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

National Child Protection Inspection Post-Inspection Review

Dorset Police
25–29 April 2022

Contents

Introduction

In April 2021, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) inspected how well Dorset Police keeps children safe. We made eight recommendations in the Dorset – National child protection inspection report.

In April 2022, we returned to the force to undertake a post-inspection review.

During this inspection we:

- examined force policies, strategies and other documents;
- interviewed senior leaders, managers and supervisors; and
- audited 31 child protection cases (10 cases were good, 10 required improvement and 11 were inadequate).

Summary of findings from the post-inspection review

The force has committed a great deal of resources, time and energy to improving outcomes for children and making improvements in line with our recommendations. Following the 2021 inspection, a gold group was swiftly formed to manage the response and is still in place today to oversee improvement activity. There is a clear commitment from senior officers to child protection, and this was evident throughout the inspection.

The force has taken steps to better understand the service it provides to children. The Make the Difference (MTD) team undertakes weekly qualitative audits of child protection cases to establish themes, areas of strength and areas for development. Feedback is provided to individual officers, and reports are prepared for senior leaders to give them a greater breadth of understanding to inform the strategic response. Assurance work is further enhanced by new multi-agency scrutiny panels which sit quarterly to analyse the joint response to a small number of cases. Learning points are discussed with individual officers and supervisors, and mitigating actions are completed. Wider learning is shared throughout the force, and where relevant, the force works with statutory safeguarding partners through the safeguarding children partnership to improve multi-agency practice.

There has been wide-ranging investment in learning and development throughout the organisation. Frontline officers and specialist teams are given the skills they need to recognise vulnerability and risk and to provide an appropriate response. While individual officers don't yet consistently make the best decisions for children, the training they receive provides a firm foundation for this to improve. Planning processes are robust in being able to determine skills gaps and plan future training.

Following the 2021 inspection, the force has worked collaboratively with the inspectorate to improve practice in important areas. Most notably, this included the holding of two training events focusing on the response to missing children. This demonstrates transparency and a culture of continuous improvement.

The force has taken the initiative in making improvements to child protection practice. The development of an intelligence portal automatically identifies areas of risk to children. This means the force can focus its resources more quickly on those children most at risk.

The inspection team found officers and staff at all levels were enthusiastic to talk about their work.

The force has worked systematically to address the recommendations from our 2021 inspection and can demonstrate clear improvements in most areas as a result. It now needs to build on these foundations to achieve consistently better outcomes, focusing on areas where most improvement is needed. We are encouraged by the force's progress and confident of its continuing commitment to making further improvements.

Initial contact

Recommendations from the 2021 inspection report

> We recommend that Dorset Police immediately reviews the force control room response to incidents where children are involved. It should make sure that the response reflects the identified level of risk, including ongoing or escalating risk.
>
> We recommend that, within three months, Dorset Police acts to make sure that children's concerns and views are obtained and recorded (including noting their behaviour and demeanour).

Summary of post-inspection review findings

Control room staff have had more training, and policies and processes have been updated. This has improved the response to incidents involving children, but there are still some delays in responding appropriately.

Police officers and staff are better equipped to work with children to understand how incidents have affected them. This has led to better quality information being shared with other safeguarding partners.

Detailed post-inspection review findings

Control room staff have received more training, and policies have been updated

Since our 2021 inspection, the force has renewed training for control room staff, focusing on vulnerability including child safeguarding. Actions include updating the training for new members of staff, providing continuing professional development (CPD) training for existing staff through 'power hour' inputs provided by safeguarding specialists, and specific training for supervisors about missing person investigations. This has been supported by regular messaging to staff to reinforce learning.

Policies and systems have been updated to help staff improve risk assessment and deployment processes in line with the identified risk. For example, control room staff have access to an information portal that provides call takers with readily accessible guides about how to respond to a variety of incidents. We found that the missing person guide had been updated to reflect national policing practice. The guide provides good information about how to respond to reported incidents in a child-centred way.

