

# Transitions Arrangements: A follow-up inspection

*An Inspection by HM Inspectorate of Probation*

**January 2016**

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# Contents

Acknowledgements .....	4
Foreword .....	5
Summary of findings .....	6
Recommendation .....	7
1. Transitions Arrangements .....	8
2. Performance against previous recommendations .....	11
Appendices .....	27
1. The inspection process .....	28
2. Effective practice example .....	30
3. Glossary .....	31
4. Role of the inspectorate and code of practice .....	32

# Acknowledgements

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We would like, in particular, to thank the staff and managers of the Youth Offending Teams, Community Rehabilitation Companies and the National Probation Service we visited, and senior managers at the Youth Justice Board and the National Offender Management Service in England and Wales.

<b>Lead HM Inspector</b>	Caroline Nicklin, <i>HMI Probation</i>
<b>HM Inspector</b>	Jenny Daly, <i>HM Assistant Inspector</i> Yvonne McGuckian, <i>HM Inspector</i>
<b>Support Services</b>	Stephen Hunt, <i>Support Services Manager</i> Alex Pentecost, <i>Communications Manager</i> Henry Skwarczynski, <i>Support Services Officer</i>
<b>HM Assistant Chief Inspectors</b>	Alan MacDonald, <i>HMI Probation</i>

*Please note – throughout this report all names referred to in the examples of notable practice have been amended to protect the individual's identity.*

# Foreword

The transfer from the youth to adult world is a challenging time for any individual, including those involved in the criminal justice system. Failure to plan a smooth and effective transfer places a barrier to compliance and rehabilitation in young people's lives.

National organisations, during this period of far reaching change, should not lose sight of their responsibility to provide support and guidance to staff, in order to ensure an effective service to young people. Whilst we accept that the cases examined during the inspection relate to the period when staff at the National Probation Service and Community Rehabilitation Companies were coping with the challenge of working in new organisations, and managing the transition to the new probation structure, we found insufficient managerial oversight from both the Youth Justice Board and the National Offender Management Service. Effective guidance and advice was needed to inform the work of the Youth Offending Teams, the National Probation Service and Community Rehabilitation Companies and its absence has led to inconsistent practice across England and Wales. The Youth Justice Board and National Offender Management Service lack mechanisms to assure themselves that young service users are well taken care of at a challenging time in their lives. Some local organisations had sought to meet this gap and had introduced some helpful guidance and processes.

We found examples of effective practice from some, but not all, case managers, offender managers and offender supervisors who had a clear understanding of the need to share information in a timely manner. They briefed their opposite numbers effectively and prepared well the young people under their supervision. Other key individuals such as family members, other intervention providers or representatives of Leaving Care teams were kept informed of key decisions on whether to transfer a young person to the adult service or not.

However, the majority of cases had not been identified as possible transfer cases. There was no consistency of practice across the areas we inspected. In many cases there was little or no preparation, a failure to use existing information and a lack of planning which impaired progress towards smooth transitions. Young people entered the adult service unprepared and uninformed of the expectations they faced. We believe that better reducing reoffending outcomes are likely to result from well-planned, uninterrupted supervision of young people moving from Youth Offending Teams to adult probation providers.

Finally, we have been concerned to note the overall lack of progress by various local and national bodies in implementing the recommendations in the 2012 joint report *Transitions: An inspection of the transitions arrangements from youth to adult services in the criminal justice system*. There has been insufficient evidence found in this latest inspection of improvements to practice during the intervening three years and we will seek action plans from the National Probation Service, Youth Justice Board and the National Offender Management Service to address this.



**Alan MacDonald**

HM Assistant Chief Inspector of Probation

January 2016

# Summary of findings

## The inspection

The objectives of the inspection were to seek to establish how far the recommendations in the 2012 joint report *Transitions: An inspection of the transitions arrangements from youth to adult services in the criminal justice system* had been implemented and whether improvements to practice had resulted. The previous inspection had been a multi-agency inspection; whereas this inspection was a single agency inspection and, therefore, we did not interview other providers such as health or education, nor did we visit the custodial estate during this inspection.

We visited six areas and spoke to strategic and operational staff from three organisations, Youth Offending Teams, Community Rehabilitation Companies and the National Probation Service. We conducted interviews relating to 50 cases using a case assessment tool we had devised, partly consistent with the previous tool.

## What can or cannot be transferred?

There are a variety of orders which can be imposed on a young person. At the 'lower' end, there are orders which do not get transferred to the adult world, such as referral orders, reparation orders and some youth rehabilitation orders with a specific activity requirement. At the more 'serious' end of sentencing, a detention and training order generally is not transferred. Other youth rehabilitation orders have specific activity requirements such as intensive fostering (pilot areas only), intensive supervision and surveillance or programme requirement, which can be transferred when the requirement has been completed and the young person has reached their 18th birthday. Other orders should be transferred to the adult services, for example, youth rehabilitation orders with a stand-alone unpaid work requirement or a long-term custodial sentence (under sections 90/91 of the *Powers of Criminal Courts (Sentencing) Act 2000*; sections 226/228 of the *Criminal Justice Act 2003*). A solid principle is, therefore, that it is for the Youth Offending Team, in conjunction with the National Probation Service, to consider whether a case should be transferred based on the assessed needs of the young person and the legal requirements of the order.

## Overall findings

In our original thematic report in 2012, we noted that although we found examples of individual effective practice, work to promote the smooth transition of young people from youth based to adult based services did not always receive sufficient attention. In the community, some young people were not identified as eligible for transfer and, in those cases which were identified; transfer was often undertaken as a purely procedural task. Young people were not as informed or involved as they should have been. Overall, there was insufficient timely sharing of information between the youth based and adult based services to enable sentence plans to be delivered without interruption. The situation was similar in custody, where insufficient forward planning and communication led to an interruption in sentence planning and delivery of interventions after young people had transferred to an over-18 Young Offender Institute/prison. Positively, there were examples of local written arrangements for transition in the community although they needed to be better understood and used by practitioners.

We made eight specific recommendations in the original report, and have assessed through this reinspection the progress made in addressing them by the Youth Offending Team/Youth Offending Service Management Boards, the National Probation Service and the Community Rehabilitation Companies in the areas we visited.

## Previous recommendations

'We recommended that Youth Offending Team Management Boards, Probation Trusts and custodial establishments, in conjunction with education, training and employment, health and other providers of interventions, should ensure that:

- the effectiveness of local arrangements for the transfer of young people from youth based to adult based services, and retention of young adults in youth based services, is monitored and kept under review
- sentence plans in Youth Offending Teams and the young person's secure estate take account of future transfer to adult services where appropriate, and plans in Probation Trusts and the adult custodial estate take account of information from youth based services, to ensure that outstanding interventions are implemented
- decisions to transfer young people to adult services or to retain young adults in youth based services are recorded in the case record and take into account the views of young people and what work needs to be undertaken to meet the aims of the sentence, to address likelihood of reoffending and risk of harm to others, and to manage vulnerability
- young people are thoroughly prepared for transfer to adult services
- notifications of transfer, and all essential advance information, are sent to Probation Trusts and adult establishments in sufficient time to ensure continuity of delivery of interventions
- all intervention providers (including health and education, training and employment providers) are informed of transfers to Probation Trusts and adult establishments in advance and involved appropriately in case transfer meetings to ensure continuity of delivery
- parents/carers are involved, where appropriate, in discussions about transfer and in case transfer meetings where it is likely to aid the young person's progress and engagement
- staff in youth based and adult based services receive sufficient information and training about the work of each other's services to enable them to prepare young people for transfer to adult services and to work effectively with transferred cases.'

## Conclusion

Overall, this reinspection found there had not been sufficient improvement in the quality of work undertaken during the transfer of cases from youth to adult services. Transitions were not always well-organised, well recorded or smooth. However, there are specific examples of effective practice in this report which, if followed by all staff, would ensure a smoother transition for these young people.

