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

National Child Protection Inspections

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Foreword

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

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

Protecting children is one of the most important tasks the police undertake. Police officers investigate suspected crimes involving children and arrest perpetrators, and they have a significant role in monitoring sex offenders. They have the powers to take a child in danger to a place of safety, and to seek restrictions on offenders' contact with children. The police service also has a significant role, working with other agencies, in ensuring children's protection and 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 agencies to play their part in ensuring that, as far as possible, no child slips through the net, and to avoid both over-intrusiveness and duplication of effort.

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)[1] is inspecting the child protection work of every police force in England and Wales. The reports are intended to provide information for the police, the police and crime commissioner (PCC) and the public on how well children are protected and their needs are met, and to secure improvements for the future.

[1] This inspection was carried out before 19 July 2017, when HMIC also took on responsibility for fire & rescue service inspections and was renamed HM Inspectorate of Constabulary and Fire & Rescue Services. The methodology underpinning our inspection findings is unaffected by this change. References to HMICFRS in this report may relate to an event that happened before 19 July 2017 when HMICFRS was HMIC. Citations of documents which HMIC published before 19 July 2017 will still cite HMIC as the publisher.

Contents

Summary

This report sets out the findings from HMICFRS' 2017 inspection of child protection services in Cleveland Police, which took place in May 2017.[2] This inspection is part of our rolling programme of child protection inspections.[3]

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

Main findings from the inspection

HMICFRS inspectors found that the force is committed to protecting children. Protecting vulnerable people is a priority for the force and the PCC and is reflected as such in the police and crime plan.[4]

The chief constable, his chief officer team and the PCC all have a strong commitment to child protection. In 2016, the force conducted an internal review of demand, which led to the allocation of additional resources for those departments responsible for child protection. The review also prompted significant changes to the governance and oversight arrangements that shape the force's approach to child protection and vulnerability.

HMICFRS found that, overall, work being done by the force is improving outcomes for vulnerable children, and that its focus on vulnerability is translating into positive action for its child protection work. In particular:

- The force has combined previously separate teams to create the vulnerable, exploited, missing and trafficked team (VEMT) to provide a more cohesive approach to these areas affecting the safety of children. This is clear evidence of the force's considered and innovative approach to child protection.

[2] 'Child' in the report refers to a person under the age of 18. See the Definitions and interpretations section for this and other definitions.

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

[4] *Police and Crime Plan – 2016–2021,* Police and Crime Commissioner for Cleveland. Available at: www.cleveland.pcc.police.uk/Document-Library/Police-and-Crime-Plan/2016-17/Police-and-Crime-Plan-DOUBLE-SPREAD.pdf

- The VEMT's investigative and problem-solving capability works alongside the children's charity, Barnardo's, specifically to mitigate the risks faced by vulnerable children.
- The force, in partnership with other safeguarding agencies, helped to develop (and now implements the work of) the local children's hub (CHUB) to provide effective and timely intervention in the safeguarding of children.
- Operation Encompass[5] is established practice within the force and has led to more timely and effective management of domestic abuse notifications from the force to the schools of affected children.
- Child sexual exploitation (CSE) and domestic abuse where children are present are reflected in force performance data sets.

These are encouraging findings. HMICFRS also acknowledges the work undertaken by the force with external safeguarding agencies, from chief officer to practitioner level, which has led to the development of a culture of continuous improvement and more effective joint working which is leading to improved outcomes for children.

However, HMICFRS also discovered some weaknesses in the force's approach to child protection.

Inspectors found that investigations often lacked evidence of supervision. This contributed to drift in the investigations and inconsistent outcomes for children.

We were concerned about the force's response to those children reported missing. HMICFRS assessed a number of cases of missing children and found a failure to properly assess risk or undertake prompt and effective enquiries to locate children – many of whom were reported missing on a regular basis.

The force needs to improve its approach to children detained in custody, who are often vulnerable and have complex needs. HMICFRS could find no evidence in any of the cases we examined of referrals being made to children's social care services for an assessment of safeguarding needs to be undertaken. In addition, in none of the cases where children were charged with an offence and denied bail were they transferred to alternative accommodation provided by the local authority. This means that children are being unnecessarily detained in police custody.

During the course of the inspection, we examined a total of 81 cases where children were identified as being at risk. The force's practice in 15 of these was assessed as good, in 42 as requiring improvement and in 24 as inadequate. This demonstrates

[5] Operation Encompass involves the force, when it has been called to an incident of domestic abuse at a child's home, informing a 'key adult' at the relevant local school before 9.00am the next morning (or before 9.00am on the Monday morning, if an incident occurs over a weekend). This enables schools to provide support to the child(ren) involved and offer practical help and information.

how there are still areas where improvement is required to ensure that the quality of the service the force provides to those children in need of help and protection is consistent and of the appropriate quality. Better recording of decisions taken, the rationale for these decisions and the actions agreed as a result would help the force to achieve this improvement.

Conclusion

The chief officer team has a clear and unequivocal commitment to protecting vulnerable children. This is widely recognised by the staff, officers and other agencies whom HMICFRS spoke to as part of this inspection.

However, while some improvements have been made, the force needs to take further action (in some areas as a matter of urgency) to strengthen its safeguarding practice in order to protect adequately those children most at risk.

To date, the force's response to HMICFRS' findings has been positive, with a willingness to make quick and tangible changes to practice. HMICFRS makes a series of recommendations aimed at supporting the officers and staff of Cleveland Police in continuing this work.

1. Introduction

The police's responsibility to keep children safe

Under the Children Act 1989, a police constable is responsible for taking into police protection any child whom he has reasonable cause to believe would otherwise be likely to suffer significant harm, and the police have a duty to inquire into that child's case.[6] The police also have a duty, under the Children Act 2004, to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children.[7]

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

In 2015, the National Crime Agency's strategic assessment of serious and organised crime established that child sexual exploitation and abuse represents one of the highest serious and organised crime risks.[8] Child sexual abuse is also listed as one of the six national threats specified in the *Strategic Policing Requirement*.[9]

[6] Children Act 1989, section 46.

[7] Children Act 2004, section 11.

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

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

Expectations set out in *Working Together*

The statutory guidance, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*,[10] sets out the expectations of all partner agencies involved in child protection (such as the local authority, clinical commissioning groups, schools and the voluntary sector). The specific police roles set out in the guidance are:

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

These areas of practice are the focus of HMICFRS' child protection inspections.[11]

[10] *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, February 2017 (latest update). Available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

[11] Details of how HMICFRS conducts these inspections can be found at annex A.

2. Context for the force

Cleveland Police has approximately 1,675 people in its workforce. This includes:

- 1,283 police officers;
- 267 police staff; and
- 125 police community support officers (PCSOs).[12]

The Cleveland Police area covers approximately 230 square miles and has a population of around 560,000.

There are four local authorities in the Cleveland Police area: Middlesbrough, Hartlepool, Stockton and Redcar & Cleveland. The force is split into four areas which are coterminous with the local authority boundaries. All specialist safeguarding resources are located in the Middlesbrough area headquarters. There are four local safeguarding children boards (LSCBs)[13] in the force area which also reflect local authority boundaries.

The most recent judgments from the Office for Standards in Education, Children's Services and Skills for the four local authorities are set out below.

Local authority	**Judgment**	**Date**
Hartlepool	Good	January 2014
Middlesbrough	Requires improvement	February 2016
Redcar & Cleveland	Requires improvement	April 2017
Stockton	Good	August 2016

The assistant chief constable (ACC) is the chief officer lead for child protection in Cleveland Police. A detective superintendent is the operational lead.

The force's central protecting vulnerable people (PVP) function oversees safeguarding throughout the force area and comprises the child abuse investigation unit (CAIU), the sex offender management unit (SOMU), the domestic abuse unit, the vulnerable adult unit and the VEMT.

[12] *Police workforce, England and Wales*, *31 March 2017*, Home Office, July 2017. Available at: www.gov.uk/government/statistics/police-workforce-england-and-wales-31-march-2017

[13] Under the Children Act 2004, section 14, the LSCB has a duty to co-ordinate how agencies work together to promote the welfare of children and ensure effective safeguarding arrangements.

