the service needs to develop its own participation strategy.
- Learning from serious incidents or practice reviews is not cascaded throughout the service well. A more systematic approach is needed.

Involvement of children and their parents or carers

Children's participation and the need to ensure that the voice of the child is heard are areas that are taken very seriously by the YJS. Recently, children and parents have attended and contributed to the management board. However, there is still a need to develop an impactful 'in-house' YJS strategy that will contribute to a consistent 'you said/we did' approach to the review of internal policy and process.

The Young Voices project provides a useful forum for children and the YJS to contribute to this. We saw evidence that children were listened to, and the upcoming online safety summit provides a marvellous opportunity to hear from children about their concerns and experiences of the 'online space'.

The YJS parents exploitation support group is an effective forum to enable the parents of exploited children to be heard. It has been running for two years now and has supported ongoing University of Surrey activity with trauma-informed research.

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. We delivered the survey independently to the nine children who consented, and six children replied. Additionally, we spoke directly to seven children and one parent during our fieldwork.

Feedback was universally positive about the support received from the YJS and reflected the relational approach taken by case managers that we saw in inspected cases. The children and parents receiving this support view it as positive, and it provides an excellent platform from which to develop practice in other areas where deficits were identified during the inspection.

Throughout our fieldwork, we identified structural barriers impacting on provision and engagement with education. While many of the issues are outside of the control of the YJS, children felt that the YJS is doing its best to assist. One child noted that supervision:

> *"helped me get back into education which was a struggle for me and showed me future opportunities that I could follow up on which helped significantly."*

Another child spoke glowingly about the in-house education support, noting that he had started college on the previous day and had just finished his second day. He told us that college was not something he had thought was on his path, but that the YJS had supported him, taken him to the Open Day, and introduced him to the head, so that he had felt safe and prepared.

More generally, what was clear from the feedback received was that case managers care about the children they work with. One child was effusive in his praise for his case manager, noting that she was:

> *"very patient with me even when I did not want to speak to her, she took the time to help my needs and get everything sorted for me any problems she would sort it out straight away. She is very kind and caring and the best worker out of them all I think personally."*

Another child told us that she had completed her intervention on the day we spoke to her, and that staff had brought in a cake to celebrate with her. She felt included, listened to, comforted, and supported throughout the duration of her intervention.

Diversity

- In Reading, the most recent Youth Justice Board annual data (2022/2023)[3] indicates that the ethnic composition of the offending population is similar to that of the general population of those aged 10–17; 43.5 per cent of the general youth population are from an ethnic minority background, whereas only 40 per cent of the YJS caseload were from this background. This caseload figure was significantly higher than both regional and national percentages, however, and data provided within the organisational spreadsheet indicates that, at the point of inspection, 63 per cent of the caseload were from an ethnic minority background, suggesting that numbers have risen in the last two years. 32 per cent of the current workforce in Reading are from a similar background with four in six caseworkers identifying as such.
- There are no male caseworkers in the team. However, there was some assurance that one of several male non-caseworkers, including a lived experience volunteer, could be accessed if a child requested a male worker.
- There is a comprehensive multi-agency racial disproportionality action plan in place, with ambitions to link in with wider local strategies. One of the objectives within the plan is to develop audit activity later in the financial year, looking at areas such as court activity and school disproportionality. The scope of ambition is appropriate.
- Equity, inclusion, and diversity practice was not consistent within the work that we inspected. Issues often arose at the assessment stage which subsequently impacted on work with children. In a number of instances, we saw no active consideration of race and ethnicity. This was exacerbated by incorrect recording of children's ethnicities; in one instance, a child had three different recorded ethnicities on the records that we viewed. This lack of initial focus had the potential to impact on the experiences of the child during these initial periods of interaction.
- Staff understood the impact that neurodiversity has on children and we saw some examples of good practice. However, staff did not always apply this knowledge to practice in their assessments, making it unnecessarily more difficult for the child to engage. We also saw an inconsistent picture regarding adapting sessions to take neurodiversity into account.
- We saw more than one example of an interpreter not being used when either the child or family members had English as a second language. We were told that interpreters were supposed to be used where appropriate.
- A communication passport has recently been introduced to facilitate interaction between children and professionals. We saw this used effectively in one instance, to aid communication. Overall, the SALT was providing some good levels of input with children, to facilitate communication needs. However, the therapist's capacity was sometimes stretched, and, with additional time, she could be more creative with her support, which currently focused mainly on screening and assessing need.