## Recommendation

The Youth Justice Board, Youth Offending Team Management Boards, the National Offender Management Service, the National Probation Service and Community Rehabilitation Companies should ensure that that the previous recommendations noted above are implemented fully and effectively.

# Transitions

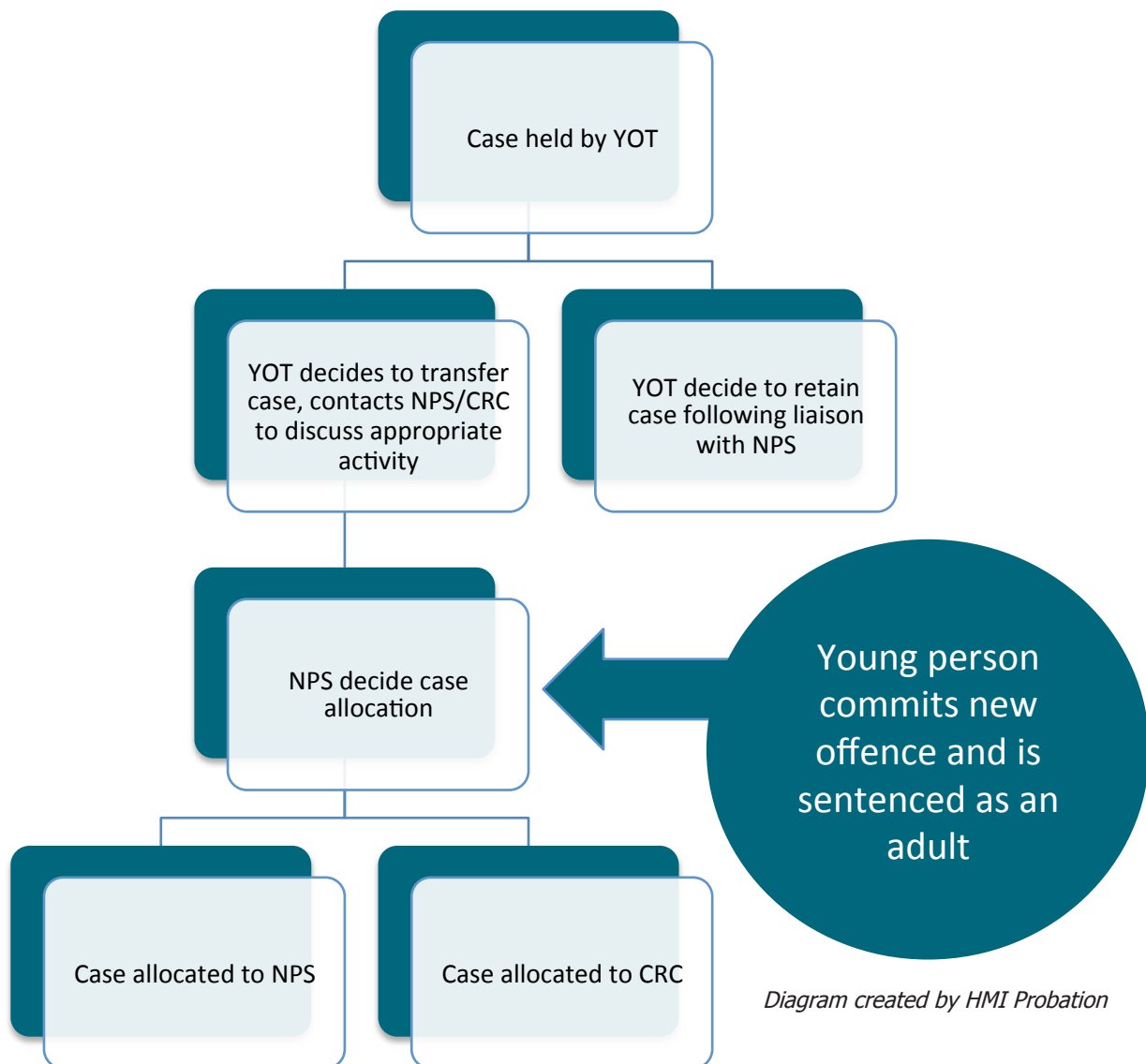
# Arrangements

# 1



# 1. Transition arrangements

Figure 1: The transition process



1.1. The main assessment tools currently used by service providers are:

- Asset; used by the Youth Offending Teams (YOTs) of England and Wales, it is supported by a variety of case management systems to assess the likelihood of reoffending, any safeguarding issues, the risk of serious harm posed by young people who offend under the age of 18, and produce plans to address identified need.
- Offender Assessment System (OASys); used by the National Probation Service (NPS) and, currently, the Community Rehabilitation Companies (CRCs), it is supported by the nDelius case management system, to assess the likelihood of reoffending, risk of serious harm of offenders over the age of 18, and produce plans to address identified needs.

1.2. Following the *Transforming Rehabilitation* reforms and dividing probation services into two separate organisations (the NPS and CRCs), the allocation of adult offenders to either the NPS or CRC is governed by the Case Allocation System (CAS). There are three steps to this process, and they are recorded in the CAS document.

- Risk of Serious Recidivism (RSR) Tool. The tool generates a summary score to indicate the likelihood of the offender committing a serious harm offence within two years. The RSR score is used to decide how to allocate a case.
  - Revised Risk of Serious Harm (RoSH) screening. The CAS includes a RoSH screening which must be completed on all offenders. Application of the RoSH screening will identify indicators of potential risk of serious harm and identify those cases that require a fuller assessment. Where the screening indicates the requirement for a full RoSH analysis, this must be completed unless there is sound justification for not doing so.
  - The final stage of the CAS identifies which agency the case should be allocated to from the RSR score, risk of serious harm level, Multi-Agency Public Protection Arrangements (MAPPA) status, public interest, and whether sentence has been deferred.
- 1.3. Medium and low risk of harm to others cases are transferred to CRCs. High and Very High risk of harm to others cases are retained by the NPS. Some other offenders are automatically reserved to the NPS, for example, those given a life sentence and foreign national offenders subject to deportation. Therefore, it is extremely important that staff undertaking those assessments have available all relevant information.
- 1.4. In the previous report, inspectors looked at cases of young adults subject to YROs that had commenced in a YOT and had then transferred to a Probation Trust, and cases of young people who would be eligible to transfer in the future. This is not the typical form of transferred cases. In fact, we observed that it is more common for a young person to be under the supervision of a YOT, which appropriately decides to retain the case, but then the young person commits a new offence for which they are sentenced as an adult. Whether a YOT (in conjunction with the NPS) is planning to transfer a case or not, staff should be able to prepare the young person for that transfer to adult services. Where a young person is sentenced as an adult, it is not always certain that the adult services will even be aware that the young person was in the care of the YOT.

# Performance against previous recommendations

# 2

## 2. Performance against previous recommendations

**First recommendation:** the effectiveness of local arrangements for the transfer of young people from youth based to adult based services, and retention of young adults in youth based services, is monitored and kept under review.

**Judgement:** Recommendation not met.

### National leadership

- 2.1. Although there had been some useful initiatives since we published our report in October 2012, for example, the 'Youth to Adult Transitions Framework', which was published in September 2012, inspectors considered that these should have been well-known and fully implemented by the time our inspection took place. However, there were inconsistencies in practice and a lack of knowledge of the effectiveness of local arrangements across England and Wales. Moreover, despite the intention of the National Offender Management Service (NOMS) that monitoring would be via the 21 Senior Contract Managers and via the NPS Deputy Directors for the 7 NPS divisions, there was no evidence of ongoing and effective national monitoring, or review, of the effectiveness of local arrangements for the transfer of young people from youth based to adult based services, and retention of young adults in youth based services.
- 2.2. With the exception of the operational level Probation Instruction PI 05/2014, which is clear regarding transfers in from YOTs, we saw insufficient evidence of the Youth Justice Board (YJB) or NOMS working to ensure that, following the changes instigated by *Transforming Rehabilitation*, there would be effective cooperation between the NPS, the new CRCs and the YOTs. Therefore, effective local arrangements for the transfer of young people depended on the work of local organisations. The YJB and NOMS have failed to fully consider the impact of *Transforming Rehabilitation* on links between youth and adult services. The national and local organisations need to address these issues.

