Northamptonshire Police Child Protection Arrangements

Initial inspection report July 2013

Inspection revisit findings January 2014

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Executive summary

This report summarises the findings from the fourth phase of an inspection of Northamptonshire Police's child protection services. Between 28 and 31 October 2013, HM Inspectorate of Constabulary (HMIC) conducted a follow-up inspection to assess the progress that the force had made in response to the child protection inspections earlier in the year. This report outlines the follow-up inspection's findings.

In July 2013, HMIC published an inspection report outlining the findings of how Northamptonshire Police responds to child protection. The report sets out the conclusions from three phases of inspection fieldwork:

- phase 1 was a multi-agency child protection inspection pilot that took place in January 2013;
- phase 2 was an HMIC re-inspection in March 2013; and
- phase 3 was a further HMIC re-inspection in June 2013.

Since the January 2013 original HMIC inspection and subsequent revisits, HMIC found that Northamptonshire Police has made significant progress in improving its child protection arrangements.

Findings from earlier inspections

The summary below sets out the failings relating specifically to Northamptonshire Police which were identified by HMIC following the multi-agency child protection inspection pilot in January 2013:

- unacceptable delays in or failing to share all relevant information about families with partner agencies, for example, children's social care (CSC);
- missed opportunities to work closely with partner agencies to protect children at risk of significant harm, and those who were missing from home or care;
- police officers not recognising potential risk to children when they attended incidents (particularly those relating to domestic abuse), and failing to make the necessary referrals to either police child protection specialists or to other agencies, in order to help safeguard those children;
- information was not shared with partners where further concerns about children were identified; this resulted in missed opportunities for agencies to assess jointly whether there was an increased risk of harm;
- significant delays in analysing seized computers to establish whether they held indecent images of children in cases where child abuse was suspected;
- insufficient staff in the team managing registered sex offenders, resulting in increased risks to children in the county;

- children being inappropriately detained in police custody after they had been charged with an offence.

By June 2013, HMIC found that Northamptonshire Police had made extensive changes. In particular it had:

- invested significantly in child protection (for example, by increasing the number of staff within its specialist teams);
- developed a comprehensive plan designed to ensure the required improvements were made. HMIC considers the timescales in this plan to be realistic, and the priorities correct; and
- chief officers that showed a strong commitment to improving the police response to child protection and worked with strategic leads in partner agencies to develop a joint improvement plan.

Therefore, HMIC found that by June 2013 there had been improvements in Northamptonshire Police's child protection arrangements. Work was ongoing to ensure that the changes were embedded across the whole organisation. HMIC concluded at that time that it was too early to say whether the force was doing enough to protect children at risk within the county.

It was therefore decided that HMIC would conduct a full re-inspection in October 2013 to assess whether there had been sufficient improvement in the way in which child protection is delivered by the force, and if these improvements could be sustained.

Findings from the October 2013 re-inspection

The force has made further improvements to its child protection arrangements since the summer of 2013. Many of the areas for improvement that HMIC indentified in its earlier report have been achieved. There are some areas where further work is required but the force is committed to addressing these.

The main findings are that the force has made a significant investment in its response to child protection by working with its partners in other agencies to develop a true multi-agency child protection approach for Northamptonshire;

- deploying additional specialist resources;
- providing development time for senior leadership within the Protecting Vulnerable People Unit; and
- providing training for specialist and frontline officers and changing working practices.

The force has largely complied with the recommendations made in the earlier HMIC child protection inspection report; although in some areas further development is still required. These have been discussed with senior officers.

Conclusion and next steps

There have been material improvements in Northamptonshire Police's child protection arrangements since HMIC's Phase 1 inspection in January 2013.

The force has complied with the majority of the recommendations made in previous HMIC child protection inspection reports, although in some areas further action is required. Senior officers have confirmed that these actions will be prioritised and implemented.

The multi-agency safeguarding hub (MASH) has been developed further and now has police and partners working together in the same office. Partner agencies including children's social care (CSC), health, education and probation, work together regularly within the same office. This means they are able to share information and discuss cases promptly and fully. An additional benefit is the enhancement of close working relationships between teams at an operational level.

During the October 2013 re-inspection, HMIC has not identified cases where children have been exposed to significant harm due to omissions by Northamptonshire Police.

The force has made a significant investment in its response to child protection. Additional resources have been allocated to specialist teams and training has been given to them. Working practices have changed and improved within these teams and more detailed information is passed to partner agencies. Senior leaders have been given time to develop and improve their understanding of child protection; a programme of training, focused on children, is being delivered to frontline staff to increase their knowledge and understanding. As a result of this and awareness raising across the force the number and quality of child protection referrals has increased.

