HMICFRS

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services

National Child Protection Inspection

Cheshire Constabulary

10–21 January 2022

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 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 organisations – have a particular role in protecting children and meeting their needs.

Protecting children is one of the most important things the police do. Police officers investigate suspected crimes involving children and arrest perpetrators, and they have a significant role in monitoring sex offenders. They can take a child in danger to a place of safety and can seek restrictions on offenders' contact with children. The police service also has a significant role, working with other organisations, in ensuring children's protection and wellbeing 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 organisations 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 and Fire & Rescue Services (HMICFRS) 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 the police protect children and secure improvements for the future.

Contents

Summary

This report is a summary of the findings of our inspection of police child protection services in Cheshire, which took place during January 2022.

We examined the effectiveness of the decisions made by the police at each stage of their interactions with or for children, from initial contact through to the investigation of offences against them. We also scrutinised the treatment of children in custody, and assessed how the constabulary is structured, led and governed, in relation to its child protection services.

The methodology for this inspection was reviewed because of the pandemic. We agreed arrangements with the constabulary to conduct the onsite inspection both safely and effectively while working within national guidelines.

Main findings from the inspection

Cheshire Constabulary has recently experienced significant changes in its senior leadership with a new police and crime commissioner (PCC) elected for Cheshire in 2021, and a new chief constable also appointed last year. The current Police and Crime Plan 2021–2024 has 6 key priorities, which include protecting vulnerable and at-risk people. There is a clear commitment to child protection and providing better outcomes for children from the chief officer group and senior leadership teams.

The constabulary has invested a significant amount of time and energy in the health and wellbeing of its staff through its wellbeing scheme, including those working in child protection roles.

We found officers and staff who manage investigations related to children to be dedicated and enthusiastic and keen to talk about their work.

Partner organisations, such as education and children's social care services, describe their relationship with the constabulary as extremely positive and say they work well together. Many said the force was responsive and innovative. Police representatives are present and active in meetings and open to constructive professional challenge.

Senior leaders prioritise vulnerability training for frontline officers, such as identifying child neglect, which is beginning to have a positive impact on practice. We saw a culture of learning and continuous improvement.

The constabulary has established a strategic safeguarding and public protection unit with specialist capabilities to assist teams tackling those who are a risk to children and to investigate some of the most difficult offences.

However, some practices could be improved, for example, how child sexual exploitation incidents are investigated and understood by the constabulary.

Specific areas of good practice include:

- effective and consistent joint working in child protection investigations;
- prioritising of domestic abuse incidents, with officers taking a proactive approach to arrests and safeguarding referrals when children are present;
- good use of body-worn video (BWV) to capture the experiences of children; and
- child protection training for frontline staff in areas such as child neglect.

Specific areas for development include:

- ensuring the voice of the child (VoC) is consistently recorded in referrals to safeguarding partners;
- addressing the lack of progress in some investigations when children are at risk of sexual exploitation;
- ensuring all frontline officers deployed to incidents involving children have the expertise to manage them;
- prioritisation of children at risk of sexual exploitation who are repeatedly missing;
- ensuring children with complex needs are not taken into custody unnecessarily; and
- reviews of children in custody and delays in requesting their appropriate adult (AA).

During our inspection, we examined 71 cases where children had been at risk. We assessed child protection practice as good in 24 cases, as requiring improvement in 27 cases, and as inadequate in 20 cases.

The constabulary needs to do more to give a consistently good service for all children.

Conclusion

The constabulary's leadership is clearly committed to providing better outcomes for children. It recognises that its current structures and performance isn't providing the level of response and quality of service that children in Cheshire require.

We are encouraged by how quickly the constabulary responded to areas of concern identified in our inspection and saw that it already has the governance and scrutiny arrangements in place to monitor the impact of its responses.

We have made some recommendations that will help improve outcomes for children if the constabulary acts on them.

1. Introduction

The police's responsibility to keep children safe

Under section 46 of the Children Act 1989, a constable is responsible for taking into police protection any child they have reasonable cause to believe would otherwise be likely to suffer significant harm. The same Act also requires the police to inquire into that child's case. Under section 11 of the Children Act 2004, the police must also keep in mind the need to safeguard and promote the welfare of children.

Every officer and member of police staff should understand it is their day-to-day duty to protect children. Officers going into people's homes for any reason must recognise the needs of any child they meet and understand what they can and should do to protect them. This is particularly important when officers are dealing with domestic abuse or other incidents that may involve violence. The duty to protect children includes those detained in police custody.

The National Crime Agency's (NCA) *National Strategic Assessment of Serious and Organised Crime* (2021) established that the risk of child sexual abuse continues to grow, and is one of the gravest serious and organised crime risks. Child sexual abuse is also one of the six national threats specified in the Strategic Policing Requirement.

Expectations set out in the *Working Together guidance*

The statutory guidance published in 2018, *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*, sets out what is expected of all agencies involved in child protection. This includes local authorities, clinical commissioning groups, schools and voluntary organisations.

The specific police roles set out in the guidance are:

- identifying children who might be at risk from abuse and neglect;
- investigating alleged offences against children;
- inter-agency working and information sharing to protect children; and
- using emergency powers to protect children.

These areas are the focus of our child protection inspections. Details of how we carry out these inspections are in Annex A of this report.

2. Context for the constabulary

Cheshire Constabulary has a workforce of approximately:

- 2,204 police officers;
- 1,558 police staff;
- 168 police and community support officers; and
- 205 special constables.

It provides policing services to the county of Cheshire in the north-west of England, covering 905 square miles and a coastline of approximately 67 miles.

It serves a population of over one million people across a large geographic area, from rural expanses to areas of extensive heavy industry. Urban areas include Chester and Warrington, which have busy daytime and night-time economies. As well as areas of great affluence, the county includes pockets of major deprivation.

The constabulary works in partnership with four local authorities to respond to adult and children safeguarding and support families with complex needs, as well as tackle crime and disorder through community safety partnerships and serious and organised crime partnership boards.

The four local authorities within the county, Halton, Warrington, Cheshire East, Cheshire West and Chester, together with the constabulary and health service commissioners, have established safeguarding children partnerships (replacing local safeguarding children boards) as required by the Children and Social Work Act 2017.

The most recent Ofsted[1] judgments of the services for children in need of help and protection provided by the local authorities are set out below.

Local authority	Judgment	Date published
Cheshire West and Chester	Good	May 2019
Warrington Borough Council	Good	August 2019
Cheshire East	Requires improvement to be good	January 2020
Halton Borough Council	Requires improvement to be good	April 2020

[1] Ofsted is the Office for Standards in Education, Children's Services and Skills in England. They inspect and regulate services that care for children and young people.

Ofsted undertook a focused visit[2] to three of the four local authorities, Halton, Cheshire East, and Cheshire West and Chester, more recently. It found there has been improvement in the overall quality of work in Cheshire East, and that Cheshire West and Chester council has continued to strengthen the quality of practice for children and families. However, in Halton they found that there has been a deterioration in the quality of social work practice for children.

Organisation of the force

Cheshire Constabulary has three policing areas. The north includes Warrington and Halton, the east includes Crewe, and the west has Chester.

