National Child Protection Inspection Post-Inspection Review

Greater Manchester Police
30 June - 3 July 2015

December 2015

ISBN: 978-1-911194-71-2

www.justiceinspectorates.gov.uk/hmic

Contents

1. Background

HMIC carried out a child protection inspection in Greater Manchester Police in July 2014 and provided the force with a report of our findings in December 2014. In February 2015, the force provided HMIC with an action plan setting out how it intended to respond to the recommendations in the inspection report. Inspectors carried out a post-inspection review in late June and early July 2015 to assess progress with the implementation of the recommendations.

HMIC's review included:

- a document review;
- a presentation given by the head of public protection and chief officer lead;
- interviews with staff, including the head of public protection; and
- audits of 34 child protection cases relating directly to areas for improvement identified in the inspection report and related recommendations. Seventeen were assessed as good, nine requiring improvement and eight inadequate.

Summary

Greater Manchester Police has prioritised child protection and it was clear to inspectors that the force desires strongly to improve outcomes for children who are at risk of harm. When officers recognised that an incident was a child protection matter, they generally responded well, taking immediate action to safeguard the child and working with children's social care services to protect the child in the longer-term. HMIC found examples of good investigations, but we also found examples of poor practice, particularly in relation to child sexual exploitation and children exposed to domestic abuse.

The force needs to ensure that it recognises and acts upon the risk to children in cases where concerns may not be apparent immediately, such as in chronic domestic abuse situations, and that it records the subsequent steps it takes to safeguard vulnerable children. Furthermore, the force needs to ensure that the same high standards it achieved in the 17 cases assessed by HMIC as good are achieved consistently across the whole force area. The force must accelerate its efforts to reduce delays in computer analysis to ensure that children are not left at risk and perpetrators do not remain free to continue offending. Further work is also required to improve the quality of prosecution files the force submits to the Crown Prosecution Service (CPS) and the timeliness of charging decisions.

HMIC considers that Greater Manchester Police recognises the challenges it faces, and understands what it needs to do to ensure that the force provides consistently good child protection services across the entire force area. The force has taken some important steps to address the recommendations from HMIC's National Child Protection Inspection in July 2014. We are encouraged by progress and saw clear evidence of improvements. However, challenges remain and the force will need to maintain its current momentum and focus on child protection for some time to come.

2. Post-inspection review findings

Initial contact

Recommendations from initial inspection report

- We recommend that, within three months, Greater Manchester Police undertakes a skills audit to determine, as a minimum:
    - how well staff understand the effect of abuse on children, including exposure to chronic domestic abuse; and
    - how well frontline staff assess risks to children, with particular attention to the extent to which staff engage directly with children at an early stage to form part of that assessment.
- We recommend that, within six months, Greater Manchester Police implements a plan to address the results of the audit and, where necessary, pays particular attention to improving staff understanding of the importance of children's demeanour and ensures that relevant information is recorded at an early stage for the purpose of achieving effective risk assessments.

Summary of post-inspection review findings

Greater Manchester Police has taken some significant steps to improve officers' initial response when attending incidents involving children at risk. Training and guidance had resulted in a better understanding of risk by staff. However, HMIC found little evidence of improvement in frontline officers' engagement with children or their recording of the effect of exposure to domestic abuse on a child's welfare.

Detailed post-inspection review findings

To strengthen its oversight of child concern incidents, Greater Manchester Police has provided a training programme to the supervisors of officers who respond to emergency calls from the public. Part of the training assessed supervisors' understanding of child protection, links with domestic abuse and child sexual exploitation, and their competence to assess risk. The force used the results from these assessments to develop further targeted training and briefings for all frontline staff to improve their ability to identify and treat those who are vulnerable, and also to assess risk in child protection cases. In addition, specialist public protection staff had taken part in risk assessment training.

Since our inspection in July 2014, Greater Manchester Police had undertaken two audits of domestic abuse incidents where a child was present. The audits identified that frontline officers were not always checking that children were safe and well.

We were pleased to find that control room staff identified children who might be at risk and passed information to officers attending the incident. We examined eight cases where a child had been present during a domestic abuse incident and assessed four as good, two requiring improvement and two as inadequate. In the cases we examined, officers always checked that the child was safe and well and immediate safeguarding measures were put in place. However, the behaviour or demeanour of the child was not recorded in any of the cases. This information should have been used to inform the initial risk assessment and shared as part of the force's referral to children's social care services.

