National Child Protection Inspections

Leicestershire Police
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Foreword

All children deserve to grow up in a safe environment, cared for and protected from harm. Most children thrive in loving families and grow to adulthood unharmed. Unfortunately, though, too many children are still abused or neglected by those responsible for their care; they sometimes need to be protected from other adults with whom they come into contact. Some of them occasionally go missing, or end up spending time in places, or with people, harmful to them.

While it is everyone's responsibility to look out for vulnerable children, police forces, working together and with other agencies, have a particular role in protecting children and making sure that, in relation to their safety, their needs are met.

Protecting children is one of the most important tasks the police undertake. Police officers investigate suspected crimes and arrest perpetrators, and they have a significant role in monitoring sex offenders. They have the powers to take a child in danger to a place of safety, and to seek restrictions on offenders' contact with children. The police service also has a significant role, working with other agencies, in ensuring children's protection and well-being in the longer term.

As they go about their daily tasks, police officers must be alert to, and identify, children who may be at risk. To protect children effectively, officers must talk to children, listen to them, and understand their fears and concerns. The police must also work well with other agencies to play their part in ensuring that, as far as possible, no child slips through the net, and to avoid both over-intrusiveness and duplication of effort.

Her Majesty's Inspectorate of Constabulary (HMIC) is inspecting the child protection work of every police force in England and Wales. The reports are intended to provide information for the police, the police and crime commissioner (PCC) and the public on how well children are protected and their needs are met, and to secure improvements for the future.

Contents

Summary

This report sets out the findings from HMIC's 2017 inspection of child protection services in Leicestershire Police, which took place in January 2017.[1] This inspection is part of our rolling programme of child protection inspections.[2]

HMIC inspectors examined the effectiveness of the police's interactions with children, from initial contact through to investigation of offences against them. Our inspectors also scrutinised the treatment of children in custody, and assessed how the constabulary is structured, led and governed in relation to child protection services.

Main findings from the inspection

Leicestershire Police has demonstrated a strong commitment to improving services for the protection of vulnerable people. This is visible at all levels of the force – from the chief constable to frontline officers and staff. The chief constable has made child protection a priority, and it is clear that there is an increased focus on improving outcomes for children. We found clear evidence of strong leadership and oversight by senior officers responsible for managing child protection.

This focus at the top of the force is leading to some positive results. For example:

- the establishment of a multi-agency hub, where agencies including the police, children's social care and health services work together and exchange information to protect vulnerable people;
- provision of over 2,000 sessions (since 2016) of protecting vulnerable people training throughout the force; and
- the production of a film about a young girl, Kayleigh Haywood, who was groomed and subsequently murdered in Leicestershire in November 2015. Its purpose is to protect children by raising public awareness of the risks of grooming.

The importance placed on safeguarding generally, and that of children in particular, is evidenced in the investment the force has made to support specialist functions and manage the associated demand. There is a clear determination to get the right people into the right posts, with senior leaders supporting those officers and staff that

[1] 'Child' in the report refers to a person under the age of 18. See the glossary for this and other definitions.

[2] For more information on HMIC's rolling programme of child protection inspections, see www.justiceinspectorates.gov.uk/hmic/our-work/child-abuse-and-child-protection-issues/national-child-protection-inspection/

possess the necessary skills and abilities, ensuring they are developed to fulfil their potential to undertake these critical roles. This positive approach has ensured there are appropriately trained detectives within safeguarding roles with few vacancies. This is at odds with the national trend where forces often encounter significant difficulties resourcing child protection investigative roles.

Finally, the force's decision to ensure it has no backlogs within its police online investigation team (POLIT) in dealing with online offending is recognised by HMIC as positive practice.

However, we found that the overall investment by the force has not yet translated into consistently improved outcomes for vulnerable children across all areas of child protection work.

This is evidenced by the fact that we graded the majority of case files we audited as either 'inadequate' or 'requiring improvement'. In particular:

- the force's response to child sexual exploitation (CSE) requires further development and co-ordination. The force has undertaken some significant steps to address this through a multi-agency response (see pages 11 - 12 and page 22); however, it still has more to do to demonstrate that it is effectively able to identify and manage the wider risks to victims or to other children;

- we have serious concerns about the downgrading of high risk domestic abuse incidents. Inspectors identified a number of examples where the re-grading was inappropriate, exposing victims and children within the family to unnecessary risk (see page 28); and

- the response to children who regularly go missing from home requires improvement (see pages 24 - 27), with a particular focus on early intervention to ensure that officers and staff understand the well-documented link between children who regularly go missing and sexual exploitation.

Conclusion

Public protection and safeguarding are clear priorities for the force, and we found chief officers were committed to improving the experience of children in need of protection. There is strong engagement with partner agencies across Leicester, Leicestershire and Rutland, who are working collaboratively and innovatively to improve outcomes for children. The force has invested in additional training for staff to improve awareness of vulnerability and child safeguarding concerns.

However, our case files audit showed that this good work is not yet resulting in consistently good outcomes for children. As the force recognises, there is therefore more to do to manage the risks posed to vulnerable children and to implement

appropriate protective plans. HMIC was however encouraged by the responsiveness and positivity of the force during this inspection, particularly where areas for improvement were identified.

1. Introduction

The police's responsibility to keep children safe

Under the Children Act 1989, a police constable is responsible for taking into police protection any child whom he has reasonable cause to believe would otherwise be likely to suffer significant harm, and the police have a duty to inquire into that child's case.[3] The police also have a duty under the Children Act 2004 to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children.[4]

Every officer and member of police staff should understand his or her duty to protect children as part of the day-to-day business of policing. It is essential that officers going into people's homes on any policing matter recognise the needs of the children they may encounter and understand the steps they can and should take in relation to their protection. This is particularly important when they are dealing with domestic abuse or other incidents in which violence may be a factor. The duty to protect children extends to children detained in police custody.

In 2015, the National Crime Agency's strategic assessment of serious and organised crime established that child sexual exploitation and abuse represents one of the highest serious and organised crime risks.[5] Child sexual exploitation is also listed as one of the six national threats specified in the *Strategic Policing Requirement*.[6]

[3] Children Act 1989, section 46.

[4] Children Act 2004, section 11.

[5] *National Strategic Assessment of Serious and Organised Crime*, National Crime Agency, June 2015. Available from: www.nationalcrimeagency.gov.uk

[6] The *Strategic Policing Requirement* was first issued in 2012 in execution of the Home Secretary's statutory duty (in accordance with section 37A of the Police Act 1996, as amended by section 77 of the Police Reform and Social Responsibility Act 2011) to set out the national threats at the time of writing, and the appropriate national policing capabilities needed to counter those threats. Five threats were identified: terrorism, civil emergencies, organised crime, threats to public order, and a national cyber security incident. In 2015, the *Strategic Policing Requirement* was reissued to include child sexual abuse as an additional national threat. See *Strategic Policing Requirement*, Home Office, March 2015. Available at www.gov.uk

Expectations set out in *Working Together*

The statutory guidance *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*[7] sets out the expectations of all partner organisations involved in child protection (such as the local authority, clinical commissioning groups, schools and the voluntary sector). The specific police roles set out in the guidance are:

- the identification of children who might be at risk from abuse and neglect;
- investigation of alleged offences against children;
- inter-agency working and information-sharing to protect children; and
- the use of emergency powers to protect children.

These areas of practice are the focus of HMIC's child protection inspections.[8]

[7] *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015 (latest update). Available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

[8] Details of how we conduct these inspections can be found at annex A.

2. Context for the force

Leicestershire Police has approximately 3,200 people in its workforce. This includes:

- 1,794 police officers;
- 1,181 police staff; and
- 221 police community support officers.[9]

The force provides policing services to the counties of Leicestershire and Rutland. The police force area covers 980 square miles in the east Midlands of England. Around 1 million people mainly live in the urban centres which include the city of Leicester and the towns of Loughborough, Market Harborough and Melton Mowbray.

There are three local authorities in the Leicestershire Police area: Leicestershire County Council, Leicester City Council and Rutland County Council, seven district councils in Leicestershire, and two local safeguarding children boards (LSCBs),[10] Leicestershire and Rutland, and Leicester City.

In 2015 the force introduced a new operating model which provides a single force-wide local policing directorate and a crime and intelligence directorate both led by chief superintendents.

The most recent Office for Standards in Education, Children's Services and Skills (Ofsted) judgments for each of the local authorities are set out below.

Local authority	**Judgment**	**Date**
Leicestershire	Adequate	May 2012
Leicester City	Inadequate	March 2015
Rutland	Adequate	February 2013

In Leicestershire Police, public protection services are led by the deputy chief constable with support from a detective chief superintendent (head of the crime and intelligence directorate). Within this directorate child protection is led by a detective

[9] *Police workforce, England and Wales*, *30 September 2016*, Home Office, January 2017. Available at: www.gov.uk/government/statistics/police-workforce-england-and-wales-30-september-2016

[10] LSCBs have a statutory duty, under the Children Act 2004, to co-ordinate how agencies work together to safeguard and promote the welfare of children and ensure that safeguarding arrangements are effective.

superintendent as part of the remit of the serious crime command, supported by a detective chief inspector providing leadership and day-to-day oversight.

The force and partner organisations have established a multi-agency safeguarding hub (MASH), where organisations including the police, children's social care and health services work together and exchange information to protect vulnerable people. Those working in the hub assess risks to individuals in a range of cases, including child abuse, child sexual exploitation (CSE) and domestic abuse.

The domestic abuse investigation unit (DAIU) which is responsible for the investigation of high-risk and some medium-risk domestic-related crimes, also co-ordinates engagement in each area with multi-agency risk assessment conferences (MARACs)[11].

[11] A MARAC is a locally-held meeting of statutory and voluntary agency representatives to share information about high-risk victims of domestic abuse, to which any agency can refer an adult or child whom they believe to be at high risk of harm. The aim of the meeting is to produce a co-ordinated action plan to increase an adult or child's safety, health and well-being.