Although the force still has work to do, particularly in the delivery of training to frontline staff, children are now made safer due to the efforts of members of Northamptonshire Police. HMIC will re-inspect the force during 2014 as part of the current national programme of child protection inspections.

Recommendations

Immediately

- Discussions on strategy for dealing with high risk domestic abuse cases are not always recorded on force systems. This is an omission, as the information needs to be available for future research should there be further incidents. The force should make sure that all of these discussions are recorded on force systems.

- Northamptonshire Police keeps a list of all high risk domestic abuse cases referred to children's social care (CSC), but do not cross refer their list to ensure all cases are considered within the multi-agency safeguarding hub (MASH). The force should use this list to check that all such cases have been subject of a strategy discussion.

- In one case reviewed by HMIC the use of powers of police protection did not result in a Section 47 enquiry and the police monitoring processes failed to identify this. This means that a case where a child was believed to be at risk of harm was not referred to CSC for a discussion to take place with other agencies about how to protect them. This omission was not identified even with the processes the force have put in place to stop this happening. The force should ensure that the exercise of powers of police protection under Section 46 of The Children Act 1989 is subject of a Section 47 Children Act 1989 enquiry.

- In three out of twelve child protection cases examined, HMIC concluded that officers had either failed to recognise or had failed to record their recognition of wider protective issues. This means that officers attending incidents should look beyond the issues they are dealing with and consider the welfare of children who are part of or connected to the family they are dealing with. The force should review the practice and skills of child protection staff to ensure that all child protection risks are identified, recorded and managed in a timely manner.

- The response by staff to the child protection training they had received was mixed. Some said they had received good training while others said it contained too much information to take in. The force should review this training to ensure it delivers the greatest improvement from its investment.

Within six months

- The police do not currently receive information from interviews of returned missing children they are responsible for that is gathered by social workers. This information would be useful for the Missing Person Co-ordinators (MPCs), who review the cases of all those who are reported as missing, to

use in determining if children are at risk of harm or to assist operational staff in locating children who are missing. Chief officers should discuss this situation with children's social care (CSC) and put this right.

- Apart from initial safe and well checks conducted by police officers, children who are reported missing (and are not currently being dealt with by CSC) are not routinely interviewed to identify any risk they may be facing. The force should monitor the proposed improvements within CSC and the Initial Response Team who will be responsible for conducting these interviews. It will be important for all information gained through these interviews with missing and absent children to be shared.

- The withdrawal of dedicated social workers from the joint team has had an adverse effect on the conduct of joint investigations. This results in delays to joint police and social services visits. On some occasions, officers have no option but to visit children or conduct interviews without social services being present which is not good practice. The force should continue in its negotiations with CSC to improve the availability of social workers for joint child protection enquiries.

- The position with children and young people being detained post-charge is much improved and the care of most is being appropriately handed to CSC. The force should continue to monitor these arrangements to ensure that correct decisions are being made.

Background and context

The police role in child protection

The police, working together with partner agencies such as the local authority children's social care department, the health service and education department, have a responsibility to protect children from harm. The Children Act 1989 and government guidance[1] outline how this should happen and what each agency must do to meet this requirement.

In order to ensure that agencies co-operate to keep children safe and look after their welfare, each local authority must establish a local safeguarding children board (LSCB). This has senior representatives from all agencies (including the police), who hold each other to account for safeguarding activities and who ensure that the protection of children remains a high priority across their area.

Every officer and member of police staff should understand their duty to protect children as they carry out their day-to-day work. It is essential that officers going into people's homes for any police purpose recognise the needs of children they may encounter. This is particularly important when they are dealing with domestic abuse and other incidents where violence may be a factor. It is also essential that this duty extends to situations where children and young people are detained in police custody.

Other teams within the police also perform important roles in protecting children from harm. Those who manage registered sex offenders and dangerous people living in communities must have sufficient time and capacity to do their jobs effectively. They must be able to visit sex offenders regularly and establish the level of risk they currently pose. Using this information, they can put in place any necessary measures to mitigate this risk. Examples of the measures officers could consider are appropriate housing or mental health support. In Northamptonshire Police, the team performing this role is called the Dangerous Persons Management Unit (DPMU).

Most forces also have a team who analyse computers seized from suspects to establish whether they hold indecent images of children. Again, it is essential that these teams are properly resourced with suitable staff, and that this work takes place as quickly as possible. In Northamptonshire Police, this team is called the Hi Tech Crime Unit (HTCU).

[1] For example, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2013.

