HMICFRS

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

National Child Protection Re-inspection

Derbyshire Constabulary

9–20 May 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.

His 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 re-inspection of police child protection services in Derbyshire, which took place in May 2022.

We initially inspected Derbyshire Constabulary's child protection services in May 2021 and published our report in November 2021.

We made 12 recommendations to help the force improve its child protection services.

In this inspection we examined the constabulary's progress against our recommendations. We considered the effectiveness of the police's decisions at each stage of their interactions with or for children. This was from initial contact through to the investigation of offences against them. We also scrutinised how the force treated children in custody. And we assessed how the force is structured, led and governed, in relation to its child protection services.

2021 inspection

Our first inspection took place in May 2021 and was part of our rolling programme of child protection inspections.

We published our findings in November 2021. These concluded that at the time of the inspection, the force wasn't adequately protecting all children who were at risk owing to widespread serious and systemic failings. The force's leadership and senior management oversight needed to improve to make sure the weaknesses in practice identified during that inspection were addressed. We also made a number of recommendations aimed at improving practice in Derbyshire Constabulary.

2022 re-inspection

Because of the serious concerns raised in the 2021 report, in May 2022, we carried out a full re-inspection of Derbyshire Constabulary's approach to child protection. This examined the effectiveness of the police response at each stage of their interactions with or for children, from initial contact through to investigation of offences against them. It also included scrutiny of the treatment of children in custody, and an assessment of how the force is structured, led, and governed in relation to its child protection services. We assessed the progress made by the force against the recommendations of our 2021 report.

Main findings from the re-inspection

During our inspection, we examined 70 cases in which the police had identified children at risk. We assessed the force's child protection practice as good in 29 cases, requiring improvement in 24 cases, and inadequate in 17 cases. This was an improvement from our 2021 assessment of 79 cases. In that assessment, we found that the force's practice in 20 cases was good, in 31 cases required improvement and in 28 cases was inadequate. But the latest assessment shows the force still needs to do more to give a consistently good service for all children.

Specific aims for improvement include:

- better processes to assess and share information with other organisations to help protect children;
- effective management of the MOSOVO team;
- increased numbers of experienced and fully trained investigators in the public protection department;
- systems to prioritise and task the arrest of high-risk offenders;
- effective multi-agency safeguarding meetings and joint operational working;
- reduced delays in digital forensic examinations; and
- better availability and use of intelligence and problem profiles for exploited children.

Conclusion

Derbyshire Constabulary has made strong progress towards some of the 12 recommendations we made after our 2021 inspection. But none of these recommendations has been fully achieved.

The force needs to consolidate the areas where it has made progress. And significant improvements to other aspects of its child protection arrangements and practices are still needed. This includes working with its partners to improve the effectiveness of multi-agency safeguarding arrangements.

There is clear leadership that is changing the force culture to understand and improve responses to vulnerability. The structure for overseeing and scrutinising all aspects of child protection is much improved. But leaders and managers need to improve their use of the force's performance management information to understand where better ways of working are needed.

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) 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 force

Derbyshire Constabulary has a workforce of approximately:

- 1,770 police officers;
- 1,625 police staff;
- 160 police and community support officers; and
- 215 special constables.

The constabulary serves a population of approximately 1m people across a county area of 1,013 square miles.

The constabulary, together with NHS Derby and Derbyshire Clinical Commissioning Group, NHS Tameside and Glossop Clinical Commissioning Group, and the local authorities of Derby City Council and Derbyshire County Council, form the Derby and Derbyshire Safeguarding Children Partnership.

3. Leadership, management and governance

Recommendation from the 2021 inspection report

> We recommend that Derbyshire Constabulary immediately improves how its leaders and managers promote the responsibility of safeguarding children to all sections of the workforce.

Re-inspection findings

Since our 2021 inspection the new police and crime commissioner has published a *Police and Crime Plan 2021–25*. This clearly describes their priorities and how they expect the constabulary to work to reduce vulnerability, fight crime, respond to the public and work with other organisations to help prevent harm to its communities.

The force has a clear governance structure for public protection activity. These should help leaders and staff understand performance and responsibility. The deputy chief constable chairs the force's improvement and performance assurance boards and is the lead officer for vulnerability.

Chief officers represent the force in the multi-agency Derby and Derbyshire Safeguarding Children Partnership (DDSCP). And senior managers are actively involved in a range of internal and multi-agency meetings which help the force to understand and manage its responses to crime, risk and vulnerability.

After our inspection in 2021, the force made an action plan to address the concerns we raised about its arrangements and responses for safeguarding children. We found that the plan was comprehensive. It shows that the force understands what it needs to do to improve the effectiveness of its responses.

Leaders have made changes to the force's structure to help achieve their plans. The crime directorate now has responsibility for public protection, information management for safeguarding and managing specialist investigation teams. This means there is greater consistency in risk management and that managers are more accountable for their teams' results.

Leaders are making changes to the force's culture to improve its responses to vulnerable children. This will help staff to understand the force's priorities and what

they must do to reduce risk and vulnerability in the community. Senior leaders communicate directly with the workforce and personally reinforce key messages. Managers and subject matter leads also give advice and guidance about key vulnerability topics, such as domestic abuse, stalking and missing children.

A campaign to improve responses to vulnerability is underway. It includes mandatory questions about vulnerability in promotion interviews, additional vulnerability modules within force training, and managers routinely auditing records of investigations and incidents with a focus on safeguarding actions.

Many staff in various roles told us they had encountered information from the campaign and understood what they needed to focus on in relation to vulnerability. We saw evidence of this in improved control room practices, in frontline responders recording the voices of children, and in supervisors telling us how they focused on safeguarding when they audited their teams' work.

The force's performance team has built an impressive analytical system using Power BI technology. It provides immediately accessible and accurate data about incidents and crime between 2017 and the present day. Information gathered from the intelligence and crime/incident reporting systems is available to leaders and most staff. And the use of Power BI allows them to filter the data to see what is most relevant to their needs. The system means that the force can monitor all types of incidents and crimes. And it can examine changes in data to understand where vulnerability exists, or which individuals are causing the risk. The system also allows leaders and managers to review the performance of their staff and teams against objectives.

But the way the force uses this information is inconsistent, and we found variable levels of knowledge of its capability among the staff we spoke to. There is further potential for the force to use its data to identify the most vulnerable people and those responsible for risks. This will help the force and its safeguarding partners to co-ordinate and focus resources more effectively.

The force recently reviewed its intelligence directorate. It is well staffed with analysts, but their deployment and focus isn't aligned well enough to the force's priority vulnerability areas. We saw that the force's response to child sexual exploitation (CSE) isn't supported by a comprehensive and regularly updated intelligence profile. This means that the force and its partners don't make full use of the information they hold to tackle offenders or reduce CSE vulnerability within a co-ordinated strategic plan.

The force knows that its staff are failing to record information about people's ethnicity and cultural heritage in their incident reports. This gap needs to be addressed quickly, because it undermines the force's understanding of vulnerability and reduces the quality of its approach to it.

The force has introduced daily meetings attended by managers and staff, who give updates on and respond to priority incidents and operational demand. These meetings are supported by IT linked to the force's intelligence system, but the information on those systems isn't always complete. However, the meetings help leaders have confidence in the force's response to risk and vulnerability, and task extra resources and capability where necessary without delay.

Another recent positive change to the operating model is the daily missing persons meeting, which is attended by local authority staff as well as force personnel. Managers oversee all missing person incidents and make sure that responses are appropriate to the levels of assessed risk. The information discussed in these meetings is up to date and is used to support operational decisions. This approach has improved supervisory direction and makes sure priority actions are clear.

More should be done to improve how the force and its safeguarding partners use the information they hold on risk and vulnerability. For example, the force's performance data and scrutiny processes don't focus on critical vulnerability (such as multiple repeat victims who are known to the force through public protection notice (PPN) reports and as crime victims). And the force and its partners should be doing more to identify cases of child neglect that may be missed when the focus is on adults. We found that this was the case in some domestic abuse incidents.

Positively, the force has involved its managers in quality assuring records of incidents and crimes. Supervisors routinely dip-sample cases and give feedback to officers on the results of this to help them improve responses. Information from well-focused audits is vital for managers to understand the end results of their staff's activity. But the force needs to be clear to staff about what good quality end results mean for the people who receive its support and services.