HMIC found a mixed picture in cases involving high-risk, chronic and long-term domestic abuse situations. We found good practice in four cases, in which police made an early assessment of risk, and ensured appropriate agencies were actively engaged in providing support to both the child and victim. However, in three cases, police had not considered the cumulative impact of domestic abuse on the children and family. Adult victims were the principal focus of officers' attention, but risks to children were not fully recognised.

In four high-risk cases, we saw no evidence that strategy meetings[1] had taken place for children exposed to persistent domestic abuse. Although three of these cases were discussed subsequently at a multi-agency risk assessment conference (MARAC),[2] we found no evidence of joint working to protect the children in advance of this.

Further recommendation

> We recommend that, within three months, Greater Manchester Police ensures that the effect of exposure to domestic abuse on a child's welfare is recorded in every case and the information is used to inform risk assessment.

[1] Whenever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm, there should be a strategy discussion involving local authority children's social care services, the police, health services and other bodies such as the referring agency. This may take the form of a multi-agency meeting or telephone calls and more than one discussion may be necessary.

[2] These are locally-held meetings where statutory and voluntary agency representatives come together and share information about high-risk victims of domestic abuse. The aim of the meetings is to produce a co-ordinated action plan to increase an adult or child's safety, health and well-being.

Assessment and help

Recommendations from initial inspection report

- We recommend that, within three months, Greater Manchester Police takes steps to secure a reduction in the time taken to prepare assessments at the Stockport MASH where delays have been identified.

- We recommend that, within three months, Greater Manchester Police puts arrangements in place to ensure that, when a missing child returns, the child is spoken to by the police to assess whether the child is safe and well. If there are concerns about the child following that assessment, the police should take action to address the risks to that child in the future.

- We recommend that, within six months, Greater Manchester Police improves its recording practice in relation to the risks to children in domestic abuse cases and provides, as a minimum, information on: any history of abuse; the number of children in a family; and court result updates to other agencies before a MARAC meeting takes place. The force should take steps to ensure this practice becomes routine.

Summary of post-inspection review findings

Greater Manchester Police has successfully reduced the time taken to assess and refer cases at Stockport's Support and Safeguarding Hub. We also found that the standard of safe and well checks for children who return after going missing from home had improved. The force has reviewed MARAC arrangements to improve the recording of risks to children in domestic abuse cases.

Detailed post-inspection review findings

In July 2014, we reported our concerns about delays in preparing assessments and making referrals at the Stockport Support and Safeguarding Hub. In response to our recommendation, the force has reviewed arrangements with children's social care services and partner agencies, improved systems and processes and embedded new ways of working.

HMIC was told by supervisors that changes to roles had enabled police staff to be more focused on their work in the hub and sharing information with children's social care, and that the force and the local authority had worked together to improve the standard of referrals. Guidance and training had been provided by partner agencies for police officers and staff co-located in the hub, which emphasised the importance of supporting and safeguarding children. The force monitored performance daily and backlogs had reduced significantly. In June 2014, 160 new cases were awaiting assessment, but by 29 June 2015, this figure had reduced to 17 which is a significant improvement.

We were pleased to see that Greater Manchester Police had reviewed its arrangements for children who return home after going missing. The force had issued staff with guidance and provided them with training to improve the quality of interviews with children, and to reinforce the need to check that children were safe and well. We considered that this had led to increased awareness of the importance of such checks and improvements in the way they were carried out.

We were told by senior officers that if a child was considered to be at risk of sexual exploitation and reported as missing from home, they would always be considered as being at high risk of harm. The force has plans in place to accelerate and improve its response to locate these children.

At the time of our visit a review of multi-agency responses to children who go missing from home was being progressed under the auspices of Project Phoenix.[3] The purpose of the review was to agree consistent service standards and resourcing for multi-agency responses to children at risk across Greater Manchester. The review was expected to report in July 2015.

Greater Manchester Police had reviewed MARAC arrangements to improve the recording of risks to children in domestic abuse cases. HMIC noted that the frequency of MARAC meetings had increased across nine of the ten policing divisions to enable more effective and timely information-sharing. We examined four cases that had been referred to MARAC, and found evidence of effective information-sharing in three. In the fourth case the police report to MARAC failed to detail the previous history of abuse held on police systems and effective information sharing did not take place.

Investigation

Recommendations from initial inspection report

- We recommend that Greater Manchester Police immediately takes steps to reduce delays in the high-tech crime unit, taking into account the increase in domestic and historical abuse cases.

- We recommend that, within three months, Greater Manchester Police discusses with the CPS how best to reduce delays in the prosecution process so that timeliness of submission of prosecution files by the police and the timeliness of prosecution decisions are regularly reviewed and improved.