The refreshed deployment policy outlines how calls to the police should be graded according to their seriousness in line with the THRIVE assessment. We were told that where vulnerability is identified, incidents should always be dealt with as a grade one (immediate response) or grade two (arrival on scene within 20 minutes). However, we found that these deployment targets aren't consistently being met.

The provision of real-time intelligence through FIB24 (the 24-hour, seven-day intelligence and research function) continues to be positive and we consistently saw research being done and relevant information being added to the logs to assist the decision-making process.

Case study: police respond to a call from worried school staff

School staff contacted the police to report that a seven-year-old girl hadn't arrived at school that morning, and they were concerned for her welfare. They had been to her address, but there was no reply. A neighbour reported that there had been a domestic abuse incident the previous evening. There had been earlier concerns about the girl living in difficult circumstances due to her parents' drug taking and alcohol consumption.

The call taker quickly conducted a THRIVE assessment and FIB24 added further relevant information about drug dealing and possible neglect in the family home. The log was allocated a grade two priority and advice added that officers should use body-worn video, consider the voice of the child and submit a police protection notice (PPN) – the means by which information about vulnerable people is recorded.

But officers didn't attend the address until approximately ten hours later. Nobody came to the door; the child and her parents weren't located. But the girl did attend school the following morning.

There was a delay of 13 days before the girl's parents were traced and spoken to by the police. The girl wasn't seen or spoken to. The officer attending the address described it as "unclean and having a bad odour". Both parents appeared to be under the influence of drugs and/or alcohol. A PPN was submitted and shared with children's social care services. A strategy meeting wasn't held.

The force regularly reviews the effectiveness of decisions made in the control room

The force's MTD team and control room quality assessors carry out regular in-depth audits to assess the quality of the control room response to child protection incidents. For example, in March 2022, the MTD team identified that 97 percent of calls had a THRIVE risk assessment. The quality assessors conduct live monitoring to assess the quality of decisions made. This means feedback is provided to staff at the time to embed learning.

In the cases we looked at, we also saw THRIVE assessments being completed for most incidents. This is positive. But we also found the quality of assessments to be inconsistent. Some lacked detail and, while following the correct process, didn't always provide sufficient information about incidents to effectively inform how the police should respond.

Where there are delays in responding to incidents, we saw that the level of risk was reassessed

During the fieldwork, we looked at the open incident queues in the control room, including those incidents to be dealt with by appointment. We dip sampled 20 incidents. We didn't find any incidents that had been graded inappropriately, which is positive. We also saw good evidence of additional THRIVE risk assessments being conducted every 24 hours but limited evidence where the victim was called back to determine if there had been any escalation in risk.

These processes, if implemented fully, should provide reassurance to the force that risk is well considered when incidents aren't dealt with immediately, and decisions about the appropriate response to incidents are sound.

We found improvements in the way officers engage with children

We saw a considerable focus on raising awareness about the voice of the child. Learning and development opportunities are consistently provided throughout the organisation. During the 2021 inspection, we commented positively on the force's Vulnerability 2 training. During this inspection, we found that Vulnerability 3 training is being rolled out. This is also a quality programme, and so far, approximately 1,200 frontline staff from many departments have received the training. It covers topics such as missing children, the importance of PPNs and online child sexual abuse. The 'Vulnerability 3' training will shortly be extended to control room staff.

Staff we spoke to were clear about their responsibilities when dealing with children and were aware that they should engage with them to understand what has happened and how they are feeling. However, we were also told that there is some confusion about when body-worn video can be used when dealing with incidents involving children. This can be a useful tool to record how children present and the conditions in which they are living. Further clarity should be provided to frontline officers about this.