3. Leadership, management and governance

The chief constable, his senior team and the police and crime commissioner have a strong commitment to child protection, which is reflected in the police and crime plan.[12] We found clear evidence that the force recognises that it can do more to manage the risks posed to vulnerable children, and to implement appropriate protective plans. Inspectors found that senior leaders are keen to build on existing good practice to improve the way in which they protect vulnerable children.

The deputy chief constable is the chief officer lead for vulnerability, supported by a detective chief superintendent (head of crime and intelligence) and a detective superintendent lead for serious crime involving children and adults. The force has invested in and developed its response to vulnerability and risk over a five-year period, and has undergone a considerable amount of change in the last six months.

The current demand on police forces to safeguard children is both complex and challenging, and these demands are increasing annually. Leicestershire Police is no exception and the force recognises this. While the police do have specific responsibilities to safeguard children, no single agency has the capacity to provide that response on its own. Effective partnerships and collaborative working are essential and as a result the force is working more closely with partner organisations to protect children more effectively, with senior leaders taking an active role in partnership working. Examples of this include:

- the support the force gives to Leicester City local authority Ofsted improvement board;
- the deputy chief constable chairs a Leicestershire, Leicester and Rutland CSE multi-agency executive group; and
- active engagement with the Leicester City Children's Trust Board, the Corporate Parenting Board (Leicestershire County) and the two LSCBs.

The force's professional relationships and engagement with partners involved in safeguarding at all levels were described by the partners we spoke to by as positive. All partners felt able to work effectively with and challenge the force where appropriate. However, partners also identified concerns, such as the lack of police attendance at review child protection conferences.

[12] The police and crime plan 2013-17 for Leicestershire is available at: www.leics.pcc.police.uk/Planning-and-Money/Police-and-Crime-Plan/Previous-Police-and-Crime-Plans.aspx. The police and crime plan 2017-21 is available at: www.leics.pcc.police.uk/Planning-and-Money/Police-and-Crime-Plan/Police-and-Crime-Plan.aspx

Force governance arrangements (which are integral to performance and demand) for child protection are clearly structured to provide scrutiny and oversight of decision making. Performance data and crimes and incidents involving safeguarding are discussed at the monthly safeguarding serious crime management and performance meeting. This feeds into the force-level monthly performance delivery group, which is chaired by a member of the chief officer team. Additionally, the head of crime meets every other month with each local authority's director of children's services, and a detective inspector holds a weekly conference call with service managers from across all three authorities to discuss and review a small sample of child protection cases.

To support the performance monitoring process there are bespoke monthly safeguarding audits, with a documented schedule for 2017. These involve dip sampling investigations, with the outcomes being fed into the force-level 'get it right first time'[13] governance meeting. This meeting receives the results from the force's rolling programme of audits conducted by its corporate services department, Any actions identified through this meeting are shared with the appropriate departmental lead. Despite these performance management arrangements, and audits undertaken in 2016 by the force, the cases examined as part of this current inspection (see p14) have highlighted areas for improvement in relation to the forces arrangements for the protection of children.

The force control strategy[14] for 2016/17 identifies the force's current strategic priorities which include child sexual abuse, online paedophilia, domestic abuse and rape offences.

The force holds a weekly tasking and co-ordination meeting,[15] which a detective chief inspector chairs. This meeting reviews identified risks and threats for the week ahead, and considers resource requirements and emerging threats regarding safeguarding matters.

Inspectors observed the daily management meeting, which a chief inspector chairs, providing good oversight of daily business and cases of significance. These briefings inform on critical risks, threats and harm, together with identified resourcing difficulties.

Throughout the inspection, it was apparent that all staff spoken to who are responsible for managing child abuse investigations are knowledgeable, committed

[13] 'Get it Right First Time' is a force meeting which oversees actions raised in response to an identified need to improve service delivery.

[14] The control strategy sets out the operational priorities for the force, including crime prevention, intelligence and enforcement.

[15] Tasking and co-ordination process enables senior managers to consider and agree tactical options and align resources with priorities.

and dedicated to providing the best service and good outcomes for children at risk. All child protection staff are trained in, or in the process of completing, the specialist child abuse investigator development programme.

Inspectors witnessed some good examples of child protection work by police officers who displayed a mix of investigative and protective approaches. This ensured that safeguarding children remained central to their efforts while all criminal investigative opportunities were pursued.

The force clearly prioritises the importance of safeguarding, in particular that of children. It has matched this commitment by increasing its investment to support specialist functions. In addition, we found a clear determination to deploy the right people in the right posts, with senior leaders supporting those officers and staff who possess the necessary skills and abilities, ensuring they are developed to fulfil their potential to undertake these critical roles.

This positive approach has ensured the force has appropriately trained detectives within safeguarding roles, with few vacancies. This is at odds with the trend in England and Wales where forces often encounter significant difficulties resourcing child protection investigative roles.

4. Case file analysis

Results of case file reviews

To determine how well Leicestershire Police deals with specific cases, HMIC asked the force to self-assess the effectiveness of its practice in 33 child protection cases. The force used HMIC criteria[16] to grade the practice in each case as 'good', 'requiring improvement' or 'inadequate'. The assessment criteria underpinning these grades are detailed and focus on an assessment of the experiences of children as opposed to simple compliance with policy or guidance. However, the meaning of the grades are summarised below:

- good – all the necessary steps have been taken to protect the child and improve the outcomes in their case, and it is clear that risks and wider threats have been understood and acted on;
- requiring improvement – elements of good practice are missing, but there are no widespread or serious failures that result in children being harmed or left at risk of harm; and
- inadequate – there are widespread or serious failures in practice that result in children being harmed or left at risk.

The force's assessors graded practice in 18 of the cases as good, as requiring improvement in 12 and as inadequate in 1. No grading was recorded in one case.[17]

HMIC also assessed these cases; grading the force's practice in 10 as good, as requiring improvement in 13 and as inadequate in 10. HMIC selected and examined a further 52 cases; practice in 15 was assessed as good, in 14 as requiring improvement and in 23 as inadequate.

Table 1: Cases assessed by both Leicestershire Police and HMIC inspectors

	Good	Requiring improvement	Inadequate	No grading
Force assessment	18	13	1	1
HMIC assessment	10	13	10	

[16] The assessment criteria for and indicators of effective practice used in this report are taken from *National Child Protection Inspection: Criteria Assessment*, HMIC, London, 2014. Available at: www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/ncpi-assessment-criteria.pdf

[17] The case types and inspection methodology are set out in annex A.

Table 2: Additional cases assessed only by HMIC inspectors

	Good	Requiring improvement	Inadequate
HMIC assessment	15	14	23

The following is an example of a case which Leicestershire Police assessed as requiring improvement and HMIC assessed as inadequate.

A 15-year-old girl met a 41-year-old man via Facebook, during which the man had sexualised conversations with the girl and offered to buy her drugs and alcohol. He also walked past her school daily due to his place of work being nearby. There was no record of any strategy discussion taking place or of any action to safeguard the girl or other children to whom the man may have access. There was a delay of over a month from the time of the report being made to the suspect being arrested despite the fact that the police had information that the suspect posed a significant risk and there may be other victims. It was nearly two months later before other children identified as possible victims were spoken to by officers, and a delay of eight months in conducting Facebook enquiries which could have taken place much earlier. The force is currently appealing a decision by the Crown Prosecution Service to discontinue the prosecution.

HMIC referred 18 cases back to the force because they were considered to contain evidence of a serious problem – for example, a failure to follow child protection procedures and/or a child at immediate risk of significant harm. The force responded to the concerns raised by inspectors in these cases, by either taking action or providing further information.

The following are examples of two cases referred back to the force.

A 14-year-old boy contacted the police to report that a 14-year-old fellow student had gone to his home address and punched him prior to showing him a knife. When speaking to the police he mentioned that the suspect kept coming to the house with weapons and had been bullying him for some time (they attend the sameschool). He also said that the suspect had told him that he was going to 'petrol bomb' his house. The investigation was delayed for over a month after the victim was spoken to. The school was not informed about the incident for over two months. We found little evidence of enquiries taking place to locate the suspect despite the fact he attended the same college as the victim. The initial response was poor with no record of whether there were visible injuries (the victim said he had been punched in the face). There were significant delays before any further contact was made by the police with the victim and his family. The victim subsequently reported a further robbery in which the same boy was named as a suspect. On this occasion the victim told police that the suspect held a handgun to the head of the victim. The delays and inaction by the force have left this boy and his family exposed to further risk.

A 9-year-old girl called her grandmother and told her that she could not wake her mother. The girl's grandmother contacted police. Information on police systems highlighted a history of domestic abuse, drug abuse and child neglect concerns. The initial police response was prompt and effective, leading to the mother being arrested for child neglect and the girl (correctly) being taken into police protection, after disclosing she was often left alone and without food. However, following this the investigation was delayed unnecessarily. Opportunities were missed in the collection of evidence (including medical evidence). The officer in charge of the investigation was also changed several times which had a detrimental effect on and caused further drift in the investigation. At the time of the inspection the case had only recently been submitted to the Crown Prosecution Service for a charging decision to be obtained, nearly six months after the incident occurred. There was no strategy meeting in this case, or in relation to an earlier similar case, which undermined the development of an effective and joint protective plan.

Breakdown of case file audit results by area of child protection

Table 3: Breakdown of case file audit results by area of child protection

Case type	Good	Requires improvement	Inadequate
Enquiries under section 47 of the Children Act 1989[18]	9	1	1
Referrals relating to domestic abuse incidents or crimes	5	6	4
Referrals arising from incidents other than domestic abuse	4	5	1
Children at risk from child sexual exploitation arising from the use of the internet	2	0	9
Children at risk from child sexual exploitation arising out of local contact and not from the internet	1	1	6
Children missing	2	3	5
Children taken to a place of safety by police officers using section 46 Children Act 1989 powers[19]	1	3	2
Sex offender management where children have been assessed as at risk from the person being managed	0	3	3
Children detained in police detention	1	5	2

[18] Local authorities, with the help of other organisations as appropriate, have a duty to make enquiries under section 47 of the Children Act 1989 if they have reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm.