### Local leadership

- 2.3. The majority of areas had in place some procedures for identifying the appropriate destination of transferred cases, to either the NPS or CRC. This depended on the calculation made using the RSR and CAS tools and included the level of risk of harm to others posed by the young person. However, with the exception of Derby City YOS, we observed no evidence of local monitoring. Derby City YOS reported back to staff and had a useful and effective intervention planning clinic to assist staff in ensuring smooth transitions. Staff confirmed their knowledge and understanding of this area, confirming that they receive "*information regarding reoffending rates by adults who were still 'open' to YOS within 3 years of transfer, which is fed back to case managers, CRC and NPS workers who take over cases, feedback on progress, on occasion, to YOS case managers*".
- 2.4. Several of the inspected areas, particularly in the adult services, were initially unable to identify transferred cases at an operational level, for the inspection case sample. This demonstrated the organisations did not know who had been transferred so were, therefore, unlikely to be able to tailor support accordingly and that there was little local awareness of the issue. Staff in most of the adult and youth services across the country said that they knew little about the effectiveness of arrangements regarding transition in their area, demonstrating either a lack of communication and/or monitoring by the inspected bodies.

*“I think it’s good that I go to probation, as I am [an] adult and want to be treated like an adult.”*

**Young person**

*“I am unaware of any feedback to staff as an organisation into the effectiveness of local transfer arrangements.”*

**Staff member**

- 2.5. It is the decision of the YOT (in conjunction with the NPS) whether a young person’s case should be transferred to adult services. Sometimes the young people themselves felt that transfer was appropriate.
- 2.6. There was a lack of consistency and monitoring of decision-making across the country. One organisation had decided not to transfer any cases to adult services, unless they were long-term custodial cases. Another area had unilaterally decided that all youth cases transferred from the YOT would be managed as Integrated Offender Management (IOM) cases by the NPS. IOM is a cross-agency response to the crime and reoffending threats posed by the most persistent and problematic offenders, who are identified and managed jointly by partner agencies working together. Although we understand that these were each considered to provide the best service to these young people, the lack of monitoring of these arrangements meant that the parent organisations could not assure themselves that best practice was being delivered.
- 2.7. Inspectors were very concerned that few areas had up to date protocols agreeing the pathway for transitions between local YOTs and NPS offices, and still fewer had agreements with CRCs.
- 2.8. However, some areas had addressed this issue effectively. Wales had recently published clear and useful guidance for staff. Derby City had a useful agreement with a clear and simple pathway for case managers to follow (see Appendix 2) and York also had a useful protocol for transition between the YOT and NPS. The local guidance from York actually cited to their staff the useful piece of guidance issued by the Transition to Adulthood Alliance (T2A), *Taking Account of Maturity: A guide for Probation Practitioners (2013)* and their report on how to design effective probation services for young adults, *Going for Gold (2012)*<sup>1</sup>. York’s protocol gave their staff good guidance on how flexible they needed to be at this challenging time, which was demonstrated by some effective joint working by their staff.

### Example of notable practice

York’s protocol stated ‘Whilst the YOT’s retain a focus on the young person and his/her wider family, promote welfare principles and acknowledge differences in terms of maturity and independence, the Probation Service is more focused on the individual offender, and assumes a level of independence, responsibility-taking and maturity that many young adult offenders may not have achieved. Transition is a process not an event that starts in the YOT and continues into Probation. For some young offenders this process extends considerably beyond the transfer date. Services need to adapt their service delivery to take account of young offender’s individual needs if they are to achieve a successful transition. Flexible working that takes account of the young offender’s individual transition needs is paramount.’

- 2.9. An agreement between youth and adult services in Stockton-on-Tees had been quoted by an NPS offender manager<sup>2</sup> in the case diary, when considering the possible destination for a case.

1 <http://www.t2a.org.uk/wp-content/uploads/2012/11/Going-for-Gold-guide.pdf>

2 In this report, inspectors have used ‘offender manager’ to identify those workers in adult services (NPS or CRC) and ‘case manager’ for those in youth services (YOTs).

### Example of notable practice

Oliver was given a YRO for robbery. The case diary noted a 'chat with case manager re transfer of Oliver, looked at CRC or NPS, offence is robbery and although he would probably benefit from CRC in terms of employment, as it is a MAPPA qualifying offence - new transfer dictates he should come to NPS'.

- 2.10. We were pleased to see that some local managers had thought innovatively about the effective use of seconded probation officers in YOTs. Some were writing useful pre-sentence reports (PSRs), or completing the RSR/CAS assessments to identify the appropriate destination for cases in the adult world. In Gloucester, the seconded probation officer worked effectively in both offices in the youth and adult world, ensuring that the new portal was transferring information. In Stockton-on-Tees, a case had been retained by the seconded probation officer so that the young person who posed a high risk of harm to others could be offered a combination of YOT and probation supervision. Long-term planning was evidenced in that the case would transfer with the probation officer when she returned to the adult service. Being reasonably closely located to the other service's office was also seen as beneficial. In Gloucester, a proper review had been made of the previous use of a specialist team for transitions.
- 2.11. Some areas had previously used specialist teams, or purposefully allocated transfer cases to offender managers who had returned from secondments in the youth services, but this was not always effective in ensuring that all transfer cases had a smooth transition, again evidencing a lack of monitoring by the different organisations.
- 2.12. We observed a mixture of management oversight during this inspection. We saw some good, clear oversight with detailed instructions to staff. However, in many cases there was poor recording; managers had failed to ensure that staff completed assessments and plans, or recorded important conversations or sessions with young people, or information from other service providers.

**One staff member identified the different factors which made a smooth transition likely:**

*“Good relationship with probation at court, having a seconded probation officer in the YOT who maintains good links with probation, good relationships between YOT and probation, YOT willing to complete PSRs at court prior to transition, and close proximity to probation officer allows us to walk young people over to make sure they know where they are going and for three-way meetings.”*

### Example of notable practice

In an email conversation in York, one manager wrote to an offender manager saying 'Would you be interested in taking this case? It would involve some three-way meetings initially before he turns 18' and a subsequent email confirmed intended actions for the case and offender manager 'I am copying in YOT worker, so that you can start an email/tel conversation together and start planning the transfer - to include three-way meetings. I think I am right in remembering that YOT worker took advice on the PSR from another PO. I plan to leave it to you two to look at the handover (two joint meetings - one at the YOT and one here?) and organise the date for transfer, after his 18th birthday.'

**Second recommendation:** sentence plans in YOTs and the young person's secure estate take account of future transfer to adult services where appropriate, and plans in Probation Trusts and the adult custodial estate take account of information from youth based services, to ensure that outstanding interventions are implemented.

**Judgement:** Recommendation not met.

2.13. In order to make an appropriate decision whether or not to transfer young people to adult services, or to retain young adults in youth based services, YOTs must first identify the young people they supervise who are approaching their 18th birthday. Unless the YOTs are identifying such cases, they cannot prepare for the decision-making process. In only one YOT were inspectors shown a process to identify such cases. In almost half of the case sample, assessments did not identify that the young person may be eligible for transfer to adult services.

### Example of notable practice

In Derby, the YOT had designed a simple process. Once every six months, it produced a list of young people approaching the age of 18, removed those cases which could not be transferred and then initiated a discussion with the case manager to exercise their professional judgement as to whether the case should be transferred.