In the cases we looked at, PPNs were being consistently submitted where there was a concern for a child. This is positive, and we saw some very good examples of quality information being recorded in PPNs. This was particularly evident in missing children and police protection cases. But this wasn't consistent. In a small number of child neglect cases, although details of children were recorded, the voice of the child wasn't recorded sufficiently. We also saw on occasion a failure to speak to children. This is an improved position from the 2021 inspection, but there is more work to do.

Assessment and help

Recommendations from the 2021 inspection report

> We recommend that Dorset Police immediately reviews its missing persons arrangements and practices to ensure that throughout the missing episode there is always an effective response to missing children.
>
> We recommend that, within three months, Dorset Police carries out a review including (where relevant) with statutory safeguarding partners. This should consider how the force is meeting its responsibilities as set out in *Working Together* when it comes to assessing risk, sharing information, participating in strategy meetings and developing joint investigative and protective plans.

Summary of post-inspection review findings

There has been some improvement in the force's response to missing children. But there are still some delays in deploying officers according to the level of risk. There is also limited evidence of a multi-agency response to try and reduce missing episodes for children who are regularly missing.

The force has made good progress in risk assessing and sharing information with other safeguarding partners when children are identified as at risk. But further improvements are needed in strategy meeting processes and the recording of information from them.

Detailed post-inspection review findings

The assessment of risk in the control room about missing children has improved, but there are still delays in officers being deployed

When children are reported missing, the call taker completes a comprehensive missing person risk assessment, which provides the opportunity for the background risks relating to the missing episode to be considered. They can click on a link which brings together the history of the child and the other people involved. This is complemented by additional research from FIB24 and in some cases the identification of flags (a mechanism by which risk is highlighted) and trigger plans. This means that decisions about how to deploy officers to such incidents should be well considered and made promptly.

But we saw in the cases we examined that deployment is often delayed. We also noted delays in the ratification of risk assessments by control room managers. While we haven't been able to fully test the hypothesis that the delays are linked, it may be that deployment is dependent upon the supervisor review, which shouldn't be the case.

In some cases, we found inappropriate language being used in missing children risk assessments

We found in a small number of cases that officers and staff conducting risk assessments when children are reported missing used language that is inappropriate. The language used implies that the child is somehow complicit or responsible for the circumstances in which they find themselves. We saw examples such as "missing through choice", "appears deliberately missing" and "voluntarily absented himself". When children have been harmed by or are at risk of exploitation, such language can have the appearance of placing responsibility on the child for going missing. This isn't appropriate given their inherent vulnerability. The format for the missing person risk assessment should be reviewed to ensure that this doesn't happen.

There has been some progress in professionalising the missing person response

The force has created missing person teams in its two local policing areas. This is a positive step as the approach to missing person investigations should be professionalised throughout the force. Although the teams are quite new, frontline staff we spoke to commented favourably on the effect they were having, as they recognised that before their implementation, the missing child response needed to improve.

But the hours of operation of the missing person teams are limited. This means that outside these hours, responsibility for missing child investigations is handed back to response teams. While improvements have been made to the way cases are handed over, we have seen that particularly overnight, there is a lack of urgency and activity generated to locate children.

Missing persons are routinely discussed at force daily tasking meetings. While this gives senior officers the opportunity to add additional scrutiny and rigour to investigations, we didn't always see that it made a material difference, with some cases left to drift for several days.

We saw prevention interviews and PPNs being completed for all missing children. Mostly, these were detailed and represented the voice of the child.

Case study: a good response to a missing child

A 13-year-old girl was reported missing by her mother. She had not been missing before. The initial call was dealt with effectively, and the risk to the child was identified and appropriately graded as medium risk.

The missing person team was allocated to the incident within 30 minutes, and initial enquiries were commenced. A supervisor reviewed the case and set out further bespoke lines of enquires. A dedicated officer was identified, and an investigation plan was recorded on the log. The child returned home approximately three hours later. Officers attended and conducted a prevention interview. A comprehensive PPN was completed which represented the voice of the child well.