Located in the north of the county is the CHUB, which combines children's safeguarding for two of the local authorities, Hartlepool and Stockton-on-Tees. The CHUB has some 40 members of staff working together, and includes representation from children's social care services, the police, CAHMS,[14] health (senior nurses from midwifery, health visitors and school nurse services provide rotational cover), education, designated officers,[15] probation and community rehabilitation, social housing providers and adult social care. At present, the two local authorities in the south of the county, Middlesbrough and Redcar & Cleveland, do not have a dedicated multi-agency safeguarding hub (MASH). There is a PVP support hub based in Middlesbrough police headquarters which processes referrals and fulfils many of the administrative functions linked to child protection throughout the force.

[14] Child and Adolescent Mental Health Services: an NHS service that assesses and treats young people with emotional, behavioural or mental health difficulties.

[15] A local authority designated officer handles all allegations against adults who work with children and young people.

3. Leadership, management and governance

As highlighted above, the PCC's police and crime plan 2016–2021[16] is clearly linked to vulnerability and the protection of children. Following a review of demand across the force, the PCC allocated approximately £2m of additional funding for protecting the most vulnerable, and this resulted in an increase in staff across a range of teams involved in the protection of children and the creation of a multidisciplinary PVP team and the dedicated VEMT.

The ACC chairs the public protection strategy group, at which senior leaders of the force discuss all matters relating to vulnerability, including child protection. The ACC also chairs a monthly tactical performance group, which focuses on, among other areas related to vulnerability, domestic violent crime and CSE. Together, these groups provide visible leadership and active governance, and aid the force's understanding of the demands of child protection, allowing for strategic oversight and practical delivery.

HMICFRS views the creation of the VEMT in July 2016 as a clear indication that leaders in the force have a considered and innovative approach to child protection. By combining different and previously separate units to form a single integrated team, the force has been able to boost its investigative and proactive capability. This is a positive step and has enabled the force to improve the service provided for vulnerable children – particularly those who regularly go missing, and those vulnerable to CSE and trafficking.

The force maintains effective oversight of the VEMT through a strategic meeting chaired by the detective superintendent and attended by the director of children's services from each local authority and one of the four LSCB chairs. All of the attendees provide the force with an assessment of issues relevant to child protection, allowing for a flexible and responsive approach. There are also regular sub-group meetings which are attended by the detective inspector from the VEMT and various other agencies and services, such as health, probation, charitable organisations, the youth offending service, housing and education. Additionally, there is a VEMT multi-agency practitioners' meeting held every four weeks, which also provides useful insight to the force from child protection practitioners.

This is positive and is evidence of the force's commitment to effective joint working, positive leadership, active governance and appropriate oversight arrangements, particularly through its joint work with other agencies responsible for the safeguarding of local children.

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[16] *Police and Crime Plan – 2016–2021,* Police and Crime Commissioner for Cleveland. Available at: www.cleveland.pcc.police.uk/Document-Library/Police-and-Crime-Plan/2016-17/Police-and-Crime-Plan-DOUBLE-SPREAD.pdf

This commitment to integrated working was also reflected in the feedback HMICFRS received from the force's partner agencies. LSCB chairs and directors of children's services, who were consulted as part of HMICFRS' inspection, all commented on the strength of their professional relationships with Cleveland Police. Partners described Cleveland Police's active involvement and its contribution to children's safeguarding, from chief constable to practitioner level. This is enabling both constructive collaboration and appropriate levels of professional challenge. Inspectors were also told that this marks a significant shift by the force in dealing with vulnerability, and has resulted in improvement in specific areas of child protection practice, such as the force's attendance at strategy meetings (which was previously criticised in the 2016 Ofsted inspection of Stockton-on-Tees' children's services).[17] Similarly, the LSCB chairs commented to inspectors on the force's consistent representation and active involvement at executive, board and sub-group levels.

The force is represented in the learning and development sub-group of the LSCBs, which conducts qualitative research in an effort to assess the effectiveness of child protection across safeguarding agencies. This work enables the force to identify areas that require improvement and take appropriate action. However, HMICFRS notes that the force does not at present have a similar function internally to assess the nature and quality of decision-making. Current performance data are based upon quantitative data which, though important, would be strengthened if complemented by a parallel focus on the quality of frontline practice.

The force has recently introduced an initiative called 'adopt a shift', in which specialist child protection officers are linked to neighbourhood and response teams. This is in order to share their knowledge and improve the understanding of non-specialist staff of child protection matters and their responsibilities. While the intention behind this initiative is positive, HMICFRS found that, at the time of inspection, some frontline officers were not yet aware of it. The force therefore has some work to do to ensure that all officers and staff are aware of the initiative, in order to give it the best chance of success.

The force is part way through a three-year rolling programme of vulnerability training for all officers and staff. This includes an electronic learning package about child safeguarding, classroom-based learning on relevant law, and development days about child protection and wider vulnerability issues.

[17] *Stockton-on-Tees Borough Council: Inspection of services for children in need of help and protection, children looked after and care leavers, and Review of the effectiveness of the Local Safeguarding Children Board*, Ofsted, 2016. Available at: https://reports.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/stockton_on_tees/053_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf

However, during the inspection, feedback from staff about the nature and extent of the training they had received varied greatly. Some staff told inspectors that they felt their training in this area had been appropriate while others stated that they had received none at all. This is something the force may wish to consider when reviewing or evaluating its training provision. The force also recognises that there are specific practice areas, such as considering the voice of the child, that are not up to expected standards and it is working to incorporate these into future training.

4. Case file analysis

Results of case file reviews

To determine how well Cleveland Police deals with specific cases, HMICFRS asked the force to self-assess the effectiveness of its practice in 33 child protection cases. The force used HMICFRS criteria[18] to grade the practice in each case as 'good', 'requiring improvement' or 'inadequate'.

Of 33 self-assessed cases, practice was rated by the force assessors as good in 15 cases, requiring improvement in 13 cases and inadequate in 5 cases.[19]

HMICFRS inspectors also assessed these cases and graded the practice in each. The quality of work in these cases was judged to be different from that of the force's self-assessment: HMICFRS rated practice in 4 cases as good, in 18 cases as requiring improvement and in 11 cases as inadequate.

Inspectors then selected and examined a further 48 cases: in 11 cases practice was assessed as good, in 24 cases as requiring improvement and in 13 cases as inadequate.

Figure 1: Cases assessed by both Cleveland Police and HMICFRS inspectors

	Good	Requires improvement	Inadequate
Force assessment	15	13	5
HMICFRS assessment	4	18	11

Figure 2: Additional cases assessed only by HMICFRS inspectors

	Good	Requires improvement	Inadequate
HMICFRS assessment	11	24	13

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

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

Of the cases assessed, HMICFRS referred seven back to the force because they were considered to contain evidence of a serious problem – for example, failure of the force to follow child protection procedures and/or a child being at immediate risk of significant harm. The force responded to the referrals by providing an updated assessment or by taking relevant action to mitigate risk.

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

A 14-year-old girl disclosed that she had been sexually active and raped by a 19-year-old man. The force's initial response was good and timely. However, record-keeping was extremely poor – there was no investigative activity documented including consideration of obtaining valuable forensic evidence. There was no evidence of joint working with other agencies to ensure that the child was safeguarded, or to provide her with any longer-term support. Days after the disclosure, the girl was assaulted by an associate of the suspect and told to withdraw the allegation. This crime was not connected to the original report and the two cases remained separate until HMICFRS inspectors alerted the force to this omission. In the assault investigation there was also evidence of poor recording and delays. No investigative activity was documented as taking place for almost three weeks; nor was there evidence (because no link to the rape allegation was made) that the force had considered offences such as witness intimidation or attempting to pervert the course of justice. The combination of these failings had left the child at a continuing risk of harm.

