National Child Protection Inspection Post-Inspection Review

Dyfed-Powys Police
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1. Background

HMIC carried out a child protection inspection in Dyfed-Powys Police in October 2014 and provided the force with a report of our findings in February 2015. In March 2015, the force provided HMIC with an action plan setting out how it intended to respond to the recommendations in the inspection report. Inspectors carried out a post-inspection review in August 2015 to assess the progress made by the force in implementing the recommendations.

The review included:

- a document review;
- interviews with staff including the chief officer lead, the head of protecting vulnerable people, and frontline staff from response teams; and
- audits of 27 child protection cases relating directly to areas for improvement identified in the inspection report and associated recommendations. The force's handling of these cases was assessed as good in ten of the cases, required improvement in a further ten and was inadequate in seven.

Summary

HMIC recognises that Dyfed-Powys Police is committed to improving the protection of children. Child protection has been prioritised and there is a strong desire to improve outcomes for children who are at risk of harm. Force and multi-agency plans were in place and the force had taken some important steps to implement some of the recommendations from our inspection in October 2014. At the time of our post-inspection review in August 2015, some improvements were evident. The force had deployed additional staff to its child protection teams and improvements to aspects of the force IT systems were planned. We found that the provision of training and guidance had improved the recording of children's demeanour and behaviour at domestic abuse incidents. Detention of children in custody under section 136 of the Mental Health Act had reduced and the force had taken some steps to improve its action to tackle perpetrators of child sexual exploitation.

However, we were concerned to find that the force had not yet implemented other recommendations. It continued to detain unnecessarily children in police custody, and the timeliness of specialist medical examination provision for children had not improved. Further, frontline officers still did not always have access to important information about children, and the force was not recording the views of children.

HMIC acknowledges that Dyfed-Powys Police has taken some steps to improve child protection practice, but its overall progress was disappointing. We consider that there is still much to be done before the force can be confident that it provides a consistently good service to children. Force leaders will want to accelerate the pace of improvement and monitor progress for some time to come.

2. Post-inspection review findings

Initial contact

Recommendations from initial inspection report

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

- We recommend that, within six months, Dyfed-Powys Police takes steps to ensure that all officers and staff dealing with a concern about children are aware of child protection plans and that this information informs their responses and risk assessments.

Summary of post-inspection review findings

Dyfed-Powys Police had improved its recording of observations of a child's behaviour and demeanour in domestic abuse incidents.

The provision of training and guidance to control room staff had improved their understanding of risk. However, inspectors found that crucial relevant information concerning children who were subject to a child protection plan was not always available to frontline officers.

Detailed post-inspection review findings

Inspectors found that some information on children who were the subject of a child protection plan[1] was available to staff in the force control room. However, they did not have access to further detail concerning the nature of the risk to these children as this information was held on a separate police system which they could not access. Frontline officers reported that they were not always informed that a child was the subject of a child protection plan when they attended incidents involving children. When such information is not readily accessible to frontline officers this can result in decisions being taken without full awareness of the risks to the child.

Dyfed-Powys Police had provided a programme of domestic abuse training to all frontline staff in 2015. This included guidance and direction to officers on the action required of them when children were living in a household where domestic abuse took place.

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[1] A child protection plan is a plan which is put in place by children's social care services to ensure a child is safe from harm and prevent him or her from suffering further harm.

Inspectors found that police attending domestic abuse incidents checked that children were safe and well, ensured their immediate safety and recorded the child's demeanour. Inspectors examined six domestic abuse cases and found that the behaviour and demeanour of the child had been recorded in all but one case. In four of the six cases, inspectors judged the overall quality of the force's response when dealing with children at an incident of domestic abuse to be of a good standard.

Frontline officers told inspectors that they had a good understanding of what was required of them, and that the Domestic Abuse Stalking and Harassment risk assessment tool (DASH) prompted them to record whether children were present. Work was progressing to develop the DASH to improve further the information about children gathered by officers attending domestic abuse incidents.

Assessment and help

Recommendations from initial inspection report

- We recommend that, within three months, Dyfed-Powys Police takes steps to improve staff awareness of the links between children missing from home and the risk of sexual exploitation.
- We recommend that, within three months, the force takes steps with partner agencies to ensure that timely forensic medical examinations are conducted in sexual abuse cases involving children.

Summary of post-inspection review findings

Dyfed-Powys Police had taken some steps to improve staff awareness of the links between children who go missing from home and the risk of sexual exploitation. The force had provided training to some staff but this had not been extended to all frontline officers. The force was also planning to make changes to one of its IT systems to improve access by staff to information about child protection referrals and multi-agency discussions about children who frequently go missing.

