HM Inspectorate of Probation

THEMATIC INSPECTION REPORT

Movement of Cases

An Inspection of the Effectiveness of Arrangements for Handling the Movement of Offender Cases Between Probation Areas

Home Office
BUILDING A SAFE, JUST AND TOLERANT SOCIETY

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Foreword

The management of offenders who move between probation areas is an important issue, particularly given the potential in such cases for contact with the offender to be lost or for other problems to arise on supervision. However, little information has been available on these cases or how they are handled, and this short thematic inspection has sought to address this. The National Probation Directorate had started work to update the guidance on handling such cases when we announced the inspection, but agreed to defer the work so that this inspection could inform the development of guidance. We are grateful for their agreement to this.

The inspection indicates that most areas have in place basic arrangements for handling cases, which move between areas, and identifies a number of examples of good practice. But our findings also show that considerably more needs to be done to ensure full continuity of supervision. Among other things there is a need for more attention to maintaining interventions aimed at reducing the likelihood of reoffending, to firm enforcement action, to the assessment and management of risk of harm and to diversity issues.

We are making recommendations both to the NPD and to Probation Boards. We hope the report and recommendations will be helpful to the NPD in taking forward the development of guidance on handling these cases, and we welcome the attention they are giving to this important subject. The recommendations will similarly be of considerable relevance to the development of the National Offender Management Service with its emphasis on the effective management of each offender throughout the sentence.

ANDREW BRIDGES
HM Chief Inspector of Probation

Acknowledgements

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KATE WHITE	HM Inspector of Probation
JOHN BROWNE	HM Inspector of Probation
KAREN PAGE	HM Inspector of Probation (now Chief Officer, Surrey Probation Area)
PETER RAMELL	HM Assistant Chief Inspector of Probation

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Glossary of abbreviations

ACO	Assistant chief officer
CP	Community punishment
CPO	Community punishment order
CPRO	Community punishment and rehabilitation order
CRAMS	Case Record Administration and Management System
CRO	Community rehabilitation order
DIDs	Drink Impaired Drivers accredited programme
DTTO	Drug treatment and testing order
ETE	Employment, training and education
eOASys	electronic Offender Assessment System
HMI Probation	HM Inspectorate of Probation
ICCP	Intensive Control and Change Programme
IT	Information technology
MAPPA	Multi-Agency Public Protection Arrangements
MP	Member of Parliament
NOMS	National Offender Management Service
NPD	National Probation Directorate: Although a part of the Home Office, the NPD is also the 'Head Office' of the NPS
NPS	National Probation Service: Consisting of 42 probation areas, each run by its own Board, plus the NPD
OASys	Offender Assessment System: The nationally designed and prescribed framework for both the NPS and the Prison Service to assess offenders, implemented in stages from April 2003
PC	Probation Circular: issued by NPD to areas
PPU	Public Protection Unit in the NPD (now called PPCU)
SALSA	Strategic Applications Linked to the STEPS Architecture
STEPS	Standard Technical Environment for the Probation Service
ViSOR	Violent and sex offender register
VLO	Victim liaison officer

1. BACKGROUND

1.1 The issue of the movement of offenders under NPS supervision around England and Wales had long been of interest to HMI Probation, not least because of a paucity of information about how many such cases existed, and how they were managed. Good information about how such cases are managed is particularly important since there is greater potential in such cases for contact with the offender to be lost or for other problems to arise on supervision. This could have serious implications for both the public protection and rehabilitative aspects of NPS work. Despite the advent of the NPS in April 2001, the vast majority of monitoring and evaluation of performance was centred on the 42 individual probation areas. The NPD measured *area* performance against fixed targets and excluded from its national standards monitoring exercises any cases which had moved between areas during the course of supervision. Similarly, we in HMI Probation have excluded transferred cases from our inspection samples in inspections of individual probation areas. As a result, a not insignificant proportion of the national caseload remained unscrutinised by another agency. This lack of information on cases which move was one of the prompts for our inspection.

1.2 There were other good reasons for our interest in this aspect of probation practice: a probation circular – PC 78/2000, governing case transfers – had been produced by the Home Office Probation Unit in 2000. However, this pre-dated the NPS and was deemed to be no longer fully adequate. Our report on the Langley House Trust, published in 2001, included a clear recommendation that the requirements of PC 78/2000 be reviewed. When this report was followed-up in 2003 the recommendation was deemed *not to have been met*, and there was *no evidence of progress*. The NPD had begun the work of reviewing the circular when we announced this inspection into movement of cases in the early autumn of 2003. They agreed to defer that work pending the findings of this inspection.

1.3 A further reason for this inspection was the passage of the Criminal Justice Act 2003 onto the statute books. This major piece of legislation, bringing with it an increased range of community sentences, would have particular implications for those offenders moving between areas, whether by necessity or choice. Issues such as equality of provision between areas, and more challenging arrangements for the prison/probation interface could impact severely on those who moved around. Since the completion of the inspection work announcements have been made about the creation of NOMS. This will give an additional focus to the point of transition for offenders being released from custody into the community.