[19] Under section 46 of the Children Act 1989, the police may remove a child to suitable accommodation if they consider that the child is at risk of significant harm. A child in these circumstances is referred to as ‘having been taken into police protection’.

The force’s response to enquiries under section 47 was mostly good, and in some of the other cases examined the initial response to safeguarding was also found to be good. However, the case audits undertaken as part of this current inspection by both the force and HMIC have highlighted that there are several areas for improvement in relation to the force's arrangements for the protection of children, in particular the response to CSE and those children reported missing or absent.

5. Initial contact

It is clear that Leicestershire Police has invested time in training frontline staff about their role in safeguarding, and this has improved their awareness of responsibility. Since 2016 the force has run over 2,000 sessions of its protecting vulnerable people training (known as PVP4) throughout the force with the use of video clips, supported by supervisors engaging with their staff. Staff we spoke to during the inspection valued both the content and style of training.

More recently the force has produced a film about a young girl – Kayleigh Haywood – who was groomed and subsequently raped and murdered. The film uses the circumstances of Kayleigh's murder to raise public awareness of the risks of grooming. Within the first 24 hours of it being posted online more than one million people were reported to have watched the film. A series of training packages are easily accessible on the force intranet and offer additional information and short videos on priority areas such as domestic abuse, CSE and safeguarding.

Inspectors saw some good examples where officers responded quickly to clear and specific concerns about the immediate safety of children. Officers attended promptly, and effectively carried out preliminary tasks, such as ensuring the immediate safety of children, securing evidence and making an assessment of how best to proceed. Officers undertook thorough initial enquiries and used their powers to arrest when necessary, as the following examples show.

An anonymous call was made to the police about an argument occurring at an address where there were three girls aged one, three and ten. The force responded promptly to the call and a man was subsequently arrested.
An effective and prompt investigation followed, which led to the man being charged with assault. The Crown Prosecution Service acknowledged the quality of the investigation, referring in particular to the video-recorded interview and body-worn video cameras the police used at the time of the incident. Children's social care services was engaged from the outset. Domestic support was also provided through the Strengthening Families Programme, with progress updates being recorded on police systems. The outcomes for the victim and children in this case were good, which demonstrated strong multi-agency working and resulted in positive comments from the victim regarding her life after the assault.

The friend of a 17-year-old boy contacted the police to report that he had posted messages on an online forum intimating that he intended to take his own life the following morning by walking in front of traffic on the way to school. A good initial response from the contact management department (CMD) identified the boy, and the fact he had been recently treated for depression. Officers were sent to check on the boy's welfare, ensuring he was spoken to at the earliest opportunity in the presence of his parents. Safeguarding measures were put in place through the child and adolescent mental health service. Officers left the boy in the care of his supportive parents, who also submitted a vulnerable child notification form. Police dealt with this incident sensitively and effectively.

The CMD manages both call handling and the dispatch of resources to reported incidents. All CMD staff have received training in the use of the National Decision Model (NDM)[20] and THRIVE (threat, harm, risk, investigation, vulnerability and engagement), which is used to assess the initial police response to incidents (including child protection concerns). They have also received awareness raising training on vulnerability related to children. However, front office enquiry staff, who are also part of the CMD, have not received training on vulnerability.

The force has also invested in the assessment of child safeguarding risks within the CMD by providing, each day, a nominated detective sergeant with a child protection background to be available to provide advice and guidance to staff within the CMD regarding incidents involving vulnerability.

We sampled reports made by the public to the CMD in which children were involved, but which were assessed as not requiring an immediate or prompt response. We found that, almost without exception, a note is entered at the beginning of every Storm[21] log stating whether children were present in the address or not. Inspectors viewed 20 logs at random to test this and found this to be consistent. In all but one case, children had been seen or were in the process of being seen.

The logs all showed elements of appropriate research being completed using Genie[22] and Niche[23] to ascertain if any previous incidents or risks were evident.

[20] The National Decision Model is a framework that the police service uses for decision-making processes. For further information, see *College of Policing - Authorised Professional Practice on National Decision Model*, College of Policing, December 2014. Available from: www.app.college.police.uk/app-content/national-decision-model/the-national-decision-model/?s=NDM

[21] Storm is the police command and control system used to manage and view all reported incidents.

[22] Genie is a search tool that enables checks across different force databases.

[23] Niche is a single police information management system.

Some searches were limited in nature, however, and some were undertaken after the decision had been made to allocate an incident to the diary car. We also found that the history of previous incidents was often missing, and that the rationale for decisions (based on THRIVE and the NDM) was rarely recorded. As a result, officers attending incidents may not have access to all the relevant information and it was often not possible to ascertain why decisions had been made.

Inspectors found officers worked well with other agencies to protect children and ensure their needs were met, and in the majority of cases examined found child notification forms (for a child protection concern) were completed when a child was at risk.

The initial response by officers to domestic abuse incidents in all the cases reviewed was generally good. They have a clear focus on the child. Officers completed domestic abuse, stalking, harassment and honour-based violence (DASH)[24] risk assessment without exception; and the children are clearly at the forefront of officers' minds, evidenced by the completion of child notification forms. Police generally checked on children to ensure that they were safe and well. We found a clear focus on children when officers attend incidents of domestic abuse.

Recommendation

Within three months, Leicestershire Police should:

- review its processes to ensure that staff (particularly those in the CMD) draw together all available information from police information systems in a timely way better to inform their responses and risk assessments. This should include ensuring that the information held on Modus (in relation to domestic abuse) is accessible to contact management staff and both response and investigating officers.

[24] DASH is a checklist for the identification of high risk cases of domestic abuse, stalking, harassment and 'honour'-based violence

6. Assessment and help

The force, together with its partner organisations, has invested time and resources in the development of the safeguarding hub that brings together staff from police, local authorities and other agencies (such as health and children's social care services) to share information and ensure a timely, consistent and coherent approach to protecting children.

Referrals identifying child vulnerability are sent to the police child referral desk (CRD) situated within the child abuse investigation unit (CAIU). This is the route for information exchange and inter-agency planning on all child protection concerns across Leicester, Leicestershire and Rutland. Leicestershire County children's social care services has co-located a team manager and social workers within the CRD since April 2015. Staff explained that this has led to significant improvements in working relationships, and a greater understanding of the roles and responsibilities of each agency.

The force holds strategy discussions with partner organisations when required. This helps to decide the basis for any criminal and safeguarding investigation, which agency or agencies will deal with the case, and how the case will be progressed. These discussions are conducted either within the CRD directly with co-located staff, or via the telephone for those cases within Leicester city.

During the inspection we observed a positive initiative where a team, made up of staff from the CAIU and social workers from the county local authority, is available each day to undertake joint visits. The co-location of partner organisations with the police enables this model to operate. This demonstrates both a clear commitment to joint working and also makes it possible to respond quickly to incidents requiring such visits.

We found some good examples of agencies working well together, identifying risks, making plans to reduce risk and supporting children and families. However, despite this HMIC found in some of our case audits neither evidence of a strategy discussion or meeting taking place nor detail of what information had been shared (even if a meeting or discussion had occurred). The consequence of this is that a joint plan to investigate the case and safeguard the children involved is not recorded, and this increases the risk that officers attending incidents or undertaking investigations are not adequately informed of relevant and important details that are crucial to decision making and the safeguarding of vulnerable children, as the following examples show.

The mother of three young children contacted police to report a domestic incident where a man known to the victim was trying to run over her and her partner. The victim was injured during this incident, and one of the children was nearly assaulted. The investigation was conducted to a good standard, the suspect was charged and bail conditions were imposed to ensure the safety of the victims. The officers submitted a vulnerable victim form which was shared with social services. However, none of the children was seen or spoken to, there was no record of a joint assessment of risk, or of a strategy discussion taking place, or of any continuing safeguarding support for the family.

A local school headteacher contacted the police following a disclosure by a 14-year-old student that a man had asked her to touch his penis in a park. There was a good initial response to this case, followed by a prompt interview of the child, which established that she and the suspect had also been in contact via social media. A referral was made to the local authority, however there was no record of a strategy meeting taking place, and while the suspect was identified, he was not spoken to or arrested by the police.

Leicestershire Police has a team of police staff dedicated to attending case conferences[25] which includes both child abuse and, since November 2016, child sexual exploitation cases. Force attendance at both initial and review conferences is informed and prioritised by a flowchart designed with, and agreed by partners, providing guidance as to which cases require police attendance. In cases where the police do not attend, the force advised that a report is sent to the conference. While this may be appropriate in some cases, value could be lost when the police are not present to respond to or challenge discussions regarding a child's welfare, planning decisions or continuing need.

Performance on child protection conference attendance is reported upon monthly. In a three-month period (October to December 2016) there were 392 invitations to conferences, of which the force attended 56 percent of the priority conferences (initial and pre-birth) and 9 percent of reviews. Inspectors were told that some conferences were not attended due to resourcing difficulties, and that in some cases they had not been invited. Efforts continue to improve the process, and an additional member of staff is due to be appointed to help address the extra demand.

[25] A child protection conference brings together family members (and the child where appropriate), with the supporters, advocates and professionals most involved with the child and family, to make decisions about the child's future safety, health and development. *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015 (latest update). Available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

The force reported that work is continuing to explore and develop more innovative approaches to conferences and strategy meetings through the use of video conferencing. As this work is still in its early stages inspectors are unable to judge the impact that it will have on the abailty of the force to attend and actively participate in these important processes.

