National Child Protection Inspections

Gloucestershire Constabulary
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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 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 ensuring 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 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 well-being 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, police 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 (HMIC) 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.

Contents

Summary

This report sets out the findings from HMIC's 2017 inspection of child protection services in Gloucestershire Constabulary, which took place in February 2017.[1] This inspection is part of our rolling programme of child protection inspections.[2]

HMIC 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 constabulary is structured, led and governed in relation to child protection services.

Main findings from the inspection

Gloucestershire Constabulary is committed to protecting children. During the inspection, HMIC encountered officers and staff throughout Gloucestershire Constabulary who are dedicated and work extremely hard to protect children. However, inspectors found that there are a number of areas which require significant improvement in order to ensure that the constabulary is adequately protecting vulnerable children.

Child protection is a stated priority for the constabulary. This is positive - but it is only one of many. Officers and staff also reported that they are unsure of how to translate this priority into action and decision-making on the front line. HMIC considers that this weakens Gloucestershire Constabulary's ability to safeguard children effectively and consistently. This is supported by HMIC's audit of case files: inspectors examined a total of 89 cases, of which 14 were 'good', and 75 either 'required improvement' or 'inadequate'.

We found limited strategic oversight by senior leaders and a lack of effective supervision of child protection investigations. This has undermined Gloucestershire Constabulary's ability to safeguard children effectively. In addition, the absence of robust performance management information - which describes the quality of the service received as opposed to the number of child protection incidents - means that the force is unable to assess the effectiveness of its decision-making, systems and processes. This was of significant concern and is something the force should address urgently.

[1] 'Child' in the report refers to a person under the age of 18. See the glossary for this and other definitions.

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

Inspectors found that the constabulary's approach to tackling child sexual exploitation (CSE) is inconsistent and that, as a result, children are left exposed to risk. Specifically, inspectors found delays in the attendance of officers at incidents, the timely arrest of suspects, the conduct of interviews and the seizure of evidence.

Recommendations from a 2015 peer review in relation to CSE have not been implemented, which suggests an absence of leadership in this critical area.

Nevertheless, there were also some encouraging findings:

- the constabulary has established a multi-agency CSE team. This team is investigating ways to work with other relevant agencies to prevent and tackle CSE;
- the constabulary has demonstrable examples of good practice, namely raising awareness of CSE in schools, licensed premises, taxi drivers and hotels;
- a CSE screening tool is being used by the constabulary and by partners, such as schools and healthcare professionals. When abuse is suspected, a form is completed and sent to the MASH[3] where it is discussed with a lead social worker, and action is taken to mitigate risk; and
- the constabulary's work to manage individuals who pose a risk to children is generally good. The team responsible for this works proactively to mitigate the risks faced by children from convicted sex offenders. Those identified as posing a significant risk are managed effectively through multi-agency public protection arrangements.

These are positive findings which provide evidence of the constabulary's commitment to protecting children, particularly in relation to CSE. However, there are other major areas of child protection work where significant improvement is required. For example:

- the constabulary's approach to children who are missing or absent is a cause for serious concern. Risk (including an increased risk of sexual exploitation) is not identified at the earliest opportunity and/or managed appropriately and, in the cases reviewed, there was insufficient activity to attempt to trace many of these children; and

[3] The multi-agency safeguarding hub (MASH) in Gloucestershire is a team of social care, police, education, NHS and domestic abuse support professionals, put in place to ensure that relevant information is shared and robust decisions are made at the earliest stages. All referral and assessment teams are located within the MASH. The MASH receives safeguarding concerns from professionals, such as teachers and doctors, as well as members of the public and family members.

- training relating to child protection and vulnerability, and attendance at multi-agency learning events, is fragmented and uncoordinated. This contributes to the inconsistent response we saw during our inspection and should be addressed by senior managers.

Conclusion

HMIC recognise that Gloucestershire Constabulary is committed to protecting children. Inspectors spoke with officers and staff in Gloucestershire Constabulary who are dedicated to the protection of children, and saw examples of effective safeguarding measures being implemented. However, overall HMIC found that the constabulary is not adequately protecting all children who are at risk of harm and in need of protection. We found serious deficiencies in a number of critical areas including the support, supervision and leadership provided to staff, the quality of investigations, performance management and quality assurance

This report makes a series of recommendations aimed at addressing these failings and providing support to the officers and staff who are working hard to improve outcomes for children.

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.[4] 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.[5]

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.[6] Child sexual exploitation is also listed as one of the six national threats specified in the Strategic Policing Requirement.[7]

[4] Children Act 1989, section 46.

[5] Children Act 2004, section 11.

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

[7] 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[8] 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 HMIC's child protection inspections.[9]

[8] *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015 (latest update). Available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

[9] Details of how we conduct these inspections can be found at annex A.

2. Context for the constabulary

Gloucestershire Constabulary approximately 1,800 people in its workforce. This includes:

- 1,067 police officers;
- 596 police staff; and
- 112 police community support officers. [10]

The constabulary provides policing services to a population of about 610,000 over an area of 1,024 square miles. Gloucester is the major city of the constabulary area, with a population of 126,000. Other significant towns are Cheltenham (population 117,000) and Stroud (population 115,000).

There is a single local authority in the Gloucestershire Constabulary area, which is responsible for child protection within its boundaries. The constabulary operates across six geographical areas: Cheltenham, Gloucester, Tewkesbury, Stroud, Cotswolds and the Forest of Dean. There is a single local safeguarding children board (LSCB)[11] in the constabulary's area.

The most recent Office for Standards in Education, Children's Services and Skills judgment is set out below.

Local authority	**Judgment**	**Date**
Gloucestershire	Adequate	March 2012

Gloucestershire Constabulary's public protection bureau oversees safeguarding throughout the constabulary.

The assistant chief constable is the chief officer lead for child protection, supported by a detective superintendent, who is the head of public protection, and a detective chief inspector, who is the lead for child protection.

[10] *Police workforce, England and Wales*, *30 September 2016*, Home Office, January 2017. Available from: www.gov.uk/government/statistics/police-workforce-england-and-wales-30-september-2016

[11] LSCBs have a statutory duty, under the Children Act 2004, to co-ordinate how agencies work together to safeguard and promote the welfare of children and ensure that safeguarding arrangements are effective.

There is a single multi-agency safeguarding hub (MASH) for child protection, which was established in 2014. This is overseen by the MASH governance board, which is chaired by the director of children's services and attended by the assistant chief constable and detective superintendent from the public protection bureau.