We found a lack of multi-agency work to consider children at risk from being missing

The missing person co-ordinator attends a daily meeting with both local authorities in the Dorset Police area, where details of those children missing in the previous 24 hours are discussed. At these meetings, decisions are made about whether strategy meetings are required and whether or not to offer independent return home interviews to the children involved. But the missing person co-ordinator doesn't receive any feedback about whether strategy meetings have been held or what the outcomes were. In the cases we looked at, we didn't see any evidence of strategy meetings specifically for missing children.

We also didn't see any evidence to indicate that independent return home interviews are being completed, as information isn't being routinely added to police systems. This would help to find children should they go missing again. The responsibility for offering return home interviews rests with the relevant local authority, and we were told that they do take place. The force has worked with partners by providing training designed to improve how information is shared with the police from local authorities. But more engagement with partners is required as we didn't see any improvement to this process during our inspection.

The missing person co-ordinator maintains a spreadsheet with information about children that have been reported missing 3 or more times in 90 days. According to national policing practice, this should trigger a referral to children's social care services. We dip sampled three of these cases. The children involved had been missing 34, 28 and 16 times respectively in the previous 90 days. While there was evidence of multi-agency meetings in these cases to consider exploitation and other child protection concerns, we didn't see any explicit consideration or action generated with the aim of reducing missing person episodes.

Improvements have been made to the way the force assesses risk and shares information

The force has worked well with statutory safeguarding partners to bring about improvements. Multi-agency strategic and operational boards have been re-invigorated with both local authorities. The detective chief inspector responsible for child protection has been an important player in this and has worked hard to improve relationships with safeguarding partners, which is commendable. Greater consistency in decision making has been achieved by the introduction of shared risk assessment documents.

The force has increased staffing levels in the multi-agency safeguarding hub (MASH) to address backlogs in workload and ensure timely information sharing. We found low numbers of cases in MASH workstreams. The oldest cases were low risk, with higher-risk cases being dealt with more quickly. This has been assisted by good innovation with the creation of an intelligence portal. This is an IT solution designed to determine risk and prioritise work. This means information on the highest-risk cases can be identified and shared more quickly with safeguarding partners.

In lower-risk cases, daily meetings are held with both local authorities to ensure that where appropriate, children and families are supported by signposting to early help and other intervention services.

Staff within the MASH routinely assess all incidents and quality assure them to ensure that all associated people and children are correctly linked in systems. This helps to make sure that appropriate risk assessments can be made. The domestic abuse cases we saw considered cumulative and escalating risk effectively, and where appropriate, multi-agency risk assessment conference referrals were made.

Where PPNs haven't been submitted by officers, a supervisor in the MASH prompts officers to complete them. But we found that this process isn't as effective as it should be. We found a domestic abuse case with a three-year-old child in the family. At the time of the inspection, the incident had taken place nine weeks previously, yet when we looked at the case, a PPN hadn't been completed or information shared with other safeguarding partners.

Further improvements are required in attendance at strategy meetings and the recording of information

Staff within the MASH have received additional training such as the Vulnerability 3 programme. A bespoke decision-makers course has also been developed for officers taking part in strategy discussions. This is a positive step, but these officers aren't child protection specialists. The effectiveness of their decision making should be sampled by supervisors in the MASH. But this isn't being done often enough. This is exacerbated by delays in strategy meeting minutes being provided by the local authorities. This means that the quality of decision making at strategy meetings isn't being consistently tested. We found several cases that should have progressed to a strategy meeting. But this didn't happen, and the force hadn't challenged or escalated this.

Where strategy meetings are taking place, we found that records aren't updated quickly enough to show the outcomes of those meetings and what actions were generated. In the cases we looked at, we saw little evidence of updates, or where they were present, there had been a delay in them being recorded. This means that it isn't always clear what is happening in a child's life, whether they are safe and what the joint plan is.