- 2.14. We did not see PSRs in every case in the youth service, however, where we did see them, they usually did not mention a transfer to adult services. This was disappointing, particularly where YOT workers had drafted reports which addressed the young person's transfer to adult provision with regard to their care status. However, there were a few PSRs which did address this issue well.
- 2.15. We saw PSRs in adult services where young people, aged 18 years old, had offended whilst being supervised by the youth services. These PSRs were properly the responsibility of the NPS staff, as part of the allocation process. However, many adult PSRs did not address the maturity of the young person when considering the relevant offending behaviour.
- 2.16. Almost two-thirds of the youth service cases in our sample either did not have an initial sentence plan (ISP) at all, or had a plan which did not take into account any future transfers to adult services. Although a YOT may have resolved to retain a young person in their supervision, a lack of contingency planning meant that, on many occasions, a young person arrived at the NPS/CRC without knowing what the adult service provider would expect of them.
- 2.17. In cases where there was no ISP, this also meant that outstanding or ongoing interventions, which would also need to be delivered in the adult world, could not easily be identified by offender managers.

**One member of staff admitted that preparation was poor:**

*"We do not always prepare young people. For example, they turn 18 while subject to a court order and commit a further offence, they are then picked up by probation without any preparation."*

### Example of notable practice

In Gloucester, an inspector found a good clear sentence plan. The first objective read: 'Due to the serious nature of Evan's offences he has acquired s90/91 status and is assessed as being MAPPA category 2. He will therefore be subject to two adult transitions:

- Probation Services transition arrangements
- Adult Prison Population transition arrangements

First transition: Evan will be jointly supervised by Youth Justice CRO and Probation until his 18th Birthday. Evan will have legal visits once a month. First Joint visit to take place in July 15.

Second Transition: Evan will move into the adult population at Parc when 18. Two weeks prior, his case worker at Parc will start the process, by an adult wing visit, then an introduction to his new case worker, followed by a phased induction.

Evan has been briefed on the two transitions and he will continue to be briefed at his custodial review meetings.'

### Example of notable practice

Ian was sentenced to an indeterminate custodial sentence for public protection under section 226 of the *Criminal Justice Act 2003* for a violent offence. He had some minor previous convictions for acquisitive crime and one for sexual offending. There was also evidence in both the youth and adult assessments of other inappropriate sexual behaviour which had not been criminalised but had affected his care arrangements. His inappropriate behaviour had continued in custody, but the ISP on file related solely to custodial objectives and did not address the ongoing sexualised behaviour.

### Example of notable practice

Charles was sentenced in June, within a month of his 18th birthday, but the PSR and assessment did not mention a potential transfer. However, after his birthday the transfer paperwork was completed and sent but there was no evidence of pre-meetings with CRC, or of preparing Charles for the transfer. A three-way meeting did take place post-transfer, but there was no record of his main identified risk factor of substance misuse being addressed since he had been transferred to the CRC.

- 2.18. Only one-third of plans in the adult services were considered adequate in our sample. This meant that, on occasions, interventions which had not been completed in the YOT were missed by adult services.



### Example of notable practice

Harry was sentenced to a custodial sentence. The YOT had previously identified that he needed to do some work around relationships. An assessment by a specialist from the third sector had apparently recommended that he needed to acquire emotional coping strategies to deal with anger, conflict resolution and problem solving. None were completed with him. There was no OASys assessment or sentence plan in place. Neither the offender supervisor in prison nor the offender manager in the community was able to identify what work had been completed with him and he was shortly to be released into the community. No work had been started by the time of the inspection on healthy attachments, working with his family to support him or setting appropriate boundaries.

### Example of notable practice

Adam was sentenced to a YRO a month before his 18th birthday for three offences of possession of Class A drugs with intent to supply, and one offence of possession of a Class B drug. During his previous supervision by the YOT, the main intervention was for drug and alcohol misuse, however, there was no objective in the adult service's sentence plan to support this work.

### Example of notable practice

In York, the inspector saw effective joint working from the YOT, CRC and NPS. Di was sentenced to a 24 month YRO for burglary. The Asset assessment had clearly recorded her views about transferring to the adult services. The case manager contacted probation well before the transfer and there was a good three-way meeting held where they discussed the issues, outstanding interventions, and risk and vulnerability concerns, because Di was in an abusive relationship. Other workers were involved and continued to support Di, and when they could not attend the three-way meeting, were updated by the case manager and offender manager. Di's partner was also being supervised by the NPS. The assessment and ISP at the CRC used the information from the YOT and clearly reflected the YOT's work with Di. The offender manager kept good contact logs which accurately reflected the situation. The contacts clearly recorded the work that the offender manager was completing in attempts to keep Di safe, for example, using Multi-Agency Risk Assessment Conference (MARAC) meetings. The risk of harm posed to Di was jointly managed by the YOT, CRC and NPS. The transition was smooth with the positive outcome that to date there had been no further offending.

- 2.19. Although the team did not visit custodial establishments on this reinspection, we saw some effective work by custodial offender supervisors. We noted documentary evidence on files of good preparation by custodial establishments for the transfer of young people to adult custodial establishments. The gender of the young person did not affect our findings. We also saw some good communication between YOT case managers, offender supervisors and some offender managers in adult services, with some attendance at three-way meetings in the custodial environment. Sentence plans were generally drafted by offender supervisors and, therefore, focused almost entirely on the custodial environment, rather than long-term planning, although the importance of contact with family was well identified. We did not always see offender managers subsequently visiting custodial establishments after the transfer had taken place.

## Example of notable practice

Neil was serving his custodial sentence in a Young Offender Institute (YOI) when his case was transferred in early September. The offender supervisor contacted the offender manager six weeks later stating that *“I wanted to make contact with you as Neil is now at Hindley and I am his allocated OS. He doesn’t have an OASys at present; I understand that he may have only recently transferred to adult probation from YOS. I’m not sure what arrangements are in place to get this done (whether YOS will do it as part of the handover or if you will now need to do it). I am happy to arrange a meeting for us. Given the serious nature of his offence I think it would be helpful if we could arrange a meeting to look at his risk, any work completed and next steps in the youth estate”*. Whilst we commend the effective work of the offender supervisor; necessary actions should have been initiated by the case manager and offender manager prior to transfer.

- 2.20. Staff in the youth and adult world did not plan beyond the immediate prevention of reoffending, although that was important. They did not also consider longer-term planning, moving towards desistance, well-being and social inclusion for the young person.

**Third recommendation:** decisions to transfer young people to adult services or to retain young adults in youth based services are recorded in the case record and take into account the views of young people and what work needs to be undertaken to meet the aims of the sentence, to address likelihood of reoffending and risk of harm to others, and to manage vulnerability.

**Judgement:** Recommendation not met.

- 2.21. The previous recommendation also suggested that it would be beneficial to staff to obtain the young person’s opinion of the possible transfer. The adult services (NPS and CRC) have different expectations of their service users to that of the youth services (YOT), focusing much more on the young person as an independent adult.

- 2.22. The young person’s opinion should be obtained, before transfer, to address concerns and ensure needs are identified and shared with the adult service provider. In two-thirds of cases, the views of the young person were not recorded in the case record.

- 2.23. In line with the previous recommendation, two-thirds of the cases in our sample did record the actual decision to either transfer or retain the young person in the case record. This meant that in one-third of cases, the case record did not note what work needed to be undertaken to meet the aims of the sentence, to address the likelihood of reoffending and risk of harm to others and to manage the vulnerability of the young person.