Section 17 cases

Section 17 of the Children Act 1989 places a general duty on the local authority to safeguard and promote the welfare of children in their area who are believed to be 'in need'. Police may find children who are 'in need' when they attend incidents. They should refer these cases to the local authority.

Section 47 cases

Section 47 of the Children Act 1989 details the duty placed upon agencies, including the local authority and the police, to make enquiries to safeguard and secure the welfare of any child within their area who is suffering (or is likely to suffer) significant harm.

Multi-agency safeguarding hub (MASH)

In order to deal with cases that are brought to the attention of the police, forces have specialist teams who deal specifically with referrals about children who are suffering or likely to suffer harm. Again, these teams must be adequately resourced with appropriately trained staff. The teams work very closely with partner agencies (such as the local authority, probation service and health service), and are often located in the same office. This makes it easy for staff to share information, which is essential in the successful protection of children from harm. This kind of joint or multi-agency team is often called a multi-agency safeguarding hub (MASH).

When a section 47 case has been identified, staff from agencies that may hold information about a child or children discuss the case and share what they know. This is called a strategy meeting. Decisions about what is the best way in which to safeguard a child or children are made in this meeting, and must be recorded. Any information which is discovered subsequently must also be shared. This means those actively involved in protecting the child from harm will be in possession of the most complete information available.

Some section 47 cases require further police investigation, and these may be referred to another specialist team dealing specifically with investigations into allegations of crimes against child victims. Again, these teams often work with partners from the local authority children's social care team, and either investigates as a joint agency or as a single agency (see the Glossary, Annex A, for an explanation of these terms). In Northamptonshire Police, when a case requires further specialist police investigation it is referred to the Joint Child Protection Team (JCPT), who will make the necessary enquiries into the case.

Findings from earlier inspections

The summary below sets out the failings relating specifically to Northamptonshire Police which were identified by HMIC following the multi-agency child protection inspection pilot in January 2013:

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- missed opportunities to work closely with partner agencies to protect children at risk of significant harm, and those who were missing from home or care;
- police officers not recognising potential risk to children when they attended incidents (particularly those relating to domestic abuse), and failing to make the necessary referrals to either police child protection specialists or to other agencies, in order to help safeguard those children;
- information was not shared with partners where further concerns about children were identified; this resulted in missed opportunities for agencies to assess jointly whether there was an increased risk of harm;
- significant delays in analysing seized computers to establish whether they held indecent images of children in cases where child abuse was suspected;
- insufficient staff in the team managing registered sex offenders, resulting in increased risks to children in the county;
- children being inappropriately detained in police custody after they had been charged with an offence.

By June 2013, HMIC found that Northamptonshire Police had made extensive changes. In particular it had:

- invested significantly in child protection (for example, by increasing the number of staff within its specialist teams);
- developed a comprehensive plan designed to ensure the required improvements were made. HMIC considers the timescales in this plan to be realistic, and the priorities correct; and
- chief officers that showed a strong commitment to improving the police response to child protection and worked with strategic leads in partner agencies to develop a joint improvement plan.

So HMIC found that by June 2013 there had been improvements in Northamptonshire Police's child protection arrangements. Work was ongoing to ensure that the changes were embedded across the whole organisation. HMIC concluded at that time that it was too early to say whether the force was doing enough to protect children at risk within the county.

It was therefore decided that HMIC would conduct a full re-inspection in October 2013 to assess whether there had been sufficient improvement in the way in which child protection is delivered by the force, and if these improvements could be sustained.

The following pages in this report outline the findings of the October 2013 inspection and, where appropriate, make comment in respect of previous concerns. The relevant concerns are highlighted at the start of each relevant section.

Force Control Room

If the Force Control Room (FCR) can provide valuable background information to frontline officers which prompts them to conduct specific tasks such as checking the welfare of a child, this can help protect children.

As a result, FCR staff have now been given specific training to enhance their knowledge of child protection issues. When domestic abuse incidents and missing children reports are created within the FCR, staff are given automatic reminders of what they should do. This causes them to complete research to identify background information about the child. Where relevant information is found this is passed to the attending officers or staff. These actions are noted on the control room record and the control room inspectors are able to see when these tasks have been completed.

HMIC found that procedures are followed; background information is gathered and passed to officers and staff attending child related incidents. This helps officers in their decision making and increases their focus on the safety of children.

Supervisors are required to finalise the control room report to ensure child related issues have been managed properly, ie the completion of referral forms informing partners such as CSC of children at risk of harm. Supervisors are routinely closing incident reports to this effect indicating active supervision in this area of policing.

Frontline staff

This report has shown that frontline officers and staff perform a vital role in protecting children and gathering information about children who may require other agencies or staff to help or protect them.