Each area is broken down into local policing units (LPUs) responsible for the delivery of neighbourhood policing and response. Each area has a child protection team, overseen by a specialist child protection supervisor (detective sergeant) where crimes against children are investigated. Specialist teams investigate online abuse of children and manage offenders who pose a risk to children.

An assistant chief constable (ACC) is responsible for child protection throughout the police force. She is supported by a detective chief superintendent, who holds a strategic responsibility for safeguarding and public protection. This remit includes overseeing improvements of child protection across the constabulary.

[2] Focused visits are undertaken as a part of Ofsted's Inspection of Local Authority Children's Services (ILACS) Framework and, unlike full inspections, are not concluded with a graded judgment.

3. Leadership, management and governance

The senior leadership is committed to improving outcomes for children

Cheshire Constabulary has recently experienced significant changes in its senior leadership, with a new PCC and a new chief constable taking up their posts in 2021.

The current Police and Crime Plan 2021–2024 has 6 key priorities, which includes protecting vulnerable and at-risk people. There is a clear commitment to child protection from the chief officer group and senior leadership teams.

The appointment of an ACC as the lead for child protection provides clear leadership at chief officer level. There is strong communication between the chief officers through regular performance reviews, which allows other types of crime affecting the community to be explored and acted upon.

The constabulary rolled out child neglect identification and trauma-informed training in November 2021 for frontline officers. It engages well with children through schemes such as police cadets. These provide opportunities to gather children's feedback, as does the PCC's Youth Commission.

In addition, there is effective communication at senior level through quarterly performance review (QPR) meetings, which are either thematic or specific to a local area. The ACC chairs the public protection QPR and has a clear understanding and vision. There is also a strong culture of commitment to improvement. Senior leaders monitor this through a monthly force performance day, with themes including domestic abuse and child neglect.

The force works effectively with its partners and they find joint solutions to concerns

Senior officers attend Cheshire's four partnership boards, where the police, the local authority and health services work with other agencies to safeguard children. Policing representatives also attend several subgroups that support this board.

The partners say relationships with constabulary staff are professional. They describe force contributions to multi-agency working and engagement at strategic and operational level as good and they felt able to challenge the constabulary where necessary. For example, safeguarding partners shared with us that they had raised

concerns about children in custody and were able to discuss them and jointly identify solutions at a strategic level.

The constabulary also regularly participates in multi-agency audits. However, it could improve the way it shares information with its partners, for example information about missing children.

It is clear who is responsible for child protection but child protection team structures could be improved

Senior officers oversee the management of child protection cases, such as missing children and domestic abuse incidents, through daily case management meetings. These have representation from across areas and teams and demonstrate an understanding of risks posed to children. Longer term management is achieved through the QPR for public protection, which has child protection and broader vulnerability as a priority.

Leaders recognise that the force isn't providing the level of response and quality of service children in Cheshire need. The risk analysis in its force management statement identifies the need to invest in and improve child protection investigations, its response to online crime against children and the ways it responds to child exploitation. To this end it has set up a new strategic public protection unit to improve standards.

The constabulary is working to improve the quality of the data it collects so it can use it to improve outcomes for children

The constabulary regularly uses its data to identify learning and good practice through audits and reviews. These take place across the force and analysis of the findings are reported to senior officers. We were told there is flexibility in this approach and senior leaders can prioritise areas to focus on. In addition, bespoke pieces of work are undertaken. For example, the constabulary commissioned an audit into child neglect and is finalising the production of a child sexual exploitation profile. Senior leaders and team managers also receive regular and detailed performance data. A real-time interactive dashboard is being developed to help managers understand their teams' performance.

However, we didn't often see how the VoC features in performance reviews, for example through qualitative assessment of frontline practice, although the force recognises this is an essential part of its wider vulnerability strategy.

We also noted that the ethnicity of children is not always recorded. It is difficult for the force to understand risk based on cultural background unless this is addressed. The constabulary also won't be able to adequately assess the equity of its service based on ethnicity.

There aren't enough qualified investigators for child protection cases

The constabulary understands the training requirements for roles that are responsible for child protection investigations. Those officers and staff should be accredited to level 2 of the professionalising investigations programme (PIP). Once accredited they can enter the specialist child abuse investigation development programme (SCAIDP).

The constabulary is aware that it has approximately 62 percent (272 of 403) of its detectives across reactive, proactive and child protection teams who are PIP 2-accredited, while approximately 50 percent (32 out of 63) within its specialist child protection teams are SCAIDP-accredited. A plan is in place to improve this ratio to ensure officers managing child protection investigations have appropriate training. Some of these roles are currently filled by trainee detectives accredited at PIP level 1. However, these officers are closely supported by accredited supervisors.

The recruitment and retention of investigators is a national problem. This has been identified and included as a recommendation in the College of Policing and National Police Chiefs Council's VAWG framework for delivery.

The constabulary has invested in the health and wellbeing of its staff

The constabulary has invested a significant amount of time and energy in its wellbeing scheme for staff, which includes people in child protection roles. There are wellbeing champions across the constabulary. Response officers described feeling supported by their line managers, who check on their welfare regularly. However some officers working in specialist child protection teams shared that they do not feel adequately supported, and sometimes they are not offered comprehensive debriefs when dealing with traumatic incidents.

4. Case file analysis

Results of case file reviews

For our inspection, Cheshire Constabulary selected and self-assessed the effectiveness of its work in 33 child protection cases. Under HMICFRS criteria, the cases selected were a random sample from across the area.

Our inspectors also assessed the same 33 cases.

Cases assessed by both the constabulary and HMICFRS

Constabulary assessment:

- 12 good
- 18 require improvement
- 3 inadequate.

HMICFRS assessment:

- 8 good
- 13 require improvement
- 12 inadequate.

38 additional cases assessed only by HMICFRS

HMICFRS assessment:

- 16 good
- 14 require improvement
- 8 inadequate.

Total 71 cases assessed by HMICFRS

- 24 good
- 27 require improvement
- 20 inadequate.

There was a notable difference in the constabulary's self-audit gradings in comparison to our inspectors. Our audits identified many more cases where investigations were inadequate. Our audits considered areas such as:

- the recording of children's demeanour and wishes;
- evidence of a safeguarding plan for the child;
- safeguarding activity beyond the immediate risks or incident; and
- outcomes for children.

Of the 71 cases assessed, we referred 9 cases (7 audits and 2 thematic issues) back to the constabulary where our analysis of the evidence in case records was that there remained serious concerns. These cases included a lack of action to ensure children were protected by police, vital information not being shared, or where a child might still be at risk of significant harm from an offender because there had not been a meaningful intervention.

We also referred our concern that reviews conducted of children in custody were not completed appropriately or thoroughly. In some circumstances, children were not spoken to.

The constabulary responded thoroughly to all our referrals. Senior managers reviewed the cases, updated risk assessments and swiftly acted on our concerns.

Breakdown of case file audit results by area of child protection

Cases assessed involving enquiries under section 47 of the Children Act 1989

- 7 good
- 1 requires improvement
- 2 inadequate.

Common themes include:

- effective joint working, with joint visits completed and joint decision-making;
- good relationships with children's services;
- appropriate and early evidence of good initial action by responding officers;
- prompt joint strategy discussions with cases resulting from them allocated appropriately to suitably qualified detectives; but
- the threshold for strategy discussions for child exploitation is not fully understood and officers sometimes defer cases to formal multi-agency meetings instead.