- 2.24. On occasion, the decision to transfer had been made in a meeting such as a Looked After Child Review or a MAPPA meeting. This was where other agencies were involved in ensuring that the young person was safe, or

### One member of staff identified a key challenge:

*“The different ideology between the services as youth justice still often has a welfare ideology and greater time to do face-to-face work. Then the young person often feels lost and doesn’t understand the bureaucracy in an adult offender management system.”*

*“I know I will have to travel to the probation office on my own, currently get seen at home or supported to the office appointments.”*

**Young person**

*“I am glad I am staying with the YOT, because I know them and trust my YOT worker; they have helped me with all sorts of things. Not sure I would go to appointments at the probation office as I don’t know them.”*

**Young person**

that the risk of harm to others they posed was managed. It was appropriate that the decision was made there, but a clear record of the decision should have been made in the case file at the YOT, so that relevant YOT officers, managers and other providers in the YOT were kept informed.

- 2.25. As previously stated, it is generally the decision of the youth offending service (in conjunction with NPS) as to whether a case should be transferred to the adult services. Factors to be considered include the age of the young person, whether they have needs which can be met better by the YOT or adult provider.
- 2.26. In the youth offending services, the local MAPPA coordinator<sup>3</sup> does not have routine access to the case records of MAPPA offenders held by the YOT. For those on community sentences, notification is required at the start of the order. For those on custodial sentences, the YOT is required to notify the relevant MAPPA coordinator of brief details of all relevant MAPPA, six months before release. We saw 26 MAPPA cases; 16 were notified to MAPPA by YOTs, although, where the YOT made a decision to manage a case at level one (the lowest level, where a single agency manages the risk of harm to others posed by the young person), this decision was not always clearly recorded on the case record, as they are required to do.

*“MAPPA involved, however, I don’t really understand it. I was given a leaflet so I know I am registered with them.”*

**Young person**

2.27. In the adult world, the local MAPPA coordinator has access to probation case records and the CRC/NPS must identify on their case management records their MAPPA level 1 cases. We were pleased to note that almost three-quarters of cases had included notification to MAPPA of the transfer to adult services, although not all decisions were clearly recorded on the case record.

### Example of notable practice

Steve was given a section 91 custodial sentence for a very serious offence. Although it had been long planned to transfer the case, in the event the case manager did not contact probation until the week when *Transforming Rehabilitation* started and they were unable to respond in a timely manner. They eventually responded and a three-way meeting took place two days before his release, but this was not sufficient to allow a relationship to be built between Steve and his new offender manager. Additionally, the case manager did not inform MAPPA of the planned release until two weeks after he was released to Approved Premises and so the MAPPA meeting took place some six weeks after his release. This meant that there was no smooth transition in this case and the young person was subsequently recalled to custody.

**Fourth recommendation:** young people are thoroughly prepared for transfer to adult services.

**Judgement:** Recommendation not met.

- 2.28. Preparation for transfer is not solely the job of the YOT case managers. Where the YOT is considering the transfer of a case, well-organised managers contacted their opposite numbers at the NPS and CRC (depending on the level of risk of harm to others posed by the young person) to discuss the potential transfer. Where a young person had committed a new offence and was to be sentenced, some YOTs commendably did plan ahead and contact the NPS representatives to discuss likely recommendations in PSRs and by which agency the young person could be managed, post-sentence.

<sup>3</sup> One person has an important role in coordinating the work of the MAPPA agencies in each area. This is the MAPPA coordinator. MAPPA Guidance 2012 Version 4

## Example of notable practice

In Gloucester, Luke's PSR for a new offence clearly advised the court of planned liaison, saying 'Luke is 18 years old in a few days time, and hence I have liaised with the Probation Service in order to allocate the case to a supervising probation worker. I will continue to liaise with her, and have arranged an appropriate meeting with her to ensure a good handover of this case and continuity for Luke'.

- 2.29. Most of the young people we interviewed recalled being told of the possibility of transfer to probation, prior to transfer.
- 2.30. However, case managers may wish to consider carefully the appropriate time to discuss a possible transfer with a young person.
- 2.31. In many cases, the YOT case records noted two-way meetings where case and offender managers (and sometimes their line managers) could discuss the planned transition and the assessed needs of the young person. Alternatively, the discussion was held via email, with managers subsequently considering transfer and allocation. Three-way meetings between the case manager, offender manager and the young person (and very occasionally a parent) were also recorded, and recalled by the young people in interview, although this was sometimes less frequent in the CRCs.
- 2.32. Encouragingly, the young people we interviewed confirmed that they had been thoroughly prepared, recalling meetings and discussions with case and offender managers, even when those meetings had not been clearly noted.

*"[I] did have worries, just the fact of getting there and what I would need to do, but it was pretty simple. I thought there would be fights and violence in bad environments, so it was better."*

**Young person**

*"[I was] told soon after being sent to custody by my YOT worker that because I was going to be 18 during the Licence period that I would probably go to probation. I didn't really think about it at the time because I had just been sent to custody."*

**Young person**

*"No worries. Was told probation's expectations."*

**Young person**

*"I remember being told that at some point during my sentence I might be transferred to probation, it was my YOT worker that told me, then she went off poorly and I got a new YOT worker. My current YOT worker has discussed it again recently as I am now 18."*

**Young person**

*"[I] did have a three-way meeting. Also had social services. That was the first time I met the PO, we had a meeting about getting the case transferred. The second time wasn't after the transfer, but the third one was, they told me properly what would happen."*

**Young person**

- 2.33. The case management system used in the NPS and CRC (nDelius) did not support the work done by the offender managers regarding transitions. We saw clear records of such meetings preparing the young person for the transfer in the YOT, and judged that 60% of the young people in our sample had been thoroughly prepared for transfer to adult services. In the adult world, only 36%

of our sample of the same young people had clear records of preparation. Even allowing for those cases where a young person had unexpectedly become the responsibility of adult services after reoffending, this was worse than we had expected. It became clear on further inquiry that, although the offender managers had been involved in preparing the young people, the nDelius system did not apparently allow for the creation of a case until it was actually transferred. It was possible for offender managers to save records such as emails and retrospectively enter them onto the system, but this was not ideal.

- 2.34. It is to be hoped that the new portal will assist with this, however, a solution needs to be found which does not require staff to retain emails and then retrospectively enter the information onto the system. There were two occasions where there were clear discrepancies between the YOT and different adult services, which, in one case, led to a gap in supervision of two months.

### Example of notable practice

Vaughan was a Looked After Child who had a YRO imposed in January for Assault Occasioning Actual Bodily Harm, a few weeks before his 18th birthday. The YOT's last recorded contact with Vaughan was on 28 January, when they also recorded that they had transferred the case to probation. Vaughan was remanded into custody on 06 March, some two months later. Probation's first record of Vaughan came when he was remanded in custody in March, and then an OASys assessment was created in May. Records in nDelius stated that probation accepted him as a transfer from YOT in June and their first contact was in July. He was, therefore, not being supervised by either the youth or adult services for two months when in the community, and for a further period when in custody.

### Contingency planning

- 2.35. Contingency planning was not mentioned specifically in the previous inspection. However, it gradually became clear during our inspection that many of the cases in our sample were not 'simple' transfers. We identified simple transfers as those where young people had received YROs of some length shortly before their 18th birthday. This meant that the case could be prepared thoroughly and then transferred smoothly, with the benefits of full information sharing. We observed two-way planning meetings between the two agencies and then three-way meetings which included the young person and, in some cases, their parents/carers. This allowed staff to prepare young people thoroughly.
- 2.36. However, on many occasions during this inspection we saw cases where there was a not a simple transfer. The young person was being supervised by a YOT. The case manager had either not yet considered transfer, or the original sentence was not suitable for transfer, so no preparation for transfer was done. Then the young person had committed an additional offence and been convicted of that offence. This meant that the NPS staff at the court were not necessarily aware that the young person was already being supervised by the YOT. Supervision had to be transferred to the adult services, without the young person being prepared for the different way the adult services would supervise them.