[3] Project Phoenix was launched in 2012 as a multi-agency response to child sexual exploitation. It brings together public and voluntary sector partners across Greater Manchester to raise awareness of child sexual exploitation, help people to recognise the signs, encourage people to report it, and to provide support to those children considered most at risk. Further information about the project's campaign 'It's not okay'' is available from: www.itsnotokay.co.uk

Summary of post-inspection review findings

Greater Manchester Police had made limited reductions to the delays in the high-tech crime unit (HTCU). Although efforts had been made with the CPS to improve the timeliness of the submission of prosecution files, delays remained.

Detailed post-inspection review findings

Greater Manchester Police reduced the time taken to analyse mobile phones. However, the force had been less successful in reducing the time taken to analyse other devices seized as part of child abuse investigations.

The force had deployed additional staff to a restructured unit dealing with both high-tech crime and mobile data examination. Changes had been made to the allocation and review of forensic examinations, and the force had outsourced the examination of low-risk cases to reduce the backlog.

In July 2014, HMIC found significant delays in the analysis of computers – often taking between 24 and 32 weeks. At the time of our post-inspection review in July 2015, delays remained. For example, inspectors found 24 urgent cases awaiting allocation, with a delay of 14 weeks for the oldest. Where the risk was classed as standard, we found 220 were awaiting analysis, with a delay of 61 weeks for the oldest. Some urgent cases dated back to March 2015 and some standard cases to April 2014. Three-quarters of these cases related to the abuse of children. This poses a significant risk to children who may not be safeguarded and protected from perpetrators at an earlier stage.

We found an improving picture for phone examinations – no urgent cases were awaiting examination. However, just over 800 standard-risk cases were awaiting examination with a delay of six weeks for the oldest. A third of these cases related to the abuse of children.

In July 2014, we also found delays in cases sent to the CPS for review and charging decisions. Working with the CPS, the force had taken steps to improve the timeliness of decision-making. Progress with investigations, case progression, case file quality and the timeliness of decision-making were reviewed by the force at regular meetings with the CPS. Nonetheless, at the time of our post-inspection review, there were delays of up to six week for cases to be reviewed and charging decisions made.

Decision making and trusted adult

Recommendations from initial inspection report

- We recommend that, within six months, where there are concerns about children, Greater Manchester Police takes steps to ensure that all relevant information is properly recorded, is readily accessible in all cases, and that information is shared with partner agencies in a timely and consistent way.

- We recommend that, within six months, Greater Manchester Police:

    - develops practice to record the views and concerns of children and to record outcomes at the end of police involvement in a case, ensuring that it is also clear from the record how children are informed of decisions made about them;

    - takes steps to provide information routinely about children's needs and views to the police and crime commissioner and to service managers to inform future practice; and

    - reviews police officer and staff interactions with children and considers what needs to be done to improve them further, working where appropriate, with other agencies to do so.

Summary of post-inspection review findings

We were pleased to find that Greater Manchester Police had provided training and guidance to frontline staff about the importance of recording information in child protection cases. The force has also provided public protection staff with guidance on recording outcomes at the end of police involvement in a case, including the importance of ensuring that children are informed of decisions made about them. However, recording practices remained inconsistent and further work is needed to ensure that HMIC's recommendations are met in full.

Detailed post-inspection review findings

In the majority of cases that HMIC examined in detail for this post-inspection review, where a concern for a child had been raised, information had been recorded and shared with partners in a timely and consistent manner. However, despite improvements such as this, we found more generally that recording practice was inconsistent. In particular, we found limited evidence that children's views and behaviour were recorded in domestic abuse and child sexual exploitation cases and little focus in the force on outcomes for children.

Greater Manchester Police does not routinely gather information on the views of children and the outcome of their cases. However, the force had contributed to and participated in events arranged by the police and crime commissioner where victims

of child abuse and sexual exploitation had presented their views to both police and partner agencies. Similarly, Greater Manchester Police is both a partner and driving influence in Project Phoenix under whose auspices the website and campaign 'It's not okay' has been developed, which provides information for children and enables them to report directly their concerns about sexual exploitation.

Management of those posing a risk to children

Recommendation from initial inspection report

- We recommend that, within three months, Greater Manchester Police ensures information on registered sex offenders[4], particularly those who are high-risk, is routinely available to local neighbourhood officers.

Summary of post-inspection review findings

Greater Manchester Police had made progress to ensure information on registered sex offenders, particularly those who are high-risk, is routinely available to local neighbourhood officers.