Cases assessed involving referrals relating to domestic abuse incidents or crimes

- 6 good
- 3 require improvement
- 1 inadequate.

Common themes include:

- control room staff assist responding officers with up-to-date information, which informs risk assessment and decision-making;
- efforts made to trace and arrest offenders if they are not arrested at scene;
- BWV is used at scenes to capture the living conditions of children; but
- the VoC was not consistently captured on safeguarding referrals by attending officers; and
- a lack of progress in some investigations, with inconsistent supervisory oversight.

Cases assessed involving referrals arising from incidents other than domestic abuse

- 6 good
- 1 requires improvement
- 3 inadequate.

Common themes include:

- timely sharing of information and attendance at strategy meetings;
- children's voices form part of information gathered;
- decisions are made with partners; but
- some poor recording of information; and
- risk was often not reviewed or escalated appropriately.

Cases assessed involving children at risk from child sexual exploitation

Cases involving children at risk of child sexual exploitation both online and offline:

- 3 good
- 3 require improvement
- 6 inadequate.

Common themes include:

- vulnerable persons assessments (VPAs) are routinely shared by officers;
- supervisory reviews are of a good standard, with clear rationale for decision-making; but
- investigations by inexperienced officers can be disjointed, often resulting in delays;
- proactive investigative opportunities are being missed, such as the seizure or examination of phones; and
- strategy meetings are not always attended.

Cases assessed involving missing children

Children missing:

- 1 good
- 2 require improvement
- 5 inadequate.

Common themes include:

- THRIVE assessments regularly completed;
- evidence of actions during the golden hour, the period immediately after a crime has been committed, are logged; but
- inconsistent initial grading of the risk to missing children;
- a lack of direction in some investigations; and
- VPAs referred to the front door in only half of the audits.

Cases involving children taken to a place of safety under section 46 of the Children Act 1989

- 0 good
- 6 require improvement
- 0 inadequate.

Common themes include:

- responding officers consider the circumstances of vulnerable children and make effective and appropriate decisions to remove them;
- VPAs routinely completed and shared; but
- managers don't consistently supervise cases or record when police protection powers end.

Cases involving sex offender management in which children have been assessed as at risk from the person being managed

- 1 good
- 7 require improvement
- 1 inadequate.

Common themes include:

- good sharing of information with neighbourhood beat officers; but
- poor use of recording systems; and
- home visits not complying with recommended best practice, such as ensuring they are undertaken by a minimum of two officers.

Cases assessed involving children detained in police custody

- 0 good
- 4 require improvement
- 2 inadequate.

Common themes include;

- poor reviews of children in custody;
- significant delays in the attendance of AAs;
- children with complex needs brought into custody; and
- safeguarding concerns not routinely shared with children's social care services and other safeguarding partners.

5. Initial contact

The control room generally uses research appropriately to highlight risks to children

Police officers and staff working in the control room are responsible for call handling, officer dispatch, obtaining relevant information from callers, and searching police databases to identify risk and grade responses. Control room staff receive training on issues such as domestic abuse, child exploitation and vulnerability. The constabulary uses an appropriate system to ensure vulnerable children are identified to inform deployment decisions. The constabulary uses the THRIVE risk assessment for each incident.

When officers are called to incidents, we saw that control room staff access systems to draw together all available information before they arrive at the scene. This broader base of knowledge helps staff manage risks and make decisions. This helps to identify children who may be at risk, for example those who are the subject of a child protection plan or children who are missing.

Flags denoting vulnerability on control room systems are removed when no longer required.

Case study: Effective control room practice helps locate missing girl

A 13-year-old girl was reported missing by her foster carer. She had been missing several times in a three-month period, often with other children in care.

On this occasion, the foster carer believed the girl might be under the influence of alcohol. The initial details were gathered by the control room, with a THRIVE assessment completed well. The incident supervisor documented initial actions and identified that the young girl could be with other missing children.

The control room used police systems effectively to help officers to locate the girl safe and well three hours later with other children found to be reported missing.

Control room staff are responding to some reports of domestic abuse with an appointment despite there being children present

The control room uses an appointment system for calls not requiring an immediate response. This is appropriate in some domestic abuse cases, but not where children were present at the incident. The appointments are considered at daily meetings in each LPU. We sampled some domestic abuse cases booked for appointments and found most to be suitable, except for two incidents which involved children. It is important for children to be seen and risks considered, as research suggests children witnessing domestic abuse is an adverse childhood experience that has an impact on them later in life.

The quality of the control room's service for children is sometimes inconsistent

The constabulary has invested in a vulnerability and safeguarding team (VAST) to support children and vulnerable people. The team provides appropriate signposting and safeguarding advice to callers over the phone and identifies and records any issues not reported at the time of the initial call. The team then creates a VPA, which is shared with officers responding to the incident. The officers then gather more information and submit the VPA to partner agencies.

However, officers attending incidents that have been through the VAST team do not always complete the initial VPA or a further VPA. Children are not always seen and relevant information is not shared with partners. Officers are also speaking with offenders before speaking with victims or children because of VAST involvement. We saw lengthy delays in officer deployment when the VAST has contacted callers, which can be unsettling for some families.

The constabulary has also invested in a team responsible for the initial investigation when children are reported missing, which works alongside the VAST. Its staff reviews all information and intelligence within police systems and relays it to officers to enable more meaningful and timely risk assessments. We were told they haven't had specific training for their role, which means they may miss important information that could inform action to mitigate risk. Current low staffing levels sometimes cause an overlap with VAST, which is having an impact on the volume of calls and incidents they can effectively manage.

The response to how missing children are graded is inconsistent

When control room staff are told a person is missing, they determine the level of risk and the response. We found incidents where the risk grading and response to missing children were inconsistent. Children missing from home are graded as medium risk as a minimum, with processes in place to review risk. A number of factors are taken into consideration, for example, their current mental and physical state, information held on police systems and their current environment. However, we found examples where some children were inconsistently graded, despite evidence of clear risk and child sexual exploitation.

Trigger plans set up to locate individual children who frequently go missing contain useful information, but they are inconsistently created, updated and used. We found that the constabulary's use of trigger plans was to direct officers to locations and not use it as an investigative tool. This can undermine the effectiveness of the response to the most vulnerable missing children.

Case study: Incorrect risk grading for boy having suicidal thoughts

The mother of a 14-year-old boy called police, stating her son jumped out of the window and ran away following an argument. She reported that he had suicidal thoughts and had one previous missing episode. Both parents were concerned and had searched the area.

Control room staff conduct a THRIVE risk assessment while the incident supervisor completed an initial grading and assessed the risk as medium. Information available to the control room suggested that he was only wearing tracksuit bottoms late in the evening, in the early part of winter. The information and the circumstances should have led to the boy being assessed as high risk.

The boy returned home, believed to be under the influence of a substance. A return home interview was completed, although he was not referred to children's social care services.

Case study: Procedures not followed when vulnerable girl goes missing

Family members called police after a vulnerable 13-year-old girl with multiple missing episodes was reported missing again. The girl was subject to a child protection plan.