The force and its partner organisations have experienced an increase in the number of referrals being made. All referrals made by the police are assessed by children's social care services to determine which cases will be accepted having met the statutory thresholds. Those that do not are managed as contacts and therefore have no further intervention. In response to this, and to support the development of more efficient and effective collaborative partnership working, the force has deployed a member of staff in Leicestershire County Council's headquarters to work with both the city and county children's social care partners. The role is mainly administrative, but the force has recently concluded a recruitment process to allow the role-holder to make decisions about child protection matters. This enables the force to improve assessments, as well as enabling more timely professional discussions, better identification of cumulative risk and supporting more effective and appropriate professional challenge.

In the cases assessed by inspectors, referrals were sent to social care following domestic incidents, but on many occasions no response was recorded on police systems. We found little evidence to indicate whether these were followed up by the force, meaning that strategy discussions to consider protective plans may not have taken place.

The force's response to missing and absent[26] children in Leicester, Leicestershire and Rutland is of concern. We assessed ten cases and judged five as inadequate, and three as requiring improvement. Only two relatively uncomplicated cases were graded as good.

Initial reports of missing people are recorded on police systems using a predetermined set of questions. An initial risk assessment is undertaken in the control room by the team leader following research by staff using police information systems. Where cases are graded as high risk, an inspector for the relevant geographic area will take control of the incident. In medium and low risk cases this responsibility falls to a sergeant. Staff we spoke to reported that it was sometimes challenging to have responsibility for managing a high-risk missing person incident, in addition to other critical responsibilities (such as those detained in police custody).

[26] A 'missing person' is defined by the police as anyone whose whereabouts cannot be established and where the circumstances are out of character, suggesting the person may be the subject of crime or at risk of harm to him or herself or to another. An 'absent person' is a person who is not at a place where they are expected or required to be and at no apparent risk.

The force also has a dedicated missing from home team (MFHT) based in the safeguarding hub, which provides specialist support to officers involved in managing cases of missing children. The MFHT has a blend of skills such as financial investigation and the ability to retrieve information from mobile telephones, all of which can assist the response to vulnerable children and adults who are missing. This practice is positive.

Inspectors found that those identified as high risk at the time of reporting receive a good response, evidenced by enquiries that are both timely and appropriate. However, there are clear inconsistencies in the assessment of risk, with many children assessed as medium who should have been high. Inspectors found that there were failures to recognise duly escalating or cumulative risk and other available information which suggested increased risk. We also found that the 25-point question set completed by call handlers can vary greatly in quality, which provides an inconsistent initial assessment process. Force policy requires that a check should also be carried out on the Genie system to ensure that information from all other force systems is drawn together to provide an holistic understanding of all the circumstances of the child and the risks they may be facing. This is not always recorded on the Storm log and in some cases there was no record that this has been undertaken.

In some of the cases we assessed where there were multiple missing or absent episodes there was an over-reliance on the last risk grading made which, in turn, was used to inform the assessed grade of the most recent episode, as opposed to making an assessment based on all the available information and circumstances of that particular report.

Leicestershire force policy states that children can be assessed as either absent or missing. However, if they are categorised as missing then they can only be graded as either medium or high risk. Children cannot be classed as absent if:

- it is their first missing incident;
- they are under 13 years of age;
- they have a CSE marker; or
- they have a profile within police systems to identify that they are at increased risk.

A child can only be categorised as absent for maximum of 24 hours. In the 12 months prior to the inspection Leicestershire Police had recorded 257 children as absent and 2,373 children as missing.

Inspectors found that the force response to those who were frequently reported as missing often disregarded obvious risk factors because a child's behaviour was not considered 'out of character', as the following examples show.

A 15-year-old boy who suffered from attention deficit hyperactivity disorder and Asperger syndrome and was abusing alcohol and drugs was reported missing by his mother. An entry on the force's missing person database system (COMPACT) stated "There is also a good chance he will return home of his own accord, but if he doesn't then this address will need to be checked". This indicates that the force relied on the child to return, rather than made efforts to find him and safeguard him appropriately. We saw this type of entry in several reports.

A child placed in Leicestershire from outside the county was incorrectly assessed as medium risk. The person making the report to police indicated the child was at risk of CSE and would abuse drugs and alcohol. However, the person also alleged that the child had committed serious sexual offences recently (but before the child was placed in Leicestershire), all of which occurred when the child was missing. Although it is clear that he had been missing on many occasions, the CMD indicated that it was the first occurrence because there was no other information on the Leicestershire systems and as a result a medium grading was applied. The child was located the same evening by care home staff. However, prior to the force being aware of this (and because of the medium grading) inspectors could find no evidence of enquiries being carried out to trace the child other than an email sent to another force. He subsequently went missing once again some days later and the previous grading of medium was (inappropriately) used to inform another medium grading. During this episode, he carried out sexual offences against young girls.

Police generally complete a 'safe and well' check when a missing child is located. The purpose of this check is to allow the police to ensure that the missing person is safe and not in need of medical attention or other support, but to also understand the circumstances of their absence, and if they have been victim of crime. The provision of independent 'return to home' interviews for children[27] is inconsistent, with 244 outstanding at the time of the inspection. Interviews with children at this stage can provide a wealth of information about why a child is running away, particularly when this is becoming more frequent and the child is reluctant to speak to police or other agencies. While Leicestershire Police does not have responsibility for the completion of return home interviews, the failure to conduct them presents a potential missed

[27] When children are found, they must be offered an independent return interview. Independent return interviews provide an opportunity to uncover information that can help protect children from the risk of going missing again, from risks they may have been exposed to while missing or from risk factors in their home. Further information can be found in *Statutory guidance on children who run away or go missing from home or care*, Department for Education, January 2014, available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf

opportunity to gather intelligence, and risk to future safeguarding. Also, in such cases inspectors found that there is seldom a 'trigger plan'[28] on the database used to manage the police response when a child is next reported missing. The case audits carried out by inspectors showed the force did not study the information from safe and well checks and return home interviews for frequently missing children to seek opportunities to improve their response to future episodes.

Force policy in Leicestershire also states that if a child is missing on three occasions in a rolling 90-day period, then this should automatically trigger a strategy meeting with partners. There was no evidence that this was happening consistently. In one case, inspectors found a child had been absent on four occasions, and missing five times in the previous 90 days, with no record of a strategy meeting having taken place. This means that opportunities to develop an appropriate multi-agency protective plan to support the child may have been lost or unnecessarily delayed.

Leicestershire Police refers domestic abuse cases assessed as 'high risk' to a multi-agency risk assessment conference (MARAC) for longer-term safeguarding plans to be put in place. A MARAC meets fortnightly for Leicester city and Leicestershire county cases, and once a month for cases in Rutland. Inspectors examined minutes of MARACs and assessed the risk management plans in eight cases involving children. MARACs were well attended by representatives from the force and a wide range of agencies. Information was routinely shared to protect both victims of domestic abuse and any children affected by it. The action plans arising for these conferences are stored on Modus, which is a confidential system accessed by partners; however, officers other than those in the DAIU do not have access to this database. The effect is that officers and staff dealing with domestic abuse cases do not have easy access to information on those cases discussed at the MARAC. Such access may assist in formulating the correct response and assessment of risk in further incidents when the DAIU staff are not available.

The force participates in Operation Encompass,[29] which provides specialist support to children whose families are involved in domestic related incidents.This is operating with Leicestershire county and Rutland's children's social care services where notifications are sent to schools. The force is assisting Leicester city children's social care services with its implementation of the process.

[28] A trigger plan is a plan to locate a child quickly when they go missing.

[29] Operation Encompass involves the reporting to schools before 9am on a school day when a child has been involved or exposed to a domestic abuse incident the previous evening.

All domestic abuse cases graded as high risk on the DASH forms are reviewed by a sergeant within the DAIU. In the last 6 months of 2016 there were 398 high risk cases, of which 164 cases were downgraded as a result of this process. We have serious concerns about the re-grading of high-risk domestic abuse incidents. Inspectors identified several examples where the re-grading was inappropriate, exposing victims and children within the family to unnecessary risk, as the following example shows.

> The female victim called the police stating her ex-partner was breaking into the house. Her children were present and the offender threatened to kill her, her children and then kill himself. The police attended promptly and arrested the suspect. A risk assessment was completed as high risk, noting the threats to kill during the most recent incident and highlighting another occasion where the ex-partner threatened to collect one of the children ,from nursery and slit her throat. His escalating behaviour was recorded as was the fact that the abuse has been continuing for some time. The DAIU downgraded this case to medium risk (wrongly) stating there were no threats made to the children. This matter should not have been re-graded.

Of the 10 investigations we sampled, nine were incorrectly downgraded. We found that the DAIU downgrades incidents in which there is clear evidence of escalation, often based on an incomplete understanding of the details of the case. Sergeants within the unit use a standard explanation for the change in risk levels, which states that unless a domestic homicide is imminent the matter should not be shown as high risk. Inspectors also had concerns that some of the language used to describe and assess risk is sometimes too vague, for example: "threats have been made to kill her but there are no details of when or where".

We have shared with the force these immediate concerns. The force advised that it has amended the process such that high-risk cases can now only have their risk level amended on the authority of an inspector, and that it will review the 164 cases previously downgraded.

Recommendations

Immediately, Leicestershire Police should:

- review its use of enhanced risk assessments for high risk domestic abuse cases. This should incorporate a review of those high risk cases previously downgraded through the use of this process.

Within three months, Leicestershire Police should:

- take steps to improve practice in cases of children who go missing from home. As a minimum, this should include:
    - improving staff awareness of their responsibilities for protecting children who are reported missing from home and, in particular, those cases where it is a regular occurrence;
    - improving staff awareness of the links between children going missing from home and the risk of sexual exploitation;
    - improving staff awareness of the significance of drawing together all available information from police systems, including information about people who pose a risk to children, better to inform risk assessments;
    - ensure that all relevant information can be accessed on a single database, or made available to inform the assessment of risk; and
    - arrangements for assessing performance should include a sample of missing cases to ensure that risk is properly assessed, risk factors are addressed and actions identified to break the cycle of children who go missing repeatedly.