During interviews, HMIC found that frontline staff are aware that keeping children safe is a force priority and that chief officers are strongly committed to protecting children.

Officers demonstrated good levels of knowledge of their child protection responsibilities when attending domestic abuse incidents and good procedural knowledge regarding the use of police powers of protection.

HMIC found that some staff have been provided with additional child protection training but these are in the minority. Many of those who have not yet had training still view child protection as a one-off task and feel their only responsibility is to pass information to others. Many staff feel that officers within the specialist child protection team are the only ones fully responsible for protecting children and do not understand that the force wants child protection to be the responsibility of every officer and every member of staff.

Officers and staff are unclear about how child referral forms are used and how the quality of what they submit affects the outcomes for children. A child referral form is the means by which officers attending an incident notify the child abuse investigation teams that they have concerns about a child.

These identified gaps are due to be covered by training already designed and being provided. The majority of staff were not trained at the time of the inspection. Training is covered in a later section within this report.

Domestic abuse

Previous concerns highlighted in the July 2013 Inspection report:

"Children and young people who are living in an environment where there is domestic abuse are not being checked to make sure they are safe by police officers who attended reported incidents. Further opportunities to help children were being missed because officers did not recognise and report on how they are being affected by domestic abuse incidents".

"Multi-agency work to support and protect children at risk of harm arising from domestic abuse incidents were hampered by the delay of relevant police information being shared with child protection partners".

"Where domestic abuse victims were assessed as being at high risk within the Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment, children connected to the victim were not automatically considered for Section 47 enquiries. This prevented early child protection measures being considered by multi-agency partners".

When police officers attend domestic abuse incidents and crimes they have an invaluable opportunity to gather information about children who are at risk of harm. Officers should ensure children are safe when they deal with these incidents and obtain background information about the well being of children and how they are being treated. Officers should also try to establish how the situation in each household is affecting the children.

Each police force passes information gathered in this way to its local partners, particularly CSC, to enable the local partnership to establish which children are in need of help and protection. The partners should then work together to determine what needs to be done and then ensure that this happens.

Within earlier inspections during 2013, HMIC identified significant delays in the passing of information from the police to CSC. This was having a negative impact on how well children were being protected.

In October 2013, the inspection teams visited and found the timeliness of referrals to be much improved, with no significant delays identified. All the referrals examined were referred to CSC promptly and efficiently.

HMIC found that the quality of the referrals is high, with detailed information about the family and what officers had seen being added by the Central Referral Unit (CRU). This additional detail is assisting subsequent decision making by officers and staff

Due to prompts on the force computers, which show staff within the FCR what questions they should ask, information regarding children is recorded more clearly

and in greater volume on incident reports. Again, this helps to inform attending officers about children at an incident and helps with decision making.

A number of referral forms completed by officers in respect of children living in families experiencing domestic abuse were examined by HMIC. These contained more information about how the children were affected by the incident or crime. This is a marked improvement on previous inspection visits.

In high risk domestic abuse incidents, referrals were found to be clearly marked in all cases and these routinely resulted in strategy discussions between the agencies represented within the multi-agency safeguarding hub **(**MASH). This is a significant improvement for local partners.

However strategy discussions relating to high risk domestic abuse cases are not always recorded on force systems. This is an omission as this information needs to be available for future research on those systems. This had not affected child safety for the cases examined but may affect decision making in the future. Supervisors within the multi-agency hub have assured HMIC that appropriate changes will be made as soon as possible.

The police keep a list of all high risk domestic abuse cases referred to CSC, but do not reconcile their list to ensure all cases are considered within the multi-agency hub. HMIC identified a case where a strategy discussion had not taken place. This case could have been identified if the police had used their list to check that all such discussions had taken place. Again, supervisors within the multi-agency hub have assured HMIC that changes will be made immediately.

The force has a dedicated unit that works from the same office as the multi-agency unit and focuses on the management of domestic abuse incidents and crime. The team investigates a large proportion of the high risk domestic abuse crimes and coordinates the safety planning and protection of high and medium risk domestic abuse victims.

Staff within the dedicated domestic abuse team also have a focus on children, and through their reviews of high and medium cases, were identifying instances where child referral forms had not been completed. When this happens officers are being prompted to submit them.

The detective sergeants in the domestic abuse unit are rarely involved in strategy discussions conducted in the multi-agency unit in respect of children at risk from high risk domestic abuse situations. HMIC considers it would be useful for them to be included within these discussions as the sergeants often have a greater level of understanding of the ongoing issues within the family.