1.4 We recognise that the movement of cases between areas is one aspect of the wider issue of movement of cases between case managers within areas within the NPS. We have focused on the former in this current limited inspection, but it will be important for the NPS and NOMS to keep in mind the wider issue for the future.

1.5 We in HMI Probation will carry out periodic focused follow-up inspections on the movement of cases further to this inspection.

Methodology

1.6 The decision was made to carry out a limited piece of thematic inspection work, principally as a fact-finding exercise meeting the objectives outlined in Appendix 1. Interviews were conducted with key NPD managers, and questionnaires were sent to all 42 probation areas asking for statistical and descriptive information about policies and procedures governing the movement of cases. In addition, we visited six probation areas: Devon & Cornwall, Dyfed-Powys, Merseyside, Northamptonshire, Sussex and West Midlands. These represented a cross-section of size and population density, and a geographical spread. In these areas we examined a total of 80 case files (see Appendix 2 for profile and results) and interviewed middle and senior managers and practitioners. The files examined in each of the six areas were a random sample of cases currently being supervised which had either been formally transferred to the area from another area, or which the area was supervising under informal 'caretaking' arrangements. Each area was given specific feedback on the findings from its inspection. We focused attention on work in the period from immediately prior to the transfer or commencement of caretaking arrangements to three months after. For certain categories of case – e.g. high risk of harm – the number of cases examined was relatively small, but the results nonetheless provided a clear picture on the way such cases were handled.

2. SUMMARY OF RESULTS

Systems

2.1 The lack of a comprehensive national case management model had led to considerable variation in practice across areas. National IT systems provided for some basic monitoring of cases which moved between areas, but implementation of a full IT-integrated case record and corresponding transfer provision was likely to be several years away. Whilst some areas were making good use of OASys and seeing it as a crucial tool at point of offender movement, in other areas it was not being sent to the importing area or was being inadequately completed.

2.2 There had been neither tracking nor collation centrally of the number of cases moving between areas, and there was also no evidence that individual areas had collated and considered these numbers. There was also no specific strategic NPD lead for this important area of work. The quality of the work done with offenders who moved was typically excluded from the usual forms of performance monitoring by the NPD, which focused on the work of individual areas, and from inspection of individual areas by HMI Probation.

2.3 Most areas had in place arrangements for handling the formal transfer of cases, largely based on PC 78/2000, though in practice the requirements of this circular were not always met in full.

2.4 The role of the NPD received a mixed response. Many staff and managers had found the NPD, and particularly PPU staff, extremely helpful in dealing with case by case difficulties and queries. On occasions there had been disputes between areas when cases moved, with the receiving area reluctant to accept responsibility for the case. There was a view from staff interviews – based on specific cases – that the NPD could, on occasions, be more proactive and directive in dealing with issues of hard-to-place offenders and approved premises.

2.5 One issue which, on occasions, raised difficulties in handling the movement of certain offenders was the lack of a central bedspace register for approved premises. This resulted in probation and prison staff spending excessive amounts of time telephoning round in the hope of having an offender referral accepted.

2.6 The guidance in PC 78/2000 was generally useful and appropriate. However, there were certain respects in which it was not fully adequate. It did not legislate for situations where offenders in the community moved with no warning at all, or where those leaving prison decided at the last moment about where to settle upon release. Furthermore, it had not been updated to reflect the subsequent introduction of MAPPA as a statutory duty. As indicated above, the NPD had commenced revision of the circular, including updating on MAPPA, but had agreed to defer the work pending the outcome of the inspection.

Case management

2.7 Whilst the making of appointments had been generally maintained well when an offender moved, there had been considerable drift in enforcing some cases as required. This had been a particular problem with offenders on orders who changed areas *temporarily*, and seemed to reflect a lack of ownership of those cases by either of the areas involved in the move. In this connection, similarly, our follow-up report on the Langley House Trust identified certain continuing problems in maintaining continuity of supervision in cases where offenders moved for a limited period.

2.8 It became apparent from the sample of cases examined that those offenders who moved sometimes had a higher than average level of criminogenic needs and also had risk of harm levels prone to rise because of their move. Some of these issues were being addressed, albeit in a reactive rather than a planned way. This would suggest that the very fact of their moving should automatically prompt a thorough needs and risk reassessment, and that greater attention should be given to offenders who move, and particularly those who move a number of times, than is currently the case.

2.9 The inspection did not seek to examine in detail offenders' motives for moving and, indeed, there would be difficulties in doing so. In general it would seem likely that offenders move for a variety of reasons. In some cases the motives may be positive, for example in order to seek to get away from the factors which lead to their offending. However, it would also seem possible that, on a worst case scenario, some offenders move in order to offend more easily, free from inhibitors such as family influence and well known local police surveillance. In this latter connection it was worrying, for example, that even in the relatively small sample of cases inspected, we found a number of offenders convicted of internet pornography offences who had moved away from their home. Risk of harm levels in these cases had not always been accurately and comprehensively reassessed.