7. Investigation

Our inspection considered the extent to which Leicestershire Police child protection investigations are thorough, timely and demonstrated that the needs of children are central.

Throughout the inspection, it was apparent that most staff responsible for managing child abuse investigations were committed and dedicated to providing the best service and outcome for children. Inspectors witnessed some good examples of child protection work by police officers who displayed a mix of investigative and protective approaches. This ensures that the safeguarding of children remains central to their efforts while all criminal investigative opportunities are pursued, which was particularly evident in the section 47 case audits, as the following examples show.

Children's social care services made a referral following contact by a school where a 7-year-old female pupil arrived with a scratch on her cheek. When asked, the girl said her mother had caused the injury. A strategy discussion took place and it was agreed that a section 47 investigation would be undertaken. A joint visit was made to the girl at school, where she was listened to and confirmed that her mother had scratched her face. The investigating officer spoke with the family support worker, the school safeguarding lead, and also the mother who provided a consistent account of how the injury was caused. Following discussions with supervisors it was correctly agreed that there was no requirement to conduct a video recorded interview or a forensic medical in this case, as no further police action was required. It was agreed that a social worker would work alongside the mother and child to provide support, and help address her needs.

Operation Eastern centred on a girl in the care of the local authority who was placed into a Leicestershire children's home because she was at risk of CSE in her home county. She began to go missing regularly, during which she was engaging in sexual activity with older men. Analytical work on her phone identified that one of these men was known to the police for serious offences, such as rape and drug supply. During a further missing episode, she was located at the home address of the man who was issued with a child abduction warning notice (CAWN). The following day the girl was again located at the man's home address at which point he was arrested. Further enquiries identified contact with other children for which he was served with additional CAWNs. The force, in support of its investigation, used covert tactics including surveillance. A warrant was subsequently executed at his home resulting in the recovery of drugs. The man was charged with child abduction.

The three force investigation units (FIUs) deal with any investigation that does not meet the threshold of being allocated to a specialist team, and is not suitable for the neighbourhood teams. Cases vary from common assault to armed robberies, and are allocated each day by the investigation management unit. Staff reported they carried between 12 and 20 cases each.

We found investigations within these units (particularly child sexual offences) were sometimes delayed and were of a poorer standard compared to those undertaken by the specialist teams. We found that staff within these units, although committed, lacked the training and specialist skills to carry out child abuse investigations effectively that did not meet the threshold for investigation by specialist teams. We also learnt that the FIU itself does not routinely review or audit its investigations to ensure the cases being allocated to the teams are appropriate, as the following example shows.

> A case where indecent images of children had been identified by the child exploitation and online protection centre was referred to the force in April 2014. It was initially responded to in a timely manner, with the warrant being executed within a matter of days by POLIT officers, but we found no evidence of a plan as to the action that would be taken in relation to the three individuals identified at the address. They were not arrested, but were spoken to under caution.
> There was then a delay of nearly a month before a strategy meeting was held in relation to one of the suspects who worked as a librarian. The officer in the case subsequently went on long-term sickness absence and the case was reallocated to another officer within FIU, who was not a trained detective. At the time of the inspection this investigation was continuing but had yet to be resolved. We consider the delays in this investigation to be unnecessary and unacceptable. Despite there being regular supervisory updates, they were ineffective, as this is a complex investigation which has been allocated to an inexperienced officer where appropriate action has not been identified, potentially leaving victims at risk. The delays have also had a significant effect on the suspects and their families.

Inspectors examined 19 cases involving child sexual exploitation and found 15 to be inadequate and one required improvement. In the majority of cases, the initial response was timely and effective with the appropriate referral forms completed. However, although a strategy discussion should take place once a referral is received by the CRD and the thresholds are met, there was no record of this happening in the majority of CSE cases reviewed; neither was there information about what has been shared, or about the decisions made. What is more, there was no evidence in any of the cases examined of any further strategy meetings held to assess progress and decide upon future action to investigate the offence and safeguard of the child.

The force uses a grading system following an assessment of risk by a detective sergeant for cases of CSE. The levels of grading are either 1, 2 or 3.[30] The force uses these to identify the department which will investigate the case. This approach has created a lack of clarity and consistency in application. CSE 1 cases are allocated to the force CSE team. This team is multi-agency, consisting of police, health, education welfare, children's social care, and a dedicated analyst. All three local authorities are part of the team (city and both counties), but Rutland local authority works remotely. The FIU manages CSE 2 cases, and CSE 3 cases are reports where there are elements of CSE, but additional work is required (by safeguarding PCSOs) to confirm CSE is taking place.

At the time of the inspection the force based its assessment of risk upon the incident rather than the child. This process is complemented by information shared by partners at a multi-agency CSE meeting. The purpose of the meeting is to ensure all information across the partnership is shared to provide an accurate assessment of risk. Partners such as children's social care, health, police and youth offending services from across the county are very well represented at the CSE meeting, which is an innovative and constructive approach to responding to CSE.

When a case was graded 1, and the matter allocated to the force CSE team, a joint investigation took place. Where the case (levels 2 and 3) was not given to the specialist CSE team but passed to non-specialists, no joint investigation was apparent and details of investigation plans and actions were not well recorded within the police systems.

There were frequent delays in arresting named suspects. In several cases, identified suspects were not spoken to, particularly if the CSE team did not consider the age gap between the victim and alleged perpetrator to be significant. Proactive activity, such as enquiries to identify potential perpetrators and disrupt their activity, was limited in cases where there was no complaint. The multi-agency CSE team did not take into account wider safeguarding considerations, including the potential risk to other children from suspects.

Referrals relating to CSE are sent to the CSE referral desk (situated within the multi-agency CSE team) for assessment, with a detective sergeant conducting strategy discussions where the thresholds are met. This process was recently merged with the CAIU CRD function, but during this inspection that decision has been reversed. While these changes to the processes of assessing risk and categorising CSE reports followed feedback from HMIC during this inspection, it is too soon to evaluate their effectiveness. However, the responsiveness of the force is extremely encouraging.

[30] CSE 1 – high risk that a child is being exposed to sexual harm in an exploitative situation, context or relationship. CSE 2 – risk that a child is being exposed to sexual harm. CSE 3 – indicators of risk that a child may be exposed to sexual harm.

The force has recently introduced safeguarding PCSOs who conduct work on behalf of teams. These PCSOs regularly receive actions from the CSE meeting to work with vulnerable children and provide support to them and their families. This is positive and helps to build the confidence of victims to report in the future and engage with intervention services. These PCSOs also conduct work with hotels, and the force plans for them to do further disruption work with taxi companies in the future. The actions they carry out are updated onto Niche records and also recorded within a spreadsheet to better understand workload.

Despite the fact that the force flags in its police systems children who are identified as being at risk of CSE, there is inconsistency in trigger plans for the highest risk cases. The force expects that every incident that the referral desk identifies as CSE 1 should be brought to the attention of the missing person team so that it can add a trigger plan to TABS (the section of Niche which records and allocates tasks). This means that every CSE 1 child should have a trigger plan attached to TABS which is visible to the control room and attending officers/supervisors to ensure the appropriate response. However, HMIC found examples of such cases where the trigger plan was missing. The impact of this is that response officers and staff are not informed about the history of these cases.

In cases where a child was reported missing, but was also shown on force systems as being at high risk of CSE, inspectors found that the risk assessment for the missing episode did not reflect this. The effect was that enquiries were not appropriately risk assessed and action to trace, find and safeguard the child was not accelerated. Moreover, the voice of the child was not evident in most of the cases examined, and information in relation to children at risk of CSE was not always updated either onto their TABS or COMPACT records. This meant that frontline staff were not aware of the level of risk in relation to the child when dealing with incidents including missing episodes, as the following examples show.

When a 15-year-old girl who had been reported as missing returned she said that she had been drinking alcohol and had engaged in sex with an older male aged 17 years, as well as having previously "done stuff" with another male. This was graded as CSE 1 but the case did not initially go to the CSE team, but to the FIU, and enquiries into the suspects were not undertaken. Subsequent incidents involving the same child had been categorised at CSE 3. The child had been reported missing four times and despite making reports of being drunk, taking drugs and various instances of sexual activity she was identified as at medium risk of CSE and very little action was taken to locate her. There was no TABS record, which is a record on the police system which should highlight the risk of CSE and priority actions that could protect the child. The child's Compact missing record did not display any strategy or information regarding the risk posed to the child or actions that should take place. The child was discussed at the CSE meeting on three occasions in a month. The first two meetings failed to instigate any meaningful activity to protect the child. The risk to the child was finally recognised at the most recent meeting and appropriate actions agreed.

The police received information about an address where young girls were suspected of living with older men. Officers attended four days later and found two 15-year-old girls and two 18-year-old men in the flat which was littered with needles and very dirty. The information about the incident was not properly recorded on police systems and no action was taken to ascertain whether any offences had occurred while the girls were in the house There was also no record to show these males had been spoken to. A referral was made promptly to children's social care and visits made to the home address of both children and parents, who were provided with advice and information. The case is still ongoing.

Following feedback from HMIC at the time of the inspection regarding the assessment process, the force amended it to ensure the assessment was based on the risk to the child rather than the incident, and use the THRIVE framework to assist the process. The force also changed the frequency of its multi-agency CSE meeting from weekly to daily. The force implemented these changes during the inspection. It is therefore too early to assess the resultant effect and consistency of outcomes.