The initial response was poor. There was no THRIVE risk assessment by control room staff and the supervisor didn't complete a risk assessment for an hour. However, it was graded as medium risk. There was a flag to alert control room staff of the child protection plan and the need to inform officers. The flag instructs the operator to document that officers have been made aware of the plan and a VPA is required, but this was not done. There was also information on police systems that the girl might be with other missing children, which was not shared with officers at the time.

The child returned home after approximately two hours and police attended the address. She disclosed sexual assault by two men who offered her drugs. The child was taken to the hospital and police began an investigation, including an urgent strategy meeting with safeguarding partners.

The links between missing children and child sexual exploitation are not always understood

The response to children graded as a medium risk when missing, despite significant concerns they may be sexually exploited, is sometimes poor. We found there is limited or delayed action to find them. In most of the cases we reviewed, the flagging of child sexual exploitation or child exploitation was inconsistent, which may prevent an appropriate response.

Case study: Missed opportunities to safeguard child at risk of sexual exploitation

A 15-year-old girl who was frequently reported missing was temporarily placed with her grandparents by the local authority. There were concerns about her wellbeing as she had previously self-harmed and had been assessed as at high risk of child sexual exploitation.

The girl left the address to visit her boyfriend but didn't return by an agreed time, so her grandparents reported her missing. A THRIVE assessment was completed and the supervisor graded the risk as medium despite the child being at high risk of sexual exploitation.

The child was eventually picked up by her grandfather in the early hours of the morning and found to be with another 15-year-old girl, who was on a child protection plan and also reported to be at risk of sexual exploitation.

Although officers visit the grandparent's address to conduct a safe and well check, VPA and a return home interview, enquiries to establish details, such as the age of the boyfriend were limited. This would have aided future safeguarding. There were also no enquiries to establish whether the other 15-year-old girl was safe and well.

Recommendation

Within three months, Cheshire Constabulary should review its processes regarding incidents relating to child protection, paying particular attention to how control room staff make decisions on officer response.

6. Assessment and help

Statutory guidance in *Working together to safeguard children* (2018) states:

> Everyone who works with children has a responsibility to keep them safe. No single practitioner can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.

The constabulary has developed an efficient system for sharing information with safeguarding partners

The constabulary has central referral units (CRUs) that support four front door assessment hubs in Cheshire, aligning with the local authority areas. It was positive to see that the CRUs are well-resourced and co-located with partners in the respective local authorities. There is reciprocal access to agency systems, for example, allowing officers to check if children have a social worker and share directly where necessary. The front door hubs in Cheshire have representation from a range of partners, including statutory and non-statutory agencies, to support effective information sharing, joint decision-making and planning. There is a clear, well-established process for making referrals to share concerns.

When an officer has a concern for a child, they submit a VPA form. In cases when children are harmed because of domestic abuse, the form is required and completed as it is embedded in the domestic abuse stalking and harassment (DASH) risk assessment. Although we found that the VPA form is completed when children are harmed, the system doesn't show whether children were involved in or witnessed a domestic incident. This means staff must manually review each report to establish if children are involved. This can lead to delays in sending VPAs involving children at medium or standard risk to safeguarding partners.

Where delays do occur, there is evidence of feedback from or escalation by children's social care services via the referral unit to supervisors and officers. The referral units research and share VPAs with partners in a timely manner, completing a secondary risk assessment. Demand within the referral units is well managed and backlogs are managed appropriately.

Officers generally complete and submit safeguarding referrals, but they aren't detailed enough

The constabulary told us there has been an improvement in the quality of VPAs following an extensive training programme. They have identified VPA champions to support their peers. The quality and timeliness of the VPAs is subject to regular multi-agency audit, which has contributed to improvements. Feedback from partner organisations is good. This has helped in managing the backlogs at the front door. The constabulary's safeguarding officers have delivered bespoke training to frontline officers and provided templates to guide officers.

However, the inclusion of children's views is often lacking. Some VPAs have good levels of detail, with a focus on the child, but some simply outline the circumstances of the case. We reviewed a sample of 11 cases concerning children and 4 had no VPA when they should have. Prior to our inspection, the constabulary had identified that the completion of VPA forms was leading to delays or information not being captured and it is producing a new, electronic VPA with templates for officers to follow.

Strategy discussions with other organisations are generally prompt

When the police or the other safeguarding partners consider that a strategy discussion should take place – typically to agree whether a joint investigation between the police and children's social care is needed because of a child protection incident in the home – it usually takes place quickly and consistently, especially since the pandemic, which has resulted in better attendance.

Staff are available to cover absences where needed. We saw evidence of contributions from relevant agencies, such as minutes or documented conversations, which resulted in decisions about whether a joint investigation was required or not. Those decisions were clearly recorded and the case promptly allocated to the appropriate team to carry out the agreed enquiries. Staff from the CRU attend strategy meetings and are suitably trained. It means children and their families are receiving a good service.

When the risk to children comes from outside the home, strategy meetings don't take place consistently

Working together to safeguard children (2018) states that a strategy discussion should take place when there's reasonable cause to suspect a child is suffering or likely to suffer significant harm. Any safeguarding organisation, including the police, can request this discussion.

While strategy meetings are routinely attended when the risk is obvious, for example, physical harm or neglect, officers aren't always taking a contextual safeguarding approach in cases such as child sexual exploitation. In over half of these cases we audited, no strategy meeting had been recorded as having taken place. In some cases where the meetings took place, it was some time after an incident and didn't instigate a joint, effective and timebound plan to address the significant concerns raised. This also means that the child's peers were not identified; potentially a missed opportunity to identify other victims of sexual exploitation.

Case study: Poor response to a report of child sexual exploitation

A 16-year-old girl disclosed to a mental health worker that a 59-year-old man had sexually assaulted her and a friend, including sending inappropriate messages. The girl also disclosed rape by a 17-year-old boy.

The mental health worker reported it to the police and a crime report was created. However, there is no record of any attempt to establish what happened or mitigate the risk to her. She was considered at low risk of child sexual exploitation and no flag was recorded. The suspect was known to the constabulary, but he was not spoken to and the matter was closed.

There were opportunities for officers to conduct or request a strategy meeting, especially as the report originated from another agency. A strategy meeting at the outset, with partners, would have helped identify risks and concerns. The constabulary and its partners could have developed a clear safeguarding plan.

The constabulary's understanding of child sexual exploitation has some weaknesses and its approach is inconsistent across force areas

The constabulary employs child sexual exploitation (CSE) co-ordinators, who are police officers, in each of its areas. They review incidents from the previous day using police systems. They also review VPAs and submit the referrals to children's social care services where needed. They do not hold cases or conduct investigations, but support officers managing investigations. However, they have not had any specific training, particularly about exploitation, and resort to learning the role from their peers.

Like domestic abuse multi-agency risk assessment conferences (MARACs), children assessed as high risk of sexual exploitation are referred to a contextual safeguarding operational group (CSOG) monthly meeting. There is one in each area and they are often chaired by the police or a local authority representative, with key partners in attendance. However, we saw different practices across the local authority areas. For example, one holds a weekly safeguarding meeting as well as the monthly CSOG. Also, the CSE co-ordinators operate differently in their differing authorities. This inconsistent approach means children in Cheshire are receiving differing levels of service.