2.10 Diversity issues were not being checked and managed well enough in general, although there were some examples of specific good practice in this area of work. Offending behaviour work and victim awareness work was not given sufficient priority. There was some loss of momentum in the supervision planning process and full use was not being made of OASys. In short, attention was being focused on contact levels and not extended to the uninterrupted delivery of relevant interventions.

2.11 There was general awareness in areas about the provisions of PC 78/2000, but detailed knowledge of its requirements varied considerably amongst staff. Many of its provisions were not being acted upon within the required timescales. Most evident was the failure to have orders formally transferred – i.e. with the sanction of the court – within six weeks of a move taking place.

2.12 Also, in only about a quarter of cases examined was a home visit carried out, or the suitability of the address confirmed, within the required timescale.

Public protection

2.13 It was of concern that risk of harm assessments were carried out appropriately following the move in only a minority of the total sample. However, where an offender about to move areas or be released from prison had been assessed as high risk of harm, that assessment was clearly designated and appropriately picked up on by receiving areas where MAPPA meetings were arranged as appropriate. In high risk of harm cases the quality of ongoing risk management work following the offender's move was generally appropriate in most cases, but there was not always sufficient liaison between the areas on victim issues.

2.14 The role of MAPPA coordinators varied widely and did not always operate to best effect. In the majority of MAPPA level 3 cases in the sample, the MAPPA coordinators were not used as a brokering point. ACO involvement was not always sought as required in transfer cases.

2.15 Some areas had particular difficulties dealing with the transfer of dangerous offenders, and there was some concern that this issue was not fully addressed at national level or seen as a *national* responsibility. Areas without their own approved probation premises faced potential difficulties when trying to place offenders, particularly high risk of harm offenders being released from custody. Also, while systematic information on offender movements was not available, there were indications from area responses and interviews that certain areas faced differing issues relating to particular types of offenders. For example, on occasions a considerable number of offenders moved to coastal areas, particularly during the summer period, when they often arrived with no prior notice in the hope of finding seasonal work. Similarly, there was a tendency for holiday resorts to attract sex offenders, which clearly had implications for probation and MAPPA structures in these areas. Also, some probation areas with a large number of prisons faced disproportionate demands for post-release resources such as accommodation, although the position varied according to the type of prison.

3. ACTION REQUIRED/RECOMMENDATIONS

3.1 This inspection has identified the need for improvements on a number of more general issues – including probation IT, the development of standard case management arrangements and offender accommodation – on which work is already in hand in NPD, although on some issues still at an early stage. It will be important to make progress on these matters, and we will continue to take a strong interest in them, though it is recognised that progress may take time. For the present the following recommendations are made on issues more specifically related to the movement of cases.

Recommendations to the NPD

The NPD, in conjunction with the NOMS as it develops, should:

1. *revise PC 78/2000, replacing it by comprehensive guidance fully reflecting MAPPA and contemporary sentencing disposals. The guidance should define a standardised procedure for the movement of cases, including a national checklist of the material which an exporting area must provide to an importing area. It should also specify the use of OASys as a vehicle for reassessment where an offender moves*

2. *ensure that the category of temporary transfers for community sentences is ended, and that an importing area assumes full responsibility for a case as soon as the offender moves to the area (albeit for what might be only a temporary stay). Where any difficulty arises in the transfer of a case, NPD/NOMS should adjudicate*

3. *explore jointly with the Prison Service more effective arrangements for the release of prisoners, covering issues such as short-notice releases, and plans for those who have employment under temporary release arrangements within the locality of their prison but outside their originating probation area. The arrangements should provide for sufficient notice to receiving probation staff and appropriate use of the 'reside where approved' condition*

4. *collect at least some summary information on the number and type of offenders who are moving, so that the scale of the issue can be known and strategic planning undertaken*

5. *ensure that transfer cases are no longer excluded from NPS monitoring samples, but scrutinised routinely, and the data captured on a national basis, separate from area targets.*

Recommendations to Boards

The Chief Officer and Board should ensure that:

6. *when a case moves to another area the exporting area provides promptly all relevant documentation including a full OASys assessment*

7. *when a case moves to another area the importing area:*

   (a) carries out an OASys re-assessment of risk of harm and of criminogenic need within four weeks of the move

   (b) gives sufficient priority (where relevant) to risk of harm management; enforcement; offending behaviour issues; victim awareness work; and diversity issues

   (c) liaises sufficiently with the exporting area on any victim contact issues.