3. Leadership, management and governance

The assistant chief constable is the chief officer lead for child protection in Gloucestershire and is responsible for operational activity in the constabulary. The detective chief superintendent is head of specialist crime. In addition, there is a superintendent in charge of public protection, and a detective chief inspector with specific responsibility for child protection. Together, these senior members of the constabulary are collectively responsible for the oversight of child protection.

Vulnerability is one of the constabulary's three main policing priorities. HMIC inspectors were consistently told that the constabulary has made significant changes to address vulnerability more effectively, including the identification of 15 thematic risk categories.[12] However, it appears that the number of categories under the heading of vulnerability has made this area confusing for officers and staff; many informed inspectors that it is difficult to know what all the categories are and how or whether they should be further prioritised.

The constabulary aims to introduce the Management of Risk in Law Enforcement (MoRiLE)[13] in April 2017. This approach could provide the force with an opportunity to better understand the risks it faces in order to prioritise and focus its activity to best effect.

The challenges of effectively protecting children are complex and no single agency can, or should, meet these challenges alone. Inspectors found that in the Gloucestershire area children's social care services, the LSCB and other safeguarding agencies felt able to engage with and challenge the constabulary where appropriate, and described positive professional relationships with officers and staff.

The director of children's services and the LSCB chair identified existing problems in relation to the attendance of police at child protection conferences and described how their engagement with the force exists predominantly at superintendent level, with very limited interaction with the chief officer team. This limits the ability of senior officers to fully understand complex county-wide safeguarding issues and take the appropriate decisions to effect change. The constabulary uses a range of IT and

[12] The constabulary has identified 15 areas of safeguarding that form part of the vulnerability priority. The specific categories are: adults at risk, child abuse, CSE, domestic abuse, female genital mutilation (FGM), forced marriage, hate crime, honour based violence, human trafficking and modern day slavery, managing violent offenders, mental health, missing persons, prostitution, serious sexual offences and stalking and harassment

[13] The MoRiLE (Management of Risk in Law Enforcement) is a national project that is developing a suite of risk prioritisation models and processes that all law enforcement agencies can use to better understand their risks.

paper-based systems to manage safeguarding processes. In effect, this means there are a number of ways in which an investigation or safeguarding concern can be recorded, managed and supervised. This is inefficient and does not support the effective supervision and oversight of investigations. A consequence of this is that the constabulary is unable fully to understand its demands, and which individuals or areas present the highest risk. This limits its ability to safeguard children effectively. While this problem has been recognised by the constabulary, it has yet to be resolved.

The constabulary's crime management investigation standards (CMIS) initiative has been introduced to improve crime management and improve compliance with the national crime recording standards.[14] It has been designed to improve investigative standards through more effective use of investigation plans, and to ensure better victim care across the constabulary. While this is positive it is too early at this stage to assess its effect upon child protection and safeguarding.

Over the past 12 months, the constabulary has introduced quarterly training days for frontline officers – this has included training on CSE, and new recruits also receive two days' training on child protection. However, the learning and development department does not co-ordinate training across the constabulary, and different departments decide upon and conduct their own training, leading to different approaches and varying levels of understanding.

The constabulary has a continuous improvement team that conducts regular reviews of service delivery to improve efficiency, effectiveness and value for money. The continuous improvement team produces a monthly public protection bureau performance document, however the focus of the document is on the quantity of child protection cases, not the quality. The force needs to do more to understand and record outcomes for vulnerable children in order to improve and further develop services.

The constabulary has experienced difficulty recruiting officers to specialist roles in the public protection bureau. The staff spoken to by inspectors were committed and recognised the importance of their work but felt that the high levels of risk and demand were not fully recognised by senior leaders. To address this, the force has introduced a reward and recognition panel to ensure that good work is commended.

We found there was inadequate supervision of the welfare of children in custody. Inspectors could find no evidence of senior leaders testing the validity of decisions made to keep children in custody, or assessing whether requests for local authority

[14] The national crime recording standard (NCRS) is a standard for recording crime in accordance with the law. It is based on applying legal definitions of crime to victim's reports. The aim of NCRS is to be victim-focused and maintain consistent data of recorded crime allegations across all forces.

accommodation are being made or met. The constabulary has recently recognised this as a problem, and is now working with partner agencies to establish a regular custody forum, to ensure there is the appropriate oversight in this area.

Recommendation

Within three months, Gloucestershire Constabulary should

- put in place arrangements which ensure that it has clear governance structures in place to monitor child protection practices, across both non-specialist and specialist units. The constabulary should then provide officers and staff with a clear understanding of what good service looks like and the standards it expects, and begin to develop a performance management framework that will operate to achieve consistent standards of service.

4. Case file analysis

Results of case file reviews

To determine how well Gloucestershire Constabulary deals with specific cases, HMIC asked the constabulary to self-assess the effectiveness of its practice in 33 child protection cases. The constabulary used HMIC criteria[15] to grade the practice in each case as 'good', 'requiring improvement' or 'inadequate'. The assessment criteria underpinning these grades are detailed and focus on an assessment of the experiences of children as opposed to simple compliance with policy or guidance. However, the meaning of the grades are summarised below:

- good – all the necessary steps have been taken to protect the child and improve the outcomes in their case, and it is clear that risks and wider threats have been understood and acted on;
- requiring improvement – elements of good practice are missing, but there are no widespread or serious failures that result in children being harmed or left at risk of harm; and
- inadequate – there are widespread or serious failures in practice that result in children being harmed or left at risk.

The constabulary's assessors graded practice in 28 of the cases as good and as requiring improvement in 5. In none of the cases was practice considered to be inadequate.[16]

HMIC also assessed these cases; grading the force's practice in 6 as good, as requiring improvement in 16 and as inadequate in 11. HMIC selected and examined a further 56 cases; practice in 8 was assessed as good, in 30 as requiring improvement and in 18 as inadequate.

[15] 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/hmic/our-work/child-abuse-and-child-protection-issues/national-child-protection-inspection/

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

Table 1: Cases assessed by both Gloucestershire Constabulary and HMIC

	Good	Requiring improvement	Inadequate
Constabulary assessment	28	5	0
HMIC assessment	6	16	11

Table 2: Additional cases assessed only by HMIC

	Good	Requiring improvement	Inadequate
HMIC assessment	8	30	18

HMIC referred 14 cases back to the constabulary because they were considered to contain evidence of a serious problem – for example, a failure to follow child protection procedures and/or a child at immediate risk of significant harm. The constabulary responded to the referrals by providing an updated assessment or taking action relevant to the respective problems identified.