### Example of notable practice

In one case, both a YOT worker and an NPS worker visited a young person in custody, to prepare a PSR. When this was discovered, the NPS and YOT worked well together to produce a report which provided the sentencers with clear options for future sentencing, but this still cost two agencies a considerable sum where one journey was not necessary.

2.37. Therefore, inspectors considered that it would be beneficial to YOTs if they were to identify cases where, if the young person did reoffend, they could potentially be the responsibility of the NPS/CRC. Then, where they were so identified, YOTs could follow the example of our pilot area, Staffordshire, where a seconded probation officer had developed a simple intervention explaining the differences between the youth and adult services. Where effort was properly made by all concerned, a successful outcome could be achieved.

### Example of notable practice

In Gloucester, Patrick was given a custodial sentence for a violent offence committed when he was drunk. There were no notes on nDelius, but YOT notes confirmed that the offender manager attended joint meetings in custody. The case manager's Asset assessment clearly identified the potential move to probation and even made statements such as 'Patrick had already identified many strategies to use to reduce his alcohol use whilst on bail for the offence, including not pre-drinking, this is a risk factor which will be factored into his supervision with probation on release'. The smooth handover was planned carefully, with proper notification to MAPPA noted on nDelius. Patrick obtained work, stayed away from alcohol and drugs, did not reoffend and had just two appointments to finish his supervision by probation, a successful outcome.

**Fifth recommendation:** notifications of transfer, and all essential advance information, are sent to Probation Trusts and adult establishments in sufficient time to ensure continuity of delivery of interventions.

**Judgement:** Recommendation partly met.

2.38. The sharing of information with the receiving agency is key in supporting the smooth transition and we were pleased that two-thirds of cases had met this recommendation. In paper files in CRCs and NPS offices, we observed paper copies of Asset assessments and, less frequently, plans to manage risk of harm to others and vulnerability. We were pleased that three-quarters of assessments in the adult services used information from youth based services, an improvement in performance from the last inspection.

### Example of notable practice

Howard was sentenced to an adult community order for 12 months. We observed good evidence of the CRC offender manager using the information from the Asset to inform the OASys assessment and ISP. However, there was other information in the Asset assessment of Howard being at risk from a known adult offender. This information was not used by the offender manager, and there was an incident between Howard and the known adult on the first day. This was subsequently dealt with, but could have been avoided.

2.39. In the previous national protocol on transfers<sup>4</sup>, best practice was recommended that communication regarding transfer should, in high risk of harm cases, be six months prior to transfer, and in 79% of our high risk cases, this had happened, an improvement in performance from the previous inspection. However, in lower risk cases, only 57% of cases were notified within 3 months and this was not assisted where young people had unexpectedly reoffended. However, the lack of monitoring to identify potential transfer cases meant that YOTs were not always able to organise transfer activity well in advance and we sometimes observed three-way meetings which had occurred on the date of transfer.

<sup>4</sup> Case transfer protocol between the YJB and NOMS: Guidance for YOTs and local probation areas/trusts on case transfers (2009)

### Example of notable practice

At the induction at the CRC, a skills checker was completed which included a disability assessment where Cory disclosed that he could not read or write, however, the offender manager continued to write to Cory to offer appointments. The information provided by the YOT was not used in the OASys assessment and no three-way meeting took place. Previous behaviour which was of concern (though not the subject of any conviction) was not included either and it was fortunate that Cory did not reoffend.

Paul was given a YRO for a violent offence against his former partner. New violent offences were committed in October, but the case manager only realised two weeks before Paul was sentenced (late the following February) that he was to be sentenced as an adult. Staff, therefore, arranged a three-way meeting, which took place on the day of sentence. The OASys assessment was left blank for two months despite the NPS completing the RSR and CAS and there was no evidence on nDelius of any preparatory work. Paul was sentenced as an adult to a suspended sentence, but within three weeks, he was remanded in custody for committing further offences.

- 2.40. Many of those interviewed hoped that the portal, when installed, would automatically transfer information and documentation, to assist the adult services in acquiring information.

**Sixth recommendation:** all intervention providers (including health and education, training and employment providers) are informed of transfers to Probation Trusts and adult establishments in advance and involved appropriately in case transfer meetings to ensure continuity of delivery.

**Judgement:** Recommendation partly met.

- 2.41. We found that other intervention providers, such as health, mental health, substance misuse and education were kept informed of transfers, although they were generally not invited to planning meetings in the community. We did see notes of planning meetings in the custodial environment which included other intervention providers, for example, from the substance misuse service and the Juvenile Enhanced Thinking Skills programme.
- 2.42. Many young people's issues were not specifically related to their age, but would continue, whichever agency was dealing with them. Where the transfer decision had been recorded, one-third of those cases did not note what work should to be undertaken to meet the aims of the sentence or other assessed needs of the young person.

### Example of notable practice

In Stockton-on-Tees, Alan was given a YRO with supervision for a sexual offence. The planned transfer took place, with several two and three-way meetings held well before the transfer, but then he was arrested for allegedly committing a rape. Alan was removed from his allocated accommodation due to the new allegation, but there was a safeguarding issue with his younger sibling and so the safeguarding concerns were properly highlighted to children's social care. We observed good liaison with an Approved Premises and an emergency MAPPA meeting attended by the case manager and offender manager because his designated risk of harm to others level was increased appropriately. The investigation continued and Alan was safely located in suitable accommodation.

- 2.43. Communication with other key agencies by, for example, the CRC, particularly with Leaving Care teams, continued, though less effectively and consistently than in the youth world.

**Seventh recommendation:** parents/carers are involved, where appropriate, in discussions about transfer and in case transfer meetings where it is likely to aid the young person's progress and engagement.

**Judgement:** Recommendation partly met.

- 2.44. We previously recommended that the parents/carers for the young person should also be kept informed during transfers. Just under half of the relevant cases had involved parents/carers or, where they were a Looked After Child, their social worker or Leaving Care representative.
- 2.45. We saw good involvement and ongoing communication with parents/carers and representatives of various Leaving Care teams. Some staff clearly understood the importance of keeping such key individuals involved in the process and worked hard to ensure that they were properly involved. Parents/carers were sometimes very well briefed on the proposed transfer and the expectations of the adult services. They attended three-way meetings at either the youth or adult service offices, or sometimes at home.

*"[I was] told by my YOT worker during supervision sessions, they also came to see my Mum and told her worries."*

**Young person**

### Example of notable practice

John was given a three year YRO with supervision and programme requirement. His parents contacted the YOT, detailing their concerns about a possible transfer to probation. The YOT sent a formal letter to John's parents explaining carefully why he was being transferred to the adult services and to whom he would be transferred. It also set out the planned three-way meetings and further activities. That letter was also copied to the relevant offender manager, ensuring all concerned understood the planned move.

*"We explain what transition will mean for them practically, whether that is single transition, dual or multiple. Have early discussions with probation service where practical between three - six months. We have three-way meetings that include the young person and if possible parents or carers. Include transition arrangements in interventions plans."*

**Staff member**

**Eighth recommendation:** staff in youth based and adult based services receive sufficient information and training about the work of each other's services to enable them to prepare young people for transfer to adult services and to work effectively with transferred cases.

**Judgement:** Recommendation not met.

- 2.46. There was one recently published framework providing guidance to staff in Wales, which was good. It detailed why smooth transitions were important and beneficial, assisting with reducing reoffending and which also provided step by step guidance for staff. Other national initiatives had been in place for some time, such as the YJB's *Transitions Framework (2012)*, however, these had not been fully utilised by the relevant organisations to ensure that all staff fully understood this key area. Post *Transforming Rehabilitation* we saw little evidence of the national organisations providing up to date support and guidance to their staff, apart from the recently published Welsh framework.



### Example of notable practice

The Welsh framework stated that 'improving transitions will produce better outcomes for young people as they are supported during a fragile time in their lives. Making improvements in the way information is shared from YOTs to adult services, adult prisons and other services will lead to more informed assessments, continuity in interventions and advances in addressing their needs. This will, in turn, have a direct effect on reducing re-offending.'