Inspectors were concerned to find that Dyfed-Powys Police had made little progress in improving the timeliness of forensic medical examinations in child sexual abuse cases. Children continued to experience unacceptable delays and lengthy journeys to undergo forensic medical examinations.

Detailed post-inspection review findings

Staff in the control room and custody suites had recently received child sexual exploitation (CSE) training provided by Barnardo's.[2] The training included the identification of the links between children who go missing from home and the warning signs of sexual exploitation. However, this training had not been extended to frontline officers, although the force planned for this to be provided to other staff in September 2015.

Inspectors examined six cases involving children who were at significant risk of CSE and who were repeatedly reported missing. Police practice in four cases was assessed as good and two required improvement. We found evidence of effective partnership working and information sharing with other agencies. The cases we examined displayed a mix of safeguarding and investigative practice that provided a good response to the incidents and supported children. Although cases examined were well-documented and relevant information to inform decision-making in the case was visible, the force did not have a warning flag for CSE within its systems and children known to be at significant risk of sexual exploitation were not flagged as such. Consequently this information was not readily accessible to frontline officers. This can result in decisions being taken without a full awareness of the risks to the child.

To improve access to information, Dyfed-Powys Police was planning to make a change to the IT system it uses to manage child protection referrals and hold information on multi-agency discussions about children who frequently go missing. This would result in all staff being able to access the information on the system directly in future. The force planned to pilot this change in January 2016.

Inspectors were pleased to find that multi-agency meetings had been set up within the force area to discuss children who were at significant risk of harm from CSE and agree plans to ensure their safety. However, many children who should have been referred and discussed were not. The force did not use a systematic and consistent assessment process to ensure that all children at risk were discussed at the multi-agency meetings. Decisions taken about which children were discussed were based on individuals' views. This left many children at risk of further harm.

Inspectors found that the force did not use trigger plans[3] to alert staff to the investigative and safeguarding action needed to trace and protect children at risk of harm when they were reported missing.

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[2] Barnardo's is a specialist voluntary sector agency which provides a broad range of services designed to improve the lives of children. Barnardo's also provides training in a wide range of child and family-related areas.

[3] Trigger plans are plans to locate a child quickly when he or she goes missing.

For example, frontline officers told inspectors that when looking for missing children, the lack of information held on police systems could lead to valuable time being lost when they were trying to find a child. Information was often missing, such as known addresses where missing children were likely to go.

Inspectors were pleased to find plans in place to conduct independent return interviews[4] for children who go missing from home or care. Interviews with children at this early stage can provide valuable information about the reasons why they are running away, particularly where episodes are becoming more frequent and the child is reluctant to speak to police or other statutory agencies. Inspectors were told that the police and crime commissioner (PCC) had funded and commissioned a service to provide independent return interviews for children who go missing, although arrangements were not in place at the time of our review.

Dyfed-Powys Police was using a recognised risk assessment tool to consider the risk to vulnerable children from sexual exploitation. However, inspectors found cases where the force had not identified the risks of CSE. Children who were clearly at significant risk of CSE had not been appropriately risk-assessed and action to locate and safeguard them had not been accelerated. We saw evidence of this in two of the six cases we examined involving missing children, and inspectors found many further examples of the force grading risk incorrectly in the case of missing children who were at high risk of CSE. For example, inspectors saw details of six other children who were frequently reported missing. Three of the children had been assessed as being at significant risk of CSE. Of these, the missing case in relation to one child had been assessed to involve a medium risk and the remaining two had not had risk levels assessed or recorded by the force.

Dyfed-Powys Police had employed a member of staff to work as a missing-from-home manager and mental health co-ordinator. The missing-from-home aspect of the role was to work alongside young people, their families and the police to find out what had caused them to run away and prevent further episodes. However, because of the volume of work arising from the mental health aspect of the role, this had primacy over work with missing children.

Inspectors found that Dyfed-Powys Police was taking some steps to improve the provision and accessibility of forensic medical examination services for children. Inspectors were told that the PCC had provided funding for two sexual assault referral centres (SARCs) for adults. We were told that work was underway through the SARC Project Board to develop a collaborative approach to services for both adults and children across the three police forces in southern Wales (Dyfed-Powys Police, South Wales Police and Gwent Police).