The following are examples of two cases referred back to the constabulary.

In the first case, two girls aged four and one were subjects of a child protection plan and were exposed to repeated episodes of domestic abuse. There were numerous occasions when assaults on the children were disclosed, but there was no evidence of any police action and, in some of the incidents, crimes were not recorded when they should have been.

Most recently, in January 2017, an assault was disclosed. Again, there was no evidence of any action taken to protect the children or arrest the suspect. This meant that, at the time of the inspection, the two children were still at risk from the perpetrator. In such circumstances the perpetrator should have been arrested, and officers should have used their police protection powers to protect the children.

In another case, a 15-year-old girl had been reported missing 16 times since November 2016. Despite clear risk indicators on the police system (COMPACT) of child sexual exploitation, the activity to locate and safeguard her did not reflect this risk. She was not flagged as being at risk of CSE on the constabulary's main computer system, UNIFI, which handles police business processes, from crime, intelligence, custody and case preparation through to the management of document production. In December 2016, the case

was discussed with the multi-agency CSE team, and it was decided that she was at high risk of CSE. However, there was no evidence of any action taken as a result. In January 2017, the child made a disclosure of previous sexual contact with a 25-year-old man. There was a delay of five days in allocating the crime to an investigator, by which time opportunities to gather forensic evidence had been missed.

The last update on the crime was in February 2017, but no evidence was found of any joint safeguarding work to develop a protective plan, or of any attempts to arrest the suspect. There was no evidence found of CSE team involvement in the investigation, or of any safeguarding measures for the child.

Breakdown of case file audit results by area of child protection

Table 3: Cases assessed involving enquiries under section 47 of the Children Act 1989[17]

Case type	Good	Requiring improvement	Inadequate
Enquiries under section 47 of the Children Act 1989	2	7	4

These are cases where a child has been identified as in need of protection, i.e., is suffering or likely to suffer significant harm. Inspectors found that:

- the initial response to high risk investigations is generally good;
- there is a failure to record actions taken on police systems; this relates to investigative action as well as strategy discussions/meetings, which are frequent but no detail is added to reports on outcomes; and
- there is evidence to show that further allegations/disclosures made during the course of an investigation do not result in the submission of a crime or an appropriate investigation.

[17] 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.

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

Case type	Good	Requiring improvement	Inadequate
Cases relating to domestic abuse incidents	2	9	1

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

Common themes include:

- there is a good initial police response to reports of domestic abuse offences;
- strategy discussions, safeguarding plans and investigative plans are not being recorded on accessible systems;
- there appears to be a lack of understanding of risk levels of domestic abuse, meaning the use of the Vulnerability Identification Screening Tool (VIST)[18] is inconsistent; and
- the level of risk within domestic abuse incidents is often re-assessed, leading to an inconsistent approach to the development of protective plans.

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

Case type	Good	Requiring improvement	Inadequate
Referrals arising from incidents other than domestic abuse	3	3	4

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

[18] The Vulnerability Identification Screening Tool (VIST) is within an app that is available to all officers on their handheld electronic devices. The completion of the form creates a referral to the central referral unit.

Common themes include:

- the response to risk is inconsistent: some incidents have timely referrals and in others no referral takes place;
- poor recording on police systems in relation to investigative activity and multi-agency involvement makes continuing safeguarding problematic; and
- there is a lack of consideration of the wider risks presented by perpetrators, with some incidents/crimes being inadequately investigated.

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

Case type	Good	Requiring improvement	Inadequate
Cases involving children at risk of child sexual exploitation both online and offline	3	11	8

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

Common themes include:

- recording of the details of investigative actions and supervision is generally of a poor standard;
- there are frequent delays in arresting named suspects, meaning risk remains unmanaged;
- the voice of the child is not evident in most cases; and
- there are multiple ways in which investigations concerning CSE can be managed, which has a negative effect on the safeguarding of children.

Table 7: Cases assessed involving missing and absent children

Case type	Good	Requiring improvement	Inadequate
Cases involving missing and absent children	1	5	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:

- in general, when children are assessed as high risk at the outset, police actions are appropriate;
- many cases highlight an inaccurate initial risk assessment when a child goes missing, with risks associated with CSE being missed; and
- trigger plans, which improve responses to children who go missing regularly, are used inconsistently or are often not used when they should be.

Table 8: Cases assessed involving children taken to a place of safety under section 46 of the Children Act 1989[19]

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

[19] 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'.

Common themes include:

- there is evidence of early identification of vulnerability and good use of police protection powers to immediately safeguard children;
- there is evidence of partnership working between police and children's social care; with joint visits to children being made and, in cases of neglect, children's social care finding appropriate accommodation when necessary;
- when offences are identified as a result of using police protection powers, there is evidence to show that some investigations lack the required urgency and this can result in the inadequate pursuance of investigations; and
- there is evidence of officers failing to investigate crime scenes when children have been taken into police protection, leading to the loss of evidence.

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

Case type	Good	Requiring improvement	Inadequate
Sex offender management where children have been assessed as at risk from the person being managed	1	3	2

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

Common themes include:

- there is good evidence of the use of proactive targeting of registered sex offenders, in both a covert and overt[20] sense;
- local policing teams are briefed on high-risk offenders and, where appropriate, undertake the gathering of intelligence; and
- there are delays in some investigations in undertaking safeguarding activity. There is also some evidence of missed investigative opportunities.

[20] Covert policing is an activity carried out without the knowledge of the individual(s) in order to obtain evidence and/or intelligence in relation to a particular offence(s) or suspected offence(s). Overt policing is more general police activity that is conducted openly.

Table 10: Cases assessed involving children detained in police custody

Case type	Good	Requiring improvement	Inadequate
Cases involving children in police custody	2	5	3

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:

- access to and the timeliness of appropriate adults attending custody is generally good;
- the joint protocol, implemented in April 2016 between Gloucestershire Constabulary and the local authority for the provision of local authority accommodation is having little effect on numbers of children detained after charge; and
- record-keeping is inconsistent and sometimes poor, particularly in respect of the reasons children were not transferred to local authority accommodation.

5. Initial contact

Gloucestershire Constabulary has a single control room co-ordinating the response to incidents throughout the county. In addition to the initial and continuing training staff receive (which includes child protection and vulnerability awareness), the constabulary has recently provided training on the effective assessment of risk when responding to incidents.