The integrated missing person and child exploitation team (IMPACT) attends child exploitation meetings and share information with other safeguarding partners. Minutes and actions from the meetings are visible within the records of the children. We dip sampled 10 of the 27 children in the high-risk cohort and saw that meeting records, risk assessments and supervisory oversight were present. In instances where missing episodes were a feature of their case, each of the children also had a trigger plan.

To make further improvements to MASH processes, the force and local safeguarding partners have committed to a review of the MASH. While this isn't yet underway, it should give the force the opportunity to consider the issues raised in this report with other safeguarding partners.

Investigation

Recommendations from the 2021 inspection report

We recommend that Dorset Police should immediately improve its child protection and exploitation investigations, paying attention to:

- improving the way cases are risk assessed and recorded;
- allocating investigations to teams with the skills, capacity and competence to carry them out well;
- improving the quality of oversight and supervision; and
- sharing information with children's social care services at the time that a risk to a child is known.

Summary of post-inspection review findings

We found the quality of investigations to be inconsistent. Officers in specialist teams are generally well trained with good supervision. But there is more work to do to improve the quality of investigations.

The response to online child sexual abuse and exploitation has improved. Risk assessments are conducted early to prioritise workloads. But problems remain with how information is shared with children's social care services.

There are insufficient resources in IMPACT to deal effectively with high-risk cases of child exploitation.

Detailed post-inspection review findings

We found the quality of investigations to be inconsistent

The introduction of an investigative standards board chaired by the detective chief superintendent is a positive step towards understanding and reviewing investigative practice and processes. But the strategic intent isn't yet leading to consistently good investigations and outcomes for children. In the cases we looked at, we found examples of a lack of investigation plans, actions not being completed, investigations being subject to drift and delay, and a lack of meaningful supervision. There is more work to do in this area.

Case study: delays in a case being progressed

A 15-year-old girl reported that she had been sexually assaulted by a 16-year-old boy on 3 occasions and he had sent indecent images to her. The officer submitted detailed PPNs for the victim and other children potentially at risk from the suspect. An urgent strategy discussion took place. At the time of the inspection, the minutes from the meeting hadn't been uploaded onto police systems.

The victim was video interviewed, but this occurred nearly two months after the report was made. The parents of the victim and social workers acting for both victim and suspect complained about the delay due to the effect it was having on the children involved.

The original officer dealing with the case tried to get it reallocated due to the pressure of other work, but this was denied. The investigation was still ongoing at the time of our inspection.

As mentioned earlier, the voice of the child can be recorded well on PPNs, but improvements could be made in considering and recording this throughout the lifetime of an investigation. This would make sure that the views of children are fully considered as investigations progress.

But we did see some very good investigations as well, particularly from IMPACT. We saw child-centred cases where children were effectively engaged and supported. These cases were appropriately investigated, with prompt steps taken to arrest dangerous suspects and make sure that wider safeguarding of other children was also carried out.

Case study: good investigation where a child is being exploited

A 15-year-old girl was reported missing. It was identified that she was being exploited and likely to be involved in county lines drug dealing.

The investigation to locate her and deal with those involved in her exploitation was good. A detailed investigation plan was endorsed within the investigation log, the safeguarding of the girl was considered, and investigative actions were recorded, actioned and resulted. All proportionate lines of enquiry were pursued.

At the time of our inspection, the case was ongoing. The suspect had been arrested and released on police bail with restrictive conditions. A referral to the national referral mechanism was being considered for the girl.

Officers in specialist departments are well trained

Investigative training and CPD opportunities are provided throughout the force. Officers in specialist roles have attended the specialist child abuse investigation development programme and professionalising investigation programme level 2 (serious and complex crime) and maintained their accreditation, with CPD provided annually and through regular 'power hour' learning. This is a strength of the force. Comprehensive records are kept on a learning management system, which gives senior officers confidence about what is being delivered and any additional training required by the organisation.