The force has its own training capability and also works with other nearby forces to provide specialist courses. The DCC chairs the force's training and commissioning group meeting. The force's training priorities are inducting new recruits and providing five continuing professional development training days for all frontline staff, with vulnerability modules throughout. The workforce also has access to multi-agency safeguarding training provided by the DDSCP. And the force's intranet features lessons learned from safeguarding and domestic abuse reviews to help staff respond better to future incidents.

The force has begun a review of its workforce's skills and capability. Results from this will be included on the training system to inform leaders and managers about existing capability gaps and help them plan more effectively for the future. Currently, this information isn't consistently in place. We found significant shortages of trained specialist investigation officers in the teams dealing with child abuse, domestic abuse, and rape and serious sexual offences.

We found that recruitment to some specialist teams had proved difficult for the force. And it has experienced similar challenges to other forces in recruiting and retaining detectives in vulnerability-related roles. These problems have been made worse by factors specific to the force. For example, a supervisor told us that after being transferred away from response duties, they had lost a substantial amount of shift allowance pay. Other staff told us about a force policy that prevented officers with child protection skills transferring in from other forces from joining the child investigation teams (CIT). Another policy meant that on selection for promotion, detectives had to take up a uniform policing role. Senior leaders told us they were now changing these policies.

The recruitment difficulties mean the force's trained child protection officers have high workloads. For some, this is very detrimental to their morale and wellbeing. The force offers wellbeing support to all its workforce, and enhanced support for some specialist units like the management of sexual offenders and violent offenders (MOSOVO) teams and the protecting children online team (PCOT). These teams welcomed the support they were offered. But in some investigation teams, such as the CIT and rape and serious sexual offences team, the provision of wellbeing support wasn't as well received.

Senior leaders told us they work hard to maintain and support their staff on investigation teams. But not all staff we spoke to realised this. They didn't understand why some specialist investigation officers were routinely assigned to other duties like public order and sporting events when their own teams were short staffed. Better communication between leaders and specialist safeguarding staff is needed to make sure the workforce receives the support it needs to work effectively in all areas.

We saw inconsistency in the understanding of risk, as well as about when PPNs are needed and what information they should include. Some supervisors didn't understand these matters well enough. The confusion means that some officers submit PPNs unnecessarily, which clogs up the system. And responding officers often make incorrect risk assessments, particularly for domestic abuse incidents. Sometimes officers don't consider risk beyond the presenting incident. For example, when responding to domestic abuse between adults, they sometimes overlook the neglect of children.

But we found that, overall, the workforce was much more attuned to vulnerability than at our previous inspection. This is demonstrated in records we saw where the voice of the child (VoC) was recorded and acted upon. We saw control room staff telling responding officers about warning markers for vulnerable children and prompting them to use body-worn video (BWV) to record incidents and children's circumstances. Officers were then asked to record the children's views and demeanours on PPNs so children and their families could get the help they need to be safe.

4. Case file analysis

Results of case file reviews

For our inspection, Derbyshire Constabulary selected and self-assessed the effectiveness of its work in 34 child protection cases. Under our criteria, the cases selected were a random sample from across the area.

Our inspectors also assessed the same 34 cases.

Cases assessed by both Derbyshire Constabulary and us

Force assessment:

- 19 good
- 12 require improvement
- 3 inadequate.

Our assessment:

- 8 good
- 16 require improvement
- 10 inadequate.

Our inspectors selected and assessed 36 more cases during the inspection.

Additional 36 cases assessed only by us

- 21 good
- 8 require improvement
- 7 inadequate.

Total 70 cases assessed by us

- 29 good
- 24 require improvement
- 17 inadequate.

Breakdown of case file audit results by area of child protection

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

- 5 good
- 5 require improvement
- 2 inadequate.

Common themes include:

- in most investigations, there are strategy discussions with children's social care (CSC);
- but the force doesn't record investigation plans well (with actions and updates);
- the force doesn't make enough joint visits with CSC;
- officers are inconsistently recording the VoC;
- officers don't always identify and address wider safeguarding risks;
- officers and supervisors don't always identify and record crimes against children; and
- officers often don't often record ethnicity.

Cases assessed involving referrals relating to domestic abuse incidents or crimes

- 4 good
- 2 require improvement
- 4 inadequate.

Common themes include:

- most responses are prompt;
- the force gives officers information about risk and vulnerability to help their approach;
- officers use BWV to record children's voices and gather evidence;
- officers often don't record ethnicity;
- the force makes referrals to schools via stopping domestic abuse together (SDAT) mobile notifications, Derbyshire's equivalent to Operation Encompass;
- officers sometimes miss offences of neglect, so strategy meetings with CSC to plan safeguarding for the children don't take place; and
- supervisory guidance and endorsement is inconsistent.

Cases assessed involving referrals arising from incidents other than domestic abuse

- 6 good
- 1 requires improvement
- 3 inadequate.

Common themes include:

- generally, there was a prompt response;
- but PPNs for some children don't reach CSC services quickly enough;
- this delays safeguarding activity;
- supervision is inconsistent;
- officers don't often record ethnicity;
- officers use protective powers appropriately; and
- crimes against children aren't always identified or recorded.

Cases assessed involving children at risk from child sexual exploitation

- 6 good
- 2 require improvement
- 4 inadequate.

Common themes include:

- online investigations are risk assessed and notified to CSC services without delay;
- control room staff don't always prioritise CSE risk;
- officers don't always complete PPNs to record risk and CSE vulnerability;
- officers often miss golden hour opportunities to gather evidence;
- there are delays in arrests for peer-to-peer abuse, and some opportunities for disruption activity are missed;
- officers don't always identify crimes against children and record these on force systems; and
- there are delays in digital investigations.

Cases assessed involving missing children

- 2 good
- 4 require improvement
- 1 inadequate.

Common themes include:

- control room staff always record a THRIVE risk assessment;
- some supervisors make sure investigation plans are tasked without delay;
- intelligence checks are quickly made available, but not included in reassessments of risk;
- sometimes exploitation risk is overlooked or diminished; and
- phone checks to locate high-risk missing children are sometimes delayed.

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

- 2 good
- 2 require improvement
- 2 inadequate.

Common themes include:

- in most cases, police attend incidents quickly and safeguard children well;
- supervisors' records are inconsistent, but we did see some good supervision and decision-making;
- the end of the use of police protection power isn't always recorded;
- in some cases, officers don't recognise crimes (in particular, neglect);
- in some cases, officers don't record crimes correctly; and
- officers don't always submit PPNs where appropriate.

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

- 2 good
- 3 require improvement
- 1 inadequate.

Common themes include:

- officers work well with probation officers and social workers to assess offenders' risk;
- officers don't always act consistently when offenders commit offences;
- officers don't always make new assessments when offenders' circumstances change;
- supervision isn't consistently in place; and
- when offenders commit offences, officers don't always take appropriate action.

Cases assessed involving children detained in police custody

- 2 good
- 4 require improvement
- 0 inadequate.

Common themes include:

- officers tell CSC services when they detain children in custody;
- appropriate adults mostly attend promptly to see detained children;
- children were seen by healthcare and liaison and diversion professionals;
- custody officers don't consistently understand the requirement to contact CSC for alternative accommodation for detained children; and
- when alternative accommodation for some children after they are charged isn't available, custody officers don't escalate the problem to senior officers.

5. Initial contact

Recommendations from the 2021 inspection report

- We recommend that Derbyshire Constabulary immediately reviews its missing persons arrangements and practices to ensure that, throughout the missing incident, there is always an effective response to vulnerable children.
- We recommend that Derbyshire Constabulary immediately reviews its arrangements and practices to ensure that officers responding to domestic abuse incidents benefit from good quality information from police systems. And that all children affected are seen and spoken with so that their vulnerability is recorded, fully assessed and acted upon.

Re-inspection findings

The force has improved its responses for missing children, but some inconsistent practice remains

We saw that control room staff always carried out THRIVE risk assessments when the force received reports of missing children. And they passed the incident to i24, the control room intelligence team, for immediate research to give further detail about the level of risk. This is an efficient process and should mean the initial risk assessment is updated quickly so the assigned response is appropriate to the child's vulnerability.

But we found that the risk assessment and response prioritisation process wasn't including the information from i24. Instead, inquiries were being assigned to response team inspectors to reassess at a later stage. This is less effective than immediately incorporating i24's research. Although information about risk was available, it wasn't being used to check risk as soon as it could be. It means that the response to some high-risk missing children is delayed. When we told force leaders about this, they made changes to rectify the process.