4. INFORMATION ON MOVEMENT OF CASES BETWEEN AREAS

4.1 In response to the questionnaire, 34 areas provided information on cases formally transferred in or out of the area in the 12 months ending 31 March 2003. Across these areas in total (which excluded London) 7,300 cases were reported as transferred out and 5,500 as transferred in. This was a noticeable imbalance and could suggest that there was some under-recording of cases transferred in. The accuracy and completeness of the information was not clear.

4.2 We compared the total reported number of cases formally transferred in or out of an area – i.e. the number of cases which involved the area in dealing with formal transfer issues – with the total caseload for that area. On average across the areas this number represented 13% of total caseload, though there was a considerable range – from 3% to 34% – in the figures for individual areas. While this comparison was not direct, it suggested that formal transfer – aside from more temporary moves – was involved in a substantial proportion of cases that the NPS handled, both in absolute terms and relative to overall workload.

4.3 Only 15 areas were able readily to provide information about the number of cases that (at the time of completing the questionnaire) they were currently 'holding' or 'caretaking' on an informal basis from another area – i.e. without a formal transfer having (yet) taken place. In total, across the 15 areas, this number corresponded to about 20% of the total number of cases formally transferred to these areas in the 12 months ending 31 March 2003.

4.4 Only a very small number of areas (four) were able readily to provide information about the number of cases that (at the time of completing the questionnaire) another area was currently 'holding' or 'caretaking' on an informal basis on their behalf.

4.5 Of the 34 areas who provided information on cases formally transferred in during the 12 months ending 31 March 2003, only 15 were able to state the proportion of these which were high risk of harm cases. It was of some concern that not all areas had readily available information on cases formally transferred in and out and that many did not have such information on caretaking issues. The issues of data availability and data quality were matters which the NPD and NOMS would need to address, particularly in the design of new information systems.

4.6 It was also of note that a recent study by the NPD and HMI Probation of serious further offence cases (i.e. those where an offender on NPS supervision is charged with a further, serious, offence) found that 7% of these cases had been transferred between probation areas at some stage.

5. FINDINGS

Criterion 1: Systems

5.1 Reliable and clear systems are in place to ensure the maintenance of effective supervision when offenders move across area boundaries, whether as formal transfers or temporary moves.

Strengths

- In a majority of the areas visited, steps had been taken to modify or develop local IT systems so case managers could record basic information on the movement of offenders in and out of their area. In particular CRAMS included facilities to enable basic monitoring. When areas had made technical upgrades or introduced new systems they had incorporated the need to track and monitor transfers. The joint police/probation system ViSOR, currently being piloted, would provide for transfer of all data on a relevant offender if supervision were transferred; however, the timescale for deployment of the system was dependent on resource availability and was not yet clear.
- Staff at the NPD PPU were commended for their accessibility and help in dealing with high risk of harm transfers, which often happened with little advance notice.
- Where areas had public protection teams, the guidance in PC 78/2000 was integrated into operational procedures and we found evidence of their use to broker transfers of high-risk cases successfully.
- In public protection teams where police officers were co-located, additional information on transferred-in offenders was more accessible, these data informing case managers' risk assessments and supervision plans.
- Areas broadly welcomed the guidance contained in PC 78/2000, and most areas had in place reasonably systemised arrangements for handling the formal transfer of cases, largely based on this circular.
- In one area visited, additional practice guidance to support PC 78/2000 had been issued to staff to support transfers in and out of the area.
- To offer support at a vulnerable time in their supervision and until any public protection issues were clearer, a number of areas put all transferred-in cases on to weekly reporting. This provided a higher level of contact initially and so facilitated the development of an effective relationship with staff in the new area.
- In a number of areas the minimum information requested in advance of transfers was a full OASys assessment or review before the case was accepted. Staff commented on the value of this in both meeting the requirements of PC 78/2000, ensuring for trouble-free transfers, and continuity of case management. In addition, contact logs and compliance

records were sought to make certain that national standards on enforcement were met.