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[4] The All Wales Protocol for Missing Children 2011 sets out the responsibilities of organisations for the safeguarding of children who go missing. *All Wales Protocol – Missing Children*, All Wales Child Protection Procedures Review Group, 2011. Available from: www.childreninwales.org.uk/wp-content/uploads/2015/09/All-Wales-Protocol-Missing-Children.pdf

Nevertheless, inspectors found that children who had been the victims of sexual abuse still had to sometimes travel overnight for several hours to be medically examined.

Investigation

Recommendations from initial inspection report

- We recommend that Dyfed-Powys Police immediately:
  - takes steps to improve the standards of investigation to include a reduction in delays, regular auditing of investigations, and better senior management oversight to ensure these standards are being met; and
  - identifies and reviews all child abuse investigation cases that have taken more than three months to investigate from the first report, and ensures that each child is supported and safeguarded, and that appropriate measures are in place to manage the risk posed by suspects.
- We recommend that, immediately, Dyfed-Powys Police takes steps to reduce delays in the high-tech crime unit.
- We recommend that, within three months, Dyfed-Powys Police discusses with the Crown Prosecution Service how best to reduce delays in the prosecution process so that the timeliness of submission of prosecution files by the police and the timeliness of prosecution decisions, are regularly reviewed and improved.

Summary of post-inspection review findings

Inspectors were pleased to find that the force had reviewed the resources allocated to public protection and deployed additional staff to child protection teams. The review had recommended a further increase in resources to meet the growth in demand associated with public protection.

Dyfed-Powys Police had also reviewed all child protection cases over three months old to ensure that risk was being managed and children appropriately safeguarded. This had improved the standard of investigations. We consider the steps taken by the force to strengthen its management of the risks posed by suspects later in this report.

Inspectors were concerned at the continuing delays in the forensic digital examination of computers and phones.

Dyfed-Powys Police had taken steps to improve the timeliness of the submission of prosecution files by working with the Crown Prosecution Service. However, inspectors found little evidence that delays had reduced.

Detailed post-inspection review findings

As we noted earlier, inspectors were pleased to find that the force had reviewed the resources allocated to public protection and deployed an additional eight detective constables to investigate cases involving children. The force recognised that more staff were required and had begun to analyse demand.

Newly recruited staff had not received specialist child protection training, although this was expected to take place within the next six months. Nonetheless, we were concerned to find that, at the time of our review, over half of the staff working in child protection teams investigating child protection cases were not child protection specialists.

The force had recruited staff to review cases related to children. Inspectors found that information gathered from these reviews was being used to improve learning and provide a better understanding of child protection matters across the force.

Dyfed-Powys Police had reviewed all child protection cases over three months old to ensure that risk was being managed and children appropriately safeguarded. This had resulted in improvements in investigations. In cases examined by inspectors there were some very good examples of child protection work. Staff ensured that safeguarding remained central to their efforts while they pursued investigative opportunities. Information was correctly recorded, important relevant information, such as minutes of meetings, was visible and actions were recorded and responded to in a timely manner.

However, inspectors were concerned to find that cases involving online grooming of children were allocated to untrained, rather than specialist staff. Many staff dealing with these cases had neither the skills nor the experience to investigate child protection matters and there was a failure to record the details of child victims.

Inspectors examined three cases relating to indecent images of children. In all three cases the details of children at risk were not recorded on police systems. Failing to record this information creates intelligence gaps and gives an incomplete picture in the event of further incidents. Officers had failed to refer information to children’s social care services or undertake research to find out if the children were known to other agencies. This action might have provided these children with support when needed and alerted agencies to wider concerns. Consideration had not been given to alerting schools to relevant online safety issues involving their students, meaning that opportunities to educate and support victims and prevent further online offending had been missed.

Overall, inspectors examined 19 cases relating to child protection. Practice was assessed as good in 10 of these cases; 6 cases required improvement and 3 were judged to be inadequate.

We found four cases, where child sexual exploitation was identified within the investigation, to be of a good standard, two such cases required improvement and two were inadequate. In the four cases judged to be good, inspectors found evidence of effective partnership working with children's social care services to safeguard children. However, in other cases we found that officers had overlooked clear signs of CSE and missed opportunities to protect children sooner.

Dyfed-Powys Police had established a digital communications and cyber-crime unit shortly before our inspection in October 2014, which incorporated the high-tech crime unit. The force had expected that this would provide it with much-needed additional capacity and thus improve the timeliness of media examination. However, delays of up to five months remained – much the same as we found at the time of our initial inspection. It was clear to inspectors that the force has more to do to reduce the time it takes to examine digital media linked to child protection cases.