The force's missing person investigation team (MPIT) takes a consistent approach to missing children investigations. We saw MPIT officers making a positive contribution by quality assuring risk assessments and making sure high priority enquiries were completed or assigned to frontline staff. But we found that the force wasn't responding to some overnight investigations with the urgency the risk assessments required. And although the force has a policy that children at high risk of CSE should be assessed as high risk when reported missing, we found that this wasn't being applied consistently.

The MPIT intelligence officer gathers information to help find missing people by checking force and national systems (including financial data) and using the police national database (PND) facial recognition facility. But we found that this work was being carried out inconsistently. For example, we saw a case where only the missing child was researched and not the named boyfriend she was believed to be with.

We found that the force's systems held good information to help responders find missing children. Some of this information is taken from comprehensive return home interviews with the children. Following the interviews, the updated information is highlighted on systems by vulnerability flags identifying risks and directing officers to relevant information, such as trigger plans to help them quickly find children. The force's missing persons system, COMPACT, is regularly updated with recent addresses and other information that helps set priority enquiries to find the child.

Frontline staff knew that vulnerability is a priority for the force. They knew not to use victim-blaming language. And they had an improved understanding of exploitation, which they said had changed their responses to missing incidents. They completed PPNs, but we found that some of these didn't focus enough on the VoC or reflect the information on the COMPACT system. So trigger plans aren't always being updated with new information. And we saw delays of up to four days in PPNs being sent to CSC services after a child was found.

We also found some unnecessary barriers and delays to obtaining data from mobile phones to help find missing children. In one incident, managers refused mobile phone applications being made for a high-risk missing child, and no urgency was attached to this clear priority line of enquiry for several days. Some investigating officers said that where there is a child exploitation risk, the urgency and seriousness of their applications isn't always understood by the senior officers who must authorise these phone use checks.

Case study: inconsistent response for a missing child

A 16-year-old boy at high risk of criminal exploitation was reported missing. The initial THRIVE assessment was medium risk because the operator didn't refer to the existing trigger plan.

The investigation was assigned to the MPIT. But no actions or tasks were recorded for seven hours until a new risk assessment confirmed the risk as being high.

Investigating officers established that they needed information about the boy's mobile phone use. Their requests were initially delayed overnight. Phone data was later obtained, allowing the MPIT officers to make numerous enquiries with the boy's contacts.

The officers told CSC services about the incident at an early stage. And they discussed the multi-agency response in a strategy meeting 72 hours after the incident was reported.

But a multi-agency decision not to carry out a media appeal was inappropriately influenced by the views of one of the boy's parents. This should have been secondary to focusing on the child's best interests.

The detective inspector reviews were timely and there was a clear handover of lead responsibility throughout the investigation. But some reviews added little impetus to finding the child, and one overnight review reduced the incident's risk level to medium without any rationale.

After nine days the boy returned home himself. Officers saw him to carry out a prevention interview, and recorded information from this on a PPN. But it took seven days to share the PPN with CSC services.

We found no record of a return home interview taking place.

The force works with multi-agency partners to reduce risks for missing children

It is vital to understand why children go missing to keep them safe. Some children run away from home because they are unhappy or being abused. Others are influenced, coerced or exploited by adults or peers who want to take advantage of them or harm them. Some are affected by both situations. But all missing children are very vulnerable.

The force holds its own daily missing persons tasking meeting, attended by staff from various teams across the force area. This updates managers about current enquiries and lets them assign and escalate resources to take cases forward.

MPIT staff identify children who are repeatedly reported as missing. And they work with multi-agency partners to better understand these children's vulnerability and the risks they face. This means they can plan interventions to help the children and keep them safe. The meetings with the partner organisations consider children who are reported as missing three times in thirty days. And formal strategy meetings are held with CSC services for children who go missing 3 times in 90 days.

There are separate multi-agency missing children panel meetings in each local authority area. These meetings would benefit from a consistent title and terms of reference to clarify their purpose and focus.

Nationally, the Philomena Protocol has been very successful in reducing the demand on police time and resources arising from missing children reports. But the force hasn't fully implemented the protocol with its safeguarding partners and the children's homes in its area. This means children's home staff aren't making enough initial enquiries to locate children before reporting them as missing to the police. Care home staff have a responsibility to make reasonable enquiries to locate children and get them back home themselves.

Control room responses to reports of domestic abuse have improved

We found that control room staff assigned appropriate responses to domestic abuse incidents. This means staff use THRIVE to assess risk and prioritise cases where an immediate police presence is needed. Where appointments are made for officers to attend later, supervisors check these incidents to make sure risk hasn't increased and that the force's response remains appropriate.

Where children are thought to be present, control room staff support responders and prompt them to follow force policy using an approach the force refers to as 'VCP'. This reminds responders to video incidents on BWVs, record the VoC, and record the incident on PPNs.

For most domestic abuse incidents, we saw officers responding quickly and making thorough investigations. And we saw flags and warning markers in place on the force's systems to alert staff about domestic abuse risk and vulnerability.

Frontline staff have been given additional vulnerability training and guidance, but this needs to continue to improve responses

The force has prioritised vulnerability training, which includes modules about child protection for frontline staff. Specialist staff from the public protection teams contribute directly to this training to inform staff about the role of each specialist team, and about how the force contributes to multi-agency processes such as multi-agency risk assessment conferences (MARAC) and strategy meetings.

There is also guidance about child protection on the force intranet system. This means that frontline staff can check what they need to do even when specialist staff aren't available. For example, we saw good guidance about what to do when taking a child into police protection. There is also guidance about how and when to complete PPNs.

But we saw that many PPNs completed by responding officers for domestic abuse incidents were below the standard the force required. In many cases, important information such as the ethnicity of adults and children wasn't recorded. And risk assessments inaccurately reflected the severity of an incident or its effects on children.

Frontline supervisors don't check PPNs submitted by their staff for completeness and accuracy. This means that staff in the domestic abuse review team (DART) have to check this work. DART has given feedback about missing information to officers, but this in itself hasn't improved the quality of PPNs.

Frontline responders don't understand domestic abuse risk levels well enough. They assess too many domestic abuse incidents as high risk. According to the force's figures, the DART assessment later reduces 61 percent of these high-risk reports to medium risk. And conversely, DART reviews changed 7 percent of medium-risk assessments to high risk. DART managers told us that this situation is getting worse. In a recent quality assurance check of 24 high-risk domestic abuse PPNs, they assessed that only 1 incident met the criteria for being high risk.

This inconsistency must be addressed. Responding officers and their supervisors need to understand risk better to act appropriately. This is particularly important when helping vulnerable children in these households, or any other children associated with the adults involved.

When officers assess that children are affected by domestic abuse incidents, they share this information electronically with the child's school using the SDAT facility on their mobile devices.

Case study: child neglect in domestic abuse incidents isn't always identified

Police responded to a domestic abuse incident between the parents of three children aged between five and nine-years-old. The parents were both drunk and the mother had been assaulted in the presence of the eldest child.

The officers arrested the father for assaulting the children's mother.

When the officers arrived, they found that all three children were very distressed. The house was very dirty and messy and there was a lack of food. The mother's intoxication meant she was incapable of looking after the children herself.

But a friend of the mother was present at the address. Despite the mother's drunkenness, the officers decided to leave the children at home with her and her friend. They didn't record the other woman's name or whether any checks had been made on her suitability to safeguard the children.

The officers didn't secure or preserve any evidence about the neglect of the children. And they didn't speak to the children about it either. No crime report for neglect was recorded.

There is no record of the responding officers' reasons for not taking the children into police protection. And there is no record of them contacting CSC services to discuss what should be done in the best interests of the children.

We saw no evidence of any later strategy discussion or plan to protect these children from the increasing risks in this home.

6. Assessment and help

Recommendations from the 2021 inspection report

- We recommend that Derbyshire Constabulary immediately reviews its arrangements and practices for incidents of missing children to align with the national standards within the College of Policing authorised professional practice (APP).
- We recommend that within three months Derbyshire Constabulary engages with its safeguarding partners and reviews its assessment and information-sharing practices to ensure that vulnerable children are identified at the earliest possible stage and referred without delay to the most appropriate level of support.
- We recommend that within six months Derbyshire Constabulary engages with its safeguarding partners and reviews the terms of reference and practices of all its multi-agency risk management meetings – including those for children at risk of exploitation or domestic abuse, and children missing from home.