Areas for improvement

- The NPD had not given strategic focus to the issue of offenders moving between areas, and there was no named NPD lead for this aspect of work. The NPD had, however, recently commenced work on a revision of PC 78/2000, as referred to above.
- We found in a number of areas that staff were not familiar with the detailed contents of PC 78/2000. In a substantial number of the cases scrutinised the requirements of this circular were not met in full.
- Less than half of all areas had in place arrangements to monitor the application of PC 78/2000.
- The lack of a national case management model or case record and the considerable number of area-based IT systems made it impossible to transfer information electronically in a reliable way. The efficient transfer of cases was also hampered by the range of different record formats between areas. eOASys 3 would allow some limited transfer electronically of data. However, the timetable for implementation of a full IT-integrated national case record and corresponding transfer provisions was not yet clear and could be several years away. Also the NPD's present plans for case records did not envisage a fully electronic record: a paper file was likely to remain. The scoping brief undertaken to date for the SALSA modules did not appear to have taken fully into account the complexity of transfers and appeared to be optimistic about the capacity of existing local IT systems. Future IT developments would of course need to reflect the developments in the planning of NOMS.
- Centrally no records were kept on the total number of transferred cases and at the time of the inspection the NPD had no plans to do this. The resource implications for net importing areas were not taken into account in the cash limits allocation formula. No specific guidance had yet been issued to areas on a common definition of a transferred case, though the NPD planned to cover this in the revision of the circular.
- DTTOs and ICCP community sentences were not fully covered by the current circular and it was not clear how varying local arrangements would allow continuity of supervision and the provision of appropriate levels of intervention. The NPD planned to address this in the revision of the circular.
- The range of documents sent by the exporting area to the importing area when an offender moved varied considerably, and key documents were often missing. In only about a half of cases scrutinised was the current assessment received, only about 45% included the contact logs and in only a third were supervision plans available. There appeared to be no uniform understanding about the documents which an exporting area should send to an importing area.
- In only about 40% of cases was it clear that the receiving area had received documents within ten days of the move. In some areas visited there was evidence of staff actively progress-chasing missing information.

- Staff interviewed did not share a common view of the responsibilities of importing and exporting areas, leading to some caretaking cases having little or no paper work on file, making judgements about risk and need extremely difficult.
- Some areas expressed concern that arrangements for moves appeared on occasions to involve an 'offender led' approach. Case managers gave a number of examples of offenders moving to a new area without any prior discussion or planning, particularly on release from custody. There was concern that on occasions prisoners changed their minds at very short notice as to the area they wished to settle and were released accordingly, apparently on the assumption that offenders could move or live where they desired, without any assessment of risk of harm and likelihood of reoffending. Prison licences contained a standard clause "reside where approved and not to move to live elsewhere without prior approval". High workloads and human rights legislation were factors cited as the main reasons why this condition was rarely enforced. It was not clear from this inspection whether these issues applied in all areas, but they were of concern.
- A need for better information-sharing and inter-agency cooperation, particularly in relation to work in prisons and resettlement, was evident. The growing role of housing providers working directly with offenders in prisons was welcomed. However, there were fears it could result in offenders gaining accommodation without the relevant case manager being made aware until after release.
- The omission of transferred cases from national monitoring exercises resulted in substantial amounts of work not being monitored. We recommend that in future such cases are no longer excluded from NPS national monitoring but are captured on a national basis, separate from area targets.

Good practice examples:

The Brighton team in Sussex was using a simple template entitled Request for Temporary Supervision for cases transferred into the area. This was a useful record of key information and also a checklist for exporting areas, guiding them in sending all relevant documents.

West Midlands staff agreed with an importing area the first appointment so they could meet the requirement of PC 78/2000 and ensure continuity of supervision.

Criterion 2: Case management

5.2 The management of cases is thorough, ensuring seamless supervision and equal access to interventions for offenders.

Strengths

- In about 90% of cases appointments continued to be made throughout the transfer period in line with at least minimum national standards requirements.

- In some of the areas visited offenders transferring in would go through an individual induction process.
- In about two-thirds of cases offenders attended all, or nearly all of the appointments arranged for them.
- Engagement with other forms of intervention, e.g. drug/alcohol counselling, ETE, was continued – at least to some degree – in 80% of applicable cases.
- Offenders moving between areas frequently had resultant accommodation needs. In about 80% of these cases there was felt to have been at least some liaison between the two areas concerned as to accommodation matters, although in only 40% was this felt to have been fully or largely sufficient.
- CP staff often showed admirable flexibility and diligence in working with offenders who had recently arrived in their area, with successful completion of their orders as their ultimate goal.

Areas for improvement

- Without a national case management model there were considerable variations in the staffing structures in each area, and little guarantee of either consistency in provision or continuity of supervision for offenders.
- Enforcement practice in relation to transfer cases was not consistently tight. In only about a quarter of applicable cases did enforcement take place fully as it should have done according to the requirements of national standards. There appeared to be two principal reasons for this: first, exporting areas did not reliably provide importing areas with an up-to-date record of absences to point of transfer and of enforcement action taken. This meant that enforcement did not have the cumulative and sequential aspect it should have. The second factor was less tangible but nonetheless apparent from case records: case managers receiving imported cases tended sometimes to enforce them less rigorously than other cases. There appeared to be some uncertainty as to which area had responsibility for enforcement during the initial stage, including decisions about the acceptability of absences. In part this probably reflected the point that during the stage prior to formal transfer the originating court still had responsibility for orders, which involved an added complication to the process.
- In only about 30% of cases was the supervision plan reviewed within four weeks, as required by a change in offender circumstances. This clearly worked against the concept of continuous seamless supervision.
- There were concerns about how diversity issues were managed in relation to offenders moving between areas. In about 60% of cases it was felt that diversity needs were not taken into consideration at all. Often there was no mechanism for comprehensively checking for individual or special needs when an offender moved, particularly if the move did not prompt a review of the supervision plan or of OASys. It was also of concern that in nearly 20% of the cases scrutinised the ethnicity code was not clearly recorded.
- In about a half of relevant cases, including on occasions high risk of harm cases, attendance at an accredited programme in the importing area was not facilitated. This was sometimes because importing areas had waiting lists for