Staff involved in investigations of CSE also reported that they had previously experienced delays with the analysis of electronic devices. The force has recently identified that there was a backlog of 150 submissions within its digital forensics unit that had not been examined, the oldest of which had been in the possession of police for twelve months. As a result, the force decided to fund the external examination of these devices. HMIC was pleased to note that there is currently no backlog in phone examinations.

The force is now planning to create a new digital hub to bring together several teams such as the POLIT, high-tech crime unit (HTCU), cyber-crime unit and digital media investigators (DMIs) to streamline processes and improve its capacity and efficiency.

The standards of investigation were mixed in the domestic abuse cases that we assessed. Where cases were graded as medium risk by the responding officers, the domestic abuse support team reviewed the case and assisted the neighbourhood policing teams to mitigate risk and make referrals to support agencies, while the FIU retains the criminal investigations. High-risk cases are allocated to the DAIU, which deal with the entire case. In these cases, the investigation was generally of a good standard. However, when an investigation was allocated to the FIU the focus on the child diminished. There were also delays identified in the investigation, some of which were significant, as the following examples show.

A DAIU detective sergeant changed the risk in a domestic abuse investigation from high to medium. This is despite the suspect hitting a 10-year-old child's head against a sideboard and assaulting the child's mother. This case identifies the need for a broader understanding of risk, as the sergeant who changed the risk stated that there needed to be a risk of domestic homicide for a case to be high risk.

The police received a report of assault on a victim by her partner, including reversing a car into her and punching her body, while her two children were present. The police responded promptly, with the attending officers completing detailed risk assessments and referrals. However, inspectors found little evidence of supervision, and significant delays and periods of inactivity. Over a month after the incident the suspect was interviewed, after which there was a further delay of five weeks before the victim was updated. At this point the victim withdrew her allegation.

The force has worked with the regional CPS to improve the timeliness of decision making and the quality of case files. Currently the agreed timescale of 28 days for the return of files to the force is not being achieved. Staff also reported delays in being able to obtain an appointment to meet with the rape and serious sexual offences lawyers to obtain advice about cases. When delays occur in gathering evidence and in the receipt of charging decisions from the CPS, the length of time between the first call to police or children's social care services and a criminal justice outcome can be considerable. Delays are not in the best interests of children, nor do they serve the suspect who may be on bail or in custody.

Recommendations

Within three months, Leicestershire Police should:

- take action to improve child protection investigations, paying particular attention to:
    - ensure investigations are supervised and monitored regularly and, at each check, the supervisor reviews the evidence and any further enquiries that need to be undertaken; and
    - review the type of cases being held within the force investigation unit to ensure those staff are adequately trained to undertake those investigations.
- take action to improve the investigation of child sexual exploitation, paying particular attention to:
    - ensuring a prompt response to any concern raised (including the timely arrest of suspects) ;
    - undertaking risk assessments that consider the totality of a child's circumstances and risks to other children; and
    - improving the oversight and management of cases (to include auditing of child abuse and exploitation investigations to ensure that standards are being met).

8. Decision-making

Our inspection considered the extent to which decisions taken by Leicestershire Police in child protection cases are child-centred, prioritise their needs and are based on good-quality evidence. These decisions may include the removal of a child from his or her home, to work jointly with other agencies or organisations to protect a child, to find and increase the number of sources of evidence that an offence may be taking place, and to conclude a case (for instance, through a charge, or through no further action being taken).

When the case was clearly defined as a child protection matter from the outset, the police response was generally appropriate, and inspectors found examples of effective decision-making to protect children. When there were significant concerns about the safety of children such as parents leaving children home alone or being unable to appropriately care for them, leaving them at risk of significant harm, officers handled incidents well, using their powers appropriately to remove children from harm's way. It is a very serious step to remove a child from their family by way of police protection. In the cases we examined, decisions to take a child to a place of safety were well considered and in the best interests of the child. We found that the appropriate police protection forms had been scanned on to the Niche record and were completed correctly.

However, there was a tendency to remove children to police stations as a place of safety rather than directly in to local authority care. The local authority was contacted in all cases within a reasonable time but there were delays in the local authority being able to find placements. This left children waiting at police stations, which is not in their best interests, as the following example shows.

> In July 2016, the force received information that child abuse files were available for sharing from an address in Humberside. The suspect was a registered sex offender with a previous conviction for the possession of indecent images of children (IIOC). The suspect was arrested in August for the possession and distribution of IIOC, and images were found on his computer. A crime record was finally created the day before he was due to appear to answer his bail and be charged in November.

In five of the six cases examined, there was no strategy meeting following the use of police protection powers. This led to difficulties for the police in identifying what the local authority was doing and whether police protection was still required.

With the exception of cases involving children at risk of sexual exploitation and missing from home, inspectors found evidence that frontline staff made effective decisions in the early stages of child protection matters. Inspectors found a good

level of understanding among frontline staff of the need to record and report information that had come to their attention when attending an incident involving concern for a child.

While there were examples of officers taking appropriate protective action, inspectors were concerned about the poor standard of recording on police systems throughout the force. Accurate and timely recording of information is essential for good decision making in child protection matters. In the cases seen, inspectors found that information, particularly in relation to strategy meetings, safeguarding plans and contact with children and families, was frequently incomplete or missing.

Recommendation

Within three months, Leicestershire Police should

- take steps to ensure that all relevant information is properly recorded and is readily accessible in all cases where there are concerns about the welfare of children. Guidance to staff should include:
    - what information should be recorded (and in what form) on systems to enable good quality decisions;
    - meetings where actions are allocated and decisions made should be minuted to ensure a comprehensive audit trail; and
    - the importance of ensuring that records are made promptly and kept up to date.

9. Trusted adult

Inspectors considered the extent to which officers and staff did what they said they would do. This included examining agreements that are made, are child-centred, and relate to protecting and helping them

In some cases, though not all, it was clear that when the concern was serious and immediately recognised as a child protection matter, officers carefully considered the approach to the child or parents and explored the best ways to engage with the child. This sensitive approach resulted in stronger relationships between the child and police, as the examples later in this section show.

Inspectors therefore found several cases where the decisions reached clearly took account of the needs of children. However, they found very little information in the majority of case files about the views of the child, the impact of the concerns identified in the case on the child or the outcomes of police intervention for the child.

We also found that insufficient consideration was given to children at risk of sexual exploitation and those who went missing from home. The examples referred to in previous sections of this report suggest an underdeveloped response to these cases.

Inspectors found evidence that, when the concern was serious and immediately recognised as a child protection matter, the force worked well with partner organisations, family members and other individuals to better protect a child. The approach to the child or parents (even when the parent was a suspect) was carefully considered, and the best ways to engage with the child were explored. This sensitive approach resulted in effective safeguarding outcomes for those children involved, as the following exaple shows.

> The victim in this case was shopping with three of his children when he was assaulted and threatened in front of them by another man. The control room call taker was able to hear the distress of the children when the call was made and (appropriately) decided to record it as a priority response. The response by the attending neighbourhood officer and subsequent enquiries were of a high standard and the children were the focus of their efforts. A child and vulnerable adult form was submitted in a timely fashion, and shared with social services as the victim suffered from epilepsy and depression, and the children were clearly distressed by the incident they had witnessed. The strengthening families team offered support to the family. This investigation was entirely child-focused and is a good example of children and vulnerable adults being at the centre of an investigation.

However, in most of the cases inspectors assessed, we found limited information about the views of the child, the effect of an offender's behaviour on the child and the outcomes of a case.

Recommendations

Within three months, Leicestershire Police should ensure that:

- staff record the views and concerns of children;
- staff record the outcome for the child at the end of police involvement in a case; and
- staff inform children, as appropriate, of any decisions that have been made about them.

10. Managing those posing a risk to children

Our inspection considered the extent to which officers and staff in Leicestershire Police identify those who pose a risk to children and young people, and work with staff from partner organisations to protect children from them.

The force has a team dedicated to multi-agency public protection arrangements, to manage known registered sex offenders (RSOs) and other dangerous individuals. The management of sexual offender or violent offender teams are frequently referred to by the acronym MOSOVO.

There are currently 860 registered sex offenders in the communities across Leicestershire. The teams were dealing with a caseload that inspectors considered to be reasonable. Police support staff are managing between 45 to 60 offenders each, and the MOSOVO detectives manage between 20 to 30 offenders, all of whom are high risk.

Officers are trained in the use of the active risk management system (ARMS).[31] Inspectors were pleased to note that at the time of the inspection 93 percent of offenders had been the subject of an ARMS assessment and that officers were proactively using these assessments to monitor and reduce risk.

The force has implemented a reactive management model to deal with offenders. This approach came about as the result of a serious case review involving the management of high risk offenders. The force does not use set timescales for visits, assessments or reviews. While this initiative is a pragmatic means of dealing with low risk, it is not in line with national guidance. However, the force is aware of this and the MAPPA[32] strategic management board approved the decision, which is part of a pilot with Kent and Lancashire forces. This system relies on offender managers being aware of information, incidents and intelligence relating to their offenders and assessing whether this affects the level at which they are managed and resultant activities.

We found links between the MOSOVO and neighbourhood policing teams to be good. Neighbourhood policing teams play a vital role in the development of community intelligence about offenders, and officers were aware of registered sex

[31] ARMS is a structured assessment process to assess dynamic risk factors known to be associated with sexual re-offending, and protective factors known to be associated with reduced offending. It is intended to provide police and probation services with information to plan management of convicted sex offenders in the community.

[32] Multi-agency public protection arrangements. For further information see: *MAPPA Guidance 2012 version 4*, Ministry of Justice National Offender Management Service, February 2015 (latest update). Available at: www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2.

offenders living in their area. They also accompany MOSOVO staff on visits and be deployed to fill any intelligence gaps surrounding those RSOs.

Multi-agency public protection meetings to develop and oversee risk reduction plans for registered sex offenders were generally well-conducted and well attended by agencies. Risks to children were identified, plans were put in place and (as above) neighbourhood officers were alerted to specific sex offenders living in their area.