Re-inspection findings

The force's policy for missing children follows national guidance

The force has reviewed and revised its policy for responding to missing children so that it complies with the national standards in the College of Policing APP. It no longer labels children as being 'absent' when they are reported as missing by their parents or carers.

Information sharing arrangements with other safeguarding organisations are still not fully effective

The force works with its statutory partners in both local authority areas to make sure there is a co-ordinated multi-agency approach to safeguard children. Both areas have arrangements in place to manage the flow of information for child protection referrals or where there are concerns about the welfare of children. Derby City has a multi-agency safeguarding hub and Derbyshire's contact and referral service is known as 'Starting Point'.

Police officers respond to many incidents where children's vulnerability, for that event itself, is below the level needed for a CSC referral. The force understands that it still needs to record any vulnerability and risk in these incidents, because it has a statutory responsibility to work with its safeguarding partners to promote the welfare of children.

Previously, these PPN records were sent directly to the local authority without any other information from police records or supervisory review. But this is no longer the case.

Statutory guidance in *Working Together to Safeguard Children 2018* states:

> "Everyone who works with children has a responsibility for keeping 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.
>
> Anyone who has concerns about a child's welfare should make a referral to local authority children's social care and should do so immediately if there is a concern that the child is suffering significant harm or is likely to do so. Practitioners who make a referral should always follow up their concerns if they are not satisfied with the response."

We were told that the local authorities have raised questions about the numbers of referrals they are sent by the police and some other organisations. They want to focus their staff's work on children at higher risk, in line with their statutory responsibility for intervention. But the force rightly wants all information about children's vulnerability to be seen and considered by staff in other organisations. This is so that early intervention and prevention services can be offered to help vulnerable children.

Some multi-agency training and advice has been given to the force's staff to help build their understanding of levels of intervention using the DDSCP *Threshold Document*.

The force recently introduced new processes and more staff to its risk assessment and referral unit (RaRU) and to its DART. Both teams now have clear terms of reference.

The force has increased the capability of its risk assessment teams, but processes and ways of working still need to improve

Encouragingly, the force has now trained its RaRU staff appropriately. They now research a minimum of six months' information from the force's systems to complete better informed risk assessments for each child.

Their primary role is to assess records of incidents made on PPNs by responding officers. They then share information about risk and vulnerability with safeguarding organisations by holding child protection strategy meetings or MARAC for high-risk domestic abuse victims. Or they may send PPNs where they have other concerns about children's welfare.

These are vital safeguarding processes. So it is important for the force to accurately identify vulnerable children in its assessments and work without delay to reduce risk and harm.

Although officers complete PPNs, they don't all fully understand the purpose of these reports and what information is needed in them. There is no frontline supervision of PPNs. They are sent to the RaRU and DART teams, where they are supervised for the first time.

These teams give feedback to some officers about deficiencies in the information recorded on PPNs. But this is often delayed due to setbacks in the PPN process, and officers' shift patterns. The lack of frontline supervision of PPNs means that if officers have missed concerns such as child neglect, there will be delays in multi-agency safeguarding activity to protect those children.

There are significant backlogs of PPNs awaiting research and supervision in both RaRU and DART. During our inspection we found the following backlogs:

- 342 PPNs about vulnerable children (the oldest dating back to 3 May 2022);
- 277 PPNs about vulnerable adults; and
- 443 PPNs about domestic abuse incidents.

Supervisors don't know what level or type of risk is contained in each PPN in the backlog until the record is opened. The backlog is dealt with in date order, being seen as a queue of records to work through.

This means that managers don't have a robust triage system to prioritise high-risk cases for research so they can be fully assessed. Triaging needs to begin without further delay to improve the force's approach to risk. The process also needs to identify PPNs that don't require research. This could be because they aren't about safeguarding or promoting children's welfare. Or because the children/adults involved are currently being assessed or protected by social workers who need to see the new information without delay.

There are delays in holding child protection strategy discussions

Strategy discussions about child protection concerns with CSC managers are assigned to RaRU supervisors. But there aren't always enough supervisors to attend these vital child protection meetings. And the force told us that sometimes the unavailability of CSC managers means there are delays in holding the meetings. Sergeants from the force's CITs also attend strategy meetings to help the force meet this demand.

During the inspection we found there were 30 child protection strategy meetings waiting to be held, but no police supervisor was available to attend these.

RaRU staff are also responsible for adding records of the strategy meetings to the force's systems. There is a backlog of about 700 documents waiting to be entered. Officers attend strategy meetings and record summaries of information shared and decisions made. But investigating officers told us that the summaries and details of action plans weren't always accurate.

These delays mean that some children may be left at risk, or without the help they need to thrive, for longer than necessary. Information about child protection concerns should be assessed quickly and accurately so the appropriate services can be put in place.

Children affected by domestic abuse aren't always being identified quickly enough

Responding officers make the initial risk assessment grading decision for domestic abuse incidents. Their decisions aren't routinely checked by supervising officers. Many responding officers are inexperienced. And although they have received some vulnerability training about domestic abuse, they aren't specialists. These officers tend to grade a high percentage of domestic abuse incidents as high-risk, and that grading is often reduced by DART staff.

When we reviewed the DART team's decisions, we found that some incidents had been inappropriately assessed as medium or standard risk. We saw examples where wider risk to children wasn't recognised or the cumulative effect or escalation of concern from previous incidents wasn't seen as significant. And there wasn't supervisory endorsement of these DART decisions.

This meant that some DART risk assessments were inconsistent and inaccurate. And that some cases that should have been referred to MARAC for multi-agency safeguarding management were missed or delayed until abuse escalated in later incidents.

Multiple repeat standard-risk domestic abuse incidents aren't considered for MARAC, despite escalating concerns being evident. In one case we saw, there were five recent incidents of assault and abuse. But no referral was made to MARAC and no strategy meeting took place for the children.

The force and its partners aren't following the national SafeLives guidance about reducing harm from domestic abuse. Such as including 3 repeat domestic abuse incidents in 12 months in MARAC meetings. Officers told us they thought MARAC cases would rise significantly if these guidelines were closely followed. But the current meeting arrangements don't have the capacity to deal with an increased volume of cases. The force and its partners need to actively review and consider their policy and MARAC terms of reference to make sure the arrangements are effective and resourced appropriately.

The multi-agency response to children affected by high-risk domestic abuse isn't fully effective. Too many incidents are incorrectly assessed, and MARAC isn't managing all the cases that it should include. Investigating officers dealing with high-risk cases told us that the current arrangements for taking notes of the MARAC meetings means they aren't available on the force's systems. So the officers can't see what decisions and plans MARAC has made to protect victims and their children.

Multi-agency safeguarding meetings

We reviewed multi-agency public protection arrangement (MAPPA) meeting records and observed one meeting. We found that the arrangements were well managed and effective.

RaRU staff attend all initial child protection conferences and all high-risk review conferences. They research force systems to make sure the information they share in the multi-agency meetings is accurate and updated. And the staff update the force's systems with information about children at risk to inform frontline responders called to those addresses.

The terms of reference for multi-agency child exploitation meetings aren't clear enough. We observed a meeting that was held online with 32 attendees. These represented a good range of organisations, but the attendees' roles and suitability to represent their organisations was unclear.

The partnership's analytical information for this meeting didn't provide attendees with enough detail to help them fully understand risk in the area. Better multi-agency intelligence profiles about locations, victims and perpetrators need to be in place to support the meeting's decisions.

Although there was an agenda, discussions didn't always benefit from multi-agency information because not all attendees were fully prepared for the case discussions. At times, the meeting became a series of individual case discussions, similar to strategy meetings. But it should be used as a higher-level tactical or strategic oversight opportunity to help the partnership reduce exploitation risk to children in its area.

7. Investigation

Recommendations from the 2021 inspection report

We recommend that Derbyshire Constabulary immediately improves child protection investigations by ensuring that:

- investigations are effectively supervised, with reviews clearly recording any further work that is required;
- safeguarding referrals are timely and comprehensive;
- joint multi-agency investigations are appropriately supported;
- investigations are assigned to officers with the skills, capacity and competence to progress them effectively; and
- the quality of practice is regularly audited, including the effectiveness of safeguarding measures and a focus on achieving the best end results for children.

We recommend that within three months Derbyshire Constabulary reviews its policy and practice for responding to incidents where indecent images of children are present on digital devices. This should include:

- issuing guidance to all operational staff;
- providing technical support to identify and remove files;
- supporting children and families;
- appropriate responses to child offenders; and
- effective supervisory oversight.