their accredited programmes, and there was a lack of clarity as to how an offender transferring in should be handled in relation to the waiting list. There was a need for clarification of this in the guidance on movement of cases. Additionally, some smaller rural areas were not able to offer a wide range of accredited programmes for reasons of geography, poor transport infrastructure, and the size and spread of population. While this was a more general point, it clearly could have an impact on offenders moving to that area.

- Formal transfer applications were made to court within six weeks (in accordance with PC 78/2000) in only 20% of cases.
- Most areas visited were not carrying out home visits on their imported cases.

Good practice examples:

Staff had taken commendable care to enlist the help of an exporting area in assessing the diversity needs of a black female offender moving into Dyfed-Powys, by proactively liaising in advance about what the potential issues might be.

An exporting area had allowed contact on a CPRO to lapse, failing to pursue the case when medical certificates expired, and proving unable at first to give an accurate account of the number of outstanding CP hours. Sussex, on receiving the case, clarified the position and quickly instructed the offender to work. She completed the remaining 50 hours of her order appropriately.

In Devon & Cornwall basing VLOs and resettlement staff in the same office enhanced good communication.

A Northamptonshire case manager was allocated an offender moving into the area, who had been convicted of driving with excess alcohol. They swiftly allocated him to the DIDs programme, even though the case had yet to be formally transferred. This ensured the condition on the offender's order was actioned in a timely way, maintaining the momentum of interventions for this offender.

Criterion 3: Public protection

5.3 Work on risk of harm issues and on victim liaison has high priority and is unaffected by the move.

Strengths

- In nearly all the cases on a high risk of harm register in the importing area it was clear that the offender had also been on a high risk of harm register in the exporting area.
- A MAPPA meeting had been convened in the new area in five of the six relevant cases.
- In most (though not all) high risk of harm cases (13 out of 16), risk of harm continued to be managed fully or largely as appropriate following the move of the case.

Areas for improvement

- Risk of harm assessments continued to be carried out fully or largely as required on cases transferred in only about a third of all the cases inspected. This was a worrying finding, with clear potential public protection implications, since risk of harm needs to be assessed regularly in all cases. However, this was in line with a general break in momentum which we saw from case files in relation to assessment and planning for cases which move.
- In relation to the transfer of high risk/MAPPA cases, contact between areas at ACO level had taken place in only three of the ten relevant cases.
- A transfer report, from the exporting area to the importing area, detailing essential information for the purpose of risk of harm management was faxed on the day of notification in only ten of 23 applicable cases (about 45%). As a consequence, judgements about risk and need had potentially been compromised.
- In about a half of cases subject to MAPPA procedures in the importing area, there was insufficient evidence that the case had been supervised as such in the exporting area.
- In less than half of level 2 or 3 MAPPA cases had salient features of risk management and the risk management plan been communicated to the new area in good time.
- Although in six of the eight MAPPA cases victim issues, specific to the transfer, had appropriately been taken into account, it was nonetheless of concern – in view of the nature of these cases – that in two cases these issues were not taken into account.
- In less than half of relevant high risk of harm cases was liaison between the areas on victim issues seen as appropriate. This indicated a clear need for improvement to ensure that victims work was given sufficient priority and attention.
- Restrictive conditions on orders and licences were enforced fully or largely in a third of relevant cases examined. This was of significant concern in view of the potential adverse implications for protection of both the public and victim.

Good practice examples:

Staff in the public protection team had a positive attitude to accepting transfers into Sussex. They preferred to have full responsibility for a case formally transferred rather than to hold cases on a 'caretaking' basis. They held fast to public protection principles even against a backdrop of demanding caseloads and staff shortages.

Good links had been forged with local MPs in Devon & Cornwall, and high quality briefings were provided on offenders moving into the area so that key decision makers had confidence in the area's public protection arrangements.

Appendix 1: Movement of cases inspection standards

Objectives

1. To investigate the number of cases in which offenders move between areas during supervision.
2. To examine how effectively probation areas handle cases where offenders move during supervision to maintain contact, supervision objectives and public protection.
3. To assess whether areas are meeting the terms of the current guidance and to assess the adequacy of that guidance.
4. To identify any specific problems encountered by areas in handling such cases, and any national issues arising.
5. To identify and promote good practice.

Criteria and examples of evidence:

Criterion 1: Systems

Reliable and clear systems are in place to ensure the maintenance of effective supervision when offenders move across area boundaries, whether as formal transfers or temporary moves.