2.47. Over half of the youth and adult services staff surveyed felt that they did not receive information about the effectiveness of local arrangements for the transfer of young people, in one case describing it as 'hit and miss at best'.

2.48. In some of our staff surveys, staff questioned expressed a clear understanding of the benefits of preparation, two and three-way meetings and information sharing. They acknowledged the challenge where young people were sentenced unexpectedly as adults and valued the role of the seconded probation officer, where it helped with maintaining good links with each agency. Beneficial factors identified included good cooperation, close geographical proximity of offices and established transfer protocols which were known to both services.

*"I cannot say for definite - but imagine that the quality of the handover can be piecemeal dependent on the young person's involvement and the officer's handling and the support/leadership they are given from their seniors."*

**Staff member**

*"I feel the three-way meeting with the young person, YOT and probation is helpful to support the transition. It can allay some of their uncertainties about the transition. It also enables a face-to-face meeting with the new supervising officer to share documents and information and can reassure young people that probation is aware of their information."*

**Staff member**

2.49. Where staff were well-trained and informed, cooperation between the youth and adult workers led to some particularly good work, ensuring smooth transfers to adult services

### Example of notable practice

In Stockton-on-Tees, Zeb was given a custodial sentence for Causing Death by Dangerous Driving at a young age. The impact of understanding his offence had led to a significant mental health issue. The case manager properly identified the reasons for transfer and, therefore, contacted probation. A professional's meeting was held at the YOI to share a psychology report with the NPS offender manager. Transfer paperwork was completed and then a three-way meeting took place with Zeb, his mother and his managers, and representatives from psychology and education, training and employment. All relevant staff liaised with Zeb's mother. They even collected her and Zeb on the day of release, to take them to probation. All of this was planned in advance, so that the actual transfer would take place on Zeb's release date, which was a week away from his 18th birthday. The inspector also noted good evidence in the records of visits to the YOI to see Zeb and discussing his view on being transferred to probation after being released into the community.

2.50. Sometimes it was not necessary to actually transfer a case in order to access adult services, where staff knew that the other service was able to assist the young person.

### Example of notable practice

In preparation for his release from an eight month DTO for possession with intent to supply class A drugs, the Sheffield YJS liaised with the NPS and requested that a probation officer was allocated to co-work with Chris. Chris had consistently been abusive to staff when in contact with the YJS, including threatening behaviour and words, and an assault against a staff member. Chris really disliked the YJS having any type of control over him. This left the YJS in a difficult position, they needed to protect their own staff and did not want Chris to think that violence and aggressive behaviour would result in them excising less control over him. An agreement was made to co-work him and to hold supervision at the probation office. When he had turned 18 he was resentenced, allowing probation to jointly work with the YJS. His licence conditions for release were agreed jointly. They developed a common and focused approach to managing his risk to others. Both worked together to plan and deliver interventions based on Chris's transition into a more pro-social life. They worked with a housing provider and got him supported accommodation and were able to challenge his behaviours and attitudes. His sentence finished without formal breach, he was settled in his accommodation, and has not reoffended.

### Example of notable practice

In Swansea, Jim was given two year YRO with supervision, prohibited activity, activity requirement and residence for offence of sexual activity with a female. Jim had a challenging family background and a disability which affected his education. The case manager identified that they needed to complete further offence specific work, so they approached the local probation team to ask for help because they had access to a specialist in personality disorders. However, the case was not to be transferred, due to the young person's disability, care history and isolation, which combined to make him too vulnerable to be transferred. The case manager met with probation to discuss this and then formally sent a form applying for the work to be done. Work with the psychologist commenced in early 2015 and has apparently proceeded well.

*"Discussed it recently and we both agreed it would be better for me to stay at the YOT, I had complied with the order, and I didn't want to start building relationships with new people. I am glad I have stayed, they have helped me, and I get on well with my YOT worker."*

**Young person**

- 2.51. Inspectors were particularly impressed by some case managers who followed the good practice examples from the previous report and undertook post-transfer telephone calls to offender managers to hear about progress, or post-transfer meetings, or home visits to support a smooth transition.

### Example of notable practice

Justin was given a custodial sentence for robbery. He had Autism and Attention Deficit Hyperactivity Disorder, and the managers on both sides in Sheffield worked together to ensure a positive transfer, by workers meeting jointly with the young adult and sharing current and relevant information. All documents were forwarded and MAPPA notified and managed appropriately. Joint work continued and the case manager assisted the probation worker in developing a relationship, a particular challenge with Justin's autism.

# Appendices

# 1. The inspection process

1. A review was undertaken of the literature regarding case transfer and transitions within the criminal justice system and allied sectors such as health, education, training and employment. Rather than developing new inspection criteria, we resolved to undertake a reinspection against the existing recommendations, to maximise efficiency. The inspection methodology, including case assessment tools for community cases, was then piloted in the Staffordshire area.
2. In undertaking the inspection, we aimed to explore what front line practitioners did to promote effective transition in practice, rather than simply to gauge compliance with local or national procedures. Using this exploratory approach we looked at 50 cases in-depth, across six areas in England and Wales.
3. We chose a mixture of urban and rural areas, shire and metropolitan for the inspection. We anticipated seeing a variety of work that would help us identify effective practice and areas for improvement. We included one location in Wales and also one location which had, coincidentally, been part of the previous inspection.
4. We were mindful that this was a reinspection, so we retained much of the original case assessment tool used in the 2012 inspection, in order to help us judge the progress made against the original recommendations albeit we were inspecting in five different areas from the six where we conducted the initial inspection. For example, due to the limited numbers of young people transferring in any one locality, we had to select cases at different stages of the transfer process to inspect. These were cases where a PSR had been prepared close to the young person's 18th birthday; cases that were eligible to transfer in future and cases that had already been transferred.
5. Despite our previous recommendation, no national data were available on the annual number of young people whose orders transferred to adult services. In producing the list of cases to be inspected, our approach was to agree with managers in the three agencies and six areas to identify cases that were within the general timeframe we wanted to inspect. Ideally, we hoped to look at cases that were around 6 to 12 months prior to inspection, although we were willing to accept older cases (post-dating the publication of the previous report). Not all areas managed to identify six cases which had been transferred from youth to adult services.
6. The YOTs also identified three additional cases each which related to a young person who had just, or was about to turn 18 years of age. The Inspectorate accepts that it is the decision of the YOT (in conjunction with the NPS) whether a case should be transferred, taking all relevant factors into account. Our methodology allowed us to include cases at the pre-transfer stage, to confirm that proper consideration was being given to this judgement, by YOT staff. We had 50 cases in total.
7. Fieldwork took place between June 2015 and July 2015. We visited offices in Sheffield, Derby, Swansea, Gloucester, York and Stockton-on-Tees. In each area, we read relevant paper and computer based records and briefly interviewed the allocated offender managers/case managers. Our aim was to seek to ascertain whether all action had been taken, as far as could reasonably be expected, to ensure a smooth transfer of a case from youth to adult services.
8. The young people whose cases we inspected had the following characteristics, which were similar to those in the previous inspection:
  - 96% were male
  - 78% were white
  - 34% were Looked After Children and/or eligible for Leaving Care services
  - 52% were cases which were MAPPA eligible during the sentence being inspected