Re-inspection findings

Child investigation teams don't have enough staff to meet demand

Positively, the force reintroduced dedicated CITs in February 2021. The intention was to provide a specialist response to carry out effective multi-agency investigations for crimes of child abuse and neglect.

There are two CITs, covering north and south divisions. But neither has the numbers of permanent and fully trained child protection detectives they need to meet rising demand. We found that the situation was worse in the north CIT, resulting in the

south CIT taking investigations for part of the north's area. Overall, CIT officers have high caseloads of approximately 17 investigations.

Managers have assigned extra detectives from other units, such as the force's surveillance team, to improve the CITs' investigative capacity. This has helped, but these officers haven't chosen to work in child abuse investigation. And as their attachment is a stopgap, they aren't assigned as lead investigators. This means they don't help alleviate the long-term caseloads of existing staff.

The CIT staff we spoke to are highly committed, appropriately trained and work hard to try to carry out effective investigations for children. The staff access safeguarding partnership training to improve their effectiveness. They applied to work on the team and are passionate about their role. But they said they feel unable to complete work to the standard that they want to because of excessive workloads and a lack of staff.

The CITs are allocated all serious sexual offences against children, including non-familial allegations. These investigations form a significant part of the teams' caseload.

All CIT detectives have personal issue force laptops. Officers and their supervisors told us that despite being told not to, they still regularly work additional hours at home to try and keep investigations up to date. This had led to some CIT staff not being available for work due to stress-related illness.

Delays lead to ineffective CIT investigations

Overall, we saw an improvement in the frontline response to child protection investigations. Control room staff risk assessed calls and sent officers to respond without delay. They supported responding officers with information from force systems and prompted them to use their BWV, record the VoC and complete PPNs.

Where children needed urgent medical help, this was provided effectively, including access to forensic sexual examination facilities.

In the cases we audited, when matters were straightforward, we saw good investigations that were quickly resolved. But in more complex investigations, (such as those needing multi-agency investigation, or where there were multiple victims and suspects) we often found delays that undermined the effectiveness of the service given to victims.

Case study: good response to an allegation of child abuse

The mother of a nine-year-old boy took her son to hospital saying his father had injured his neck.

Response team officers went to the hospital and used their BWV to record the child's account. They recorded the allegation and submitted a PPN which was sent without delay to CSC services.

A strategy discussion between CSC, health services and police decided that a multi-agency investigation was needed to gather evidence and protect the child and his family.

As no CIT officers were available, the investigation was allocated to criminal investigation department detectives. They acted quickly and arrested the boy's father to reduce the risk to the child and his mother. The father denied the allegation of assault. He was bailed with conditions to safeguard the family while the case was reviewed by the CIT detective inspector.

The boy and his mother didn't want to prosecute the father and the case was appropriately closed.

Since the start of the pandemic, strategy discussions have been mostly held virtually. They are generally run by supervisors from the RaRU. They are usually well attended by partner agencies. This allows for information to be shared effectively to understand children's vulnerability.

But we found significant delays in holding strategy meetings. Sometimes this is because of capacity in the RaRU to hold them. This means that CIT sergeants often need to hold strategy meetings for investigations allocated to their team. One CIT detective sergeant told us they had held six strategy meetings the previous day and two meetings already on the day we spoke. Sergeants in situations like this are unavailable for their main supervisory roles.

There are significant delays before records of strategy meetings are added to the force's system. Although notes of actions from the meetings are quickly available, the delay with the main records means that investigators and their supervisors aren't aware of everything that has been discussed. We found that there were approximately 700 strategy meeting records waiting to be added to the force's system. This represents an ineffective process.

CIT managers accepted these delays and said some were the result of factors outside the control of the team. These included regular waits for 8 to 12 weeks to get intermediaries to help interview vulnerable children, delays of about 12 months for digital forensics results, and delays in getting advice from the Crown Prosecution Service.

But we found that supervisory reviews of CIT cases were inconsistent. They didn't drive investigations forward or make sure safeguarding planning was in place. In too many cases, supervisors didn't record or review timely investigation and safeguarding plans.

Sergeants told us they sometimes received calls from managers in other agencies who were frustrated about the lack of progress in police investigations.

Case study: ineffective investigation and safeguarding

The force was informed about a sexual assault by an uncle on a young adult at her home when she was 11 to 12 years old.

A crime report was made, but there was a delay before a PPN was sent to CSC services. The victim was now an adult, but the suspect had access to his own children who were potentially at risk.

At a strategy meeting it was agreed that a joint investigation was needed. The suspect was later arrested and released with bail conditions to protect his children.

Indecent images of children were found when the suspect's phone was eventually examined nearly two months after his arrest. Several of these images were of a partially naked young girl in a school shirt.

The suspect wasn't arrested for these new offences or questioned about the images.

CSC services wasn't told about the new evidence. And no new investigative strategy was implemented to identify the child/children in the images and check on their safety.

Supervisory oversight of this investigation didn't drive it forward well enough. So there were investigative delays and risks to children remained unassessed and unknown.

We brought these matters to the attention of the force, and managers have responded appropriately.

The CIT uses inappropriate ways of working to reduce demand

Supervisors and managers aren't making sure that multi-agency investigation practice standards are effective.

We saw some crime allegations where there was an inappropriate reliance on CSC services to make the initial investigations and assessment. For example, for allegations of assaults, social workers were often told to visit the child and family alone

to assess the concern. Police would only join the investigation in these cases if additional and serious evidence was reported back.

Supervisors said that demand and limited resources meant that joint investigation visits would generally only take place for serious sexual offences. This means the force isn't properly investigating all child protection allegations.

CIT officers routinely ask suspects to voluntarily attend police stations for interviews rather than arresting them. This is to save time and to help manage workloads. Investigating officers try to gather supporting evidence before interviewing suspects unless an arrest has already been made. This way of working undermines opportunities to investigate proactively and seize some corroborating evidence – such as digital media. It also means there may be delays in safeguarding victims and witnesses, because bail conditions can't be placed on a suspect to stop contact.

The constabulary has a backlog of 58 outstanding suspects who are wanted for serious sexual offences. This includes offences against children. The longest of these delays date back to August and September 2021. The supervisory reviews of some of these investigations are also delayed. And this means the risks from offenders isn't being fully assessed and understood. Because of workloads, the investigating officers only have very limited capacity to make arrest enquiries themselves.

Managers haven't recognised this problem sufficiently or involved force leaders in addressing it. And they haven't sent requests for the arrests to be included in the force's tasking process. We brought this situation to the force's attention. It then took action to review the risks and introduce a new process to monitor and ensure effective management of the outstanding suspects. This confirmed that managers weren't using the information on the force's systems to drive activity against high-risk offenders.

Arrangements to investigate child exploitation have improved

A child exploitation investigation unit (CEIU) is now in place, with clear terms of reference to safeguard children, investigate offences and disrupt offenders. This is a new arrangement, and its capability was still being established during this inspection. But, at present, the unit has enough supervisory capability. There are four detective sergeants to drive work forward and hold strategy discussions with CSC services to jointly plan interventions and investigations. We saw good multi-agency interventions and investigative planning in strategy meetings held for exploited children.

The CEIU and the missing persons investigation team are led by the same detective chief inspector and detective inspector. This is designed to make sure the teams work closely together to use information and intelligence more effectively. (Many of the children the teams are concerned are vulnerable because they are frequently missing, and they are also at risk of exploitation.) This arrangement should help the force work more efficiently to identify children at risk earlier. And to assign an appropriate multi-agency response to get the best outcome for the children.

CEIU officers are specialist detectives with the investigation skills to carry out complex investigations and participate in multi-agency safeguarding activity. A dedicated exploitation co-ordinator is responsible for managing information on force systems, including flags and warning markers, association charts and trigger plans. And the team's intelligence development officer researches and analyses the previous 24 hours of police data to identify children at risk, perpetrators and places linked to exploitation. We found that officers at all levels understood that exploited children shouldn't be criminalised. And we saw evidence of children being diverted away from criminal justice processes.

We saw that in some sexual offence cases, investigating officers delayed arresting the suspects until after victims were interviewed. But some interviews are delayed for a long time due to the availability of intermediaries. This means that some investigations are stalled unnecessarily despite victims having made actionable disclosures about an offence. This way of working also doesn't allow the force to implement protective measures such as offender bail conditions.