Examples of evidence:

- *PC 78/2000 is clearly understood in areas and fully implemented.*
- *Central guidance and support to areas from the NPD, including probation IT systems, is clear and effective.*
- *Recording and monitoring arrangements are in place to ensure the tracking of offenders who move.*
- *The respective responsibilities of importing and exporting areas are clearly understood, particularly for temporary moves.*
- *Case records are shared across area boundaries in a timely and helpful way.*

Criterion 2: Case management

The management of cases is thorough, ensuring seamless supervision and equal access to interventions for offenders.

Examples of evidence:

- *Contact levels with offenders are maintained, at least to national standards requirements.*
- *Enforcement action is taken in accordance with national standards.*
- *Race equality and wider diversity issues are prioritised.*
- *Attendance at accredited programmes and other provision is supported so that the impact of interventions to address likelihood of reoffending is not reduced.*

Criterion 3: Public protection

Work on risk of harm issues and on victim liaison has high priority and is unaffected by the move.

Examples of evidence:

- *Work to assess and manage risk of harm continues, including the enforcement of licence and order conditions which are restrictive.*
- *In MAPPA cases the transfer arrangements specified in the MAPPA Guidance 2003 are adhered to.*
- *Arrangements for victim liaison work are clearly understood and the feedback of victim concerns to case managers continues reliably.*
- *In cases where approved premises are or have been involved, there is good liaison and appropriate attention given to accommodation matters.*

Appendix 2: Details of case sample

Characteristics of sample

Offender gender	Number	Percentage
Male	64	80%
Female	16	20%

Offender ethnicity	Number	Percentage
White	56	70%
Mixed	1	1%
Asian	2	2%
Black	7	9%
Other ethnic group	0	0%
Ethnicity not recorded	14	18%

On high risk of harm register	Number	Percentage
Yes	17	21%
No	63	79%

Offender subject to MAPPA	Number	Percentage
Yes	8	10%
No	71	90%

Offender currently resident in approved premises	Number	Percentage
Yes	5	6%
No	73	94%

Type of order/licence	Number	Percentage
CRO	29	37%
CPO	14	18%
CPRO	7	9%
Licence	27	35%
DTTO	1	1%
Other	0	0%

Transfer or caretaking	Number	Percentage
Transfer	48	61%
Caretaking	31	39%

Results

Notes:

- Figures exclude cases where issue was not applicable/not relevant.
- Because of lack of clarity in records, information was not always available for all relevant cases.

Background and liaison issues

Evidence on the file of communication between areas in advance of the transfer/caretaking	In 61 of 79 cases (77%)
Where communication between areas, move notified by phone or fax in line with PC 78/2000	In 53 of 61 cases (87%)
Where communication between areas, written confirmation in two days in line with PC 78/2000	In 44 of 61 cases (72%)
If dangerous/high risk of harm case, evidence on file of ACO involvement with transfer/undertaking	In 3 of 10 cases (30%)
If dangerous/high risk of harm case, exporting area ensured that transfer report detailing essential information for risk management was faxed on day of notification	In 10 of 23 cases (43%)
If dangerous/ high risk of harm case, full information on the offender transferred to the importing area within five working days of notification	In 14 of 24 cases (58%)
Planned first appointment made by the exporting area and clearly communicated to the receiving area	In 34 of 80 cases (43%)
This first appointment kept	In 30 of 46 cases (65%)
Home visit done or suitability of address confirmed within five working days of notification	In 19 of 75 cases (25%)

Documents received with transfer	Number	Percentage
Assessment	39	49%
Supervision plan	27	34%
MAPPA notes	1	1%
Other risk information	3	4%
Copy of order/licence	41	51%
Contact log	35	44%
VLO information	4	5%
Accredited programme reports	1	1%
Other	46	58%

Clear from file that documents relating to case were received by importing area within ten days of transfer or commencement of caretaking	In 31 of 73 cases (42%)
If case on high risk of harm register in the importing area, clear from file that it was on high risk of harm register in the exporting area	In 7 of 8 cases (88%)
If case subject to MAPPA in the importing area, clear that was subject to MAPPA in the exporting area	In 2 of 5 cases (40%)
If case subject to level 3 MAPPA in the importing area, transfer brokered via MAPPA coordination point (as MAPPA Guidance)	In 1 of 6 cases (17%)
If case subject to level 2 or 3 MAPPA in the importing area, the salient features of the risk assessment and management plan were communicated to the importing area in good time (as MAPPA Guidance)	In 3 of 7 cases (43%)
If case subject to level 2 or 3 MAPPA in the importing area, MAPPA meeting was convened in receiving area to transfer case (as MAPPA Guidance)	In 5 of 6 cases (83%)
If case subject to level 2 or 3 MAPPA in the importing area, victim issues specific to the transfer taken into account (as MAPPA Guidance)	In 6 of 8 cases (75%)

Continuity of supervision/case management issues

Note: The following results relate to the period from immediately prior to transfer/caretaking to three months after.