There is an incident assessment unit in the control room that should provide information to officers attending incidents, such as any history of domestic abuse or information held about children. However, we were told that the ability of the unit to provide information in a timely way is inconsistent because of high levels of demand.

Control room staff can access children's social care systems to establish if children are the subject of a child protection plan. This is positive. However, there was no evidence that these checks were being conducted routinely. This is a missed opportunity because knowledge of a child protection plan could significantly influence the decisions attending officers make to safeguard vulnerable children. We were also told that the nature and quality of information received by frontline officers often depended on officers proactively seeking information. When officers do receive information concerning children being on a plan, there is no detail available of why the plan exists, which means they cannot assess risk based on the moist complete understanding of the situation.

Children subject to child protection plans and those children at risk of CSE are not routinely flagged on police systems. Nevertheless, children are at the centre of decision-making when officers attend incidents and the constabulary generally makes appropriate use of police protection powers.

Inspectors found some good examples where officers dealt with incidents quickly, clearly identifying the immediate needs of the children involved and taking appropriate action. Such incidents include the appropriate use of police protection powers, as well as securing evidence and arresting offenders.

An eight-year-old girl disclosed to a teacher that she had been assaulted by an adult relative. The constabulary acted quickly, which resulted in a strategy discussion and joint visit taking place where the child's views were listened to. A medical examination was conducted, the child was safeguarded and the offender was traced and interviewed under caution on the same day. Continuing support was put in place for the child by social care.

However, this is not always consistent and there were a number of cases where the initial response did not address immediate safeguarding concerns and this meant that children were exposed to unnecessary risk, as the following example shows.

Police received a call about two young children seen walking alone in the street. When the officers arrived they found the children aged one and two years but could not find their parents. The officers visited the children's family home where they found their mother asleep along with her 15-year-old sister. The house was in a poor state and this, along with the children being found wandering in the street, prompted officers to take them into protection and arrest the mother. This was clearly the right course of action for the young children however, there was no evidence that officers recognised the risks to their 15-year-old sibling. Consequently, opportunities to provide safeguarding support were missed.

Gloucestershire Constabulary uses the Vulnerability Identification Screening Tool (VIST), which is an electronic application available to all officers on their mobile data terminals. It is used as a single method of capturing information and evaluating risk relating to vulnerability and contains a series of mandatory questions, as well as the domestic abuse, stalking, harassment and honour-based violence (DASH)[21] risk assessment. When used correctly this tool can be a positive step for improving the quality of child protection and domestic abuserisk assessment and referral, but its use is inconsistent and there is little evidence of effective supervision. This means that opportunities to intervene to protect children at the earliest opportunity are missed, exposing children to unnecessary risk.

When officers attend an incident of domestic abuse, they should complete and submit a VIST to the central referral unit. However, in our review of cases we found the VIST was not routinely submitted for domestic abuse incidents where children were present. In addition, there were a number of occasions where an incident was closed and the domestic abuse marker was removed from the electronic record because the officer attending did not believe the incident met the criteria for the submission of the VIST. A lack of supervision means that the appropriateness of these decisions is not scrutinised routinely. We found that some addresses had been the subject of calls for service on a number of occasions without the submission of the VIST. This means that the force is less able to recognise, assess or respond to escalating or cumulative risk.

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

Recommendation

Within three months, Gloucestershire Constabulary should

- review 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.
- reviews its processes for the supervision of the decisions made when police attend incidents where children are at risk or vulnerable.

6. Assessment and help

The single MASH is the focal point for information exchange and inter-agency planning throughout the constabulary area. The constabulary and its partner agencies have invested significant time and resources into the development of the MASH and we found a clear commitment to improved joint working.

Inspectors found examples of agencies working well together; identifying risks, making plans to reduce these risks and effectively supporting children and families. However, HMIC has significant concerns about the effectiveness of some elements of the referral and assessment processes within the hub and the effect this can have on the development of appropriate protective plans. HMIC found there were delays in holding strategy discussions because of increasing demand. At the time of the inspection there were 43 cases awaiting a meeting (the oldest was 11 days), meaning that risk in these cases was not being addressed. There was also evidence that children were not always identified when referrals were assessed which also led to delays in strategy meetings being requested.

The following example highlights this issue.

An officer attended a house after the constabulary received reports of a female shouting and swearing at a child. The officer witnessed this behaviour and briefly saw the child, who was sullen and withdrawn (and should have been at school). The house smelt strongly of cannabis. The boy's mother asked the officer to leave before there was an opportunity to speak to the child and assess their welfare. Despite there being sufficient grounds to use police protection powers under section 46 of the Children's Act 1989, the officer left the property and submitted a VIST.

The VIST was received in the constabulary central referral unit the next day, where it was assessed by a safeguarding officer and forwarded to children's social care. There was no evidence of any consideration being given to whether the police should act immediately to safeguard him.

Ten days after the incident, children's social care made a request for a strategy discussion. This took place another 11 days later. At the meeting there was disagreement about whether the case met the threshold for a formal safeguarding investigation. The officer who attended the meeting felt it did reach the threshold; but when a different decision was made, the matter was not escalated (in line with constabulary and LSCB policy on threshold disagreements).

Inspectors also found examples of the failure to recognise the needs of children present at the scene of offences.

> A five-year-old boy was awake in the same bedroom at the time his mother was raped. The constabulary failed to consider the effect this could have had on the child. When the incident was discussed at the central referral unit meeting, details of the incident were not forwarded to children's social care because it was decided the child was not at risk. This shows a clear lack of awareness of the immediate needs of the child. The safeguarding of the child happened some time later, and only as a result of the intervention of the detective leading the rape investigation.

HMIC acknowledge that as soon as the constabulary was made aware of these issues, it acted quickly by establishing a new system in which a detective sergeant reviews all VIST submissions to ensure children are not overlooked, and that appropriate safeguarding measures are implemented promptly.

Gloucestershire Constabulary, like other police forces, has seen an increase in incidents requiring action to be taken to protect children. In December 2016, in an effort to understand the effect of this increased demand, the constabulary conducted a comparative analysis of data between November 2014/15 and November 2015/16. This showed:

- domestic abuse referrals involving children had increased by 9.8 percent;
- child protection referrals had increased by 47 percent;
- CSE referrals had increased by 48 percent; and
- CSE made up 7 percent of all child protection referrals (up from 2 percent).

There have been limited increases in staffing within the MASH since 2009, despite the significant increase in demand and additional responsibility for management of matters such as child sexual exploitation, vulnerable adults and modern-day slavery.