CSOGs require a risk assessment to have been undertaken for children to be referred to the meeting. But there are different risk assessments for criminal exploitation and child sexual exploitation across Cheshire. This may result in an inconsistent threshold for response for the police when dealing with vulnerable children.

The constabulary has commissioned a child sexual exploitation problem profile to better understand the impact of exploitation across its area as it is becoming more prevalent. It should make sure that this is comprehensive by including the force's current levels of understanding of child sexual exploitation, its IT capabilities and how it works with its partners and their processes.

There is good multi-agency planning and support for victims and children affected by domestic abuse

The CRUs review all VPAs, which have the DASH risk assessment embedded. Victims of domestic abuse are consistently referred to support organisations. These organisations provide vital support, which in turn helps children affected by it.

Innovative practice: Effective work with the community safety partnership

The Cheshire East Community Safety Partnership funded an independent domestic violence adviser to attend a custody suite for a three-week period in December 2021. This was not to discuss cases with arrested offenders, but to offer them referrals on to perpetrator programmes. Officers told us an evaluation of the pilot has been funded as they hope to extend it to other areas of Cheshire.

The constabulary has a MARAC in each area, and an E-MARAC, that takes place through video conferencing, in Cheshire East. The police officers who manage the MARACs understand their roles, and the minutes are well documented. Police meet with partners at the E-MARAC to focus on the cases with the most pressing need for multi-agency support. It doesn't replace the original MARAC. The constabulary intends, with partners, to introduce E-MARACs across the other areas.

The constabulary supports Operation Encompass, which means children receive extra support from their school if they are exposed to domestic abuse. The control room prompts officers where children are associated with an address, but response officers often rely on control room staff to contact the CRUs, who then notify education colleagues. However, when demand increases, notifications are not consistently sent. Officers often miss children who are not physically present during incidents, or when researching systems to identify children, who may still be affected by domestic abuse despite not being in the home.

The constabulary loses some opportunities to better understand why children go missing

Return home interviews between a child who has been missing and an independent trained professional uncover information that can help protect children from going missing again, including risks they may have been exposed to and factors at home. Police must record the interview on their systems. These are routinely completed by an external provider in Cheshire and uploaded on constabulary systems by the police.

However, the constabulary is not maximising the information gathered from the interviews, for example, to inform trigger plans. This is because it doesn't have a framework to consistently assess overall practice in the cases of missing children. A framework would help it identify where its response could be improved.

Recommendations

- We recommend that Cheshire Constabulary immediately improves its response to missing children so that it is consistent with the risks identified and ensures that the response is effectively supervised.
- We recommend that Cheshire Constabulary immediately engages with its safeguarding partners to review the terms of reference and practices of its multi-agency risk management meetings in relation to missing children and children at risk of exploitation.
- We recommend that within three months, Cheshire Constabulary should act to make sure that officers obtain and record children's concerns and views (including noting their behaviour and demeanour) to help influence decisions made about them.

7. Investigation

Investigations are generally allocated to teams with the skills and experience to carry them out

In Cheshire, investigations into child abuse are assigned to child protection teams in CID. These teams take on investigations regarding children that take place in a family setting or crimes committed by a person in a position of trust. They also manage cases involving children who are on child protection plans or when a joint investigation is necessary. These are usually managed by officers accredited to PIP level 2. Officers have a good working relationship with safeguarding partners and workloads are manageable. When children are harmed online, these crimes are managed by the online child abuse investigation team (OCAIT).

There is a high standard of investigation when cases are allocated to specialist teams

When there is a clear risk to children from the outset, there is a swift response and good decision-making by attending officers. Strategy discussions are prompt and followed up by timely strategy meetings. We saw effective joint working, with joint visits being completed and joint decision-making.

Case study: Effective response to allegation a child was assaulted

A father was alleged to have assaulted his son. The initial call was appropriately graded for an immediate response and research completed by the call taker who completed a THRIVE risk assessment. Units were dispatched and arrived during the call, quickly arresting the suspect.

A detailed VPA was submitted in a timely manner and was subject to an additional assessment by the supervisor. This clearly recorded the child's views, but not his siblings' views nor the home conditions. The case was allocated to the child protection team with a good investigation plan and good supervisory oversight. An immediate strategy discussion took place with a timely follow-up strategy meeting, and a joint visit.

Some investigations are poorer when allocated to non-specialists

When children are involved in a call for service, some investigations are allocated to CID teams and some remain with response teams. Some of the investigations remaining with response teams were of a good standard with clear direction from supervisors. But when those cases are more complex, we found that some risks weren't recognised or lines of inquiry not followed. For example, when reviewing sexual images of children, the risk the offender posed to other children was not always recognised.

Case study: Risks not recognised by response officers

A mother reported that her 11-year-old son was being violent towards her and police attended the home. The boy was on a child protection plan for neglect and there was a history of domestic abuse between the boy's parents.

When officers arrived, the mother told them she had had to place a lock on the kitchen door because her son kept stealing food. Although the child had injuries, a crime against his mother was not recorded. There wasn't a clear record of the living conditions, the boy's room or where he slept, or his views about the situation at home.

However, officers informed him that as he gets older, he may be arrested if his behaviour continued. They didn't see the incident from the child's perspective, nor identify the risk factors of being on a child protection plan.

There is sometimes a delay in the allocation of crimes for investigation and investigation plans are sometimes incomplete

Each policing area has a crime hub that reviews all crimes and is responsible for allocating them to the most appropriate team. The crime hubs' interpretation of the force's allocation policy can lead to delays in determining the team best placed to deal with an investigation. There are backlogs in crimes waiting to be allocated, although the size varies between the areas. For example the east area had very low numbers, while north had approximately 600. Although crimes involving vulnerability are prioritised, there isn't a way to identify hidden risk, for example a crime report of criminal damage in a home might not identify children in the house. The constabulary is aware of this, but the risk to children will remain unknown until the backlog is addressed.

Crime hubs should add investigation plans to crimes before they are allocated unless the case has been allocated to a specialist unit. These should be bespoke and direct the next steps to be taken. However, often these plans are templates that have not been updated or attached. The constabulary is unable to easily measure their quality or completion.

The constabulary has invested in training for its frontline staff but sometimes child neglect is not properly recorded

The constabulary has rolled out Every Child Matters training for frontline officers and some safeguarding partners, with a focus on trauma-informed approaches and child neglect. The constabulary commissioned a review of 50 cases of crimes and incidents recorded as child neglect to assess the quality of investigations. They found that investigations were of a good standard but that VPAs were not always submitted. This mirrors our findings.

We saw instances where the threshold to record neglect cases was not always understood. Cases were not always recorded appropriately when neglect had been clearly identified by frontline officers and arrests made. Where this happens, children are not being supported by the police as they should be.

The constabulary needs to improve the way it tackles child sexual exploitation

The constabulary has recognised it must improve the way it tackles child sexual exploitation and senior leaders have commissioned a problem profile as mentioned earlier in this report.

It doesn't have a team that investigates child sexual exploitation and there is no clarity which team – response, CID or child protection – they should be allocated to. The CSE co-ordinators do not hold investigations as their role is largely a co-ordinating function, with little similarities in the way they operate across force areas. This may mean an inconsistent response for children.