[3] Youth Justice Board. (January 2024). *Youth Justice annual statistics: 2022 to 2023.*

Domain two: Court disposals

We took a detailed look at seven 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?	57%
how to keep the child safe?	57%
how to keep other people safe?	**29%**

A comprehensive assessment is crucial for ensuring that the needs of children are understood. Staff showed some understanding of how to assess effectively; Asset Plus assessments were invariably co-produced with children and their parents or carers, and were strengths based. This approach assists in tailoring subsequent interventions.

However, other assessing activity to support desistance was not always consistently done well. Structural barriers were not always understood and analysed effectively. For example, one assessment lacked clarity on education and attainment, and no contact had been made with professionals who might have known more about the impact of the child's autism spectrum disorder (ASD) diagnosis. Such omissions impacted negatively on the service's understanding of its children. The barriers to effective engagement often lie in external structural factors rather than the child's personal willingness to engage and so a failure to understand these factors at the earliest opportunity did not afford the child the best chance of securing a positive outcome at the end of intervention.

There was congruence between the YJS's classification of safety and wellbeing and our own, and we were assured that defensible decisions were being made regarding the level of risk faced by children. However, we observed room for development in relation to how well staff analysed support and interventions to promote the safety and wellbeing of the child. For example, one child had reported to an accident and emergency hospital department several times in a 12-month period with various physical injuries, and the case manager had not sufficiently explored this to gain an understanding of why this might be. In another instance, a child had had a knife pulled on him, but this was not explored in the Asset Plus analysis. A more in-depth understanding of the background and context of these potential risks to the children would have enabled a suitable understanding of what now needed to happen and be put in place to safeguard them, going forward.

Practitioners were inconsistent when identifying and analysing how best to keep others safe. The classification of potential harm to others was not always accurate

[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 on our website.

and there was an underestimation of some children's potential to cause harm to others. For example, the victim of one child lost consciousness during an assault. In addition, this child had a previous pattern of non-convicted peer-to-peer aggression and recognised issues with thinking skills, exacerbated by a desensitisation to violence. There had also been evidence of an altercation involving the child outside the court room after sentencing which had required de-escalation. However, these factors had been overlooked in assessing activity, nor appropriately considered in considering the risk of causing harm to others. Inaccurate assessment can have significant implications for the efficacy of the activity that the YJS then delivers. Identity shift for a child such as the one noted above is crucial, but it cannot be fully achieved if initial concerns are underestimated, overlooked and critical traits of their presenting identity, such as violence, are not considered.

In addition, assessments did not always analyse controls or support to manage risk of harm to others. In some instances, this was because of greater prioritisation on the needs and views of the child than on those of the victim. A child-first approach is vital, and it was positive that the service was genuinely beginning to operationalise this. However, this approach is delivered by youth justice professionals and so commensurate consideration must also be given to victims, many of whom are children. A strengthening of operational victim arrangements within the service would help to achieve this balance.

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?	86%
keeping the child safe?	29%
keeping other people safe?	**14%**

Planning to support desistance was done very well by case managers, reflecting the green shoots of emerging, effective child-first practice. It was positive to see that plans were genuinely co-produced with children and their parents or carers. This approach is crucial in ensuring engagement, as the child feels invested in the activity that they are agreeing to engage with, and the case manager is also clear about how they can facilitate positive outcomes. Such co-production also increases the opportunities for specific adaptations to service delivery to be made, as the child can articulate suggestions clearly and assure themselves that their views have been listened to. For example, in one case we inspected, the plan allowed the case manager to support the child by factoring in relevant adaptions in response to an ASD diagnosis by using the sensory room as they did not like noise and focusing on trust building exercises.

However, planning that helped achieve safety for the child and the community was not done so well. Contingency planning was particularly weak. We saw generic considerations within contingency plans that did not align with the complexities presented by children. Activity could have been strengthened if more detail were included that outlined and analysed the required monitors and supports, such as the impact of parental boundary setting.