Members of the domestic abuse team have established a domestic abuse forum (DAF) for each of the four geographic areas allocated to their force domestic abuse advisors. These forums review the circumstances surrounding medium and low risk

victims who have been subject of repeated incidents. In so doing they provide an additional level of scrutiny that assists in the identification and protection of children at risk of harm from domestic abuse.

Non-domestic abuse related referrals

Previous concerns which were highlighted in the July 2013 Inspection report:

"Police intelligence that indicates children are at risk of significant harm was not always being recognised as such and was not being referred to multi-agency partners. Children were not able to access the services to help and protect them".

"Where the police were referring non-domestic abuse concerns to the children's social care team, opportunities were being missed to work more closely with partner agencies in the consideration of section 47 enquiries".

"Police referrals to the children's social care team in respect of children and young people at risk of harm from situations not connected to domestic abuse did not always contain all the relevant police information regarding the child. Information that would have been useful for the children's social care team in determining the needs of the child was missing".

Police officers and police staff members regularly encounter children at risk of harm in circumstances other than when they are at risk from domestic abuse.

These can be either through direct concerns where the child is the subject of a report being made to the police; such as being poorly looked after by a parent, or through indirect concerns; for example when a parent is being prosecuted for controlled drug offences. In all of these cases it is important that officers and staff members report their concerns in a way that fully explains how the child is being affected. The force should then share and consider this information with its local partners to determine if a child is at risk of harm and, if so, how to protect them.

Officers in Northamptonshire Police are now regularly identifying children at risk of harm in a wider range of situations and are submitting referral forms detailing their concerns.

Upon receipt of these concerns, staff within the Central Referral Unit (CRU), are completing detailed additional research. The quality of information being passed to CSC has greatly improved and is supporting effective decision making to help and protect children.

HMIC previously found that research conducted within the Child Protection Team (CPT) was of a lower standard than that conducted within the CRU. The amount and depth of information was lacking and failed to contain relevant information. In October 2013, HMIC found the research conducted by the CPT had improved and is now of a similar level of detail to that provided by the CRU.

Referrals from both the CRU and CPT are leading to good multi-agency working within the multi-agency hub where protective measures are being put in place for children who otherwise may not have been protected. One example reviewed was where children in a multi-occupancy property were identified as being at risk from a

fellow resident with mental health problems. As a result of the police referral CSC are working with the family to reduce the risks and find alternative accommodation for them.

The same process is followed for cases where children are taken into police protection and this enables the police supervisors within the multi-agency hub to ensure correct statutory procedures are followed. However, HMIC found an incident where the use of powers of police protection did not result in a Section 47 enquiry and police monitoring processes failed to identify this. CSC had not followed statutory guidance. Fortunately the children were not affected by the oversight as they were still subject of ongoing assessments by a social worker. This case was highlighted to police supervisors within the multi-agency hub for further enquiries.

During previous inspections a number of cases were identified where information had been submitted to the Force Intelligence Unit (FIU) without being passed to the CRU. On those occasions staff in the FIU had not recognised the need to check that referrals had been made to CRU and as a result children remained unprotected. Since these gaps were identified, staff within the FIU have received additional child protection training and are now aware of their responsibility in checking that referrals have been made.

Multi-agency safeguarding hub (MASH)

Previous concerns highlighted in the July 2013 Inspection report:

"Where further concerns were raised over children already subject to child protection plans, opportunities were being missed to assess jointly any new information which indicated an increased risk of harm. There was a tendency for agencies to deal with these concerns on their own as opposed to working with others. This limits the approach by agencies and the opportunities available for children".

The hub is now staffed by CSC, health, police and education teams working from the same facility. The local probation trust supports the hub with resources accommodated elsewhere but is still able to supply valuable information. This means that the multi-agency hub is now identifying risks and sharing information to protect children. In creating the multi-agency safeguarding hub, the force sought out and considered best practice by visiting other forces that had already established hubs.

The multi-agency hubs' working practices are effective and it uses a risk- based approach to recognising children in need of additional support and protection. These children are then referred to the appropriate operational team for further investigation and intervention. There is now effective joint working. Strategy discussions are taking place more frequently and decision making is based on improved information sharing.

The multi-agency safeguarding hub provides scrutiny for incidents where children on child protection plans (CPP) have been exposed to further harm or risk of harm. This was a significant issue raised by earlier inspections during 2013 where HMIC was concerned about the lack of response in such situations.

The police staffing within the hub is sufficient to manage the demands placed upon the police. Staff are able to use their time constructively on other non-hub tasks when work demands reduce.

Child sexual exploitation (CSE)

There is now a dedicated multi-agency team specifically looking at CSE.