Officers often miss investigative opportunities to safeguard children when dealing with sexual exploitation

Child sexual exploitation investigations in Cheshire are assigned to officers in either LPUs or CID with little or no background in child protection. Investigations are sometimes disjointed. A case involving one child could be investigated by several officers, all of whom may be trying to engage the child. We saw that action taken and language used at times displayed a lack of understanding of the signs and symptoms of children experiencing sexual exploitation and how to help and support them. Additionally, it was not always evident that officers understood key legislation that could help their investigations, such as the seizure and examination of phones, bank enquiries and the use of child abduction warning notices (CAWNs), which can be especially beneficial when there is difficulty engaging young victims. This impacts on the safeguarding of the victim and quality of investigation.

Case study: Officers didn't arrest a man suspected of sexually exploiting teenager with learning disabilities

A 16-year-old girl with learning difficulties at significant risk of child sexual exploitation was reported missing by her mother after a neighbour alerted her that her daughter was picked up by a man in a car. There was almost an hour's delay in grading the incident as high risk. Officers attended the address of the car's registered keeper and found the child in the bedroom with the 35-year-old male. She was wearing shorts and a hoodie; he was wearing just shorts. Despite clear concerns and suspicions of trafficking and sexual exploitation, the suspect was not arrested, and evidence was not seized from any parties. This was a missed opportunity. It was only when further offences were reported several days later that officers from a neighbouring force took action to secure and preserve evidence in conjunction with Cheshire and the man was arrested.

Case study: Poor response to allegation teenagers were sexually assaulted

Police received a report that two friends, girls aged 13 and 14, had been touched sexually by a man. Although both children were known to social services, there was no multi-agency planning and the police didn't interview the girls. Civil orders or CAWNs were not considered and the suspect was not arrested, meaning valuable opportunities to gather evidence were lost. The rationale for not arresting the suspect was not recorded, missing a further opportunity to protect the children. If there had been a joint plan with partner agencies, appropriate support for the children and their families could have been identified.

The constabulary usually acts promptly to trace people sharing child abuse images, but there are significant delays in downloading devices

The OCAIT investigates the sharing and distribution of child abuse images online. The team regularly reviews systems to identify potential offenders and we found it usually deals with cases within its timescales. Prompt action means children harmed online are not left at risk.

The digital forensics unit is responsible for analysing phones that officers have seized and submitted for analysis, but there are significant delays in the examination of devices. The constabulary has worked hard to reduce delays from 3 years to 7 months for computers, and from 26 weeks to 2 weeks for mobile phones, which has impacted the progress of some investigations while officers wait for the results. The constabulary is investing in training and more staff to continue to address the backlog and safeguard children sooner.

Cases of online child abuse are generally managed well but we saw lengthy delays in their allocation to officers

We found the OCAIT has effective processes, from initial research to identifying suspects and addresses, to case planning and warrant execution. Supervisory reviews are consistently of a good standard. They are timely and give clear direction and appropriate rationale for decision-making.

But the team is insufficiently resourced and has a significant backlog of cases awaiting allocation and investigation. The oldest cases are more than two years old. There is no formal process to review these cases to re-assess vulnerability, leaving some children at unknown levels of risk. The constabulary is aware of this and put in temporary measures during our visit, such as a review of each case in backlog. However, staff told us that without additional resources, the risk cannot be addressed more quickly.

The constabulary doesn't share information about online abuse with its safeguarding partners early enough

We found that officers usually do not share information about online abuse with safeguarding partners until they have taken action, such as executed a warrant, although we saw that this is usually followed up with a strategy discussion and meeting. Officers told us that the execution of a warrant or similar action prompts a referral to children's social care services, because full details are not known until this point. However, it is a missed opportunity to share information with other organisations or take account of known risk to children during the intelligence-gathering phase. This would help to better understand the risks to children and put protective plans in place ahead of police action.

Recommendations

Cheshire Constabulary should immediately improve its understanding of child sexual exploitation, paying particular attention to:

- improving staff awareness, knowledge and skills in this area of work;
- the importance of timely sharing of information with partner agencies;
- undertaking risk assessments that comprehensively consider a child's circumstances and risks to other children; and
- improving the oversight and management of cases.

8. Decision-making

The use of police protection powers was appropriate in all the cases we audited but the constabulary needs to improve its recording

It is a very serious step to remove a child from a family using section 46 powers. When there are significant concerns about the safety of children, such as parents leaving young children at home alone or being intoxicated while looking after them, officers handle incidents well and speak to the children. They use their powers appropriately and in the best interests of the child. We saw cases where officers made enquiries to safeguard children promptly and effectively. There is early liaison with children's social care services, with a good understanding of risk to the child and timely VPAs submitted.

But the powers of police protection have a time limit of 72 hours and a record should be made when it ends. When this ended before the 72 hours had elapsed, such as when the child was passed to the care of a family member, these details were rarely entered. When the powers were eventually rescinded, details of the designated officer, who provides supervisory oversight and provides input into the use of the power, were sometimes absent. When these details are absent, supervisors cannot be assured that the practice is consistently effective. Entries from the designated officer were absent in most of the cases we audited.

Case study: Teenagers attempting to travel to London taken into police protection

Two sisters aged 16 and 14 were reported missing and attempted to leave the local area by train to London. The sisters were located quickly and the attending officers made an appropriate decision to use their powers to take them into police protection. They held an immediate strategy discussion with a social worker. The sisters were subsequently accommodated with their mother, who signed a working agreement outlining the care the girls required.

Although details of the designated officer were recorded, there was no documented rationale or any reviews of the powers despite them lasting for 72 hours. Even when the sisters had been placed back with their mother two hours after the powers were used, the powers were not reviewed nor rescinded.

Both girls were eventually placed on child protection plans, with child social care service support.

VPAs are completed routinely, but they inconsistently capture the VoC

It is important for police to gather views from children and share this information to help professionals understand the wishes and feelings of children. We saw that officers completed VPAs in all the cases we reviewed. However, the VoC was poorly captured, and lacked any detail in some cases. When it was captured properly, there was good insight into children's views.

Case study: Officers record the views of a child repeatedly reported missing

A 14-year-old girl was reported missing twice in a 24-hour period with concerns over self-harm. The attending officers appropriately used section 46 powers and liaised promptly with children's social care services, providing referrals on both occasions.

Officers clearly spent some time talking to the girl during both missing episodes. This was demonstrated by good, detailed records of her views on the VPA, which was shared with children's social care services. The child was later safeguarded, and a return home interview took place.

The constabulary works closely with partners to avoid taking children to a police station

We found prompt discussions taking place with children's social care services when it was known section 46 powers would be used, or shortly after, to jointly agree initial next steps, such as where children could be taken. Children were usually quickly taken to an appropriate place of safety. Strategy discussions and agreed activity were recorded well.

Recommendations

We recommend that, within three months, Cheshire Constabulary reviews guidance to improve practices for when children are taken into police protection to make sure:

- all relevant information is properly recorded and made readily accessible;
- it consistently records relevant information and decisions; and
- officers regularly review and endorse the use of protective powers.