In another case, a registered sex offender (RSO) was convicted in September 2012 of historical offences against a ten-year-old boy and sentenced to a term of imprisonment as a result. The force had not visited him for two years before our inspection during which time it was managing him as a low-risk offender where visits should have been conducted on an annual basis. This was despite him having been subject to an ARMS[20] risk assessment in July 2015 indicating that he was of medium risk. Inspectors found that records relating to the RSO contained insufficient rationale in support of this assessment, and little evidence of effective supervision to ensure that the force was effectively managing the risks posed by this RSO.

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

Breakdown of case file audit results by type of investigation

Figure 3: Cases assessed involving enquiries under section 47 of the Children Act 1989[21]

Case type	Good	Requires improvement	Inadequate
Enquiries under section 47 of the Children Act 1989	3	6	3

Further detail of some of these individual cases, or referrals made in relation to children suffering, or likely to suffer, significant harm, is given in the chapters that follow. Common themes include:

- The force's initial approach to such incidents is mixed, with some good early action taken and other cases in which there are unacceptable delays, particularly in conducting interviews and arresting named suspects;
- The force's investigative activity is not always timely and this has led to the loss of potential evidence in some cases; and
- There is often an absence of recorded joint working, leaving it unclear as to what protective plans have been implemented to safeguard the child.

Figure 4: Cases assessed involving referrals relating to domestic abuse incidents or crimes

Case type	Good	Requires improvement	Inadequate
Cases relating to domestic abuse incidents	3	5	2

Further detail of some of these individual cases, relating to domestic abuse incidents, is given in the chapters that follow. Common themes include:

- The force generally acts promptly in response to such incidents, and officers make arrests at the appropriate times;

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

- PVP support officers are generally proactive in conducting follow-up work, for example by effectively using force records to link cases with related historical incidents;
- In most cases involving children, the force is using Operation Encompass effectively as a safeguarding measure;
- There is a general absence of information recording as a result of strategy meetings, leading to a lack of clarity on what, if any, broader safeguarding is in place;
- There is little evidence of the voice of the child being considered by officers attending domestic abuse incidents; and
- Officers do not always consider making referrals to external safeguarding agencies in instances where it would be appropriate and in the best interests of children affected.

Figure 5: Cases assessed involving referrals arising from incidents other than domestic abuse

Case type	Good	Requires improvement	Inadequate
Referrals arising from incidents other than domestic abuse	3	6	2

Further detail of some of these individual cases, relating to non-domestic abuse incidents, is given in the chapters that follow. Common themes include:

- The force has a proactive approach to such incidents, and officers make arrests at the appropriate times;
- Officers are not consistently documenting investigative activity, and therefore the progress and adequacy of investigations often cannot be monitored; and
- There is a general absence of information recording at strategy meetings, leading to a lack of information for the force on what, if any, broader safeguarding is in place for children affected.

Figure 6: Cases assessed involving children at risk from child sexual exploitation

Case type	Good	Requires improvement	Inadequate
Cases involving children at risk of child sexual exploitation both online and offline	3	11	2

Further detail of some of these individual cases, relating to CSE, is given in the chapters that follow. Common themes include:

- The force's frontline officers have made tackling this area of child protection a priority, and this is apparent through their proactive approach to such incidents;
- There is some evidence of the force's involvement in a multi-agency approach in the early detection and disruption of CSE incidents;
- In too many investigations, the force fails to review or command supervisory oversight; and
- There is often a lack of recording of the force's joint working, with a particular weakness in failing to record strategy discussions/meetings and the outcomes for the investigation.

Figure 7: Cases assessed involving missing and absent children

Case type	Good	Requires improvement	Inadequate
Cases involving missing and absent children	1	3	4

Further detail of some of these individual cases, relating to missing and absent children, is given in the chapters that follow. Common themes include:

- The force has a good preventative approach. The VEMT problem-solving unit consistently conducts extensive work to reduce the frequency of children going missing;
- The force control room's approach to the initial risk assessment of children who frequently go missing is inconsistent. It does not always take into account all information or circumstances relevant to the child. The result is that, in

some cases, the risk to the child has been determined incorrectly and the child does not benefit from adequate investigative activity or safeguarding measures and therefore faces continuing risk; and

- The investigation of children who are reported missing is a cause for concern and requires improvement. In many of the cases examined, there was a lack of any meaningful activity to trace missing children, even those assessed as medium risk.

Figure 8: Cases assessed involving children taken to a place of safety under section 46 of the Children Act 1989[22]

Case type	Good	Requires improvement	Inadequate
Children taken to a place of safety by police officers using section 46 of the Children Act 1989 powers	0	4	3

Further detail of some of these individual cases, relating to section 46 of the Children Act 1989, is given in the chapters that follow. Common themes include:

- The force is proactive in its use of Section 46 powers. The initial response from those in the control room and responding officers is appropriate, as are the subsequent decisions that determine whether to take a child into police protection;
- HMICFRS encountered cases in which the force had used effective means, such as the use of body-worn video cameras, to provide evidence of the correct use of these powers;
- The force's approach to subsequent investigative activity in these cases can be slow and with little evidence of supervisory oversight. This leads to delays which are unexplained and may adversely affect outcomes for children; and
- There is some evidence of the force participating in multi-agency activity to support safeguarding for children who are at risk, but the recording of this is poor. Where strategy meetings do take place, outcomes are not often recorded and it is not clear what the agreed actions are for each agency, including the force.

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

Figure 9: Cases assessed involving sex offender management where children have been assessed as at risk from the person being managed

Case type	Good	Requires improvement	Inadequate
Sex offender management where children have been assessed as at risk from the person being managed	0	3	3

Further detail of some of these individual cases, relating to sex offender management, is given in the chapters that follow. Common themes include:

- Appropriate referrals to children's social care services for children who may be at risk from an RSO were made in the cases examined, although not always at the earliest opportunity;
- Where children may be at risk from an RSO, there is no evidence of strategy meetings taking place and no recorded activity on the force's information systems following such referrals being made;
- The force does not adequately monitor practice in this area, and this lack of oversight means that overdue visits to RSOs go unchecked; and
- RSOs are not flagged within the force's command and control system, which stops relevant information being accessible to responding officers, who may be unaware that they are attending incidents which involve RSOs.

Figure 10: Cases assessed involving children detained in police custody

Case type	Good	Requires improvement	Inadequate
Cases involving children in police custody	2	4	5

Further detail of some of these individual cases, relating to children detained in police custody, is given in the chapters that follow. Common themes include:

- None of the cases assessed by HMICFRS contained a referral to children's social care services, and consequently there was no follow-up work or monitoring by the force in relation to longer-term safeguarding for the child in custody;

- As with some other areas of child protection, the recording of information is inconsistent and in some cases poor, particularly in relation to requests for secure and alternative accommodation; and
- This lack of information recording often leads to a lack of clarity about the type of accommodation requested (i.e. secure or alternative). All of the cases examined had little or no information about which type of information was appropriate and why.

5. Initial contact

During its inspection, HMICFRS found that where the matter was clearly a child protection one the initial response by staff was good. Control room staff responded quickly to obtain as much information as possible and pass it to the officers on patrol, where the response was also effective, as the following example shows.

A male suspect returned home while intoxicated and assaulted both his female partner and the couple's 13-year-old daughter. Control room staff conducted a good initial assessment and officers attended promptly, arresting the suspect and obtaining statements from both victims. HMICFRS was also pleased to note that the follow-up in this case was also good, and put in place longer-term safeguarding and support for the victims.

Cleveland Police has a single force control room, comprising a mix of police officers and staff, the latter dealing with the management of calls (known as 'dispatchers'). In late 2015, the force established an incident crime management team (ICMT) to resolve incidents and low-level crime matters without the need to send staff. However, if deemed appropriate, some incidents, including those involving children, will be dealt with by way of an appointment arranged by the ICMT.

Dispatchers are responsible for reviewing and prioritising reported incidents based on a THRIVE[23] assessment. To better manage demand, incidents are assessed on the basis of risk and rated from 0–4 (with 0-graded calls being the highest priority and requiring an immediate response).