The police online investigation team (POLIT) risk assesses cases appropriately but there are still issues with how they share information

Since our last inspection, the POLIT has seen an increase in resources. And the team is regularly using KIRAT risk assessments to understand and prioritise risk. We saw evidence of appropriate checks and research being completed to inform the assessments.

But in cases where children were identified as being at real or potential risk, we found the sharing of information with children's social care services at the earliest opportunity to be inconsistent. Prior to the inspection, we were told that a new information-sharing protocol had been introduced in respect of POLIT cases. This process relies on contact with children's social care services to share intelligence about suspects and children potentially at risk. We didn't see any cases where this process had been instigated. We investigated this and found that a separate process was being used outside the one agreed with safeguarding partners. Timely emails are being sent by the POLIT to children's social care and health services separately to share information. We were told that informing children's social care services by PPN had previously resulted in disclosure being made to the family and the investigation being undermined. Safeguarding of children should be the primary focus of the POLIT and adopting processes outside agreed protocols and procedures is not an effective or transparent method of determining risk.

IMPACT lacks resources to deal with all children being harmed by or at risk of exploitation

IMPACT deals with high-risk children harmed by or at risk of exploitation. Lower-risk cases are allocated to the neighbourhood policing teams. But there are significant resourcing problems in IMPACT. This means that work has had to be redistributed to other teams, some without the requisite skills and experience to deal with them. We dip sampled some cases in the high-risk cohort. One child had reported two sexual assaults by two different men in February. Although crime reports had been created, we didn't see that any action had been taken by the time of our inspection in April, despite there being a wider risk from the perpetrators.

The force has acknowledged that this is a gap and is working hard to increase resources in IMPACT in the short term. In the longer term, the plan to form multi-agency safeguarding teams in each local policing area should alleviate the situation, with the lower-risk cases also receiving more specialist responses.

Decision-making

Recommendations from the 2021 inspection report

We recommend that, within six months, Dorset Police should improve its approach to children taken into police protection, making sure that:

- offences are properly investigated; and
- all relevant information is properly recorded and made readily accessible in all cases where there are concerns about the welfare of children.

Guidance to frontline staff and designated officers should include:

- advice on what information they should record on their systems, and in what form, to help them make good decisions; and
- an emphasis on the importance of making sure records are made quickly and kept up to date.

Summary of post-inspection review findings

We found police protection powers were used appropriately. The quality of PPN submission and liaison with children's social care services had also improved.

Detailed post-inspection review findings

The response to taking children into police protection has improved

In the cases we looked at there was good initial identification of risk to children by the officers attending. We saw that the use of police protection powers was appropriate in all cases, with a clear and detailed rationale given by the designated officers.

There was good liaison with children's social care services following use of the powers, which led to the timely identification of appropriate accommodation for the children to be taken to. In one case, we saw challenge and escalation when the out-of-hours social worker gave an inappropriate response to the request for accommodation. The use of challenge in these circumstances is positive and demonstrates an improved understanding of each organisation's responsibilities.

We saw that PPNs were consistently submitted with good detail recorded, including the voice of the child. Information was shared quickly with children's social care services. In each case, a strategy discussion took place within an appropriate timescale. We also saw that where offences were identified, they were investigated appropriately.

There are governance processes in place to ensure that there is an appropriate response to children taken into police protection. In addition to MTD team audits, each case is discussed at daily tasking meetings, and alerts within the Niche IT system notify child protection supervisors that the powers have been instigated.

However, improvements could be made to the way information is recorded within Niche. There is a specific police protection template on the system, but it is not being used. Entries are spread across different fields and systems. This means that it can at times be difficult to understand what is currently happening with the case. We also found that the time police powers are rescinded or expire isn't always recorded.

Case study: child taken into police protection

A 15-year-old boy was taken into police protection when he was located following a high-risk missing episode. His family had said they didn't want him home due to his behaviour. The officer submitted a detailed PPN including the voice of the child. The designated officer updated the Niche record with details of the case.