9. Trusted adult

The constabulary has schemes to ensure that children's first interaction with police is a positive one

Cheshire constabulary is involved in initiatives ranging from Mini Police for younger children to more intensive programmes for young people affected by child criminal exploitation. Officers capture the views of children and their families through this outreach work or community conversations held across LPUs. These interactions include:

- PC Panda attends school, community and sporting events, having positive interactions with very young children. During the first lockdown, PC Panda visited children to sing happy birthday and hand out gifts donated by businesses.
- The KOP N Kids scheme (Keep On Playing Sport) is a pan-Cheshire initiative to drive engagement and encourage young people to take part in sports. The free sessions are run after school and during summer holidays. PSCOs have reported improved engagement with young people.

We found that the constabulary works well with external organisations, family members and other people to protect children when they need immediate safeguarding. In the cases where this happens, the constabulary's carefully considered and sensitive approach enables effective safeguarding outcomes for vulnerable children.

Innovative practice: Interactive scheme gets children involved in their community

The constabulary runs Mini Police, an interactive volunteering opportunity for 9 to 11-year-olds that gives children a positive experience of policing and gets them involved in their community. The selected school is in a deprived part of the county, with some mistrust of police.

The children identify their priorities to address and with assistance and guidance from school staff and police they tackle them in meaningful and age-appropriate ways. This empowers the children to create solutions to solve problems, giving them a sense of achievement.

Some examples of positive engagement include Mini Police pupils conducting road safety checks at hotspots, displaying emojis at drivers, and assisting with deliveries at food banks.

The constabulary is engaging well with children through its cadet scheme

The constabulary's cadet programme gives young people a practical understanding of policing and inspires them to participate positively in their communities. The programme is open to all Cheshire residents aged 15–17 years, with sessions running in community buildings, schools and colleges. There are 70–90 cadets each year, with 12–16 police cadets in each group.

Cadets visit different policing teams, such as firearms and forensics, where they can talk to specialist officers and see how equipment is used. The programme includes life skills such as job application and interview technique, building resilience and maintaining healthy relationships.

10. Managing those who pose a risk to children

The constabulary is working to increase the number of sex offender managers but home visits to sex offenders do not meet best practice standards

The constabulary has a management of sex offenders and violent offenders (MOSOVO) team, known locally as the sex offender management unit (SOMU). The team is managed centrally, but each area has its own operational team. The team works closely with partner organisations, such as housing and probation, and is dedicated to multi-agency public protection arrangements (MAPPAs) of registered sex offenders in the community.

At the time of our inspection, there were 1,663 registered sex offenders in Cheshire, with 1,254 managed in the community. Not all offenders convicted of sexual offences are subject to supervision. There are 20 offender managers in post, including a part-time position, and there is 1 vacant position. This provides an average of 63 offenders to each manager. This is slightly above national recommendations (approximately 50–55:1) but during our inspection we saw the constabulary was actively recruiting to increase the number of managers and improve the caseload ratio.

The constabulary has a policy of allowing visits to be completed by a single sex offender manager unless there is an identified reason requiring a visit by two officers. This doesn't conform with the College of Policing's Authorised Professional Practice (APP) and the MOSOVO supervisors recognise that this is not best practice. Officers should work in pairs to allow for an effective assessment to be carried out.

All registered sex offender managers received initial specialist training in MOSOVO or the active risk management system (ARMS) but there is no refresher training. Staff told us they need refresher training, especially in vulnerability.

The constabulary employs a MAPPA administrator jointly with the National Probation Service. The administrator has access to both police and probation systems, which makes it easier for those agencies to share information. This proactive work shows good initiative and it protects children.

The review of risk management decisions needs to be clearer

When the police are the lead agency for managing a registered sex offender, offender managers should complete an ARMS risk assessment within 15 days and develop a risk management plan setting out what actions they will take. This might include regular visits. Officers should complete police ARMS assessments at least every 12 months, or when something happens that may significantly change the current assessment and risk management plan for the offender.

We found that the constabulary has a good understanding of ARMS processes. It has recently allocated additional resources to reduce the number of overdue ARMS assessments. Supervisors are expected to fully review the assessments before approving. However, in some cases, ARMS are not initiated when they should be, possibly adding to the existing backlog.

To place a registered sex offender under reactive management, National Police Chiefs' Council (NPCC) guidelines stipulate that they should have been managed as low risk and not reoffended for at least three years. This allows officers to focus on medium and high-risk cases.

Cheshire Constabulary revised its policy in 2020 to accept cases for reactive management if they are subject to a sexual harm prevention order (SHPO) and managed at low risk for over 12 months. The constabulary's approach has led to more than 90 additional cases being placed under reactive management, when they should not have been. An annual review should take place on all reactive management cases and be documented on ViSOR to ensure up-to-date safety planning.

Case study: Officers are too slow to act on concerns about a registered sex offender

Cheshire Constabulary received information in May 2021 that a registered sex offender may be distributing illegal images of children through peer-to-peer networks. In August, probation supervision of the offender ended and the police became the lead agency. Despite this and the report of further offences, a police ARMS risk assessment and a new risk management plan were not completed, with the offender's risk level remaining at medium.

Police executed a warrant in December where the sex offender lived with his parents. Officers became aware that a grandchild was regularly visiting the house and submitted a VPA. An ARMS and risk management plan were subsequently completed and the risk increased to high.

The registered sex offender was not visited during the seven months from the police receiving the information and executing the warrant. Although the child at the address was safeguarded, there was a period where updated risk assessments could have led to quicker action.

The recording of information about registered sex offenders is often poor

ViSOR is a national database used for recording and sharing information about registered sex offenders to reduce the risk they pose. In Cheshire, we found that recording of information on ViSOR was often poor. Where there is information recorded on the constabulary's crime management system, it is recorded on ViSOR with a heading but no further detail. If a sex offender moves to another area, the force taking over responsibility for their management will not have complete information.

Case study: Officers do not record information about registered sex offenders on the national database

A registered child sex offender's partner gave birth to his child, who was subject to a child protection plan. Police received information from probation that the offender had been in contact with his new-born child, breaching the terms of the SHPO in place.

A police investigation was launched, with officers working well with other organisations and sharing information to safeguard the child. But although there were regular updates on the force system, no information was recorded on the national database. Furthermore, the registered sex offender had been assessed as high risk but only had 1 visit in a 12-month period, which had been unsuccessful.

The force could improve the way it schedules some visits. When managers visit sex offenders, subsequent visits are not always scheduled according to the known risks posed by the offender. Sometimes officers schedule visits automatically in one year's time. In cases involving children, this means they are not being seen according to bespoke risk assessments.

The SOMU is beginning to share more information with neighbourhood officers

During the past 12 months there has been a drive to improve the sharing of information within the force. SOMU supervisors sometimes attend neighbourhood team meetings and put forward a registered sex offender so local intelligence officers can create a problem profile. It is then allocated to a beat officer. Briefing the neighbourhood teams can lead to better information gathering across the constabulary, allowing it to better protect children.

The constabulary is investing in modern technology to better protect children

The constabulary is in the final development stage for an application called DyTASK, which will map sex offenders in an area using flags on the force's crime management system. In addition, it can map crime types, other flags such as CAWNs and offences by victim gender. This will enable officers to accurately identify and target problem areas and give them immediate access to briefings on sexual offenders in their area.