Within the case audits inspectors found limited evidence of proactive work being undertaken. The standard of investigation into breaches was generally poor with long delays evident. For example:

> The police were contacted by the probation service in November 2016 regarding an RSO who was convicted of child abduction in 2016. When he was sentenced he was given a sexual harm prevention order, which places prohibitions on an offender for the purpose of protecting the public or vulnerable children and adults. The social worker of the child he is prevented from contacting stated that the child had been in contact with the RSO. The police conducted enquiries to obtain evidence in relation to the breach identify that the offender has been in contact with the child on over 200 occasions within a six-week period. At the time of the inspection the RSO had not been arrested, and it took over two

> An RSO went to the police station for a routine visit with his offender manager. The offender manager asked to see the offender's mobile telephone (this is a condition of his sexual offences prevention order (SOPO) which required him to allow his phone to be examined for images and internet history). The officer seized the phone as he believed that the internet search history had been deleted (this is contrary to the conditions of the court order). The examination revealed several breaches, including deleted search histories and failures to present it previously. He was interviewed and required to appear in court to answer for the breaches of SOPO and notification requirements. However, this investigation had long delays, examination of the mobile telephone took over two months, and it took over five months (from the initial admission of breach of SOPO) to submit a file to the CPS.

The force POLIT deals with all referrals from the National Crime Agency, and uses the child protection system to identify paedophiles sharing and distributing indecent images of children. They also work closely with the force's hi-tech crime unit (HTCU), which is responsible for the examination and triaging of electronic devices. Prior to July 2016, the POLIT team dealt only with those cases identified by the child protection system as high risk. This meant that some 520 cases were not subject of assessment or investigation. Further analysis by the force identified that these 520 cases equated to 150 individual users. The force has subsequently deployed

additional staff into the team, enabling it to investigate all cases on the system, to identify suspects. Once a suspect is identified, the team carries out a risk assessment and undertakes enforcement. POLIT recognises that it needs to improve still further how it identifies victims, and has recruited a victim identification officer into the team to develop this area. Inspectors were pleased to see that there are currently no backlogs.

The force also has a regional capability (shared with other forces) to deploy covert resources, with a newly created covert online team, which the had provided opportunities to target perpetrators posing significant risk to young people.

11. Police detention

Our inspection considered the extent to which children and young people are detained in police custody only when absolutely necessary. We sought evidence that children in custody are protected from harm and every effort is made to release them or to transfer them to more appropriate accommodation.

The force provides child protection training to all custody sergeants as part of their rolling programme of detention and custody authorised professional practice training. It has also taken steps to raise awareness about vulnerability for all officers via the force intranet. However, training in child protection has yet to be extended to custody detention officers (who are provided by an external company).

Inspectors were pleased to see that in all the cases reviewed, the investigating or arresting officers completed vulnerable person notifications, which were sent to social care services to alert them to the circumstances of children who had been arrested.

Although we were told that both the Leicestershire Youth Offending Service and the appropriate adult[33] scheme provided an efficient service, inspectors noted that the attendance was often linked to the times of interviews rather than to the need to support a child in detention. This is leading to unacceptable delays. The cases we examined revealed significant delays for children presented to custody before consulting an appropriate adult; in the case of one 14-year-old, it was over 18 hours before the child had access to an appropriate adult, and in a further two cases there were delays of more than 18 hours.

Inspectors examined eight cases of children in detention. They had been detained on suspicion of offences that included theft, common assault and criminal damage. In the cases examined all were charged and refused bail. In cases of post-charge detention, the local authority is responsible for providing appropriate accommodation if a child is to be detained overnight.[34] It is only in exceptional circumstances that the transfer of the child to alternative accommodation would not be in the child's best interests. In rare cases, for example if a child presented a high risk of serious harm

[33] Under section 63B of the Police and Criminal Evidence Act 1984 an appropriate adult is a parent, guardian, social worker or any responsible person over 18 years old and is not a police officer or a person employed by the police. In England and Wales, an appropriate adult must be called by the police whenever they detain or interview a child or vulnerable adult. An appropriate adult must be present during a range of police processes, including intimate searches and identification procedures, to safeguard the interests of children detained or questioned by police officers.

[34] Under section 38(6) of the Police and Criminal Evidence Act 1984, a custody officer must secure the move of a child to local authority accommodation unless he or she certifies that it is impracticable to do so or, for those aged 12 or over, no secure accommodation is available and local authority accommodation would not be adequate to protect the public from serious harm.

(which is defined as death or serious injury, whether physical or psychological) to others, secure accommodation might be needed.

Record keeping was inconsistent and sometimes poor, which is a concern. This is particularly important when it relates to the legal grounds for taking the serious step of detaining children, the rationale for refusing bail, and explanations for not transferring children into local authority accommodation.

Detention certificates, which outline to a court the reason for a custodial remand, are essential for police accountability, and enable forces to monitor how they are discharging their responsibilities under the Police and Criminal Evidence Act 1984. Inspectors found only two records where detention certificates were completed in the eight cases reviewed. In the two cases where there was a detention certificate, they had not been completed correctly and the reasons for detaining the children were not given. Consequently, important information such as the justification for detaining the child in police custody overnight is not being recorded or shared with the court.

Leicestershire Police, the Youth Offending Service and Leicestershire County Council meet quarterly as part of a regular audit process to review instances where a child has been detained overnight post-charge. However, this review is limited to those cases where a juvenile detention certificate has not been completed, and therefore does not review cases where a detention certificate has been completed for either the quality of that certificate, or whether the recorded rationales regarding continued detention were correct.

Out of the eight cases examined we assessed one as good, five requiring improvement and two were inadequate. In five of the cases, the force had made a request for accommodation to the local authority. However, no children were transferred. This led to remands in custody of up to 17 hours post-charge.

Staff told us about the lack of appropriate bed provision in some cases for those children charged and detained, which the force and its partners have acknowledged.[35] The East Midlands custody procedures, which provide guidance to custody staff in relation to their custody duties and responsibilities, outline that any failure by a local authority to provide accommodation should be brought to the attention of the duty inspector and, if appropriate, escalated to the on-call superintendent. We found no record of this process being complied with in any of the cases examined.

In six cases that we reviewed, concerns – such as children having made recent threats to commit suicide or harm themselves – had been raised in the initial risk assessment. For such individuals there should be access to mental health nurses

[35] In January 2015, the then Home Secretary and the Education Secretary wrote to lead members for children's services highlighting problems in some areas in complying with the need to transfer children from police custody to local authority accommodation.

and also a drugs and alcohol service within the police custody suite. However, in the six cases we reviewed there was no record of these concerns being identified or recorded on the pre-release risk assessment when the care of the child or young person was transferred on to court. This means that receiving staff will not be aware of critical information and potential risks affecting that young person and their ongoing detention, as the following example shows.

> A 17-year-old boy was detained in custody for 38 hours. He was subject to a child protection plan due to neglect, suffering from depression and having self-harmed previously. The custody risk assessment also recorded previous threats to hang himself and that he was being assessed for schizophrenia. During his detention he was found to be self-harming with cutlery and was physically restrained by staff. The force's pre-release risk assessment stated he had medical problems for which he was seen by a health care practitioner while in custody, but assessed there to be no risk that the boy would threaten to commit suicide or self harm.

Section 136 of the Mental Health Act 1983 allows a police officer to remove an apparently mentally disordered person from a public place to a place of safety. Although a place of safety can include a police custody suite, such a suite should only be used in exceptional circumstances and it is preferable for the person to be taken directly to healthcare facilities such as a hospital. Inspectors were pleased to find that in the past year no children were detained in police custody under section 136 of the Mental Health Act.

The force has implemented a mental health triage car facility which it runs in partnership with mental health nurses, responding to those in need of immediate health support. This facility provides an improved service to those in need of such care and reduces the number of individuals detained in police custody when suffering from mental health illness.

Recommendations

Within six months, Leicestershire Police should:

- in conjunction with children's social care services, review how it manages the detention of children. As a minimum it should:
    - assess at an early stage the need for secure or other accommodation and working with children's social care services to achieve the best option for the child;
    - review the provision of both secure and alternative accommodation;
    - ensure that custody staff comply with their statutory duties by completing detention certificates and custody record entries to the required standard, if children are detained in police custody for any reason; and
    - secure adequate appropriate adult support in a timely manner.

Conclusion: The overall effectiveness of the force and its response to children who need help and protection

Leicestershire Police has demonstrated a strong commitment to prioritising the protection of children and to the development of a culture of continuous improvement. This is particularly evident among the chief officer team and senior officers who have invested in its staff to support these specialist functions and manage the associated demands, ensuring that those officers and staff possess the necessary skills and abilities, and are developed to fulfil their potential to undertake these critical roles.

This positive approach has ensured that staff are appropriately trained and that there are limited vacancies. This is at odds with the national trend where forces often encounter significant difficulties resourcing child protection investigative roles.

The force is also working with senior representatives from partner organisations, enabling them to scrutinise and challenge where appropriate, but as importantly to work co-operatively to assist the force in its response to child protection.

Senior leaders made a clear and unambiguous commitment that public protection and safeguarding are priorities for the force. It has increased its efforts to improve staff awareness of vulnerability and wider child safeguarding through training. This was evident in the knowledge and understanding of all the staff we spoke to, and in those teams undertaking safeguarding roles.

Inspectors found good engagement with frontline partners from across the three local authorities, which are brought together within the safeguarding hub to enhance the multi-agency response to child protection matters.

HMIC commends the force on its decision to ensure it has no backlogs within its POLIT team in dealing with online offending.

As highlighted in this report, we found some examples of good work by individual frontline officers responding to incidents of concern involving children, and that specialist staff responsible for managing child abuse investigations were knowledgeable, committed and motivated. Despite this, there are inconsistencies and some areas for improvement in the service provided to children, particularly in a domestic abuse setting, children who go missing and absent and those who are at risk of, or victims of, sexual exploitation. These inconsistencies need to be addressed to ensure all children are appropriately safeguarded.