During the inspection, the constabulary changed the structure of the child abuse investigation team (based on the results of its comparative analysis). It is too early for HMIC to assess whether this will effectively resolve the problem of increased demand; but it is positive that the constabulary has recognised the problem, and is working to remedy it.

A daily multi-agency meeting is held in the MASH in relation to standard- and medium-risk domestic abuse incidents, to enable early assessment and identification of risk and support action within agencies. High-risk cases are immediately referred to partner agencies.

HMIC was told that since the process had been in place the meeting downgraded approximately 30 percent of incidents a day because it was felt they did not meet the level that would benefit from multi-agency intervention, despite most of these cases meeting the national definition of domestic abuse (and consequently should have resulted in the submission of a VIST). On occasions the meeting also re-graded risk upwards from standard to medium and medium to high. When HMIC observed a meeting, three cases out of nineteen were graded higher than the initial assessment provided by the officer submitting the VIST. However, at the time of the inspection there were 288 standard- and medium- risk incidents yet to be recorded on police systems, the oldest dating back three weeks. Although these incidents had been assessed in the daily MASH meeting, because they were not available on police and agency systems, the force would be unable to effectively assess escalating or cumulative risk if other incidents occurred in the meantime.

The MASH conducts multi-agency risk assessment conferences (MARACs)[22] every day (in many areas they are only held on a fortnightly or monthly basis). A police staff manager decides which incidents are to be heard, sharing both the decision and the rationale with other agencies. While this is positive, there are also backlogs due to limited supervisory capacity at detective sergeant level. At the time of the inspection, there were 40 high-risk domestic abuse incidents awaiting assessment by a supervisor on their appropriateness for MARAC: the oldest of these dating back a month. As a result, the risks faced by people affected by domestic abuse are not being addressed in a timely manner, and the potential benefits of a daily meeting are negated.

HMIC observed this process and reviewed the minutes from several meetings regarding domestic abuse incidents involving children. Despite the backlogs, there were some good examples of action being taken to address risk factors. It was encouraging to see a high proportion of the cases being tackled proactively such as planning for the release of high risk domestic abuse perpetrators from prison.

However, we reviewed domestic abuse incidents that occurred between November 2016 and January 2017 and found that only a small minority of those cases referred to MARAC were actually considered. Although this allows MARAC to focus on the most critical cases, it also means that many high risk cases are not benefitting from the process and do not have joint strategic plans in place to manage risk effectively.This means that children living in families where domestic abuse occurs are left at potential risk from perpetrators.

[22] A MARAC is a locally-held meeting of statutory and voluntary agency representatives to share information about high-risk victims of domestic abuse, to which 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.

Attendance at initial and review child protection conferences[23] is a significant cause for concern. Staff within the MASH prepared reports for initial and review child protection conferences, but the force rarely attends these because of a lack of available staff. The constabulary provided information that shows there were 706 initial and review child protection conferences in Gloucestershire from November 2015 to November 2016, but the constabulary attended only five.

This lack of attendance causes HMIC considerable concern because the constabulary has been unable to contribute effectively to multi-agency decision-making. It cannot understand the information provided in that meeting without having the context of its presentation and it cannot test the validity of the information given by parents during the meeting. This presents an unacceptable gap in the protection of children.

The LSCB and children's social care services have both expressed concern at the lack of police involvement in child protection conferences. There have been some attempts to address the issues such as providing detailed reports to each conference and by using telephone conferencing. These measures were agreed with children's social care services when they were implemented but it is clear that concerns remain about the nature and quality of police involvement.

Recommendation

Within three months Gloucestershire Constabulary should

- undertake a review, together with children's social care services and other relevant agencies, to ensure that the constabulary 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;
    - attendance at, and contribution to, initial child protection conferences; and
    - recording decisions reached at meetings, on police systems to ensure that staff are aware and of all relevant developments.

[23] A child protection conference brings together family members, the child, where appropriate, and those professionals most involved with the child and family, to make decisions about the child's future safety, health and development. *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015 (latest update). Available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

7. Investigation

HMIC found some good examples of police child protection work, with child abuse investigators displaying an appropriate mix of investigative and protective approaches. This ensures that the safeguarding of children remains central to their efforts while criminal investigative opportunities are being pursued.

A young baby was brought into hospital with unexplained serious injuries. The control room identified that the child was known to be at risk of physical harm, which prompted a swift response by officers. A timely strategy meeting was held where clear actions were decided. Police powers under section 46 of the Children's Act were exercised, which led to an application for an interim care order by children's social care. The parents of the child were arrested, and a sibling was placed in foster care.

This is an example of effective inter-agency working and of good engagement resulting in clear actions set at the strategy meeting. The investigation was well-handled, with a focus on the welfare of the children, and taking action to ensure that the best possible evidence was gathered.

Gloucestershire Constabulary has a dedicated child abuse investigation team (CAIT), which has responsibility for the investigation of familial child abuse and allegations against those in a position of trust. Investigations involving other child abuse offences, such as sexual offences, are dealt with by non-specialist officers. HMIC found that specialist staff responsible for managing child abuse investigations are dedicated and want to provide the best possible outcomes for children who are at risk of harm. However, fewer than half (45 percent) of CAIT officers and staff have completed the specialist child abuse investigator development programme training, meaning they may not have the skills needed to deal with the complex investigations for which they are responsible. Gloucestershire Constabulary have found it difficult to recruit experienced detectives into child protection roles. Inspectors were told by senior officers and specialist detectives that this is because of the high levels of risk, and heavy workloads.

In December 2016, the constabulary undertook a review of how the CAIT functions, and identified a number of areas that required improvement. It found that the CAIT and other specialist teams were not routinely creating investigation plans, conducting supervisory or management reviews, setting or complying with the victim's code of practice or routinely recording the rationale for decisions. HMIC found evidence of these issues and the impact they have on child protection practice whic h, in turn, results in poorer outcomes for children, as the following example shows.

An 8-year-old-boy (who was already the subject of a child protection plan) was suspected to be the victim of continuing assaults by his mother. On one occasion, the child attended school with a cut lip after his mother pushed him into furniture. This should have led to an early arrest of the mother and the child being taken into police protection. Instead, the interview was delayed for over two months, and there no medical examination took place because of poor communication between the police and children's social care. The delays in making an arrest led to the child being at home with the suspected perpetrator and the loss of evidence. The mother was eventually interviewed however following this there were no updates on the case for a year. This resulted in the investigation being discontinued because the CAIT supervisor considered that, due to the passage of time, any further action would be an abuse of process.