Children's social care services were contacted, and the boy was given accommodation after relevant checks were carried out. A supervisor in the MASH requested a strategy discussion, which took place promptly, and the case was discussed at the daily tasking meeting.

The child was later placed in foster care and is on a child protection plan.

Managing those posing a risk to children

Recommendations from the 2021 inspection report

> We recommend that Dorset Police immediately acts to improve its management of registered sex offenders, paying particular attention to:
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> - how it monitors offenders through home visits;
> - how it uses reactive management processes;
> - how it deals with those offenders who don't comply with notification requirements; and
> - how it records information.

Summary of post-inspection review findings

Improvements have been made to the management of registered sex offenders. Officers involved have had more training, and processes have been updated. But further improvements are required to fully establish the new ways of working.

Detailed post-inspection review findings

The force has increased the number of offender managers and improved training

There has been an increase in the number of offender managers on the management of sexual offenders and violent offenders (MOSOVO) teams. This means that the average number of registered sex offenders being managed by each offender manager is 50. This is reasonable and in line with accepted national policing practice.

We also found that MOSOVO officers have received extra training, including violent and sexual offender register (ViSOR) training. The force now has its own ViSOR trainers so further training can be given quickly when the need arises. We examined records which clearly reflected that the training had been successful, as risk management plans for RSOs were drawn up using the four pillars approach (supervision, monitoring and control, interventions, and treatment) outlined in multi-agency public protection arrangements. This is good practice.

The force has comprehensively reviewed its MOSOVO processes to make improvements to practice, but there is still more work to do

Following the 2021 inspection, the force commissioned an independent review of its MOSOVO processes. This led to the development of a delivery plan. This is reviewed monthly by team managers and gives the force a clear view of its improvement journey.

While this is positive, some improvements aren't yet fully accepted by MOSOVO team members. We found that some new processes aren't being consistently followed. For example, we dip sampled 15 cases from March 2022 where crime reports had been submitted for breaches of sex offender notification requirements. In all 15 of these cases, the investigations were completed by words of advice being given to the registered sex offender. While this might be appropriate in some cases, in line with wider risk management plan considerations, it shouldn't be routine and isn't in line with national policing practice. We also saw that in 10 of the same 15 cases, there wasn't a corresponding entry on the ViSOR system, which would help in longer-term management processes.

The force has developed a comprehensive monthly MOSOVO performance pack, which is reviewed by senior managers. The completion of active risk management system (ARMS) assessments is included and remains at a level consistent with the findings from the 2021 inspection – 83 percent. Further improvement is required as we found 63 ARMS assessments in the March 2022 data that still needed to be completed.

We found some delays in responding to cases where children were identified as being at real or potential risk from registered sex offenders

Across the cases we looked at, we saw examples where information about children at risk wasn't dealt with quickly enough.

Case study: a registered sex offender poses an online risk to children

A registered sex offender known to pose a risk to children online had software installed on his device to help the police to monitor his activities. Through this, it became known that the registered sex offender had on two occasions been involved in a video chat with a girl who appeared to be in her early teens, in worrying circumstances.

There was a delay of four days in notifying a supervisor and the registered sex offender's probation officer. The following day it became known that the registered sex offender had engaged in a further chat with a different girl, who also appeared to be a teenager. The registered sex offender was arrested and interviewed, stating that he believed the girls to be over 18 years of age. Enquiries were initiated to try and identify the girls and the registered sex offender was released under investigation.

Four months later, the registered sex offender breached his notification requirements. This wasn't investigated.

Improvements have been made to reactive management processes and work with neighbourhood policing teams

A policy has been implemented to provide a consistent approach to ensure the criteria are met for placing registered sex offenders into reactive management and that the cases are reviewed regularly. The policy adopts the national guidance for determining eligibility for reactive management and once approved, the records are allocated for administrative management. This ensures that there are annual reviews with a consistent process of checks which are then approved by a supervisor.