Case study: an effective CSE investigation

A 14-year-old girl was approached on social media by a male who had offered her money to perform sexual acts on him.

She told school staff about the incident and the headteacher reported it to the police. A strategy discussion was held without delay and safeguarding measures were put in place to protect the child. The girl was consulted, and she and her parents were informed of the plans.

Detectives quickly identified the suspect and confirmed that he was also suspected of similar offences that were being investigated by non-specialist officers. The investigations were linked by CEIU.

They assessed the case and decided not to delay action until after the victim had been formally interviewed with the help of an intermediary.

The suspect was quickly arrested, interviewed and released on conditional bail while forensic investigations into digital media were under way.

Through their actions, the investigating officers prioritised the safety of the girl and other potential victims. They kept the family and safeguarding partners updated about progress and carried out a thorough, child-centred investigation.

There is a good approach to criminal exploitation and county lines vulnerability

The force responds well to serious youth violence and criminal exploitation linked to drug supply. It works effectively with its safeguarding partners to identify vulnerable children and people who are a risk to them. Operation Wintershield is an example of a

multi-agency operation to tackle serious and violent crime across the county. In this operation, problem-solving techniques such as dispersal orders are used alongside proactive criminal investigations to target offenders. And Operation Blofeld was a partnership-based approach to reduce harm to vulnerable children who were identified as being at risk from county lines drug supply gangs.

The approach to digital child abuse is focused on safeguarding children

Immediately after our last inspection, force leaders made fundamental changes to improve the approach to online child abusers. The paedophile online investigation team (POLIT) was renamed the protecting children online team (PCOT) to emphasise the force's priority on safeguarding children.

PCOT staffing levels have been increased to meet increasing demand and speed up investigation work. Previous backlogs of intelligence notifications about online offenders from the National Crime Agency and other law enforcement organisations have been significantly reduced, with a sustainable plan to reduce these further. And the force has introduced new intelligence officer roles to manage and risk assess these referrals. These officers record the referrals on force systems with appropriate flags and warning markers to alert all staff.

A new operating procedure, with accompanying guidance, on the force intranet helps all staff respond effectively to incidents involving indecent images of children. This makes sure that all staff have access to specialist advice and policy on how to deal with online child abuse.

PCOT supervisory reviews are consistently good, giving clear direction and recording the reasons for any decisions taken. But we saw some delays in PCOT PPNs being sent via the RaRU to CSC services. Intelligence about this type of potential risk to children should be notified without delay.

We saw that sergeants were often sharing information directly with CSC services when police research indicated that children were associated with a suspect or an address. But this practice is inconsistent with the clearly defined strategy meeting process that should be followed if children are at risk of significant harm. Strategy meetings bring safeguarding organisations together at the earliest stage to understand the information they hold separately and decide how best to protect children. PCOT managers contacted CSC managers to start using the strategy meeting process to discuss online risk to children after we raised our concerns about them not routinely following this process.

The force makes sure that PCOT staff have access to regular psychological screening and wellbeing support. This reflects the leadership's clear understanding of the negative effects that repeated exposure to child abuse images may have on its specialist officers.

Rising demand from online child abuse means the force has to change its approach to better support victims

PCOT has a high caseload. Each officer has about 29 crimes at various stages of investigation. Managers have created an additional sergeant post in the team to improve supervisory oversight.

The force recently invested in digital triaging equipment and training. This means that suspects' digital devices can be triaged at crime scenes or while searches of premises are made. This helps the team to find evidence quickly and focus forensic examinations more effectively, saving time and resources. It also supports more effective safeguarding, because decisions to arrest and apply bail conditions are supported with earlier evidence.

PCOT provides support for non-specialist officers who investigate allegations of indecent images of children where these are sent between individuals – for example, self-generated naked images known as sexting. These investigations were mostly the responsibility of local policing team staff. We saw delays in progress and inconsistent supervision. But PCOT doesn't have the capacity to investigate these crimes itself. The force is considering how best to respond to this increasing demand.

Case study: online offence investigation delays don't support victims

Two sisters, seven and nine years old, were sent indecent images to their phones by a suspect using a social media site. The older sister took some indecent images of herself and sent them back to the suspect. He asked to meet the girls close to their home. Police were informed but the suspect didn't attend.

Responding officers sent both girls' phones for examination. The officers recorded a safeguarding incident and PPNs for both children and gave advice to their family. A supervisor closed the incident.

An officer from a local policing team was allocated the investigation. The officer recorded an investigation plan and submitted the phone for a forensic image examination about two weeks after the incident. But there were no investigation updates of contact with the victims' parents for over three months. There was an entry recording that the officer was unable to take enquiries forward due to other commitments.

The one supervisory entry during this period added no value to the investigation.

Six months after the incident, an entry from a digital media investigator noted that the investigating officer had requested their support. But no actions or plan in relation to this was recorded.

This investigation was still open and awaiting updates.

Forensic examination of digital media is the responsibility of the force's digital forensic unit (DFU). We found significant delays in the time it took the DFU to complete these examinations. Managers told us that it regularly took 12 months before an examination of a mobile device (such as a phone) was completed. But they said that in urgent cases, such as if a suspect was remanded in custody, examinations could be prioritised.

The officers and managers we spoke to were unaware of the force's service level agreement with the DFU for timescales to complete examinations. This meant they didn't use any escalation procedure to challenge delays. Instead, PCOT staff relied on informal contact with DFU staff to prioritise cases. But this arrangement is less available to staff who are unfamiliar with DFU processes.

The force's policy is that all gradings about the content and severity of indecent images of children are assessed by DFU staff, even though PCOT are also trained to do this. This creates unnecessary extra work in the DFU.

The DFU isn't servicing the force's demand well enough. Delays in examinations have adverse effect on children, who may lose access to their phones for long periods. This affects their ability to communicate with friends and family. Criminal justice is also delayed, to the detriment of victims.

8. Decision-making

Recommendation from the 2021 inspection report

We recommend that within six months Derbyshire Constabulary engages with its safeguarding partners and reviews guidance to improve practices for when children are taken into police protection to:

- reduce the time before children are found appropriate accommodation;
- consistently record relevant information and decisions; and
- regularly review and endorse the use of protective powers.

Re-inspection findings

Responding officers and supervisors have immediate access to guidance about protecting children

We saw that the force provided clear and comprehensive guidance on its intranet system to help officers understand how and when they should use their lawful power to protect children.

The guidance makes the designated officers' responsibilities clear. They must authorise police protection, speak with children, their carers and social workers to let them know why the police have acted, and record decisions together with the reasons for these. We saw that this was followed in most cases.

This meant that officers felt confident about knowing when they should act decisively in children's best interests. This is positive and demonstrates a child-centred approach from the force and its officers.

PPNs were usually completed and sent quickly to CSC. And strategy meetings were usually held without delay. When we found delays in the sharing of PPNs, this didn't delay actions to safeguard children, as arrangements for suitable accommodation were immediately put in place. But we found that officers were often not recording the ethnicity of children. The police and their partners need this information to help understand the prevalence and level of risk in different communities. This can help them to develop plans to reduce vulnerability and prevent child abuse.

Police protection power isn't consistently reviewed

We found that the force wasn't consistently monitoring its use of police protection power, either on handovers between duty inspectors, or within the agenda of its tasking meetings.

Handovers between inspectors acting as designated officers while children remain in police protection aren't consistently recorded. And there is no regular review by these managers focusing on the children's welfare. This means that the force is unable to assure itself that the use of the power is still necessary or appropriate. We also saw that the force's guidance doesn't tell designated officers to record their decisions to end the use of the power.

CSC services were contacted every time police protection was used to make sure that children were safely placed with appropriate carers. But we saw cases where the CSC's response to find suitable places of safety was delayed. Response team officers also told us that they were sometimes required to stay with children for many hours before placements were available.

There are two vulnerable witness suites, where officers can keep children safe while waiting for CSC accommodation. But despite this, we found times where officers were taking children to police stations while waiting for CSC decisions. In one case, during a joint Trading Standards operation, a 16-year-old unaccompanied asylum-seeking boy who was found to be exploited was taken into police protection. He was missing from the London area and was taken to a police station in Derbyshire, where he stayed for almost 12 hours before a social worker was able to collect him.

The force's inconsistent monitoring meant it wasn't able to challenge CSC services about delays. This diverted response officers from other duties and negatively affected children's welfare.