In another example, a 7-year-old girl attended hospital with a suspicious injury. The initial response to arrest suspects and safeguard the child was effective and timely. However, the child subsequently disclosed a history of assaults, both physical and sexual, committed by three suspects, one of whom was a family member. A lack fo effective supervision contributed to drift in the investigation. The investigation has now been underway for over 19 months with little evidence of meaningful activity and the three known suspects have, at time of writing, not been arrested, exposing the child to continuing risk.

There is one sexual assault referral centre (SARC)[24] in Gloucestershire which provides services for adults and child victims. SARC crisis workers assist victims and police officers and independent sexual violence advocates (ISVA) also offer further support to victims. The constabulary is also working with partner agencies to develop a dedicated child ISVA role. There is a good understanding among SARC staff that child protection concerns must be referred to the MASH.

The constabulary has identified a small number of officers as safeguarding champions in each local policing area and has also worked with local young people who have been in the care system. These young people meet with new recruits and attend training days, and talk about their experiences and how they felt they were treated by the police. This helps to improve response officers' understanding of the needs of missing children, and the effect their actions and behaviour can have. This is a positive initiative and will help improve the police response to children who go missing.

[24] A sexual assault referral centre provides services to victims of rape or sexual assault regardless of whether the victim reports the offence to the police. These centres are designed to be comfortable and multi-functional, providing private space for interviews and examinations, and some may also offer counselling services.

However, despite this HMIC is concerned about the protection of some children who regularly go missing from home. The use of trigger plans (a plan to locate a child quickly when they go missing) is sporadic. They are written by children's social care and then shared with the police missing person co-ordinator, who adapts them for the police to use. The majority of the plans have not been reviewed to assess their current relevance. In addition, there is no defined process for linking a trigger plan to a child's record, meaning their use is inconsistent. The force has a policy of holding a strategy meeting when there are three missing episodes in 90 days, but we could find no evidence of this happening routinely as required.

In the majority of missing from home cases examined by inspectors, the voice of the child was not evident. Information is often recorded on separate systems, which are not accessible to all staff, and therefore impedes reviews occuring and reduces the ability of officers and staff to manage risk effectively.

Although the daily management meeting reviews missing children each morning children can be reported missing on numerous occasions with limited evidence of early intervention. In many of the cases of missing children inspectors reviewed there was no recognition of the wider risks faced by a child and little evidence of action being taken to protect them, as the following example shows.

A 15-year-old girl in foster care who went missing regularly, and was at significant risk of CSE, was not recorded as missing in a timely manner on police systems because this "would serve no purpose". As a result no action was taken for 10 days to find her.

When she was finally recorded as missing, she was inappropriately assessed as medium risk, meaning limited action was taken to trace her. She was eventually found at the home address of a 54-year-old man, where she had been systematically raped and abused by several older men, and given crack cocaine.

HMIC also found that officers and staff do not always recognise that children who go missing from home regularly may be at increased risk of being groomed for sexual abuse. Many of the cases we examined contained an inaccurate initial assessment of the risks to the child or children concerned. There was also a failure to recognise clear signs of the risk of sexual exploitation being faced by a child (particularly those children who were routinely reported as missing). This means that opportunities to intervene at the earliest opportunity were missed, leaving children at ongoing and unmanaged risk, as the following example shows.

A 15-year-old girl was reported missing. She had been reported missing on 13 previous occasions. She lived with her mother and had an allocated social worker. She was classified as at high risk of CSE, and had previously been in two relationships with older and violent men, one of whom had a restraining order in place not to contact her. She was also known to have previously self-harmed and abused substances.

The girl had been missing for two days and was initially classified as medium risk, a decision which was ratified by a supervisor in the control room. There was a delay in her case being allocated to an investigating officer. Although she was located the same night, she was allowed to stay at an adult male's house overnight instead of being returned home to her mother. It is not clear whether any police or social services checks were conducted to ascertain the man's suitability to look after the girl. It transpired that the man had a criminal history of violence. No record could be found of a strategy meeting taking place.

The use of 'flags' on the constabulary's systems to highlight children at risk of CSE is inconsistent. The facility to use flags has only been in existence since November 2016, and its use to date has been minimal; at the time of inspection only 15 children were flagged as high risk of CSE. This suggests that opportunities to detect and deal with increasing risks associated with vulnerable children are being missed, especially when those children go missing.

There is limited use by the constabulary of child abduction warning notices (CAWNs)[25]. HMIC reviewed a number of cases where issuing these notices would have been appropriate, but they had not been considered meaning that safeguarding opportunities had been missed.

HMIC was informed by intelligence managers and senior officers that very few intelligence reports relating to child protection are submitted by frontline officers (particularly relating to CSE). Intelligence, research and analysis are essential to the development of an accurate understanding of the nature and extent of issues in a force area. The constabulary has worked with partners to develop a dedicated multi-agency CSE team which is based in the same building as the MASH. This is positive however, we found that the volume of work and risk being managed by the team (particularly in relation to very complex investigations with multiple victims or perpetrators) is excessive and a cause for concern. The recording of information is frequently poor, and inspectors found that some officers are leading investigations that are too complex for a single detective to manage, as the following example shows.

[25] 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 , as well as warning the adult that the association could result in arrest and prosecution.

A mother reported that her 14-year-old daughter was sexually active with an adult man. A referral was made to children's social care, as a result of which four further girls were identified as potentially being at risk. While there was evidence of a good initial police response neither the victims nor the suspects were flagged in relation to CSE on police systems.

A CAWN was considered (and would have been appropriate) but was not issued. A number of multi-agency meetings took place, but the record lacked sufficient detail to ascertain what was agreed from a multi-agency perspective and who was responsible for undertaking particular actions.

There was some evidence of good investigative activity, but this relied too heavily on whether or not the victim and witnesses supported particular action at a given time. There appears to have been a lack of consideration given to using more proactive and disruptive tactics against the perpetrators. There was limited evidence of supervisory oversight of the case as it progressed.

At the time of the inspection, the constabulary was moving its child protection and domestic abuse databases on to the main IT system (UNIFI). This should avoid the duplication of information and confusion for officers when trying to locate the most recentinformation about a child. This is a positive step that will consolidate information held within the constabulary, and enable senior leaders to quality assure investigations more effectively.