It has recently expanded with the addition of two social workers and the team is re-defining its working practices. Police officers are now adopting a more investigative based approach and social workers will carry out the supportive work for those at risk of exploitation.

The team receives referrals from a range of different agencies including health and the third sector, such as the NSPCC. Partnership staff understand the need for different approaches to deal with victims of CSE, including the need to gain greater confidence with victims to obtain information about the offence and how they can address their own behaviours which may put them at greater risk.

The partnership employs a risk-based prioritisation matrix to determine which resources manage specific CSE victims. This means that those who are at greatest risk receive a higher level of attention and support from specialist staff and there are community based resources to support victims assessed as being at a lower risk.

The team is still at an early stage of development, particularly in relation to the addition of the two social workers. Although there are examples of good outcomes for children it is too early to determine its true efficiency and effectiveness.

Missing children

Previous concerns: highlighted in the July 2013 Inspection report

"Opportunities to identify children at risk of harm were being missed by police and the children's social care team not jointly working on information about missing children. The children's social care team and police were not conducting systematic analysis of their information to identify which children and young people were at risk of harm and to work out the best way to protect them".

Since earlier inspections the police and children's social care partnership has improved its approach to dealing with missing children and agencies are now working in a more structured manner as outlined below.

The force has recently introduced the 'Compact' IT system to manage all missing person reports. One specific function of the system is the ability to notify all missing children reports to CSC on a daily basis. As a result, all missing children reports are notified to Northamptonshire CSC promptly and efficiently. This means the CSC has a far clearer understanding of the risk faced by children and can tailor an appropriate response more quickly.

At the same time as introducing the 'Compact' IT system, the force adopted the national policing definitions of 'missing' and 'absent'. It has introduced new working practices to ensure that Force Control Room FCR staff actively monitor the cases where children are considered to be 'absent'.

Dedicated Missing Person Coordinators (MPC) routinely conduct a daily review of all missing and absent children reports. As 'Compact' does not currently provide automatic notifications of 'absent' children to CSC, a separate daily report is created by the MPCs and is forwarded to CSC by e-mail. This provides CSC with a more complete picture of children who may be at risk.

Due to their daily monitoring, the MPCs are able to identify children at risk of harm, either by the nature of individual incidents or by the frequency of missing or absent reports. Where a child is identified at risk of harm he or she is referred to a multi-agency forum where work to protect them is initiated and monitored.

When missing children return home police officers are sent to speak to them to ensure that they are safe and to establish if they have been the victim of a crime. Staff routinely submit intelligence they gather from these interviews which helps the force identify any patterns that might exist and any people who may be involved with children when they go missing.

It is now widely accepted that further interviews conducted by social workers, youth workers or workers from the third sector are often very useful in gathering additional

information about where a child has been or what they have been doing.[2] In Northamptonshire, social workers responsible for a child who goes missing are expected to conduct further interviews and it is believed that they regularly do so. The police do not currently receive information gathered by social workers from interviews of children they are responsible for. Such information would be useful for the MPCs to use in determining if children are at risk of harm or to assist operational staff in locating children who are missing.

Apart from initial police safe and well checks, children who are reported missing and are not the responsibility of CSC are not routinely interviewed to assist risk identification. This issue has been identified by the LSCB and is potentially going to be covered by the Initial Response Team due to be established in the near future by CSC. As yet, there are no timescales for this. This is an important element in identifying children who may be at risk of harm and the police should continue to work with their LSCB partners to ensure this gap is closed.

[2] Ofsted, *Missing Children* report, published February 2013.

Child protection team (CPT)

Previous concerns highlighted in the July 2013 Inspection report:

"Case recording within Section 47 enquiries was generally good within the police, however on occasions decisions made and actions agreed within strategy discussions and meetings were not adequately recorded on police systems".

"Police referrals to the children's social care team in respect of children and young people at risk of harm from situations not connected to domestic abuse did not always contain all the relevant police information regarding the child. Information that would have been useful for the children's social care team in determining the needs of the child was missing".

The quality of recording of decisions on case files and the rationale behind decisions has improved since earlier inspections. The volume of and quality of information passed to CSC from cases managed within the CPT has improved and is now of a good standard.

Strategy discussions are now routinely recorded on case files which is an improvement on earlier inspections where many were simply not recorded.

In three out of twelve cases examined by HMIC it was felt that officers had either failed to recognise, or had failed to record, their recognition of wider protective issues. An example of this is a case where a five year old boy had been sexually assaulted by older boys. Although the five year old was safe it was not clear that the welfare of siblings related to the suspect had been considered until much later during the investigation (at least one week later).