9. Trusted adult

Re-inspection findings

Approximately 160,000 children live in Derbyshire. The constabulary has developed a strategy for engaging with children in collaboration with the DDSCP. This joint strategy has the following aims:

- proactively seek out the views of children and their families; and
- ensure the individual and collective voice of children in decision-making, planning and review processes across the partnership to help drive forward how we all work together to keep children safe from abuse and neglect.

It is important that children can trust the police. We saw that in some child protection cases, officers consider carefully how best to approach a child and the parents or carers. Officers generally also explore the most effective ways to communicate with them. Such sensitivity builds confidence and creates stronger relationships between a child, their parents or carers and the police. We found that the constabulary works well with CSC to protect children when they need immediate safeguarding.

The force is developing its volunteer police cadet scheme, aimed at 13 to 17-year-olds. There are currently 50 cadets based in 3 groups at Derby, Chesterfield and Glossop. Meeting weekly, the groups are led by police officers and civilian volunteers. The organisers aim to have children from a range of backgrounds in their cadet groups, with at least 25 percent from disadvantaged or vulnerable backgrounds.

Cadets also work towards obtaining a level 2 vocational qualification, and some may progress to join Derby University's policing degree course.

The constabulary works closely with other organisations to involve children in its work

As part of its multi-agency approach to preventing harm to vulnerable children, the CEIU's staff now work with two specialist charitable organisations. These organisations work with vulnerable children, their carers and families to give advice on and raise awareness about exploitation.

The force has a youth engagement team. Where possible, this is allocated crimes between children, especially when these concern children sending indecent images to one another.

A youth engagement officer works with secondary schools to develop lesson plans about how to stay safe online and what to do if children are targeted by sexting. Police community support officers (PCSOs) visit participating schools to give these structured lessons. These PCSOs also work with children and their parents at weekends within a 'consequence course' to help divert children away from criminality. Youth engagement team officers work closely with the local authority youth offending services and contribute to multi-agency panels to manage young offenders.

But officers told us that the force didn't have enough staff to do all the preventative work with vulnerable children that it wanted to. Sometimes they asked colleagues from safer neighbourhoods teams to visit schools by themselves and use pre-prepared presentations to support the lessons.

There are over 400 schools in Derby and Derbyshire. And there is clearly a demand from schools for police information about children's vulnerability. This is evident from the widespread adoption of SDAT notifications for children affected by domestic abuse. This type of information gives school staff a better understanding of how to support children. It can also give context to other concerns and encourage schools to refer children at an earlier stage. There are opportunities for the force to involve schools more in its work, such as by working closely with them to reduce children's missing episodes.

The force introduced a Mini Police scheme for school children aged between 9 and 11 in 2021. This is part of a national initiative. It is designed to give young children the opportunity to learn about safety and their own roles in the community, as well as what the police do. After a review found the three initial pilot schemes had been successful, the force has secured more funding to extend Mini Police to ten more schools.

10. Managing those who pose a risk to children

Recommendations from the 2021 inspection report

- We recommend that Derbyshire Constabulary immediately reviews its MOSOVO arrangements and practices to ensure that the risk from offenders in the community is effectively managed.
- We recommend that within three months Derbyshire Constabulary engages with its safeguarding partners (local authority CSC and the National Probation Service) to develop the effectiveness of multi-agency operational activity to protect children at risk from registered sex offenders (RSOs).

Re-inspection findings

There are good multi-agency partnership arrangements

Derbyshire Constabulary works with its statutory partners to support MAPPA. It has teams of specialist staff that manage sex offenders and violent offenders (MOSOVO).

There are two area-based MOSOVO teams (with responsibilities for the north and south of the county), as well as a central team that administers the Violent and Sex Offender Register (ViSOR). The teams are well staffed. Offender managers are each assigned to about 50 offenders, in line with the nationally recommended ratio. All offender managers are MOSOVO and ViSOR trained. And they all have the opportunity for face-to-face counselling every six months.

Officers work closely with the MAPPA manager to co-ordinate meeting agendas with other organisations and make sure actions are completed. All appropriate organisations are invited to MAPPA meetings. We saw that there was good attendance and engagement from all the partner organisations. Attendees contributed to effective multi-agency planning for offenders, identifying risks to children and assigning responsibility to the most appropriate agency.

There is a multi-agency approach to offender management. MOSOVO staff work with probation officers and, less often, social workers, who they make joint visits to offenders with. This leads to more holistic offender risk assessments and prevents the offender playing one agency off against the other.

Case study: effective multi-agency offender management

A high-risk RSO with a history of repeated offending against adults and children was released from prison.

His release on licence was carefully planned and accommodation was assigned in premises approved by the probation service.

Police offender managers contacted their probation service colleagues to arrange an assessment during a joint visit. They made a good record of the visit on the force's system as an interim update while waiting for probation officers to carry out an active risk management (ARMS) assessment.

Officers completed a risk management plan for the offender, and accurately recorded the actions they took so that other staff would understand the results and purpose of activity.

The offender managers focused on safeguarding children by sending a PPN to CSC services. And together with probation officers, they made disclosures to local schools about the offender's risk.

Information was also given to housing officers to help them find suitable accommodation in appropriate locations for when the offender left his current accommodation.

MOSOVO staff generally understand what they should do to safeguard children

We saw examples of offender managers actively seeking to attend strategy meetings with CSC services where they thought they could add value to safeguarding planning for children. But we found that there were significant delays in the time it took for the force to add strategy meeting records to its systems.

We saw some inconsistent safeguarding practice, and delays in recording concerns for children on PPNs. This led to delays in the time it took CSC services to consider the risk to some children. In one case where an offender manager had information about a child being taken to visit a RSO's address, their response was only to record the information on a PPN.

MOSOVO staff tell other forces and CSC services in other areas about potential risks from their offenders in those areas. One example was when a RSO registered plans for his holidays at caravan parks around the country. Relevant forces were identified and informed of the offender's plans and their assessed risk. These well evidenced disclosures prevented the RSO from staying at some of their intended venues. This way of working helps to protect children.

Many frontline staff told us they weren't fully aware of the work of MOSOVO staff. They also had an inconsistent knowledge about where RSOs lived and the risk they presented. Some knew that very high-risk and high-risk offenders are flagged on force systems, but didn't know about the risk management of medium or low-risk offenders.

The MOSOVO team suffers from poor management and leadership

The two area-based (north and south) MOSOVO sergeants mostly supervise their own team's work by themselves, and each team generally works independently. While the sergeants regularly speak to each other, they focus almost entirely on their own ViSOR cases and only help each other in urgent situations. So when supervisors return from absences there is always a significant rise in their workload.

Despite the addition of another supervisor based at the force's headquarters, there are significant supervisory backlogs which the teams haven't been able to deal with. The unsupervised matters include home visits to assess offenders, risk management plans and ViSOR entries.

These backlogs shouldn't be present in an efficient and effectively managed team. We were given different figures, ranging from 776 to 1,264, for the numbers of outstanding tasks in the supervisors' backlog. And we were told that the additional supervisor had helped to reduce these from 1,693 in January 2022.

This situation means that offender managers' casework, assessments and decisions aren't being checked and approved by their supervisors as they should be. It means the force has a significant systemic weakness in its ability to assess the risk presented by its MOSOVO cohort.

ARMS assessments and risk management plans aren't systematically reviewed. We saw that ARMS reviews are only recorded if changes are made. When no changes are made to existing ARMS, these decisions aren't visible on the records. This makes it difficult to evaluate the quality of the supervisory decision.

Faced with this situation, the unit's managers should either implement an achievable recovery plan or involve senior managers in addressing the problem. But we found they didn't fully understand that it is unacceptable.

The force's performance management system for MOSOVO didn't clearly show senior leaders when effective supervision wasn't in place in this high-risk area. This needs to urgently change, and greater scrutiny is needed.

The ViSOR system can produce performance information, but we found that the force hadn't fully accessed this capability. Some quantitative data on overdue visits was available. But it didn't specify the actual length of delays or describe the quality of visits. And supervisors aren't checking the quality of visits or the detail in officers' assessments.

There isn't a clear policy to advise offender managers about when to make single or double officer visits to offenders. Or about when these visits should be announced or unannounced. Managers don't record or monitor the use of different types of visit to understand the results of their staff's work. So there is no supervisory oversight of this vital aspect of offender management. This situation also means that offender managers can work in isolation. So they may be unaware of their ineffective ways of working or attempts by offenders to groom or manipulate them.