Furthermore, planning to keep the child safe did not always align sufficiently with activity being undertaken by other services, or reflect what was being done. Greater consideration of external controls and measures that were already in place was needed, with a recognition of how the YJS could bring additionality to this activity.

Planning to keep others safe was not sufficient. Activity was hampered by the previous misclassification of levels that we saw in assessment. For example, if a child was incorrectly assessed to present a low risk of serious harm, there was insufficient formal or structured planning taking place to keep others safe.

The consideration of how other services could assist with planning to keep others safe was not consistent. In one instance, reference was made to a 'deprivation of liberty safeguards procedure', with minimal detail of who would assist in ensuring that this was delivered effectively. In another case, there was limited evidence of liaison with partners to consider additional monitoring of the movements of a child within an area from which they had previously been excluded and where they could

[5] 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 on our website.

now conceivably re-encounter their victims. As partnerships seemed to be committed to trying to work together effectively, we considered that the YJS should have made better use of the opportunities that this presented when planning to achieve safety for the community.

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?	100%
effectively support the safety of the child?	71%
effectively support the safety of other people?	**43%**

There were clear indications that some of the services being delivered to children were effective. The relational-based approach of the YJS meant that there was good interaction with the child and that the focus on supporting the child's desistance was impactful. For example, we saw clear attempts to engage children. This approach was facilitated by appropriate sequencing of the interventions that were delivered. This sequencing was combined with a commensurate degree of flexibility that was designed to promote engagement and allow the child the best opportunity to finish their intervention. One-to-one work undertaken between the case manager and the child was undertaken within a comfortable environment and delivered as session plans were intended.

We saw a similarly positive picture regarding service delivery to support the safety of the child. Shortcomings in interaction with partners that had been identified within assessing and planning activity were overcome. For example, in one instance we saw effective ongoing work with social care providers to support the implementation of a child-in-need plan. Case records also evidenced meaningful discussions with the family to explore the child's behaviour and monitor his safety actively.

In another instance, there was effective interaction with child and adolescent mental health services and health colleagues to assess and address physical health and cognitive needs. This effective practice reflected the strong health provision arrangements that we had seen in partnerships and services. There was assurance, therefore, that arrangements with Berkshire Health Trust were having a positive impact on the wellbeing of YJS children.

However, earlier failures by staff to identify and plan support to keep the community safe meant that the positive activity noted above sometimes lacked the impact needed to foster consistently an effective identity shift. In one case, for example, very little work was undertaken to address and explore familial pro-criminal attitudes to violence and conflict resolution. Additionally, as there were concerns about potential sexual harm and harassment towards an ex-partner, work on healthy intimate relationships and consent would have been beneficial.

Consideration of the victim was inconsistent. In one instance, the child displayed ongoing grievance thinking towards the victim, but coordinated activity to safeguard

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the victim was lacking. One child's case record indicated that no victim-related intervention had been delivered. This lack of victim focus in service delivery reflected the previously noted ineffective operational victim arrangements overall, and these arrangements need to be addressed as a matter of urgency.

2.4. Reviewing

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

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

Does reviewing focus sufficiently on:	% 'Yes'
supporting the child's desistance?	86%
keeping the child safe?	86%
keeping other people safe?	**57%**

Reviewing activity was the strongest area of practice in court disposals. In a number of instances, we saw evidence that staff were proactively reviewing and responding to changes in the child's circumstances effectively. This provided a level of assurance that case managers understood how to support children and keep them and the community safe. This understanding was not universal, however, and the YJS needed to refine its approach to ensure that reviewing activity and responding to changes consistently took place.

Where we saw positive reviewing activity, it was done very well. For one child, the case manager noted emerging evidence that the child was using substances and responded by making a referral to Reconnect for substance misuse support. Additionally, the case manager sought to support this child's educational provision following his GCSE results and inability to access a college placement, by actively considering the alternative options. Formal reviews were completed, which took account of changes in circumstances, ensuring that all professionals working with the child had a clear understanding of these.

Of the cases where reviewing activity to keep others safe was done well, this was mainly evident where there had been no significant changes to factors that were likely to keep them safe. Case managers noted that there had been no significant changes in concerns and provided a clear rationale for their new assessments.