Detailed post-inspection review findings

The force had provided guidance to local officers to enable them to access details on registered sex offenders though information systems. We were told that officers from the sex offender management unit attended monthly vulnerability meetings in each of the force's ten divisions to share information in high-risk cases for that area. Information was subsequently passed to neighbourhood officers and formed part of electronic briefings at the start of each shift.

Police detention

Recommendations from initial inspection report

- We recommend that, within three months, Greater Manchester Police undertakes a review 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 custody staff make a record of all actions and decisions on the relevant documentation;

[4] A person required to provide his or her 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 or she has otherwise triggered the notification requirements (for example, by being made subject to a sexual offences prevention order).

- ensure specific additional consideration is given to conducting reviews of children in person and that the child is spoken to;
- make available previous risk assessments to all custody staff; and
- assess at an early stage the likely need for secure or other accommodation, and work with children's social care services to achieve the best option for the child.

Summary of post-inspection review findings

Greater Manchester Police has taken some significant steps to improve its custody provision for children. Fewer children and young people were being detained unnecessarily in police custody overnight due to a lack of local authority provision of alternative accommodation and custody. Staff have access to better information to inform decisions about children in detention.

Some children were still being detained unnecessarily, but the force was continuing to address this with local authorities. More work is needed to ensure that children have timely access to appropriate adults and to ensure that child detention certificates are completed.

Force recording practices had improved, but not consistently so. Custody staff did not always record all actions and decisions on the relevant documentation.

Detailed post-inspection review findings

HMIC examined ten cases of children detained in police custody after charge. We assessed three as good, four as requiring improvement and three as inadequate. Greater Manchester Police had taken some important steps to improve the assessment of a child's needs when detained in police custody. All custody staff now had access to previous records of risk assessments for children. These records contain important information about individual children and their vulnerabilities and risks. This enabled staff to make more informed assessments of a child's needs and better decisions about the child's care.

In September 2014, the force had conducted an audit to assess whether detention reviews of children carried out by senior staff, complied with the requirements for the detention of persons in custody in the Police and Criminal Evidence Act 1984.[5] The audit identified that the force was conducting too many reviews over the phone rather than in person. The force subsequently issued guidance to staff and a second

[5] *Police and Criminal Evidence Act 1984 (PACE) - Code C, Revised code of practice for the detention, treatment and questioning of persons by police officers*, Home Office, October 2014 (latest update). Paragraph 15.3.C states "The benefits of carrying out a review in person should always be considered, based on the individual circumstances of each case with specific additional consideration if the person is (a) a juvenile..." www.gov.uk/government/publications/pace-code-c-2014

audit in June 2015 showed an improvement, with the majority of children being informed face-to-face of the reasons for their further detention. Our own examination of ten cases of children in detention showed a similar improvement.

We found that force had made limited progress to address another concern highlighted in its 2015 audit, namely, the failure to record contact with appropriate adults. In one case an appropriate adult had attended custody within a reasonable time and in another case the child was detained for an hour before court and an appropriate adult had not therefore been requested. However, in four of the ten cases we examined, police had not provided children with access to an appropriate adult to advocate and challenge on their behalf. In the remaining four cases, where appropriate adults were contacted, there had been long delays in them attending of between four and fifteen hours.

In one case, a 15-year-old was arrested and taken into custody at 10.00pm and strip-searched without an appropriate adult present. This is contrary to Code C of the Police and Criminal Evidence Act 1984.[6] We could find no record to explain why the search was considered necessary, or the reasons for any urgency in conducting the search in the absence of an appropriate adult.

Custody staff had received guidance which required them to consider the circumstances for granting bail instead of detaining children after charge. In February 2015 the force detained an average of three children a week in custody after charge. In March 2015 this had reduced to an average of one child each week. We were pleased to see that senior managers scrutinised all cases where a child had been detained after charge.

Greater Manchester Police had worked with local authorities to agree a protocol to improve the provision of alternative accommodation for children. This had resulted in more children being transferred from police custody to local authority accommodation. In the first quarter of 2015, local authority accommodation was provided for 10 of the 25 children for whom it was requested. This was a significant improvement on the third quarter of 2014 when alternative accommodation was provided for only 3 of the 25 children for whom it was requested.

HMIC examined 7 cases of children under 17 years old, who had been detained in custody after charge where a request for alternative accommodation would be expected. The force had requested alternative accommodation in three cases, two of which were for secure accommodation. Alternative accommodation had been provided in one case where the request was made four hours after charge. We found evidence that custody officers had challenged the local authority to provide

[6] *Ibid*, paragraph 11(c) of Annex A to Code C. This states that "except in cases of urgency, where there is a risk of serious harm to the detainee or to others, whenever a strip search involves an exposure of intimate body parts, there must be at least two people present other than the detainee, and if the search is of a juvenile…one of the people must be the appropriate adult."

accommodation but when this was agreed transport was not available, and the child remained in custody.