Senior leaders are committed to MOSOVO

The constabulary has a comprehensive development plan for the unit and is making concerted efforts to identify gaps and drive improvements. Senior managers have a monthly oversight meeting, with a view to improving quality assurance processes. The superintendent and the chief superintendent have monthly Public Protection Department governance meetings.

Recommendations

We recommend that Cheshire Constabulary immediately improves the way it manages registered sex offenders, paying particular attention to:

- how it records information on local and national systems; and
- ensuring its risk management processes are clearer and bespoke to individual registered sex offenders; and
- risk assessments on home visits, and officer attendance comply with APP.

11. Police detention

The review of children in custody needs to improve

Custody reviews are carried out by the custody inspector to assess the welfare of those who have been brought in but have not yet been charged. A joint inspection of Cheshire custody in 2018 identified that the constabulary didn't comply with Police and Criminal Evidence Act 1984 (PACE) rules for the detention, treatment and questioning of suspects, particularly the conduct and recording of reviews of detention.

In our inspection, custody inspectors completing the review didn't always demonstrate an awareness of the child, their welfare or the investigation into the offence that led to their arrest. Some reviews were recorded as taking place when the child is either "unaware or asleep". Having this awareness helps staff understand the impact that being in custody has on the child's wellbeing.

Alternative accommodation to custody isn't requested early enough and juvenile detention certificates are not always completed properly

Where it was likely that alternative accommodation would be needed for a child, the local authority was not contacted early enough to give it sufficient time to place the child. It was not always recorded that alternative/secure accommodation had been requested and some delays were not explained.

Juvenile detention certificates outline to a court the reason a child should be remanded in custody overnight. They are essential to make sure that the police are accountable and meet their responsibilities under the PACE, but we saw that they were not always completed properly. Some lacked detail about the circumstances of the case. This means the rationale for detaining the child is not shared with the court.

We found delays in the attendance of AAs to support children in custody

We found in all our audits that it is not recorded whether young people or their AAs are informed that a custody review has taken place. Children who required the support of an AA didn't receive one early enough or consistently through their time in custody. Sometimes custody staff delegated contacting an AA to the arresting or investigating officers. In all audits, AAs were asked to attend for the police interview and not before. The young people experienced long waits before the adult arrived, leaving them without early support and an advocate to ensure they were appropriately treated.

Case study: Delays in support for 17-year-old arrested for threatening care home staff

A young woman who had been missing from her care home handed herself in to police at 9.00am. The young woman was arrested for threatening staff at her care home. Her detention records show that custody staff asked the officer in the case to arrange an AA for her. This led to a long delay in the AA being informed at 7.00pm.

The custody reviews were poor and didn't reflect her circumstances or the investigation during her lengthy stay in custody.

Children have access to health services when brought into custody

Health services in custody are provided through an integrated model of care between the police and commissioned health service providers. Custody community workers from liaison and diversion are available to support children from 7.00am to 10.00pm. They check all detained children on mental health systems and where relevant share information with the healthcare professionals based in custody.

Healthcare professionals see all children in custody and assess whether they are fit to detain. Easy-read information on rights and entitlements is given out if required. The healthcare professional contacts the local authority to inform them of all children who have been detained. There are regular discussions between the healthcare professional, the officer in charge and the custody sergeant to determine whether alternative accommodation will be required.

The constabulary has provided tools to support neurodiverse children, such as fidget toys and edible chalk. The healthcare professionals use them to help engage children and they often spark conversation.

Detained children with complex needs sometimes aren't referred to children's social care services

Many children brought into police custody have complex needs. A referral to the children's social care service allows it to arrange support if needed. Custody staff do not submit VPAs or add to the assessments opened by the arresting or investigating officer. If a significant concern is raised in custody, it is flagged on the force's computer system. Although this is positive, it misses the point of a VPA and its role in the referral process that ensures important information is shared with partner organisations.

Where VPAs were submitted for young people in custody, they were inconsistent. They didn't always identify wider risk, for example, speaking to other children linked to the case.

The VoC is inconsistently captured in custody

Where VPAs were submitted, the VoC was either missing or poor. For example, the statement “he will be asked for his version of events in interview”, doesn’t consider the child’s welfare. However, there were examples of good practice. One detention officer who had visited in her cell a young woman who self-harms documented in the custody log:

> “I have spoken with the DP (detained person) about how she is feeling – she said everyone would be better off if she wasn’t here, and that she feels like she is/was being bullied by a teacher. However, her mood changed when I noticed the artwork on the chalk board. When I said how good it was and suggested she would make a great tattoo artist she said she had been thinking about it. Hot drink provided.”

Information such as this is helpful to others including safeguarding partners in building a picture and providing support to this young woman. Such sensitivity builds confidence and creates stronger relationships between the police and the child, parents and/or carers.

Recommendations

We recommend that Cheshire Constabulary immediately undertake a review of how it manages the detention of children. This should be done jointly with children’s social care services, youth offending services, and other partner agencies. The review should include, as a minimum, how best to:

- make sure that AAs promptly attend the police station;
- make sure officers consider the needs and record the VoC and refer them to children’s social care services when necessary; and
- work with local authorities to ensure that children charged and refused bail are moved to appropriate alternative accommodation and not held in custody overnight.

We recommend that within three months, the constabulary should improve its programme of vulnerability training for staff working in custody to improve:

- the recording of information in custody logs to reflect the individual circumstances of a child and the investigation of the offence they have committed; and
- a rationale for the action they have taken to detain and continue to detain.

Conclusion

The overall effectiveness of the constabulary and its response to children who need help and protection

There is a clear commitment from the constabulary's leadership that child protection and wider vulnerability is a priority. It is committed to providing better outcomes for children. Senior leaders prioritise vulnerability training for frontline officers, such as child neglect, which is beginning to have a positive impact on practice.

The constabulary has established a strategic safeguarding and public protection unit with specialist capabilities to assist teams tackling those who are a risk to children and to investigate some of the most difficult offences. We also saw a culture of learning and continuous improvement, and a commitment to achieve better outcomes for children.

Leaders recognise that the current structures and performance isn't providing the level of response and quality of service that they require for children in Cheshire. There is also an acknowledgement that some of the frontline officers who respond to incidents of concern involving children lack the expertise to manage them.

We are encouraged how quickly the constabulary responded to areas of concern identified in our inspection and saw that it already has the governance and scrutiny arrangements in place to monitor the impact of their responses.

We have made some recommendations that will help improve outcomes for children if the constabulary acts on them.

Next steps

Within six weeks of the publication of this report, we require an update of the action the constabulary has taken to respond to the recommendations that we have asked it to act on immediately.

Cheshire Constabulary should also provide an action plan within six weeks of the publication of this report, specifying how it intends to respond to our other recommendations.

Subject to the update and action plan received, we will revisit the constabulary no later than six months after the publication of this report to assess how it is managing the implementation of all 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 organisations 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 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 police 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 of practice, and of management and leadership.
- Case inspections.
- Discussions with officers and staff from within the police and from other organisations.
- 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 HMICFRS); 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 in which police officers and staff identify children who are in need of help and protection (for example, children being neglected);
- information sharing and discussions about children who are 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; and
- the detention of children in police custody.

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