When reviewing activity to keep others safe was not undertaken well, it was characterised by the same underestimations of concerns that we had seen in other activity. For example, in one instance a child had absconded from an out-of-area children's home and encouraged a younger peer to leave with her, and case managers had not considered the potential risks. In another case, there had been a lack of professional curiosity regarding a child's deteriorating behaviour, a dip in their engagement and the links to a domestic abuse incident; and no intelligence had been sought from the police to gain a fuller picture.

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Domain three: Out-of-court disposals

We inspected 11 cases managed by the YJS that had received an out-of-court disposal. These consisted of four youth conditional cautions, two youth cautions, four community resolutions, and one other disposal. We interviewed the case managers in nine cases, and the line manager in two 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?	**18%**
how to keep the child safe?	**18%**
how to keep other people safe?	**18%**

We inspected two strands of assessing activity during our fieldwork: activity related to children who had been discussed via a joint decision-making process within Reading, and activity related to children who had not.

A lack of consistency in processes hampered the sufficiency of assessing activity for children who had been transferred in from out of area or who had received a community resolution. For example, one child did not receive an assessment until six weeks after the first meeting with him, thus delaying the service's understanding of the child's literacy and how interventions needed to be adapted. In another instance, it was not deemed necessary to complete an assessment on a child due to an incorrect reliance on an assessment that was out of date. This meant that relevant information was not effectively reviewed or considered at the appropriate time.

For children whose disposal was agreed at a joint decision forum, more robust assessing activity processes were in place, and so the shortcomings were related mainly to the quality of this activity. For example, in one instance we saw an insufficient assessment signed off by a non-case-holding practitioner, rather than a manager.

One of the biggest areas of concern with practice related to the service's analysis of the impact of diversity issues. For example, one child had previously lived overseas outside of the country for a period and there was no meaningful consideration or discussion of the impact of this in the assessment. In another case, an interpreter was not used when liaising with the mother of a child whose first language was not English, and for another child there was no clarity about their diagnoses of ASD and attention-deficit hyperactivity disorder (ADHD) and the potential impact of these on desistance. In instances such as these, a failure to understand fully the impact of a child's diverse needs or the protected characteristics of a child and their parents or

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carers can mean that subsequent plans and interventions are made with insufficient clarity on the likelihood of the child's responsivity to activity.

We found there was insufficient analysis of the impact of structural barriers for children, particularly in relation to education, training, and employment. This area was, by far, the most frequent factor related to desistance in the inspected cases. We saw insufficient consideration of approaches to develop engagement with provision or the availability and appropriateness of the provision itself and the subsequent impact this might have on supporting desistance.

Assessment activity to keep the child safe required development. If a child was potentially at high risk of harm, practitioners recognised this and appeared to analyse information appropriately. However, where risks were more nuanced in relation to children's safety and wellbeing, we found assessment activity was sufficient in only a minority of cases. These issues often related to case managers' use and analysis of information, particularly that contained in partner records, which lacked depth and exploration. For example, we saw children who were at risk both in and outside the family home who were known to children's social care services. However, information was not explored, and social care knowledge was not utilised in the YJS assessment activity to understand the child and their circumstances. We saw disconnect between workers and the information they knew, and this meant there were gaps in the YJS assessment.

We encountered a similar picture regarding the activity to understand the risk of harm to others. We felt that this was sufficient in only a minority of instances, again due to an underestimation of concerns This appeared to be impacted by an oversight in appropriately analysing or considering other relevant behaviours outside the index offence. We saw several examples, across multiple children, where concerning behaviours were known about by the case manager but had not been incorporated or effectively considered in assessment. These behaviours included evidence of suspected involvement in drug related crime, evidence of harm to parents or siblings in the family home, and non-convicted sexually inappropriate behaviour.

There was often an underestimation of the complexity of this pre-court cohort of children. Practitioners did not understand fully the impact of this complexity in their assessment or consider this when analysing the implications in supporting desistance and the safety of both the child and the community.

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?	27%
keeping the child safe?	**18%**
keeping other people safe?	**18%**

Planning activity was impacted by insufficient assessment activity. Again, local processes played a part in our rating, and the absence of records from the recently developed joint decision-making panel (JDMP) made it difficult to assess the efficacy of the planning activity. We received assurance that the YJS was now putting in arrangements to ensure that records were more reflective of the discussions taking place.