HMIC had concerns about the lack of effective supervision seen in the cases reviewed during this inspection. Generally, there was little evidence of consistent investigative planning or of supervisors guiding the progress of an investigation. The initial response to high-risk investigations was generally good. However, many investigations were characterised by delays and a lack of effective supervision resulting in drift and missed opportunities to provide the best outcomes for victims. We also found evidence of a failure to record further crimes when they are disclosed, as the following example shows.

Two young children, the subjects of a child protection plan, were exposed to repeated episodes of domestic and physical abuse. There were a number of occasions when assaults were clearly disclosed during the investigation, however there was no evidence of the crimes being recorded or any action being taken by the police. There was no rationale given to explain why the crimes were not recorded.

In conclusion, HMIC has concerns about the quality and timeliness of investigations relating to vulnerable children. Signs of risk are missed, record-keeping is poor and supervision is inconsistent, which leaves children at increased risk of harm.

Recommendations

Immediately Gloucestershire Constabulary should:

- take action to improve child protection investigations by ensuring that:
    - it provides guidance to staff that identifies the range of responses and actions that the police can contribute to multi-agency plans for protecting children;
    - every referral the police receives is allocated to those with the skills, capacity and competence to undertake the investigation;
    - investigations are supervised and monitored, with supervisor reviews recording clearly any further work that may need to be done; and
    - it conducts regular audits of practice that include assessing the quality, timeliness and supervision of investigations.
- take steps to improve 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 those who pose a risk to children, to better inform risk assessments;
    - ensuring that staff are aware of the need to pass this information 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.

8. Decision-making

Gloucestershire Constabulary's response is generally good when the case is clearly defined as a child protection matter from the outset. It is a very serious step to remove a child from their family by way of police protection. In the cases we examined, decisions to take a child to a place of safety were well considered and in the best interests of the child. However, we found that while the initial response was often appropriate, record-keeping and subsequent safeguarding action was less consistent and there were some delays. For example, in one incident the initial response and the decision to take a child into police protection were appropriate. However, the child was kept at a police station for 14 hours before being released into the care of social workers.

The constabulary's multiple IT and standalone offline systems holding information has a significant impact on its ability routinely to access information to inform decisions and manage risk effectively. HMIC found that record keeping was frequently poor and when it was recorded, it could be on multiple IT systems and offline paper based files meaning information was not readily accessible to all staff. The outcome of strategy meetings was not always recorded and there were delays in records being updated (if they were at all) with the progress of an investigation. This means it was not always clear what decisions had been made to protect a child. In the majority of investigations we examined, we found consistent failings to record information. This is a significant concern and undermines the constabulary's ability to protect vulnerable children.

The force has recently merged the child protection database and the domestic abuse database on to UNIFI, the main computer system. This is a positive step and will help to make information more accessible.

As previously stated, the force does not assess children who go missing as either absent or low risk. This shows the force recognises the additional risks that children can face while they are missing. However, this is only effective if there is suitable activity to trace a child when they are reported missing. In the cases we assessed, we considered that many missing episodes initially graded as medium risk should have been graded high. As a result, there were a number of occasions, particularly in relation to children who go missing regularly, where there was little or no effective activity to trace the child. Effective decisions on the response to known risks need to be considered more carefully, with supervisors controlling and directing the activity of officers charged with locating vulnerable children.

9. Trusted adult

We found a number of cases in which the decisions made clearly took account of the needs of the children, but there was very little information in the majority of case files on the views of the child, the impact on the child or the outcomes of police intervention for the child. The VIST has a section to record the demeanour and voice of children at incidents the police attend. However, on the forms we reviewed the recorded information was limited. The force recognises the importance of capturing the child's voice and has created specific training on this subject, which is currently being given to all frontline officers. Although at an early stage frontline officers spoken to by inspectors were aware of the training (or had received it) and clearly understood its purpose. This is positive and could provide the force with the means to improve the decision-making of frontline staff.

The missing persons co-ordinator works closely with care homes, taking time to speak to children and young people in an attempt to build relationships and trust with them. The aim is to reduce the number of missing episodes and therefore reduce risk. We found that independent return interviews[26] for children missing from home are available throughout the constabulary area, but whether they were in fact conducted and what was said were not always recorded on police systems. In those cases where the interviews had taken place, inspectors could find no evidence of their 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 when this is becoming more frequent and the child is reluctant to speak to police or other agencies.

[26] 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: www.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf

Recommendation

Within three months Gloucestershire Constabulary should

- take action to improve child protection investigations by ensuring 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.

10. Managing those who are a risk to children

Gloucestershire Constabulary has a dedicated unit to manage registered sex offenders, called the management of sexual offender and violent offender (MOSOVO) team.

HMIC found that there were plans in place to manage risks and that these were proportionate and kept up to date. We also found that monitoring visits to check that registered sex offenders were keeping to their registration requirements were normally made at the appropriate time. However, at the time of the inspection there were 40 overdue reviews.

The unit is 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).[27] We were pleased to note that at the time of the inspection 80 percent of offenders had been the subject of an ARMS assessment and these assessments were being used proactively to monitor and reduce risk. HMIC found that officers used their powers to arrest those who failed to keep to their registration conditions (although, as described above, there were some delays) or other requirements, such as prohibitions on contact with children.

Frontline staff we spoke with were positive about the information received from this unit about those who pose a risk in the community. We found links between the dangerous offender units and neighbourhood policing teams to be consistently good throughout the constabulary area. Officers are made aware of registered sex offenders living in their area through regular intelligence updates which provide information about those who pose a risk to children.

Flags are applied to IT systems about where registered sex offenders live and their offending behaviour. This provides officers and staff with a better understanding of the risks posed by offenders and supports more effective decision making to mitigate risk and safeguard children. There is good evidence of the constabulary and other child protection agencies working together to manage the risks posed by registered sex offenders. MAPPA[28] meetings are well attended by agencies such as children's social care, and police representation is of the appropriate seniority.

[27] ARMS is a structured assessment process to assess dynamic risk factors known to be associated with sexual re-offending, 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.

[28] Multi-agency public protection arrangements. For further information see: *MAPPA Guidance 2012 version 4*, Ministry of Justice National Offender Management Service, February 2015 (latest update).

The constabulary routinely searches for evidence of children being abused or exploited online, and has a dedicated unit to oversee these investigations. We saw evidence that processes are in place to monitor these investigations centrally, and were pleased to see that most investigations progressed well. Safeguarding planning was evident in most of the cases we reviewed, although some delays in cases graded as low and medium risk were apparent.