The majority of cases we examined were found to be inadequate or requiring improvement. There were poor responses by some officers who often missed the wider risks faced by a child and failed to record their decisions appropriately.

Records of effective supervision were also poor and often delayed (when they did occur). These are not merely administrative exercises; they will help the force make the right decisions for and, take actions to protect, the safety of children in future.

The section 47 cases undertaken by specialists within CAIU demonstrate that where specialists undertake investigations and have the appropriate supervision, there is a positive outcome for a child; this now needs to be replicated across all areas of child protection to ensure consistency of service. HMIC acknowledges that the forthcoming schedule of audits proposed for 2017 should enable the force to identify areas of strong practice and areas for development that it can address quickly.

The inappropriate down grading of the level of risk faced by some victims of domestic abuse who are clearly at high risk is of significant concern. This approach places an unacceptable emphasis on the management of demand over risk and has potentially removed the opportunity from vulnerable victims and children to receive support and engagement from a wide range of partners who attend MARACs.

The response to children who regularly go missing from home also requires significant improvement, with a particular focus on early intervention that places emphasis on ensuring that officers and staff understand the link between children who regularly go missing and sexual exploitation.

Work to address CSE is also a priority and requires further development and co-ordination. The force has taken some significant steps to address this through a multi-agency response. However, it still has more to do to demonstrate that it is effectively able to identify and safeguard children at risk of sexual exploitation.

In cases of detention, we found that children were frequently detained in police custody after they had been charged, rather than being moved to more appropriate accommodation. It is incumbent upon the force to work with the local authority to ensure there is appropriate accommodation available to transfer children to. It is not in the best interests of any child to be detained in a police cell under the Mental Health Act 1983. Inspectors were pleased to find that children were not routinely detained in this way, and none had been detained in the 12 months before the inspection.

The force has already recognised and acknowledged the main areas of concern identified during this inspection, and its response to act quickly to address these areas is welcomed by HMIC, although it is not possible at this early stage to assess the effectiveness and consistency of the outcomes they will deliver. It must now maintain the momentum, both in relation to its commitment and the energy it has invested together with partners, to secure consistently good outcomes for children.

Summary of recommendations

Immediately

Leicestershire Police should:

- should review its use of enhanced risk assessments for high risk domestic abuse cases. This should incorporate a review of those high risk cases previously downgraded through the use of this process.

Within three months

Leicestershire Police should:

- review its processes to ensure that staff (particularly those in the CMD) draw together all available information from police information systems in a timely way better to inform their responses and risk assessments. This should include ensuring that the information held on Modus (in relation to domestic abuse) is accessible to contact management staff and both response and investigating officers.
- take steps to improve practice in cases of children who go missing from home. As a minimum, this should include:
    - improving staff awareness of their responsibilities for protecting children who are reported missing from home and, in particular, those cases where it is a regular occurrence;
    - improving staff awareness of the links between children going missing from home and the risk of sexual exploitation;
    - improving staff awareness of the significance of drawing together all available information from police systems, including information about people who pose a risk to children, better to inform risk assessments;
    - ensure that all relevant information can be accessed on a single database, or made available to inform the assessment of risk; and
    - arrangements for assessing performance should include a sample of missing cases to ensure that risk is properly assessed, risk factors are addressed and actions identified to break the cycle of children who go missing repeatedly.
- take action to improve child protection investigations, paying particular attention to:

    - ensure investigations are supervised and monitored regularly and, at each check, the supervisor reviews the evidence and any further enquiries that need to be undertaken; and
    - review the type of cases being held within the force investigation unit to ensure those staff are adequately trained to undertake those investigations.
- take action to improve the investigation of child sexual exploitation, paying particular attention to:
    - ensuring a prompt response to any concern raised (including the timely arrest of suspects) ;
    - undertaking risk assessments that consider the totality of a child's circumstances and risks to other children; and
    - improving the oversight and management of cases (to include auditing of child abuse and exploitation investigations to ensure that standards are being met).
- take steps to ensure that all relevant information is properly recorded and is readily accessible in all cases where there are concerns about the welfare of children. Guidance to staff should include:
    - what information should be recorded (and in what form) on systems to enable good quality decisions;
    - meetings where actions are allocated and decisions made should be minuted to ensure a comprehensive audit trail; and
    - the importance of ensuring that records are made promptly and kept up to date.
- ensure that:
    - staff record the views and concerns of children;
    - staff record the outcome for the child at the end of police involvement in a case; and
    - staff inform children, as appropriate, of any decisions that have been made about them.

Within six months

Leicestershire Police should:

- in conjunction with children's social care services, review how it manages the detention of children. As a minimum:
    - assessing at an early stage the need for secure or other accommodation and working with children's social care services to achieve the best option for the child;
    - review the provision of both secure and alternative accommodation;
    - ensuring that custody staff comply with their statutory duties by completing detention certificates and custody record entries to the required standard, if children are detained in police custody for any reason; and
    - securing adequate appropriate adult support in a timely manner.

Next steps

Within six weeks of the publication of this report, HMIC will require an update of the action being taken to respond to the recommendations that should be acted upon immediately.

Leicestershire Police should also provide an action plan within six weeks to specify how it intends to respond to the other recommendations made in this report.

Subject to the responses received, HMIC will revisit the force no later than six months after the publication of this report to assess how it is managing the implementation of all of the recommendations.

Annex A – Child protection inspection methodology

Objectives

The objectives of the inspection are:

- to assess how effectively police forces safeguard children at risk;
- to make recommendations to police forces for improving child protection practice;
- to highlight effective practice in child protection work; and
- to drive improvements in forces' child protection practices.

The expectations of agencies are set out in the statutory guidance *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, the latest version of which was published in March 2015. The specific police roles set out in the guidance are:

- the identification of children who might be at risk from abuse and neglect;
- investigation of alleged offences against children;
- inter-agency working and information-sharing to protect children; and
- the exercise of emergency powers to protect children.

These areas of practice are the focus of the inspection.

Inspection approach

Inspections focus on the experience of, and outcomes for, children following their journey through the child protection and criminal investigation processes. They assess how well the service has helped and protected children and investigated alleged criminal acts, taking account of, but not measuring compliance with, policies and guidance. The inspections consider how the arrangements for protecting children, and the leadership and management of the police service, contribute to and support effective practice on the ground. The team considers how well management responsibilities for child protection, as set out in the statutory guidance, have been met.

Methods

- Self-assessment – practice, and management and leadership
- Case inspections

- Discussions with staff from within the police and from other agencies
- Examination of reports on significant case reviews or other serious cases
- Examination of service statistics, reports, policies and other relevant written materials

The purpose of the self-assessment is to:

- raise awareness in the service about the strengths and weaknesses of current practice (this forms the basis for discussions with HMIC); and
- initiate future service improvements and establish a baseline against which to measure progress.

Self-assessment and case inspection

In consultation with police services the following areas of practice have been identified for scrutiny:

- domestic abuse;
- incidents where police officers and staff identify children in need of help and protection, e.g. children being neglected;
- information-sharing and discussions about children potentially at risk of harm;
- the exercising of powers of police protection under section 46 of the Children Act 1989 (taking children into a ‘place of safety’);
- the completion of section 47 Children Act 1989 enquiries, including both those of a criminal nature and those of a non-criminal nature (Section 47 enquiries are those relating to a child ‘in need’ rather than ‘at risk’);
- sex offender management;
- the management of missing children;
- child sexual exploitation (CSE); and
- the detention of children in police custody.

Annex B – Glossary

child	person under the age of 18
multi-agency public protection arrangements (MAPPA)	mechanism through which local criminal justice agencies (police, prison and probation trusts) and other bodies dealing with offenders work together in partnership to protect the public from serious harm by managing sexual and violent offenders; established in each of the 42 criminal justice areas in England and Wales by sections 325 to 327B of the Criminal Justice Act 2003
multi-agency risk assessment conference (MARAC)	locally-held meeting of statutory and voluntary agency representatives to share information about high-risk victims of domestic abuse; any agency can refer an adult or child whom they believe to be at high risk of harm; the aim of the meeting is to produce a co-ordinated action plan to increase an adult or child's safety, health and well-being; agencies that attend vary, but are likely to include the police, probation, children's, health and housing services; over 250 currently in operation across England and Wales
multi-agency safeguarding hub (MASH)	hub in which public sector organisations with responsibilities for the safety of vulnerable people work; it has staff from organisations such as the police and local authority social services, who work alongside one another, sharing information and co-ordinating activities to help protect the most vulnerable children and adults from harm, neglect and abuse

Office for Standards in Education, Children's Services and Skills (Ofsted)	a non-ministerial department, independent of government, that regulates and inspects schools, colleges, work-based learning and skills training, adult and community learning, education and training in prisons and other secure establishments, and the Children and Family Court Advisory Support Service; assesses children's services in local areas, and inspects services for looked-after children, safeguarding and child protection; reports directly to Parliament
police and crime commissioner (PCC)	elected entity for a police area, established under section 1, Police Reform and Social Responsibility Act 2011, responsible for securing the maintenance of the police force for that area and securing that the police force is efficient and effective; holds the relevant chief constable to account for the policing of the area; establishes the budget and police and crime plan for the police force; appoints and may, after due process, remove the chief constable from office

registered sex offender	a person required to provide his details to the police because he has been convicted or cautioned for a sexual offence as set out in Schedule 3 to the Sexual Offences Act 2003, or because he has otherwise triggered the notification requirements (for example, by being made subject to a sexual offences prevention order); as well as personal details, a registered individual must provide the police with details about his movements, for example he must tell the police if he is going abroad and, if homeless, where he can be found; registered details may be accessed by the police, probation and prison service