Positively, planning to support desistance often gave sufficient attention to the needs and wishes of the victim.

However, planning to support desistance did not always take the child's circumstances into account effectively, or consider their ability and motivation to change. For example, there was some planning to support a child with ADHD, but this did not include appropriate referrals, planning was not specific about how or when pieces of work would be delivered, and it did not consider that this child had clearly indicated a lack of motivation to engage. Planning was not specific, measurable, achievable, realistic, and time bounded (SMART), potentially resulting in a lack of clarity for both case manager and the child.

Frequently, partner agencies were not routinely contacted when planning activity considered how to support a child's safety. In one instance at the end of a previous intervention there had been concerns about the child's safety. However, no contact was made directly with other agencies to check current levels of concern to aid planning for the new intervention. For another child, assessed as presenting a high risk of safety and wellbeing, there was no active contact with children's social care services or the education provider, and no evident planned referrals to be made to support the child, unless there was a change in circumstances, whereas a holistic approach would have benefitted from this. Collaboration between relevant partners appeared limited in many of the cases we inspected, and this prevented a comprehensive shared understanding for those professionals all working with a child.

Shortcomings in collaboration with partner agencies to manage risks from the child was also evident within the inspected cases and we also found limited evidence of effective contingency planning to reduce risks to others if circumstances changed. The service needs to review procedures to ensure that identified potential negative

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eventualities are sufficiently considered and appropriate individualised planning occurs.

We also found evidence of drift and delay in planning activities. For example, one child's plan was not completed for seven months, and when it was, it overlooked effective consideration of how issues relating to potential sexually harmful behaviour and associated risks to peers needed to be managed. When planning was timely, we found instances where potential risk concerns, such as suspected involvement in drug-related crime, were overlooked. The lack of timely and comprehensive planning covering all relevant areas of support was likely to impact on the YJS's capacity to plan for a change in circumstances. We also found that planning for complex children was not agile and evolving, and we lacked assurance that case managers could proactively respond should circumstances change.

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?	55%
the safety of the child?	27%
the safety of other people?	**18%**

The implementation and delivery of services to support desistance, while not consistently effective, was stronger, and reflected the 'identity shift'-focused approach of case managers and the range of services available locally. This suggested that the child-first approach to service delivery was beginning to embed and be reflected within relationship-based approach activity done with children. Furthermore, it was an approach supported by a philosophy that we saw in Reading which placed sufficient emphasis on promoting engagement.

However, not all practice to support desistance was positive. We saw avoidable blockages to the support that was on offer. For example, a delay in the imposition of a youth conditional caution resulted in insufficient time to deliver it. In cases inspected it was not clear how interventions were adapted to meet a child's individual learning needs, and we saw instances of a young child receiving intervention with limited involvement of their parents or carers.

The involvement of other services to keep the child safe was not sufficiently coordinated in a large majority of instances. On more than one occasion, we saw no active delivery of interventions focusing on the safety and wellbeing of the child, despite concerns having been noted at the assessment stage. Active liaison with other colleagues who could support the child was not always done well. We saw instances of a lack of liaison with Family Help workers, despite information from a 'Team Around the Family' meeting indicating known concerns, and saw examples where work delivered with children focused only on victims, with little or no regard to their own safety and wellbeing. The YJS appeared to be delivering some interventions in a silo, rather than taking a holistic approach, thus reducing assurance that the child's safety was consistently being considered or supported.

In addition, in several instances we saw identified risks to others, where no interventions were delivered with a focus upon achieving safety. Furthermore, we saw examples where practitioners had been incorrectly advised against taking proactive action.