Appointments were made in line with national standards (at minimum), or commensurate with risk	In 73 of 80 cases (91%)
The offender attended all or nearly all planned appointments	In 51 of 77 cases (66%)

Breach or other enforcement action taken in accordance with national standards where relevant, taking account of any unacceptable absences in exporting area	Number	Percentage
Fully met	10	26%
Largely met	14	37%
Partly met	4	11%
Not met	10	26%

Supervision plan reviewed within four weeks of transfer/commencement of caretaking	In 22 of 79 cases (28%)

File contains information which demonstrates that the offender's race and/or wider diversity needs taken into consideration	Number	Percentage
Fully met	1	2%
Largely met	6	12%
Partly met	12	24%
Not met	30	61%

Attendance at any accredited programme supported so that the impact is not reduced	Number	Percentage
Fully met	4	25%
Largely met	3	19%
Partly met	1	6%
Not met	8	50%

Attendance at any other intervention supported so that the impact is not reduced	Number	Percentage
Fully met	5	14%
Largely met	11	31%
Partly met	12	34%
Not met	7	20%

Work to assess risk of harm continued, including a reassessment within four weeks of the transfer/caretaking	Number	Percentage
Fully met	13	17%
Largely met	14	19%
Partly met	15	20%
Not met	33	44%

Work to manage risk of harm continued	Number	Percentage
Fully met	9	14%
Largely met	14	22%
Partly met	20	31%
Not met	21	33%

Any restrictive conditions were appropriately enforced	Number	Percentage
Fully met	3	17%
Largely met	3	17%
Partly met	7	39%
Not met	5	28%

Evidence of active liaison between the areas on victim issues	Number	Percentage
Fully met	3	7%
Largely met	2	5%
Partly met	4	10%
Not met	32	78%

Good liaison between the areas on accommodation matters	Number	Percentage
Fully met	7	15%
Largely met	11	23%
Partly met	19	40%
Not met	11	23%

A new application to court formally to transfer the case to the receiving area made within six weeks of transfer (as PC 78/2000)	In 14 of 70 cases (20%)

Arrangements made to ensure the offender's participation in accredited programmes or other appropriate constructive interventions	Number	Percentage
Fully met	5	18%
Largely met	7	25%
Partly met	4	14%
Not met	12	43%

Appendix 3: Information from the questionnaires sent to all 42 probation areas

Area policy and practice guidelines

Nineteen areas had a specific area policy, or practice guidelines, in relation to at least some aspects of movement of cases. In a further nine areas the policy and guidelines were PC 78/2000. The remainder of areas reported no specific policy or guidelines on movement of cases.

Systems to track movement of cases

All but two areas had some system in use to track the movement of offenders into and out of the area. In most areas this was done using the case management IT system in use in the area; in the majority of areas this system was CRAMS. In some areas, the IT system was used only to track formal transfers, but some areas with CRAMS were using it also to track temporary moves.

The numbers of cases involved in transfers or caretaking arrangements

(As indicated, some areas were not able to provide some of this information.)

Thirty-four areas provided information on cases formally transferred in or out of the area in the 12 months ending 31 March 2003. (A further two areas provided figures but considered them to be unreliable.) Across these areas in total (which excluded London) 7,300 cases were reported as transferred out and 5,500 as transferred in.

We in HMI Probation compared the number of cases formally transferred in or out for each area with the total caseload for that area. This showed a considerable range, from 3% to 34%, with an average of 13%.

Fifteen areas were able to provide information about the number of cases that (at the time of completing the questionnaire) they were currently 'holding' or 'caretaking' on an informal basis from another area – i.e. without a formal transfer having (yet) taken place. In total, across the 15 areas, this number corresponded to about 20% of the total number of cases formally transferred to these areas in the 12 months ending 31 March 2003.

Four areas were able to provide information about the number of cases that (at the time of completing the questionnaire) another area was currently 'holding' or 'caretaking' on an informal basis on their behalf.

Of the 34 areas who provided information on cases formally transferred in during the 12 months ending 31 March 2003, 15 were able to state the proportion of these which were high risk of harm cases.

Monitoring the application of PC 78/2000

Fourteen areas had some arrangements to monitor the application of PC 78/2000; a further five had arrangements just in respect of high risk of harm or certain other specific cases. The remainder of areas did not have monitoring arrangements in place.

Monitoring the application of the transfer arrangements in the MAPPA Guidance

Eighteen areas had arrangements to monitor the application of these transfer arrangements, and a further two had arrangements in respect of some of the relevant cases. The remainder of areas did not have monitoring arrangements in place.

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HMI Probation
Room 217
Ashley House
2 Monck Street
LONDON
SW1P 2BQ

Tel: 020 7035 2207 Fax: 020 7035 2237

Web address:
www.homeoffice.gov.uk/justice/probation/inspprob/index.html