Dyfed-Powys Police held regular meetings with the CPS to improve the timeliness of the submission of prosecution files but inspectors found little evidence of a reduction in delays.

Decision making

Recommendations from initial inspection report

- We recommend that, within six months, Dyfed-Powys Police takes steps to ensure that relevant information is accessible, either directly or indirectly, to all officers and staff dealing with cases where there are concerns about the welfare of children.

Summary of post-inspection review findings

As noted earlier, Dyfed-Powys Police was undertaking development work to improve the accessibility of information about child protection referrals and multi-agency discussions about children who frequently go missing.

Detailed post-inspection review findings

Frontline officers expressed frustration at being unable to access important information about children held by specialist teams. Critical child protection information was stored on separate IT systems which frontline officers could not access. Consequently, important information to inform officers' decisions about the best action to take to safeguard children was not shared. For example, one frontline officer told inspectors that after attending an incident he had made a referral to children's social care services because of concerns for the children involved. He expressed frustration that if police were called to the same address in the future, officers would not be aware of any actions that had been taken in the interim.

As noted earlier, Dyfed-Powys Police was undertaking development work to improve the accessibility of information about child protection referrals and multi-agency discussions about children who frequently go missing.

Trusted adult

Recommendations from initial inspection report

- We recommend that, within six months, Dyfed-Powys Police ensures that:
    - all staff record the views and concerns of children and any available outcomes at the end of police involvement in a case; and
    - information about children's needs and views is regularly made available for consideration by the police and crime commissioner (PCC) and to service managers to inform future practice.

Summary of post-inspection review findings

Inspectors were concerned to find that the force had not developed practice to capture effectively the views and concerns of children. Furthermore, the force had not gathered information about children's needs and views for consideration by the PCC.

Detailed post-inspection review findings

Inspectors examined a number of cases where the decisions reached had clearly taken account of the views and needs of children. However, in most of the cases the child's wishes or views, the subsequent impact on the child, and the outcomes of police intervention for the child were not recorded.

For example, a 15-year old-girl reported as missing from home who had taken an overdose, was found by ambulance staff and taken to hospital. Although the incident was recorded by police, and it was noted on the case file that the girl had made an allegation of a potential offence, there was no investigation and the case was closed without officers speaking to her.

Inspectors were told that supervisors were trying to encourage staff to gather information on children's needs and views but this was not yet routine practice. Nor had information been made available to the PCC.

Managing those posing a risk to children

Recommendations from initial inspection report

- We recommend that, within three months, Dyfed-Powys Police takes action to improve the identification, disruption and prosecution of those involved in CSE.

Summary of post-inspection review findings

Dyfed-Powys Police had made some progress to improve the identification, targeting, and disruption of perpetrators of CSE. Nonetheless, inspectors found that the force had no plans in place for managing the risk associated with individual perpetrators of CSE, and action taken against suspects was inconsistently recorded and ‘flagged’ on police systems.

Detailed post-inspection review findings

Dyfed-Powys Police had started to develop its practices for identifying and taking action against individual perpetrators of CSE. For example, a 15-year-old girl who had gone missing after being placed in a care home in Dyfed-Powys by another local authority was found by police at the home of a 30-year-old man. Police took swift action to protect the girl and prosecute the man.

However, inspectors found cases where the force failed to pursue lines of enquiry and investigate potential perpetrators. For example, a 15 year-old-girl came into contact with police and officers identified her as being potentially at high risk of sexual exploitation. Officers completed a risk assessment highlighting a number of concerns, including that the girl had an older boyfriend and intelligence suggested she had been seen getting in and out of cars with other men. No investigative tasks were recorded on the case file and it was not known if action had been taken to protect her.

The force had developed a CSE problem profile[5] which was based solely on police intelligence and data. Because the profile did not include any information from partner agencies, such as local authorities and the voluntary sector, it did not represent a complete picture of the nature and prevalence of CSE in Dyfed-Powys.

Inspectors were pleased to find that high-risk suspects linked to child protection cases were discussed in daily management meetings. In addition, the force selected a number of suspects linked to CSE cases each month for additional activity to disrupt offending. However, the force had no criteria for prioritising those selected. Consequently, it could miss other suspects who might be more of a risk to children.

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[5] A problem profile is usually commissioned by the force’s tasking and coordination group to provide data and analysis to improve understanding of established and emerging crime or incident series, priority locations or other identified high-risk issues.

Inspectors were told that child abduction warning notice (CAWNs)[6] were used by Dyfed-Powys Police to deter suspected perpetrators of CSE from associating with children. However, the force could not evaluate the effectiveness of these measures because it did not have a consistent way of recording, or flagging information. Frontline officers reported a lack of awareness of the purpose or use of CAWNs.