> *"Despite Dan having a child with children's services intervention there is no contact made with children's social care to discuss this. The practitioner advised that they checked Mosaic, but this is not recorded. Management oversight indicates that the*

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> *practitioner should wait for children's social care to make contact, which leaves the potential risk outstanding. Further, there is no active exploration of lifestyle and associations to actively consider and respond to any other identified risks to others."*

This practice example typifies the approach to risk management that we saw in several of the cases we inspected. The need for collaborative intervention was poorly considered, and decisions were made in isolation. There was a need for the YJS to recalibrate its approach to ensure that service delivery actively promoted 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.	Requires improvement

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 had improved significantly in the last nine months. The police were using more appropriate child-first guidance, created with regional YJS input, and the introduction of a JDMP in Reading, five months before our arrival had strengthened collaborative decision-making.
- Partners demonstrated a positive attitude to the recent development of the JDMP. All appropriate services attended and engaged. Attendance was impressive. They now had the ability to share information more effectively to facilitate decision-making.
- Thames Valley police are looking to launch Outcome 22 imminently. Once it has launched it will provide additional assurance that children will be able to access all appropriate outcomes to prevent net widening and potential escalation within the youth justice system.
- Turnaround funding had been used to facilitate support for children receiving street-delivered community resolutions.
- The partnership responded positively to feedback within a recent HM Inspectorate of Probation report on a neighbouring YJS and this was a main driver for recent changes in approach.
- Scrutiny panels had recently been introduced to review the consistency and suitability of decision-making, although it was too early to determine the effectiveness of these arrangements.

Areas for improvement:

- While welcome, the new JDMP arrangements had not yet impacted on improving outcomes for children. Assessments for this panel were of a low quality and the lack of recording of attendees and rationales for decision-making at the panel made it difficult to assess the effectiveness of the new arrangements.
- Turnaround workers needed more support to ensure that interventions for children receiving a community resolution received a commensurate response, in line with their levels of risk, need, and responsivity.
- A lack of capacity to facilitate community justice peer courts, ensuring that a more robust, victim focussed intervention is provided for community resolutions, has had a significant impact on their effectiveness.
- The timeliness of interventions for children receiving an out-of-court disposal was sometimes impacted by the punctuality of police decision-making.

- Children receiving an out-of-court disposal could access a wide range of support. However, we found examples of inconsistent access to this support.
- The analysis of out-of-court disposal data was underdeveloped. For example, the partnership lacked clarity on victim consent levels and engagement with community resolutions given to children not receiving youth justice support.
- Children had not been involved in recent activity to review policy and provision.

4.1. Resettlement

4.1. Resettlement policy and provision

This standard has not been rated because there were no resettlement cases that fell within inspection timeframes. Our key findings were as follows.

We inspected the quality of policy and provision in place for resettlement work, using evidence from documents, meetings, and interviews. Our key findings were as follows.

Strengths:

- The YJS had developed an innovative 'resettlement and transitions' policy. It placed an appropriate focus on the principles of constructive resettlement, within a framework that recognised that each of the various stages of a child's resettlement journey constituted an episode of 'transition'.
- The YJS placed an appropriate focus on identity shift, and the use of 'reachable moments' within the resettlement journey to facilitate this shift.
- Custody panels were to be introduced before the end of the financial year, to ensure greater oversight of children at risk of custody.
- There was a dedicated assistant team manager with lead responsibility for resettlement who acted as a conduit for assimilating information about good practice.

Areas for improvement:

- Partners were committed to working together to improve outcomes for children in custody, but they had minimal involvement with the development of the resettlement policy and had missed an opportunity to align resettlement activity with a broader transitional safeguarding approach for vulnerable adolescents.
- There was minimal consideration of diversity within the policy, and how the latter could be used to effectively to impact on disproportionality.
- The policy failed to acknowledge explicitly the impact of structural barriers, such as the absence of education, on resettlement planning.
- Arrangements for accessing and exchanging information needed to be clearer within the policy. Current guidance was too vague to be of practical use to practitioners. For example, there was no reference to the youth justice application framework.
- Greater consideration of health needs within the policy was required.
- Greater consideration of victim needs, and statutory victim liaison officer arrangements was required in the policy.
- While partners assured us of good access to appropriate pathways of support, we were unable to test this out in an inspected case. We did not always see consistently effective access to pathways within the domain two and three cases inspected, so the partnership may wish to review

arrangements to assure itself that these are in place for children leaving custody.

- We did not see that the support group for parents of exploited children or the Young Voices project had inputted into a review of the policy and provision, this would be a meaningful addition when the policy and provision is reviewed.

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.