Available at: www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2.

11. Police detention

If a child is denied bail and detained, the local authority is responsible for providing appropriate alternative accommodation. Only in exceptional circumstances (such as during extreme weather) would transferring the child to alternative accommodation not be in their best interests. In rare cases – for example, if a child presented a high risk of serious harm to others – secure accommodation might be needed.

In September 2016 Gloucestershire Constabulary implemented a joint protocol with the local authority for the provision of alternative accommodation for young people transferred from police custody.[29] The aim of this protocol is to safeguard children and avoid, so far as is practicable, their detention overnight in police custody following charge where bail is inappropriate. Custody officers are required to complete a juvenile transfer request form and to send it to the emergency duty team in children's social care by email, copying it to the custody manager. The intention of this is to help gauge the demand for alternative accommodation and allow for appropriate challenge and escalation if the requested accommodation is either refused or unavailable.

However, we found that this form is rarely completed and when it is the information is often incomplete. This results in children being detained unnecessarily in police custody in spite of this protocol. We also found that the reasons for keeping children in custody and denying bail were also not well documented and sometimes contradictory. Custody staff spoken to were also unaware of the existence or purpose of the protocol.

A custody sergeant charged and refused to grant bail to a 17-year-old. The constabulary indicated that contact was made with the local authority to request secure accommodation but none was available (although no evidence of this contact was recorded on the custody log).

The constabulary indicated that in the absence of secure accommodation, other accommodation would not be suitable to protect the public from serious harm from the detainee. The record shows that the detainee was denied bail to prevent further offending, but not that the public required protection from serious harm, therefore there was no justification for requesting only secure accommodation.

[29] 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.

Data the constabulary provided showed that during 2016 (before the protocol was introduced) on average two children a month would have been eligible to be accommodated under the protocol once remanded after charge. Since the protocol has been in place there has been no reduction in the average number of children detained after charge indicating that the protocol has had little or no impact.

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. Inspectors were told that completed detention certificates remain with the file that goes with the detainee to court. No copies of the certificates are retained by the constabulary. Consequently we were unable to assess their quality and judge whether important information such as the justification for detaining the child was properly recorded. More significantly however, this restricts the ability of senior leaders to understand the quality and appropriateness of decisions, and to be ensure that decisions about the continued detention of children are proportionate, necessary and lawful.

In only 2 of the 11 police detention cases we reviewed had the officer in charge completed child referrals to social care. Custody staff spoken to by inspectors were unaware of the VIST risk assessment, meaning that the process may not be used to alert other officers and/or social care to concerns about vulnerable children detained in police custody.

Recommendation

Within three months Gloucestershire Constabulary should

- undertake 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.

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

Throughout the inspection, HMIC encountered specialist staff responsible for managing child abuse investigations that are knowledgeable, committed and motivated. Despite this, there are inconsistencies and many areas for improvement in the service provided to vulnerable children, particularly in relation to domestic abuse, missing children and child sexual exploitation.

Recording information on multiple IT and standalone paper systems, combined with a lack of supervisory oversight, is limiting Gloucestershire Constabulary's ability to effectively safeguard children. This is compounded by the lack of an effective governance and performance management framework.

In some areas of the constabulary the volume of work is contributing to delays, drift in investigations, poor supervision and backlogs. There also remain inconsistencies in the management and oversight of investigations across the constabulary, and this has an impact on the provision of safeguarding, and ultimately leaves children vulnerable to harm. The majority of cases examined were found to be inadequate or requiring improvement. In a significant number, poor supervision and record keeping had undermined decision making and safeguarding measures. If the constabulary is to be confident that it is adequately protecting vulnerable children, safeguarding arrangements require improvement.

Arrangements for managing high-risk sex offenders are generally good across the constabulary, and there is sufficient capacity to allow for some proactive work. Inspectors found evidence of some good inter-agency plans to manage risk and were pleased to note that neighbourhood teams are kept well informed of the offenders living in their areas.

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.

Work to address CSE is under-developed and lacks co-ordination. While the constabulary is taking some steps to address this, it still has more to do to demonstrate that it is effectively able to identify and safeguard children at risk of sexual exploitation.

In conclusion, while it is clear that there the constabulary is committed to the improvement of outcomes for vulnerable children, and some isolated examples of good practice were seen, the constabulary needs to do more to improve its safeguarding practice in order adequately to protect those children at most risk of harm.

Summary of recommendations

Immediately

Gloucestershire Constabulary should:

- take action to improve child protection investigations by ensuring that:
    - it provides guidance to staff that identifies the range of responses and actions that the police can contribute to multi-agency plans for protecting children;
    - every referral the police receives is allocated to those with the skills, capacity and competence to undertake the investigation;
    - investigations are supervised and monitored, with supervisor reviews recording clearly any further work that may need to be done; and
    - it conducts regular audits of practice that include assessing the quality, timeliness and supervision of investigations.
- take steps to improve 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 those who pose a risk to children, to better inform risk assessments;
    - ensuring that staff are aware of the need to pass this information 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

Gloucestershire Constabulary should:

- put in place arrangements which ensure that it has clear governance structures in place to monitor child protection practices, across both non-specialist and specialist units. The constabulary should then provide officers and staff with a clear understanding of what good service looks like and the standards it expects, and begin to develop a performance management framework that will operate to achieve consistent standards of service.
- review 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.
- review its processes for the supervision of the decisions made when police attend incidents where children are at risk or vulnerable.
- undertake a review, together with children's social care services and other relevant agencies, to ensure that the constabulary 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;
    - attendance at, and contribution to, initial child protection conferences; and
    - recording decisions reached at meetings, on police systems to ensure that staff are aware and of all relevant developments.
- take action to improve child protection investigations by ensuring 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.
- undertake 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 from the publication of this report, HMIC will require an update of the steps taken in response to the recommendations that should be acted upon immediately.

Gloucestershire Constabulary 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 responses received, HMIC will revisit the constabulary 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 police 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 March 2015. 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 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 HMIC); 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 regarding 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 and non-criminal nature (section 47 enquiries are those relating to a child 'in need' rather than a child 'at risk');
- sex offender management;
- the management of missing children;
- child sexual exploitation (CSE); and
- the detention of children in police custody.

Below is a breakdown of the type of self-assessed cases we examined in Gloucestershire Constabulary:

Type of case	Number of cases
At risk of sexual exploitation	4
Child in custody	3
Child protection enquiry (s. 47)	4
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 – Glossary

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; 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)	a 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, 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