Police detention

Recommendations from initial inspection report

- We recommend that, within three months, Dyfed-Powys 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, with partner agencies, that children detained under section 136 of the Mental Health Act are only detained in police custody in exceptional circumstances;
  - provide training for custody staff to improve their awareness of child vulnerability, child protection and CSE;
  - assess at an early stage the need for alternative accommodation, and work with children's social care services to secure transfers where this is required; and
  - ensure that custody staff record all actions and decisions with a clear rationale if children are detained in police custody and comply with statutory duties, completing detention certificates where required.

Summary of post-inspection review findings

Inspectors found that the number of children taken into police custody under section 136 of the Mental Health Act had reduced significantly, with two instances of children being detained in these circumstances in the 12 months to 31 March 2015.

Inspectors were also pleased to find that staff had received training on CSE from independent specialists, as well as training on dealing with vulnerable people detained in police custody.

[6] A non-statutory notice issued when the police become aware of a child spending time with an adult who they believe could be harmful to them. A notice is used to disrupt the adult's association with the child or young person, as well as warning the adult that the association could result in arrest and prosecution.

Inspectors were concerned to find a lack of understanding by custody sergeants of the grounds for requesting secure accommodation, which resulted in vulnerable children being detained in custody unnecessarily. Recording practices continues to be poor.

Detailed post-inspection review findings

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, these should only be used in exceptional circumstances and it is preferable for the person to be taken directly to healthcare facilities such as a hospital. There are four such designated places of safety in the Dyfed-Powys force area. There were two separate detentions, both involving the same child, under section 136 of the Mental Health Act between 1 April 2014 and 31 March 2015, which represents a significant reduction compared to the position at the time of our original inspection.

Inspectors were pleased to find that Dyfed-Powys Police had provided specialist CSE training to custody staff. The force would benefit from monitoring the effectiveness of this training.

The assistant chief constable responsible for custody had written to the heads of children's social care services in each local authority area to establish what provision was in place for alternative accommodation for children who would otherwise be detained in police custody.[7] Beyond this, work had not progressed to address our earlier recommendation.

Inspectors examined 8 cases where children were detained overnight aged between 13 and 17-years-old. Four cases required improvement and four were inadequate.

Four of the 8 cases examined related to children under 17-years-old who had been detained in police custody. Two required improvement and two were inadequate. Three custody records showed that a request had been made to the local authority for secure accommodation after a decision to refuse bail. In rare cases, secure accommodation might be needed if the child poses a high risk of serious harm to others. Inspectors found that staff had requested secure accommodation when the threshold for this had not been met and they should have requested residential (open) care places.

[7] 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. Local authorities are under a duty to provide this accommodation.

For example, in one case the force detained a 15-year-old child in custody for 22 hours following an allegation of assault on staff in the care home where he was placed. Custody staff had requested secure accommodation when the grounds for this type of accommodation had not been met. Staff should have sought alternative non-secure accommodation for the child.

In another example, two children had been placed in the area by another local authority and custody staff had difficulty identifying which local authority had responsibility to provide alternative accommodation.

Inspectors concluded that custody sergeants and staff did not fully understand the type of accommodation required and in what circumstances.

Inspectors found that recording practices within custody were of a poor standard and that key requirements in the Police and Criminal Evidence Act in a number of areas were not being met.

For example, inspectors examined a case involving a 14-year-old girl with a history of self-harm, who was in the care of a local authority. Police arrested her following an incident at the care home where she lived. On arrival in custody she was not read her rights and was placed in a cell; the custody record did not contain the justification for this action. Similarly, custody staff had strip-searched the girl urgently, without recording the justification for the action or the reasons for the urgency. They carried out the search without an appropriate adult being present. Furthermore, they restrained this very vulnerable child in a cell using handcuffs, which were fastened behind her, for over two hours. No justification was recorded for this restraint.

We found that Dyfed-Powys Police did not always consider at an early stage who was best placed to provide support and guidance to children. The force often used the appropriate adult scheme to provide support for and advocate on behalf of children in preference to parents or those known to the child. This was not in the best interests of vulnerable children.

3. Recommendations

We recommend that Dyfed-Powys Police continues to work to implement the recommendations made by HMIC following the child protection inspection in October 2014 and ensures that the recommendations are implemented in full. The force should systematically review the effect of its improvement activity on the quality of frontline services to protect children at risk of harm and provide regular reports on progress to its police and crime commissioner.