This process is overseen by the force-wide daily management meeting and in periods of high demand additional staff can be used to assist control room dispatchers. However, inspectors were concerned to find that during these periods of high demand clear signs of risk were often missed when incidents were assessed, leading to a delayed or ineffective response, as the examples on the following page show.

[23] THRIVE is a risk assessment tool that considers six elements to assist in identifying the appropriate response grade based on the needs of the caller and the circumstances of the incident, namely: threat, harm, risk, investigation, vulnerability and engagement.

A man contacted the force in the early hours of the morning, alleging that he was being assaulted by his female partner in the presence of their baby. Although the victim refused to give any details, the force had details linked to his mobile phone number, yet no effort was made to attend the address, establish the victim's whereabouts or condition, or to safeguard the child.

In a separate priority 1 queue incident, a woman contacted the force after she and her young child had fled their address following a domestic incident, in which a named man had grabbed her round the neck and dragged her around the house. The suspect has a history of domestic abuse with another partner. At the time inspectors reviewed the incident, some 11 hours after it had been reported, neither the female victim nor her child had been seen by officers from the force.

In addition, there were 32 incidents that the ICMT had deemed as appropriate for appointment. HMICFRS reviewed this list and assessed that 3 of the 32 incidents were inappropriate for an appointment, and should have been dealt with more urgently, as demonstrated by the following example.

A woman contacted the force to report that her ex-partner (and father to her two very young children) had left her intimidating voicemail messages, and she was afraid that he would turn up at her address. Force records showed previous domestic abuse incidents between the couple. However, as the suspect lived some distance away, the ICMT deemed the matter to be appropriate for an appointment, which was made for nearly 24 hours later. The incident log contained information that the suspect had, that morning, hired a car – clearly increasing the risk of him travelling to the victim's address. Despite this information and the victim's distressed state, the force advised her to call 999 if he came to her address but took no immediate action. Given the known risks, this incident was unsuitable to be dealt with by appointment and the force should have taken more effective steps to safeguard the female and her young children, in both the short and medium term.

Staff and officers across the force control room have been trained in the use of the THRIVE process. New staff also receive a one-month induction course, which includes training in various IT systems as well as meeting the PVP teams to gain an insight into their work. However, staff told inspectors that the availability of other training related to child protection was inconsistent with no co-ordinated or continuing training programme provided to the majority of control room staff. Control room staff, under the direction of the force's PVP support hub, are responsible for placing electronic 'flags' on the command and control system to identify risk posed

by specific individuals. Flags are also used for addresses where children may be at risk (including those on a child protection plan). CSE flags and flags for RSOs do not appear on the command and control system, but rather on individual records within the force's intelligence system. Despite these flagging systems, inspectors found that this information is not consistently informing decisions about risk, particularly at times of high demand within the control room. As a consequence, there is an increased risk that frontline officers attending incidents are not adequately informed of all the relevant and necessary information, which could be crucial to their decision-making.

The force demonstrates an encouraging approach to monitoring the quality of the initial response by staff in its control room. Supervisors review samples of ten calls, assessing initial communication with the caller, risk assessment, response and management of the incident, and incident recording and resolution. This provides the opportunity to share good practice and identify learning for the individuals and teams. Additionally, the force intends to use these data to provide a means of identifying emerging themes related to the management of risk which will assist the force to improve its response to vulnerable children.

Most frontline officers spoken to as part of the inspection informed HMICFRS that they had received training on vulnerability – specifically on CSE and, more recently, human trafficking. However, some officers (including PCSOs) stated that they had received no training on child protection matters, and that as a result they did not feel confident in their ability to recognise and respond to safeguarding issues. Most staff spoken to were clear about their responsibility to record whether they had checked that children present were safe and well, and whether they had ensured their immediate safety. In the majority of cases these details were recorded, although inspectors found a number in which officers had not recorded thorough assessments of the behaviour and demeanour of a child. A child's demeanour, especially in those cases where a child is too young to speak to officers, or where to do so with a parent present might present a risk, provides important information about the impact of the incident on the child. Information about this demeanour should inform both the initial assessment of the child's needs and the decision as to whether there should be a referral to children's social care services.

Recommendations

- We recommend that, within three months, Cleveland Police reviews its processes to ensure that its staff can draw together all available information from police systems in order better to inform their responses and risk assessments.
- We recommend that, within three months, Cleveland Police ensures that its officers always record their observations of a child's behaviour and demeanour in records of domestic abuse incidents so that better assessments of a child's needs are made.

6. Assessment and help

The CHUB in the north of the force area and the PVP support hub in the south are the focal points for information exchange and inter-agency planning across the force area. The force and its partners have invested significant time and resources in the development of the CHUB and there is a clear commitment to improved joint working. Inspectors found some instances of agencies working well together, identifying risks, making plans to reduce these risks, and supporting children and families. This is shown by the following example.

The force made a referral to children's social care services in relation to a family in which officers had determined the presence of risks to an unborn child, namely incidents of domestic abuse, poor home conditions and the family having a dangerous dog in the home. The force's referral led to 'early help' involvement from the local authority as well as a subsequent referral to the CHUB. Through the CHUB, the force provided relevant information and took part in strategy meetings and an initial child protection conference. As a result of information shared between the relevant agencies, the force was able to raise a number of flags and warnings within its intelligence systems in relation to the family. The long-term outcomes for the unborn child were improved through the implementation of appropriate safeguarding measures.

However, at the time of the inspection, the force had a number of different ways in which information about risk could be submitted for further assessment. This is inefficient and could result in duplication, because (depending on the incident) the same information may need to be submitted separately to three different email addresses.

In response to the identification of these problems, the force has stated that by the end of 2017 it will implement a 'police protection notice application' on its intelligence system, in order to combine the three referral pathways into one. The force is confident that this will increase the efficiency and effectiveness of its referral process and will improve outcomes for children by way of more timely intervention and support.

MARACs were well attended by representatives from the force and a wide range of agencies. Information was routinely shared to protect both victims of domestic abuse and any children affected by it. The minutes are comprehensive, well recorded and accessible to all agencies. However, the actions recorded as a result of these meetings vary in quality, with many lacking substance or sufficient information. Additionally, in some of the cases reviewed, the actions recorded are not an accurate reflection of the victim's needs.

Inspectors were also told, and concerned to find, that workload pressures and staff vacancies within the PVP support hub have contributed to a significant backlog of standard-risk domestic abuse incidents awaiting assessment. This means that the force is far less able to assess escalating or cumulative risk, and those children who are repeatedly witnessing domestic abuse are not being identified. Furthermore, it is evident that as a consequence referrals are not routinely made to children's social care services in these cases and strategy discussions therefore do not always occur. This could leave children at risk because information is not shared and joint action taken at the earliest opportunity.

At the time of inspection, there were 593 cases awaiting action, the oldest dating back to January 2017. HMICFRS examined a sample of 80 of these cases and 10 were found to contain incidents of domestic abuse where children were present but where no referral to children's social care services had been made. This means that the development of a multi-agency protective plan for children exposed to domestic abuse (as required by the Working Together guidance) is not taking place (or not taking place at the earliest opportunity). For example:

A woman contacted the force to report that her partner was in possession of a large knife and was threatening to harm himself. There were three children aged between 3 and 8 years present in the house at the time. There was no referral made to children's social care services. A further incident took place involving the same family in which the suspect had attempted to gain entry to the house prompting the woman to notify the police. Despite this being a second incident involving the same family, there was no record of a domestic abuse, stalking, harassment and honour-based violence (DASH)[24] risk assessment having been completed; nor were any referrals made, either in respect of the victim or the children at the address. Two months later, one of the victim's children informed a school teacher that their father had breached the conditions of his bail by coming to the house, although his mother later denied that this had happened. Despite this third incident, the force still failed to make any referrals for safeguarding.