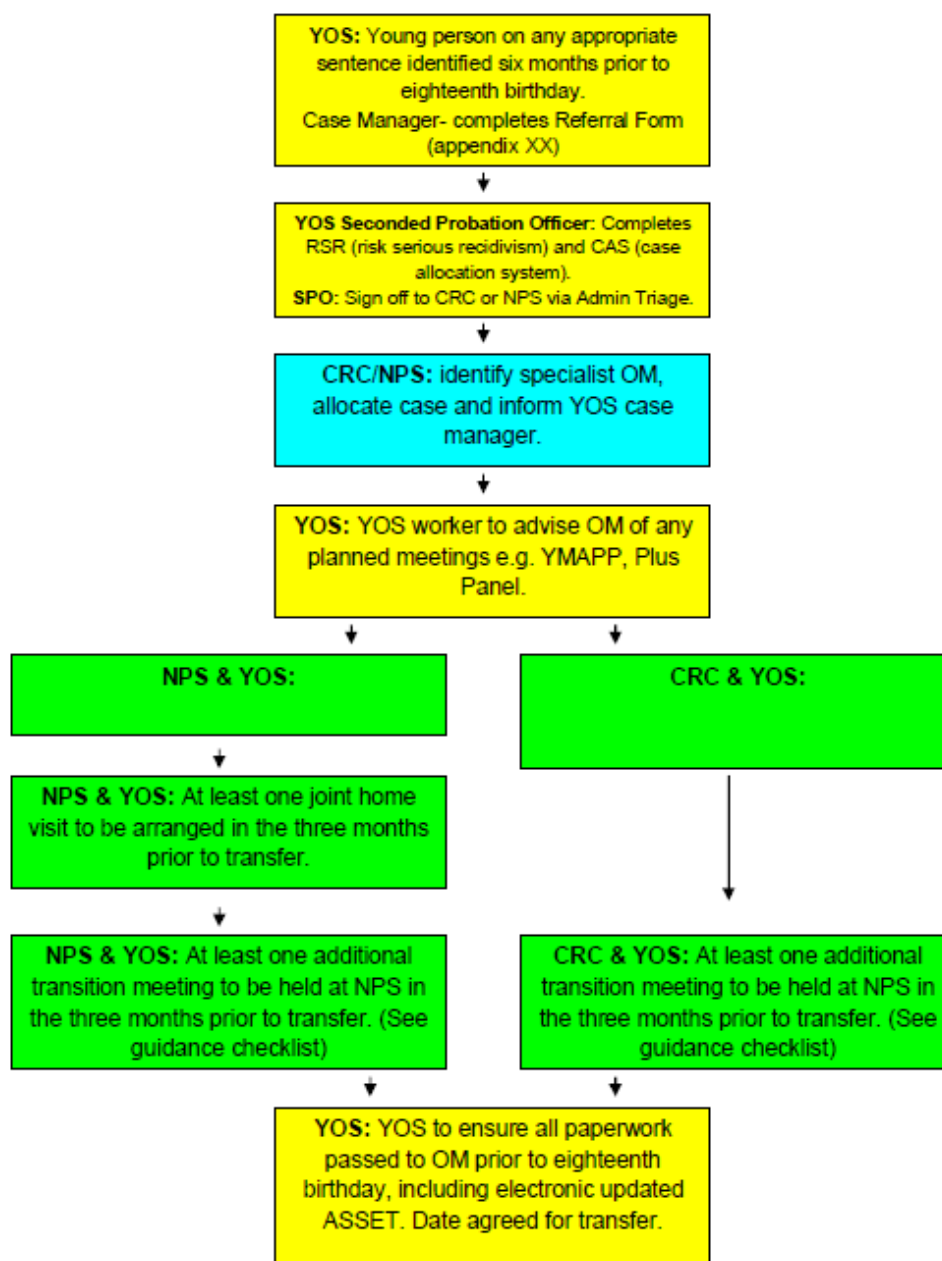
- 27% of cases were YROs with other requirements, 27% were section 91 custodial sentences, 20% had DTOs, 9% were community orders, 7% were YROs with supervision only, 4% were YROs with ISP, 4% were detention for public protection custodial sentences and 1 case was a suspended sentence.
9. Evidence for this inspection was gathered from interviews conducted, in each area, with managers and staff from the three agencies (YOTs, NPS and CRCs).
  10. We interviewed eight young people, some of whom had been transferred to adult services, and some who had not.
  11. We also electronically surveyed case and offender managers from the three agencies in the 6 locations we inspected and received 50 responses.

## **The national picture**

12. Following our visits to the offices of the CRCs, NPS and YOTs, meetings were held with senior managers with responsibility for the transition process from NOMS and the YJB. The purpose of the meetings was to consider how the organisations monitored and kept under review the effectiveness of the procedure. It was confirmed that there is no national monitoring of the effectiveness of the transition process across England and Wales.
13. A planned joint national protocol has been drafted, which would appear to answer some of the issues identified in these reports. However, although the protocol was being disseminated for signature between the YJB and the NPS, there was no guarantee that the CRCs would also become signatories, although the recommendation from the Ministry of Justice was apparently that they should do so. The protocol does remind signatories of their responsibility to monitor arrangements locally, but there is no mention of any national monitoring of the effectiveness of arrangements.
14. In the previous report the Inspectorate commended a pilot project where a portal, which could electronically transfer documents between the youth and adult IT services, was being tested. By coincidence, this portal was being rolled out across England and Wales during the summer of 2015. We only saw the portal in action in one location but again would encourage staff to utilise its functions fully, particularly with regard to its 'transition diary', which would support staff in providing a smooth transition to young people.
15. All names in case examples in this report are fictitious.

## 2. Effective practice example

### Youth Offending Service Transfer Flow Chart to CRC/ NPS - Derbyshire



*Diagram provided by Derby City YOT*

### 3. Glossary

nDelius	The case management system being used at the time of the inspection by the NPS.
HMI Probation	HM Inspectorate of Probation
Interventions; constructive and restrictive	<p>Work with an offender which is designed to change their offending behaviour and to support public protection.</p> <p>A constructive intervention is where the primary purpose is to reduce reoffending. In the language of offender management this is work to achieve the 'help' and 'change' purposes, as distinct from the 'control' purpose. A restrictive intervention is where the primary purpose is to keep to a minimum the offender's risk of harm to others. In the language of offender management this is work to achieve the 'control' purpose as distinct from the 'help' and 'change' purposes.</p> <p>Example: with a sexual offender, a constructive intervention might be to put them through an accredited sexual offender programme; a restrictive intervention (to minimise their risk of harm to others) might be to monitor regularly and meticulously their accommodation, employment and the places they frequent, whilst imposing and enforcing clear restrictions as appropriate to each case.</p> <p>NB Both types of intervention are important.</p>
IOM	Integrated Offender Management
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others.
MARAC	Multi-Agency Risk Assessment Conference; part of a coordinated community response to domestic abuse, incorporating representatives from statutory, community and voluntary agencies working with victims/survivors, children and the alleged perpetrator.
NOMS	National Offender Management Service
OASys	Offender Assessment System
Risk of harm to others	This is the term generally used by HMI Probation to describe work to protect the public, primarily using restrictive interventions, to keep to a minimum the individual's opportunity to behave in a way that is a risk of harm to others.

ViSOR	ViSOR is a national confidential database that supports MAPPA. It facilitates the effective sharing of information and intelligence on violent and sexual offenders between the three MAPPA Responsible Authority agencies (police, probation and prisons). ViSOR is no longer an acronym but is the formal name of the database.
YJB	Youth Justice Board for England and Wales
YOI	Young Offender Institute
YOT/YOS/YJS	Youth Offending Team/Youth Offending Service/Youth Justice Service

## 4. Role of the inspectorate and code of practice

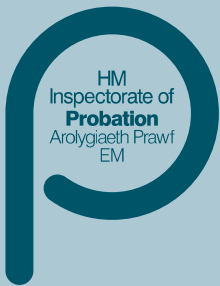
Information on the Role of HMI Probation and Code of Practice can be found on our website:

<http://www.justiceinspectorates.gov.uk/hmiprobation/about-hmi-probation/>

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

HM Chief Inspector of Probation  
1st Floor, Manchester Civil Justice Centre  
1 Bridge Street West  
Manchester, M3 3FX





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