These cases were discussed with the senior managers within the Protecting Vulnerable Persons Unit (PVPU). HMIC was assured that further development work will be undertaken with staff in the team.

The withdrawal of dedicated social workers from the joint investigation team has had an adverse effect on the conduct of joint investigations. On occasions officers are experiencing delays in completing joint visits whilst on other occasions they are conducting single agency visits or interviews.

Dangerous offender management

Previous concerns highlighted in the July 2013 Inspection report:

"The Dangerous Persons Management Unit (DPMU) did not have sufficient staff to ensure that child protection risks were consistently identified thus potentially exposing children to unnecessary risks. Initial visits were not conducted in line with force policy (14 days), gaps existed within intelligence analysis, and mandated visits were not conducted in line with national guidance".

Since the initial inspection in January 2013, the force has increased the staffing levels by one sergeant, one constable and one police staff member. There are 541 registered sexual offenders (RSO) within the community, now being managed by two sergeants, ten constables and three support staff members. This is an improved position for the unit and the caseload is within that recommended by ACPO guidance.

The force has recruited three members of the Special Constabulary and three volunteers to support unit members in completing 'home visits'. This is seen as innovative practice and is leading to an increase in the number of home visits.

The unit has built improved relationships with other units within the force, ie Safer Community Teams and CID, to improve the knowledge of sex offender management. Officers from these other teams complete attachments, are provided with training and experience live operational activity by going with members of the DPMU to visit registered sex offenders. This expands the knowledge and experience of RSO management across other departments within the force.

HMIC reviewed a number of cases where offenders are being managed by the unit. This showed prompt and thorough home visits, detailed risk assessments where risks to children are identified, with effective risk management plans being put in place.

The risk management plans and actions include working with other agencies, including Children's social care in Northamptonshire and other local authority areas.

Hi-tech crime unit (HTCU)

Previous concerns highlighted in the July 2013 Inspection report:

"The welfare of children was being adversely affected by the delays experienced during the evidential analysis of computers within indecent imagery enquiries. Enquiries lasting in excess of six months meant that, in some cases, children were affected by restrictions on family members for excessive periods of time".

Since previous inspection visits the force has reviewed how the welfare and protection of children is considered within the unit.

After the initial inspection staff within the unit immediately conducted a review of all of the cases held to ensure that the needs of children were given the appropriate prioritisation.

The force amended how it prioritised the review of cases to ensure that child welfare and protection received the highest score to reflect their importance and ensure those cases receives early attention.

The unit has recruited additional staff and this, combined with more effective performance management procedures, has reduced backlogs.

The force has outsourced a number of suitable cases to approved private companies and this has further reduced the unit's backlog. It is now anticipated that within three months of the inspection the backlog will have been completely removed.

The force is actively managing the work being sent to the unit and is confident that the additional staffing and management plans will prevent further backlogs.

HMIC did not identify any cases where the welfare or protection of children was being affected by the performance of the HTCU.

Training

The force has provided child protection training for approximately 500 staff between March and July 2013. This training has been based on lessons learnt from serious case reviews and has included issues raised by the inspections.

A more detailed training programme featuring a significant input on child protection has already commenced and will be delivered to 1,500 frontline officers and staff over the next 12 months. At the time of the inspection three pilot sessions and three actual sessions had been delivered, training approximately 180 officers.

Staff interviewed after being trained provided a mixed response. Some said they had received good training while others said it contained too much information to take in. HMIC have recommended a training review.

Post-charge detention of children

Previous concerns highlighted in the July 2013 Inspection report:

"Children and young people continued to be detained and alternative accommodation arrangements had not been addressed at a strategic level. Multi-agency partners had recognised this as an issue, but had experienced difficulties in effecting a practical resolution".

Since the inspection in January 2013, the force has worked with CSC to create a system to ensure children and young people are not unnecessarily detained in police custody. The system was introduced in February 2013 and police custody staff were made aware of it in March 2013.

All post-charge detentions where a child or young person is kept in police custody are reviewed by a superintendent and regular meetings are held between the police and CSC to make sure children and young people are not being kept unnecessarily in custody.

HMIC examined eight custody records relating to children and young people who had been detained in custody after being charged with a criminal offence or breach of bail.

In the majority of cases the child or young person had been passed into the care of the local authority, a marked improvement on the position in January 2013 (where five out of six children were detained in police custody). Two of the young people had been detained inappropriately in police custody although these detentions were in the earlier part of the sample (May 2013) and the more recent cases indicated no such detentions.

HMIC remain concerned over the use of appropriate adults (AA). AAs often only attend custody for the purposes of the criminal interview as opposed to the giving of the child or young person's detention rights. There was limited detail within custody records regarding calls being made to AAs to secure their attendance at the custody facility. This means that some children or young people may not fully understand their rights during their initial detention.