At the time of the inspection, the force had recognised this as an issue and had taken steps to respond. It had implemented a 'triage' process to review incidents in the backlog and make referrals for support. However, HMICFRS found that the referrals made were to charities or to an independent domestic violence advocate (IDVA) and that referrals to children's social care services were not made when this should have been the case. The result of this is that children exposed to domestic

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

abuse in Cleveland are at increased risk because they are not being provided with the appropriate multi-agency safeguarding support at the earliest opportunity. For example:

The force received notification of an incident where a man had hit his partner in the face following an argument after a night out, causing her a nose bleed. An 11-year-old boy was present at the address at the time (it is unclear whether he had been left home alone before the incident – this is not investigated by the officers attending). No direct referral was made by the officers attending and the record of the incident was sent to the PVP support hub. The hub referred the matter to a charity that provides support to victims. There is no record of any referral to children's social care services or of any specific measures being considered to address the vulnerabilities faced by the child.

Throughout the county, initial child protection conferences are well attended with all agencies, including the force, being active participants. Attendance at strategy meetings is also consistently high (approximately 90 percent), and the force uses video-conferencing facilities to allow more efficient participation and the discharge of its responsibility to share information.

Operation Encompass is an established practice within the child protection teams in the force. During the course of the inspection, HMICFRS did find a small number of examples in which a referral was required but had not been made, and two in which the referrals had been made late (two days and more than two weeks after the incident, respectively). Nevertheless, overall we found Operation Encompass is being used to good effect, and is contributing positively to safeguarding children in the county. External safeguarding agencies also commented on its positive impact through encouraging schools to be more active in their role of safeguarding children across the county.

Recommendation

- We recommend that Cleveland Police immediately undertakes a review, together with children's social care services and other relevant agencies, to ensure that the force is fulfilling its statutory responsibilities as set out in Working Together to Safeguard Children. As a minimum, this should include:
    - the assessment of risk, how information is shared and the development of joint protective plans; and
    - recording on police systems decisions reached at meetings to ensure that staff are aware of all relevant developments.

7. Investigation

Inspectors found some good individual examples of police child protection work within the protecting vulnerable people units, with child abuse investigators displaying a good mix of investigative and protective approaches. This ensures that the safeguarding of children remains central to their efforts while all criminal investigative opportunities are pursued. This is shown by the following example.

A 15-year-old girl was groomed for sexual abuse online by a man in his forties. The force arranged an intermediary (an advocate who assists vulnerable victims through the criminal justice process) and the child took part in a visually-recorded interview. This led to the prompt identification and arrest of the suspect. Numerous electronic devices were seized and sent for prompt forensic examination. The force also conducted thorough enquiries in the area where the suspect lived to establish if there were other potential victims. A rigorous investigation followed, as a result of which the suspect was charged with a number of offences and remanded into custody.

All officers within the child abuse investigation unit (CAIU) have received the appropriate training and the department is well resourced. All staff in the unit with whom inspectors spoke were enthusiastic about their work and committed to protecting children from harm. Inspectors witnessed some good inter-agency working with effective communication and information exchange between the unit and children's social care services.

Staff within the CAIU feel they are adequately supported by their line managers, but inspectors were told that the work of child protection officers is difficult to manage because of high workloads. Historical investigations are also investigated by the CAIU, exacerbating demand pressures. While inspectors did find some examples of good supervision, this is inconsistent because of supervisors' heavy workloads. Supervisors within the unit oversee approximately 130 cases each, which we consider to be too many to monitor effectively; and inspectors found that in a number of the cases examined a lack of supervision had contributed to delays in the investigation. In an effort to remove the additional demand from the CAIU, the force is in the process of reviewing the investigation of historical offences and intends to create a dedicated team of officers and staff which it believes will ease workload challenges within the CAIU and support improvements in the quality of investigations.

The force's major crime unit deals with non-familial rape offences. HMICFRS reviewed a small number of cases involving child victims and found that officers, specially trained in dealing with victims of sexual offences, were unavailable to assist the victims in these cases at the time they were reported. In addition, investigators found that there were unacceptable delays in conducting enquiries and poor recording of strategy meetings and joint working, as shown by the following example.

A 15-year-old girl who was the victim of a rape attended her recorded interview with the major crime unit 13 days after her initial disclosure. Following the interview (and at the time of the inspection), there was no record of any further investigative activity taking place and no supervision; no record of any referral being made to children's social care services could be found; and no evidence of her being provided with any other support. HMICFRS referred this matter back to the force, which undertook a review of the investigation and took steps to ensure that effective safeguarding measures were in place for the victim.

The problem-solving unit within VEMT has a dedicated employee from the children's charity, Barnardo's. Together they work closely with children's homes and other agencies, in addition to working with children who repeatedly go missing from home, to reduce the number of further missing episodes. This is achieved through meetings between the force and relevant agencies, and the development of tailored interventions and an agreed multi-agency protective plan. This is positive and provides the force with an opportunity to build trust with vulnerable children.

As a result of the work of the VEMT problem-solving unit, HMICFRS noted a significant improvement in the quality of decision-making and safeguarding support provided to vulnerable children. In the cases reviewed, the unit effectively considered all options to support and safeguard vulnerable children, and worked in a sensitive and considered manner with the child to implement them.

However, inspectors remain concerned about the protection of some children who regularly go missing from home. In the cases reviewed, initial risk assessments were often inappropriate; but even where they were accurate there was often little or no evidence of appropriate activity to locate the children. Inspectors also found that officers do not always recognise that children who regularly go missing from home may be at risk of being groomed for sexual abuse. This is demonstrated by the example on the following page.

A 15-year-old boy who was at risk of CSE was reported missing by staff at the children's home in which he was living. The initial assessment made by the control room was appropriate. However, there was no evidence of any investigative activity to locate the boy until the next morning when the VEMT completed a review and located him. A review of this case revealed that there was limited supervision of the initial stages of the investigation and that the response officers and their supervisors failed to acknowledge the VEMT marker as an indication of risk and to tailor their actions accordingly.

HMICFRS also found other examples of risks to missing children not being effectively managed even when those risks were serious. This is demonstrated by the following example.

A 12-year-old boy who was at risk of neglect and abuse by his parents was living in care and the subject of a full care order. There was a restraining order in place against the child's father in relation to his mother and the family had been appropriately referred to the MARAC process. In April 2017, the boy's foster mother reported him missing. However, he was instead recorded as absent by the force control room. There is no evidence of any checks being conducted in relation to the risks posed to the child by his parents. In fact, force records indicate that the child was determined as being at no immediate risk because he was assumed to be with his family (this assumption should have suggested that he was at greater risk). Moreover, force records indicate that while the boy was vulnerable he was described as having 'elements of independence' and 'street knowledge'. The failure to properly assess risk meant that activity to trace him was limited and ineffective.

On 10 May 2017, the force raised its assessment of risk to high, and this finally led to an appropriate investigation to trace the child, who was eventually located a week later, some 24 days after he was reported missing.

In the majority of cases examined, officers conducted 'safe and well' checks promptly (to check the child's immediate safety) after a missing child was located, but some records contained scant information. Inspectors found that independent return interviews[25] for children missing from home are available across the force

[25] When children are found, they must be offered an independent return interview. Independent return interviews provide an opportunity to uncover information that can help protect children from the risk of going missing again, from risks they may have been exposed to while missing or from risk factors in their home. For further information see *Statutory Guidance on Children who Run Away or Go Missing from Home or Care*, Department for Education, January 2014, available at:

area, although the details of whether they were in fact conducted and what was said were not always recorded on police systems. Inspectors could find no evidence in the cases assessed of them being used to inform the development of protective plans. Interviews with children at this stage can provide a wealth of information about the reasons why they are running away, particularly where this is becoming more frequent and the child is reluctant to speak to police or other agencies. A better understanding of why a child has run away can provide vital information to partner agencies and support more effective risk management, and it should inform planning and decision-making about future safeguarding action.

Cleveland Police has recognised the need to improve its response to tackling CSE. Operation Shield is the force's overarching response to CSE across the county. Its purpose is to encourage intelligence submissions from frontline staff, in order better to identify perpetrators and reduce the risks to identified children. This appears to be well understood by frontline officers and is improving the force's understanding of the nature and extent of CSE across the county, the development of protective approaches and the efforts of the force to disrupt perpetrators.