The teams told us they rarely saw, or interacted about case management, with their senior managers. And this included supervisory presence on force systems and ViSOR.

Managers aren't driving effective MOSOVO practice

We found other aspects of MOSOVO work that team managers aren't taking forward well enough.

The teams weren't focused enough on finding offenders who were wanted for offences, or who weren't complying with registration requirements because they had gone missing. We were told there were ten such offenders. And we found that managers didn't have a system in place to scrutinise and escalate force activity to arrest them.

MOSOVO staff understand the use and benefits of sexual harm prevention orders (SHPOs) and sexual risk orders to deal with the risk posed by some sex offenders. But frontline staff and officers in other investigation teams had little understanding of how these preventative orders can be used. The MOSOVO team managers should be subject matter experts in their speciality. But they hadn't identified this gap in the force's response to sexual offender risk and taken action to improve colleagues' knowledge.

Case study: ineffective offender management

A middle aged female RSO convicted for sexual assault on a 13-year-old boy has an SHPO in place to not have boys under the age of 16 in her home without prior permission from police and CSC services.

A school safeguarding lead told police they were concerned about a developing relationship between the RSO and her daughter's 13-year-old boyfriend, who was regularly visiting the RSO's home.

The offender manager recorded the information on a PPN. But they didn't take any further action to confirm the information from the school, or to arrange a multi-agency meeting to assess risk to the child and take appropriate safeguarding action.

The risk management plan wasn't updated with the new information and no other assessment was begun. And we saw that visits to the RSO had been missed and delayed for over a year.

The force didn't begin a criminal investigation for the potential breach of the SHPO.

The force's supervision of the risk from this offender was ineffective. This was only identified before our inspection because the force selected the case in its self-audit.

The force has now taken appropriate action.

The force has agreed to trial a simplified polygraph system called validated automated screening technology to help it assess offenders' risk. But this resource is underused: offender managers have only tried it seven times.

Similarly, offender managers told us that they rarely used digital triage equipment to examine offenders' digital devices. This should be done to check they aren't using the internet or social media in breach of their registration or licence conditions.

11. Police detention

Recommendation from the 2021 inspection report

> We recommend that Derbyshire Constabulary engages with its safeguarding partners and reviews the effectiveness of arrangements for children in police detention.

Re-inspection findings

The force understands that children should only be detained in custody when absolutely necessary

Officers should arrest a child only when this is absolutely necessary. Officers arrest and detain fewer children than they did in previous years because they now find other ways of dealing with children who commit offences.

In five of the six cases we reviewed, the arrest and detention of the child was necessary and appropriate. Children are generally arrested as a last resort, and officers are encouraged to first discuss the need to arrest with their supervisors. But the force doesn't understand how many children are being interviewed outside custody, as officers aren't asked to record their interviews other than on case files.

Investigating officers know they have to record the incidents that children are arrested for, noting the child's demeanour and recording the VoC on PPNs.

Before children enter the force's custody facilities, police assess them for risk and whether they need to be detained. Supervisors scrutinise the situation for every child and ask them questions about their welfare and mood. Any concerns are highlighted within handovers. Thirty-minute observations are completed and recorded for all children in custody.

Officers who review children's detention visit them, speak to them and listen to them. This way, they balance any need to continue detention against the child's welfare needs. We saw records of decisions taken about a child who was asleep being explained to them after they woke.

Overall, we saw improvements in custody staff's understanding of vulnerability and how they supported children in detention. This was despite the staff telling us they hadn't received any specific child safeguarding training.

The force has worked with its safeguarding partners to improve the ways it supports the welfare of detained children

Healthcare professionals are always present within the force's custody suites, and they make referrals about the children they see directly to CSC services. The local criminal justice liaison and diversion (L&D) team works daily between 9am and 7pm. They assess children in custody and provide reports to other parties such as courts, CSC, GPs, parents and guardians. Both healthcare professionals and L&D staff have access to the force's systems and write updates directly on custody records. This is so there are no information gaps that would leave children at risk.

Child Action North West provides appropriate adults, who are professional and timely, for the force on a 24/7 basis. We saw records of them visiting to help and advocate for children, and not just to be present when children were interviewed. They provide distraction items for children in custody such as stress balls, colouring materials and reading books. But sometimes when custody staff prioritised adult detainees because of custody time limits, there were delays before children were seen by appropriate adults.

The force and its partners have agreed that CSC services will be informed when a child enters custody. The intention is to let CSC know as soon as possible so that social workers can check their records about the child. This allows them to consider what support, including providing accommodation, is likely to be needed.

We saw that this arrangement worked particularly well out of hours, as custody staff made contact by phone directly to the CSC emergency duty team. But during the day it wasn't as effective, because contact was made by email from custody to RaRU and then another email to CSC. Delays in this email contact meant that some children were released from detention before custody staff received a response from CSC.

Derby City CSC has responded to concerns raised by the force about the lack of provision of alternative accommodation for children who need safeguarding, including those charged with criminal offences. It has now commissioned five emergency beds for children who need to be urgently accommodated.

But the force and its partners told us that the provision of secure accommodation for children charged with offences was extremely limited and that it was highly unlikely for any to be locally available.

Custody officers don't have a good enough understanding of when alternative or secure accommodation for children is needed

Under statutory guidance in the *Concordat on children in custody*, the relevant local authority is responsible for giving suitable alternative accommodation to a child charged with offences and denied bail. Only in exceptional circumstances is this not in a child's best interest (for example, if bad weather makes it impossible to

transport them). In rare cases, such as when a child is at high risk of causing serious harm to others, they may need secure accommodation.

The custody staff's understanding of the concordat's guidance for children following a charge is inconsistent. The thresholds for requesting secure accommodation aren't understood well enough. This means that contact with local authorities may be delayed until after a charge, or that a request isn't properly made.

We saw examples of custody staff requesting secure accommodation where the threshold for this wasn't met. We also saw examples of non-secure alternative accommodation being offered but declined by police. We saw courts later bailing these children to non-secure accommodation after their first hearing.

When local authority accommodation isn't available, custody officers inform their inspectors. But we didn't see any records of the force escalating the issue beyond this. On several occasions, officers recorded that it would have been pointless to do so.

Case study: no justification to refuse a child bail

A teenage boy was arrested for assaulting another boy.

The detained child was known to be at high risk from criminal exploitation. A court had previously given him a referral order and he was being supervised by the youth offending service.

Custody staff recognised his vulnerability and contacted CSC services. He was seen by a healthcare professional and L&D staff, who also identified his vulnerability.

Staff contacted the child's mother, and she attended the custody suite, acting as his appropriate adult.

The boy was interviewed in the presence of a solicitor, charged and then refused bail by the custody officer. The force asked the local authority to provide secure accommodation as an alternative to staying in police custody.

The local authority didn't offer secure accommodation because it felt the request didn't meet the threshold for this. The custody officers didn't challenge this refusal or escalate the situation to senior managers.

Custody staff didn't complete a juvenile detention certificate to inform the court why police believed it was unsafe to bail the child. The only custody record entry was that they were awaiting further information from CSC services.

The court agreed to release the boy on conditional bail at the first hearing.

Conclusion

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

Derbyshire Constabulary has made strong progress against some of the 12 recommendations we made after our 2021 inspection. But the force has yet to fully achieve any of these recommendations.

There is clear leadership that is changing the force culture to understand and improve responses to vulnerability. The structure for overseeing and scrutinising all aspects of child protection is much improved. But leaders and managers need to improve their use of the force's performance management information to understand where better ways of working are needed.

The force needs to consolidate the areas where it has made progress. And significant improvements to other aspects of its child protection arrangements and practices are still needed. This includes the effectiveness of multi-agency safeguarding arrangements.

Specific aims for improvement include:

- better processes to assess and share information with other organisations to help protect children;
- effective management of the MOSOVO team;
- increased numbers of experienced and fully trained investigators in the public protection department;
- systems to prioritise and task the arrest of high-risk offenders;
- effective multi-agency safeguarding meetings and joint operational working;
- reduced delays in digital forensic examinations; and
- better availability and use of intelligence and problem profiles for exploited children.

Next steps

Derbyshire Constabulary should provide an updated action plan, within six weeks of the publication of this report, setting out how it intends to incorporate the findings of this re-inspection into its ongoing work to respond to the recommendations of our inspection report of November 2021.

Subject to this update, we may revisit the force to assess further how it is managing the implementation 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 organisations are set out in the statutory guidance *Working together to safeguard children: a guide to interagency 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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