Annex A: Glossary

Children at risk of significant harm – A child is defined as being at risk or subject of significant harm where there is ill-treatment or impairment of health or development:

- ill-treatment includes sexual and emotional abuse as well as physical abuse;
- health means physical and mental health;
- development means physical, intellectual, emotional, social or behavioural development;
- significant harm turns on the question of the harm suffered by a child in respect of his health and development compared with the health and development reasonably expected of a similar child. (Children Act 1989, section 31(10))

Children in need – A child is defined as being a child in need if:

- he is unlikely to achieve or maintain, or have the opportunity of achieving, or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority;
- his health or development is likely to be significantly impaired, or further impaired, without the provision of such services;
- he is disabled. (Children Act 1989, section 17(10))

Child protection plan – When a child protection case conference decides a child or young person is at risk of abuse or support they are known as a 'child subject of a child protection plan'. This plan outlines what each agency will do to keep a child or children safe.

Children's social care (CSC) – The dedicated team within a local authority social care department which deals specifically with children who are in need or at risk.

Dangerous Persons Management Unit (DPMU) – A specialist team which manages those who are required to register on the sex offenders register, as well as other people who are categorised as 'dangerous'. This team will undertake visits and otherwise manage sex offenders, informed by the level of risk they pose to communities.

DASH risk assessment – Domestic Abuse Stalking and Honour Based Violence risk assessment is made up of a number of questions (based on academic research and work with victims of domestic abuse), which are designed to identify the level of risk faced by a victim of domestic abuse. These are usually categorised as standard, medium and high risk.

Joint Child Protection Team (JCPT) – A specialist team comprising police and children's social care staff who complete further investigations to establish whether a child is at risk, and deal with the protection of children from harm.

Joint or Single agency investigations – Where a case requires further investigation a decision is made during the strategy discussion to determine who should do this. In some cases, for example where a crime has been committed, the case work is likely to be completed by the children's social care team and police working together. In other cases (where, for example, parenting skills are highlighted as an issue within a family), this would be dealt with by a single agency (ie the children's social care team)

Multi-agency safeguarding hub (MASH) – A joint or multi-agency team comprising children's social care workers, police and other agencies (such as local health, probation and education services). Within these teams staff members are able to share information easily, which is essential in the successful protection of children from harm.

Section 17 enquiries – Section 17 of the Children Act 1989 places a general duty on the local authority to safeguard and promote the welfare of children in their area who are believed to be 'in need'. Police may find children who are 'in need' when they attend incidents. They should refer these cases to the local authority.

Section 47 enquiries – Section 47 of the Children Act 1989 sets out the duty placed upon agencies, including the local authority and the police, to make such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard and secure the welfare of any child within their area who is the subject of an emergency protection order, or is in police protection, or if they have reasonable cause to suspect is suffering or likely to suffer significant harm.

Strategy discussions – When a section 47 case has been identified, staff from agencies that may hold information about a child or children (for example the police, the health service and the local authority) discuss the case and share information. This is called a strategy discussion or meeting. Decisions about what is the best way in which to safeguard a child or children are made within this meeting, and must be recorded.

Annex B: Methodology

The methodology used by HMIC included an examination of different types of police incidents and case files, a review of relevant documents and interviews with teams including police managers and supervisors.

HMIC reviewed the following case files during the inspection:

- 10 domestic abuse incidents or crimes where children were part of the family;
- 10 non-domestic abuse incidents where children were identified as being at risk of harm;
- cases where children had been identified as suffering or likely to suffer significant harm (section 47);
- custody records where children and young people had been remanded in custody post-charge;
- multi-agency public protection arrangements (MAPPA) Level 1 or 2 cases where children had been identified within the risk assessment or risk management planning.

HMIC reviewed the following documents during the inspection:

- force policy on child protection;
- force guidance/procedure document(s) on child protection;
- Northamptonshire Police Improvement Plan;
- Northamptonshire Police document pack, supplied October 2013.

HMIC interviewed the following staff during the inspection:

- Detective Sergeants from the Multi-Agency Safeguarding Hub
- Detective Sergeant, Domestic Abuse Unit
- Detective Inspector, Dangerous Person Management Unit
- Detective Inspector, Child Protection
- Detective Inspector, Force Intelligence Bureau
- Detective Inspector, Missing people/Child sexual exploitation
- Uniform staff in operational roles across the force
- Unit manager and sergeant, Hi-Tech Crime Unit

- Child protection training lead
- Inspector, Force Control Room