However, inspectors were concerned to find that in several serious CSE cases there was no record of risk being identified or acted upon, with the consequence that opportunities to safeguard children at the earliest opportunity appeared to have been missed, sometimes repeatedly. As a result, there was no evidence that proper safeguarding processes were applied, as demonstrated by the following example.

The mother of a 13-year-old girl contacted the police after she discovered that her daughter had sent indecent images of herself to a 17-year-old boy. At the same time she also stated that her daughter had been sexually active since the age of 12. Force records show that there was a delay of five weeks before the girl was spoken to, and an account obtained from her, by which time she did not wish to support an investigation. In addition, there is no evidence of any examination of the girl's phone (which the police had seized as evidence) taking place. A further three months passed before the suspect was interviewed on a voluntary basis. There is no evidence of any electronic devices belonging to the suspect being examined. There is no record of any strategy meetings taking place or any multi-agency work taking place to support this child, despite the obvious risks and concerns about the child's well-being.

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www.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf

The force routinely searches for evidence of children being abused or exploited online, and has a dedicated unit for overseeing these investigations. Inspectors saw evidence that processes were in place to monitor these investigations centrally and were pleased to see that in the majority of cases the investigations were progressed well. Safeguarding planning was evident in most of the cases reviewed. There is currently a backlog of electronic devices awaiting examination. This is not in the best interests of children – although HMICFRS acknowledges that the force has invested in additional equipment which can be taken to the scene of operations to conduct immediate examinations. In time it is anticipated that this will significantly improve the timeliness with which computers and other electronic devices are examined.

HMICFRS was pleased to find that when a child is identified as at risk, both the digital forensics unit and the paedophile online investigation team submit timely referrals to children's social care services. Officers attend strategy meetings and safeguarding planning was evident in most of the cases reviewed.

Recommendations

- We recommend that Cleveland Police immediately improves practice in cases of children who go missing from home. As a minimum, this should include:
    - improving staff awareness of their responsibilities for protecting children who are reported missing from home and, in particular, those cases where it is a regular occurrence;
    - improving staff awareness of the links between children going missing from home and the risk of sexual exploitation;
    - improving staff awareness of the significance of drawing together all available information from police systems, including information about people who pose a risk to children, better to inform risk assessments;
    - ensuring that staff are aware of the need to pass this information from police systems, including information about people who pose a risk to children, on to other agencies; and
    - identifying the range of responses and actions that the police can contribute to multi-agency plans for protecting children in these cases.
- We recommend that, within three months, Cleveland Police improves its child sexual exploitation investigations, paying particular attention to:
    - improving staff awareness, knowledge and skills in this area of work;
    - ensuring a prompt response to any concern raised;

- undertaking risk assessments that consider the totality of a child's circumstances and risks to other children; and
- improving the oversight and management of cases (to include auditing of child abuse and exploitation investigations to ensure that standards are being met).

8. Decision-making

When the case was clearly defined as a child protection matter from the outset, the police response was generally appropriate, and there were examples of effective decision-making to protect children. When there were significant concerns about the safety of children, such as parents leaving children home alone or being drunk while looking after them, officers handled incidents well, using their powers appropriately to remove children from harm's way. It is a very serious step to remove a child from their family by way of police protection.[26] In the cases examined, decisions to take a child to a place of safety were well considered and in the best interests of the child.

The force's child protection policy provides clearly set out guidance via flow charts which officers and staff can use to inform their decision-making, including guidance on legislation, associated police powers, roles of initial and designated officers, and the force's referral process.

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

A 1-year-old boy and a 3-year-old girl were taken into police protection and placed with foster carers following the arrest of their mother for abuse and neglect. The officers dealing with the incident gathered all necessary information to inform their decision to exercise their powers under section 46 of the Children Act 1989. Officers used body-worn video cameras to obtain evidence and they completed the appropriate forms. However, these forms were not uploaded to the intelligence system. There is some evidence of multi-agency working but there is no evidence of a record of what happened or was agreed at the strategy discussion/meeting to direct activity. At the time the case was reviewed, after some initial actions were completed there had been no further activity in four months since the initial incident.

[26] Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to (a) remove the child to suitable accommodation and keep him/her there, or (b) take such steps as are reasonable to ensure that the child's removal from any hospital, or other place, in which he/she is then being accommodated is prevented.

Recommendations

- We recommend that, within three months, Cleveland Police takes steps to ensure that all relevant information is properly recorded and is readily accessible in all cases where there are concerns about the welfare of children. Guidance to staff should include:
    - what information should be recorded (and in what form) on systems to enable good-quality decisions;
    - the importance of sending the information to the correct police department and/or relevant partner agency; and
    - the importance of ensuring that records are made promptly and kept up to date.

9. Trusted adult

In the majority of cases, though not all, it was clear that when the concern was serious and immediately recognised as a child protection matter, officers carefully considered the approach to the child or parents and explored the best ways to engage with the child. This sensitive approach resulted in stronger relationships between the child and the police. What the force often fails to demonstrate is a clear record of the views of the child, the effects on the child, or the outcomes of police intervention for the child.

As already described, the force's introduction of the VEMT problem-solving unit is a positive step and provides the force with an opportunity better to understand the reasons some children go missing. When a child is reported as missing three times within a 90-day period, they are allocated a case worker and a multi-agency safeguarding process is implemented.

Children who are known to be at risk of CSE are discussed at the monthly VEMT practitioners' meeting. VEMT staff work alongside external agencies to consider whether the necessary support is in place, including mental health services and drug and alcohol support. This approach also involves close contact with the child, speaking with them face to face and listening to them in an effort to understand their reasons for going missing.

In 2016, Barnardo's conducted research with a number of children about how they felt the police treated them. This information was fed back to the force and used in training sessions to provide officers with awareness on matters such as the importance of making referrals to improve outcomes for children and the possible effects of unconscious bias (where officers fail to identify risk because they perceive a child to be 'streetwise'), particularly in relation to those children who go missing regularly.

The VEMT also makes a significant contribution to investigations. HMICFRS found examples of cases in which officers had worked hard to gain the trust of children, not only in implementing safeguarding measures for them but also to encourage them to provide evidence in order to secure prosecutions against perpetrators. This is demonstrated by the example on the following page.

A referral was made to the force about two girls, aged 16 and 15 years. One of the girls had made contact with an adult male via social media, had met with him and engaged in sexual activity. The subsequent investigation was both thorough and timely. The investigation identified that one of the children was at risk of so-called honour-based violence from her family. The officer from the VEMT made a concerted effort to listen to both of the children and gain their trust, and over time they slowly disclosed more information and eventually provided statements to the force via visually-recorded interviews. The extensive enquiries by the VEMT not only identified the immediate offenders but also additional offenders and other children to whom they posed a risk, which resulted in further victims being safeguarded.

In a few of the cases examined, it is apparent that the force could have done more to communicate with and gain information from children in order to understand their behaviour and advise them about the risks to which they were exposing themselves. Such information is essential to the development of effective long-term safeguarding plans. This is demonstrated by the following example.

A 15-year-old girl was reported missing. The force's initial approach was appropriate with a timely response and an accurate risk assessment. There was evidence of effective supervision as a result of which it was quickly established that the child was suffering from depression and anxiety, had previously attempted suicide and self-harm, and was scared of going to school because of bullying. However, despite the force's good initial early action and assessment of the risks, there is no record of continued activity or supervision. Once the girl returned home of her own accord, the force conducted a welfare check but there is no evidence that an independent return interview was conducted to gain further insight into her behaviour. Additionally, there is no evidence that the force investigated what the girl had been doing while she was missing and whether she had been at risk during that time. This is despite being reported missing on a number of previous occasions during which a family member had seen her in the company of an unknown man. Despite the child's obvious vulnerability, the force did not make a referral to children's social care services nor, it appears, involve any external agencies to develop a joint protective plan.