Improvements have been made to information sharing about registered sex offenders and liaison with neighbourhood policing teams. MOSOVO champions have recently been identified in each area. They have received additional training for this role. At the time of the inspection, this had only recently been introduced. This means it is too early for us to test the effectiveness of the process, but it is a step in the right direction to improve knowledge among the wider workforce of registered sex offenders and the risks they pose. The new intelligence portal includes a MOSOVO link which allows registered sex offenders to be mapped down to a neighbourhood policing area and will link to their Niche record when selected. This is also a positive innovation.

Police detention

Recommendations from the 2021 inspection report

We recommend that, within six months, Dorset Police should carry out a review of how it manages the detention of children. This should be done jointly with statutory safeguarding partners. The review should include, as a minimum, how best to:

- make sure that appropriate adults (AAs) promptly attend the police station;
- make sure officers consider the needs of the child and refer them to children’s social care services, when necessary;
- make sure that custody officers are clear about when secure accommodation is or isn’t needed;
- 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; and
- when alternative accommodation can’t be found, escalate the problem to find a solution.

Summary of post-inspection review findings

The force has made some improvements to the way children are dealt with in custody. But further improvements are required in the attendance of AAs and the recording of information.

Detailed post-inspection review findings

There have been some improvements to the way children are treated when detained in custody

We found that officers are encouraged to seek alternatives to arresting children. And when they are arrested, efforts are made to ensure that they are in detention for as little time as possible. This means there are only small numbers of children arrested and few are detained overnight. We also found that there are discrete areas for booking children in at both custody suites. This is good child-centred practice.

In addition, custody managers examine the records of all children brought into custody. This quality assurance process identifies if there are gaps in practice. Results are shared with senior managers, and the learning is passed on to individual officers and their supervisors.

The force has devised a system for collecting data about the attendance of AAs, but this should be reviewed to ensure their arrival time is recorded

The force tracks data about AA attendance on a spreadsheet. Details are recorded about how long after a child's arrival in the custody suite an AA is requested but not when they attend. This means it isn't always possible to tell when a child is being appropriately supported. We found other data that indicated when a child's rights and entitlements in custody were explained to them. We found one case where this was recorded as taking place after the child had been interviewed, when the AA must already have been present. We also saw a small number of cases where the rights and entitlements weren't recorded as being given at all and others with significant delays of up to 23 hours.

Examination of this dataset didn't provide us with the reassurance that AAs were attending as soon as they should be to advocate for children. The force should consider alternative measures to gather this data and ensure children are appropriately supported.

PPNs aren't always being submitted for children detained in custody when it would be appropriate to do so

We were told that the investigating officers were responsible for submitting PPNs for children detained in custody. But we found that this isn't always happening. The failure to submit PPNs for these children means that the background information about the circumstances of their arrest or risks identified while in custody isn't shared with children's social care services. This, in turn, means it is likely that these children won't get the help they need when they need it.

The force has worked hard with other safeguarding partners to improve the provision of alternative accommodation for children detained overnight after charge. At the time of the inspection, we were told that the policy was under review by the Dorset Combined Youth Offending Service so we weren't able to fully test its effectiveness. We also found that the number of children denied bail after charge and detained overnight is very low.

We looked at one case which occurred during the inspection. In our assessment, this was dealt with well. In the circumstances, the decision to deny bail was appropriate and attempts were made to seek alternative accommodation from a neighbouring authority. When this wasn't provided, the case was escalated between managers. This is good practice, but alternative accommodation still couldn't be found, and the child remained in police detention.

Next steps

Dorset Police has made good progress in response to our 2021 recommendations. But the force recognises that it still needs to improve in some areas to provide consistently better outcomes for children. We are, however, confident that the force understands where it needs to improve. We are also satisfied that senior leaders have plans to make these improvements and to monitor progress. As part of our routine monitoring of all police forces, we will continue to evaluate Dorset Police's performance in relation to these recommendations and instigate closer scrutiny if necessary.

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