10. Managing those posing a risk to children

Cleveland Police has a dedicated unit – the sex offender management unit (SOMU) – to manage registered sex offenders. The unit was dealing with a caseload that inspectors considered to be reasonable with most staff managing between 50 and 60 offenders each. The unit was resourced appropriately and staff working in the teams were clear about their responsibilities, undertook relevant enquiries, assessed risk and took action to reduce it. Officers are trained in the use of the active risk management system (ARMS). At the time of the inspection, approximately 80 percent of offenders had been the subject of an ARMS assessment, and these assessments were being used proactively to monitor and reduce risk. More work is needed to ensure that a higher percentage have been ARMS assessed, but the force is clearly working well to achieve this.

In January 2017, the National Police Chiefs' Council (NPCC) agreed that the management of RSOs would move towards active and reactive management approaches. Where offenders have had an ARMS assessment indicating low levels of risk, and where the offender manager is satisfied that they have committed no offences or presented any concerns for a 3-year period, the force may move from active management (where visits are prescribed) to reactive management (which means visits do not occur). This is kept under regular review and would change if there was a significant change in circumstances.

Although this style of management is still in its early stages in the force, it is expected that its effective use will allow more focus on those RSOs posing the highest risk and will, to an extent, ease demand through the reactive management of those who fit the criteria.

The force provides SOMU officers with the appropriate training to conduct their role and, when needed, it makes resources available to support their work in proactively monitoring the highest-risk sex offenders. RSOs are flagged on the force's intelligence system (both their name and address) which notifies their offender manager each time an RSO comes to the notice of the force. Although the intelligence flagging system is a useful one, the same process is not used on the command and control system, meaning that officers attending an incident are unlikely to be aware of an RSO's offending status.

HMICFRS found that links between the SOMU and neighbourhood policing teams were underdeveloped across the force area. Local officers are not routinely informed about the RSOs living in their areas other than when they are due to be released from prison. As a consequence, opportunities to use the neighbourhood teams to gather information about those who pose a risk to children may be lost. In September 2016, the force ceased proactively monitoring SOMU performance data. This means that senior leaders are unable to effectively oversee rates of ARMS

completed assessment or the number of overdue RSO visits. This is demonstrated by the following example.

A high-risk RSO was convicted in August 2015 for sexually assaulting a 26-year-old woman while her children were in the house. He was convicted and received a suspended sentence. The following month he underwent an ARMS assessment. At the time of inspection, the last visit made by the force to the RSO was in July 2016 – a pre-arranged visit. Before that he had been visited by the force only twice – in August 2015 and February 2016 – both of which were pre-arranged (as opposed to unannounced) visits. This meant that a high-risk offender (who, at the time, should have been visited every three months) had not been visited for ten months and had never received an unannounced visit. In August 2016, the RSO returned to the attention of the force after he was the victim of an assault. He subsequently moved away from the Cleveland area, apparently fearing for his safety. Records show that he may have breached his notification requirements when he moved. However, there is no evidence that this was investigated or that any further action was taken.

HMICFRS found that Cleveland Police was sometimes represented at MAPPA level 2 meetings by the SOMU detective sergeant, and level 3 meetings by a detective inspector. National guidance[27] states that the officer attending the meetings should be of a high enough rank to allocate police resources. This will usually be an inspector for level 2 meetings and a chief inspector for level 3 meetings. However, a lower-ranking officer may attend where necessary if they have experience of the MAPPA process and delegated authority to allocate police resources at the appropriate level. During the inspection, the force recognised that these criteria were not always met and indicated that an officer with sufficient seniority and experience will represent the force at these meetings in future.

[27] *Multi-agency public protection arrangements (MAPPA)*, Ministry of Justice, National Offender Management Service and HM Prison Service, 2016. Available from: www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2

11. Police detention

If a child is to be denied bail and detained after being charged with an offence, the local authority is responsible for providing appropriate alternative accommodation.[28] Only in exceptional circumstances (such as during extreme weather) would the transfer of the child to alternative accommodation not be in the child's best interests. In rare cases – for example, if a child presented a high risk of serious harm to others – secure accommodation might be needed.

HMICFRS found that the risk assessments conducted by Cleveland Police when children are detained in custody are generally of good standard, with appropriate adults[29] attending promptly, usually within two hours. However, the force itself indicated that, in some areas of the county, it can be difficult getting appropriate adults to attend custody, particularly after 1.00am, and occasionally this leads to unnecessary delays for the detained children. To address this, the force is currently working with third sector organisations to provide an additional service for children in custody when the local authority's emergency duty team is unable to attend. This is positive.

The force has a liaison and diversion team that works in the custody unit and speaks to children in custody (as well as adults), signposting sources of help and support in an effort to prevent them reoffending – a service which continues post-release. There is also an arrest referral team within the custody unit, which discusses drug-and alcohol-related problems with prisoners; again, this provision extends to children and young people.

However, HMICFRS did have concerns about some aspects of the detention of children. Many children entering custody have complex needs and are likely to be vulnerable and in need of safeguarding support. In many cases a referral to children's social care services is warranted. However, in HMICFRS' review of case files, there was no evidence of any referral forms submitted for a child in custody.

Cleveland Police has provided additional guidance to staff emphasising that children should only be detained in custody when absolutely necessary. This has resulted in a reduction in the number of children being brought into custody. In January 2016, 186 children were detained by the force compared with 53 in January 2017.

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

[29] Under section 63B of the Police and Criminal Evidence Act 1984, an appropriate adult is a parent, guardian, social worker or any responsible person over 18 years old who is not a police officer or a person employed by the police.

While this is positive, HMICFRS was concerned that, despite this, there were still some children being unnecessarily detained in police custody (on some occasions for significant periods of time). In none of the cases reviewed were children transferred to alternative accommodation following a decision to refuse bail. Inspectors found a number of cases where the force had requested accommodation from the local authority but none was provided. This is demonstrated by the following examples.

A 17-year-old boy was arrested for robbery and spent 34 hours in custody, 10 of which were after being charged with an offence. In addition to significant delays until an appropriate adult arrived (16.5 hours), no alternative accommodation was available despite the custody staff making a request to the local authority. The request was declined and the boy kept in custody. There is no evidence on the detention log of any attempt being made to challenge this decision or escalate concerns. Neither is there evidence of any referral to children's social care services for the child, or of a submission of a detention certificate to the court to justify the child's detention.

A 16-year-old boy was arrested for holding a knife to his brother's stomach. He was held in custody for more than 21 hours, 12 of which were after charge. While the file shows elements of good practice by the force, including the completion of a detention certificate (see below), the rationale for bail being refused is not logged. From the file it appears that it was not until five hours after charge that the emergency duty team was called by the force, whereupon the team said there was no accommodation other than in Lincoln, which was deemed too far away to transport the boy at the late hour. In addition, the file is unclear on the type of accommodation (i.e. secure or alternative) requested by the force and that which was stated to be unavailable by the emergency duty team.

Detention certificates, which outline to a court the reason for a custodial remand, are essential for police accountability and enable forces to monitor how well they are discharging their responsibilities under the Police and Criminal Evidence Act 1984. Of the force's six cases audited by HMICFRS in this regard, only one contained a correctly completed detention certificate.

In April 2017, the first meeting of the multi-agency children and vulnerable people in custody (CVPIC) working group took place, which had been formed in response to a joint inspection by HMICFRS and HM Inspectorate of Prisons of police custody in

Cleveland and the thematic inspection by HMICFRS of the welfare of vulnerable people in police custody.[30] While this is positive, it is too early at present to comment on the effectiveness of this group or outcomes for children.

At the time of inspection, the force had 28 actions in progress intended to deliver better outcomes for children and vulnerable people detained in custody. However, the force currently lacks any process by which to test the effectiveness of its activity.

Section 136 of the Mental Health Act 1983 allows a police officer to remove an apparently mentally disordered person from a public place to a place of safety. Although a place of safety can include a police custody suite, this should only be used in exceptional circumstances, and it is preferable for the person to be taken directly to a healthcare facility such as a hospital. The force has given clear guidance to custody sergeants and operational staff that children who are detained under section 136 must not be brought into custody.

Recommendation

- We recommend that, within three months, Cleveland Police undertakes a review (jointly with children's social care services and other relevant agencies) of how it manages the detention of children. This review should include, as a minimum, how best to:
    - ensure that all children are only detained when absolutely necessary and for the absolute minimum amount of time;
    - assess, at an early stage, the need for alternative accommodation (secure or otherwise) and work with children's social care services to achieve the best option for the child;
    - ensure that custody staff comply with their statutory duties to complete detention certificates if a child is detained for any reason in police custody following charge;
    - ensure that custody staff make a record of all actions taken and decisions made on the relevant documentation; and
    - improve awareness among custody staff of child protection (including the risk of sexual exploitation), the standard of risk assessment required to reflect children's needs, and the support required at the time of detention and on release.

[30] *Report on an Unannounced Inspection Visit to Police Custody Suites in Cleveland, 8-12 December 2014*, HM Inspectorate of Prisons and HMIC, May 2015 and *The Welfare of Vulnerable People in Police Custody*, HMIC, March 2015. Both available at: www.justiceinspectorates.gov.uk/hmicfrs/our-work/joint-inspections/joint-inspection-of-police-custody-facilities/

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

Cleveland Police has demonstrated a strong commitment to improving services for the protection of children and vulnerable people, and this is visible at all levels of the force from the chief constable to frontline staff. The chief constable and the PCC have prioritised vulnerability and child protection. It is clear that there is a force-wide focus on safeguarding and improving outcomes for children. However, while there were a number of examples of good work to protect children, this commitment has not yet resulted in consistently improved outcomes for children. It is evident that Cleveland Police has good working relationships with partners. Inspectors found some good examples (such as the VEMT problem-solving unit) of the force protecting children who were most in need of help with good multi-agency work and a child-centred approach.

However, in a significant number of cases, poor supervision and record-keeping had undermined decision-making and safeguarding measures. If the force is to be confident that it is adequately protecting vulnerable children, these aspects of safeguarding arrangements require improvement.

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

Cleveland Police has good working relationships with the four local authorities and other services that operate across the force area. It is to be commended for its partnership working to improve the treatment of vulnerable children in custody, but this work is at an early stage and more needs to be done through joint working to deliver better services, particularly for children in police detention who are in need of alternative accommodation.

Alongside this, a performance framework that focuses more on outcomes for children who need protection (rather than the number of cases processed) should be developed and introduced to enable the force continuously to monitor and improve its child protection work.

We make a series of recommendations aimed at helping the force to make these improvements.

Recommendations

Immediately

1. We recommend that Cleveland Police immediately undertakes a review, together with children's social care services and other relevant agencies, to ensure that the force is fulfilling its statutory responsibilities as set out in Working Together to Safeguard Children. As a minimum, this should include:

    - the assessment of risk, how information is shared and the development of joint protective plans; and

    - recording on police systems decisions reached at meetings to ensure that staff are aware of all relevant developments.

2. We recommend that Cleveland Police immediately improves practice in cases of children who go missing from home. As a minimum, this should include:

    - improving staff awareness of their responsibilities for protecting children who are reported missing from home and, in particular, those cases where it is a regular occurrence;

    - improving staff awareness of the links between children going missing from home and the risk of sexual exploitation;

    - improving staff awareness of the significance of drawing together all available information from police systems, including information about people who pose a risk to children, better to inform risk assessments;

    - ensuring that staff are aware of the need to pass this information from police systems, including information about people who pose a risk to children, on to other agencies; and

    - identifying the range of responses and actions that the police can contribute to multi-agency plans for protecting children in these cases.

Within three months

3. We recommend that, within three months, Cleveland Police reviews its processes to ensure that its staff can draw together all available information from police systems in order better to inform their responses and risk assessments.

4. We recommend that, within three months, Cleveland Police ensures that its officers always record their observations of a child's behaviour and demeanour in records of domestic abuse incidents so that better assessments of a child's needs are made.

5. We recommend that, within three months, Cleveland Police improves its child sexual exploitation investigations, paying particular attention to:

    - improving staff awareness, knowledge and skills in this area of work;
    - ensuring a prompt response to any concern raised;
    - undertaking risk assessments that consider the totality of a child's circumstances and risks to other children; and
    - improving the oversight and management of cases (to include auditing of child abuse and exploitation investigations to ensure that standards are being met).

6. We recommend that, within three months, Cleveland Police takes steps to ensure that all relevant information is properly recorded and is readily accessible in all cases where there are concerns about the welfare of children. Guidance to staff should include:

    - what information should be recorded (and in what form) on systems to enable good-quality decisions;
    - the importance of sending the information to the correct police department and/or relevant partner agency; and
    - the importance of ensuring that records are made promptly and kept up to date.

7. We recommend that, within three months, Cleveland Police undertakes a review (jointly with children's social care services and other relevant agencies) of how it manages the detention of children. This review should include, as a minimum, how best to:

    - ensure that all children are only detained when absolutely necessary and for the absolute minimum amount of time;
    - assess, at an early stage, the need for alternative accommodation (secure or otherwise) and work with children's social care services to achieve the best option for the child;
    - ensure that custody staff comply with their statutory duties to complete detention certificates if a child is detained for any reason in police custody following charge;

- ensure that custody staff make a record of all actions taken and decisions made on the relevant documentation; and
- improve awareness among custody staff of child protection (including the risk of sexual exploitation), the standard of risk assessment required to reflect children's needs, and the support required at the time of detention and on release.

Next steps

Within six weeks of the publication of this report, HMICFRS will require an update of the steps taken by the force in acting upon the immediate recommendations made.

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

Subject to the updates and action plan received, HMICFRS will revisit the force no later than six months after the publication of this report to assess how it is managing the implementation of all of the recommendations.

Annex A – Child protection inspection methodology

Objectives

The objectives of the inspection are:

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

The expectations of agencies are set out in the statutory guidance *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, the latest version of which was published in February 2017. The specific police roles set out in the guidance are:

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

These areas of practice are the focus of the inspection.

Inspection approach

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

Methods

- Self-assessment – practice, and management and leadership
- Case inspections
- Discussions with staff from within the police and from other agencies
- Examination of reports on significant case reviews or other serious cases
- Examination of service statistics, reports, policies and other relevant written materials

The purpose of the self-assessment is to:

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

Below is a breakdown of the type of self-assessed cases we examined in Cleveland Police:

Type of case	Number of cases
At risk of sexual exploitation	3
Child in custody	3
Child protection enquiry (s. 47)	5
Domestic abuse	5
General concerns with a child where a referral to children's social care services was made	5
Missing children	3
Police protection	3
Online sexual abuse	3
Sex offender enquiry	3

Annex B – Definitions and interpretations

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

Office for Standards in Education, Children's Services and Skills (Ofsted)	non-ministerial department, independent of government, that regulates and inspects schools, colleges, work-based learning and skills training, adult and community learning, education and training in prisons and other secure establishments, and the Children and Family Court Advisory Support Service; assesses children's services in local areas, and inspects services for looked-after children, safeguarding and child protection; reports directly to Parliament
police and crime commissioner (PCC)	elected entity for a police area, established under section 1 of the Police Reform and Social Responsibility Act 2011, responsible for securing the maintenance of the police force for that area and securing that the police force is efficient and effective; holds the relevant chief constable to account for the policing of the area; establishes the budget and police and crime plan for the police force; appoints and may, after due process, remove the chief constable from office
registered sex offender	a person required to provide his details to the police because he has been convicted or cautioned for a sexual offence as set out in Schedule 3 to the Sexual Offences Act 2003, or because he has otherwise triggered the notification requirements (for example, by being made subject to a sexual offences prevention order); as well as personal details, a registered individual must provide the police with details about his movements, for example he must tell the police if he is going abroad and, if homeless, where he can be found; registered details may be accessed by the police, probation and prison service