In another case, a 14-year-old boy was detained for 27 hours before charge. Secure accommodation was requested shortly after he was charged, but none was available. He spent a further 15 hours in custody.

In the case of the15-year-old mentioned earlier, a request was made to the local authority for secure accommodation when the boy had been detained for 23 hours. None was available. Staff were told that the boy had been placed in a care home in Manchester by a local authority in another part of the country. As such, funding was not available for secure accommodation and as a result the boy was detained for 34 hours in police custody.

At the time of our post inspection review, the force was negotiating actively with local authorities in Greater Manchester for the provision of secure accommodation for children who would otherwise be detained in police custody.

Recording practices had improved, but not consistently so. Custody staff did not always record all actions and decisions on the relevant documentation. For example in the case above there was a failure to record the reason the 15-year-old was strip-searched without an appropriate adult present. In five other cases there was no record of a request for alternative accommodation for children under 17 years old. It was not clear to us whether this was due to a failure to make a request or a failure to record that request within the custody record.

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 fulfilling their responsibilities under the Police and Criminal Evidence Act 1984. Inspectors were not presented with evidence that detention certificates had being completed for any of the 8 children under 17 years old who were remanded in police custody after charge.

Further recommendation:

- We recommend that, Greater Manchester Police complies immediately with its statutory obligations in completing and producing detention certificates before the court, in relation to children under 17 detained in custody post-charge.
- We recommend that, within three months, Greater Manchester Police undertakes a review with children’s social care services to ensure that children in custody are given early access to appropriate adults.

Leadership, management and governance

Recommendations from initial inspection report

> We recommend that, within six months, Greater Manchester Police develops a force-wide good practice regime that improves its response to child protection issues, so that no child receives a poor service by reason of the place where they live.

Summary of post-inspection review findings

Greater Manchester Police is committed to improving the protection of children. The force has prioritised child protection and desires strongly to improve outcomes for children who are at risk of harm. HMIC found that the force had made progress in developing a good practice regime that responds well to child protection issues. However, there is more to do to ensure consistently high standards of practice across the full range of child protection matters.

Detailed post-inspection review findings

Greater Manchester Police has good working relationships with local authorities and other partners. The force is represented at a senior level (divisional superintendent or chief superintendent) on the ten local safeguarding children boards. The force continues to work with a wide range of partners (through Project Phoenix) to develop common standards and a consistent approach to identifying and responding to tackle child sexual exploitation.

At the time of our visit, the force was conducting a review of services for vulnerable people to develop a model for public protection across Greater Manchester that is ‘consistent, clear and appropriately resourced’.

Greater Manchester Police improving its practice to safeguard adolescents. It has developed and provided a training programme to raise awareness of child protection issues and improve the skills of police officers and staff.

The force has developed a framework for the dissemination of good practice across the force. This included lessons learned from multi-agency peer reviews of services to address child sexual exploitation conducted under the umbrella of, and against standards agreed by Project Phoenix. These peer reviews and audits focused on the quality of the investigation, accuracy of risk assessment, standard of recording, timeliness of cases, interactions between agencies, listening to children and the effectiveness of safeguarding measures.

HMIC considers that the force should undertake similar audits of its own child protection practice. This, coupled with routine and systematic monitoring of performance measures that focus on outcomes for children, would enable the force to evaluate the impact of its day-to-day practices across all divisions. HMIC was pleased to find that the force was in the process of developing such a framework.

We examined nine cases relating to the sexual exploitation of children. Three were judged as good, three requiring improvement and three inadequate. Children were recognised as vulnerable in every case and appropriate referrals were made to children's social care services. Nevertheless, we found inconsistent practice and investigations that the force did not handle well. Seven of these cases involved a suspect who may pose a risk to children. In three of the seven cases, the force pursued insufficient enquiries and took little action.

For example, a 13-year-old girl who had previously been of concern due to risk of sexual exploitation went missing. She was found to have travelled to London to see her boyfriend. The girl was located by the Metropolitan Police, and returned home to her stepfather, where she was visited by a social worker. We found no recorded enquiries or joint work to discover who the boyfriend was and whether he posed a further risk to the child. In a further two cases a strategy meeting should have been considered but was not recorded as having taken place. Overall, strategy meetings been arranged in only three of the eight cases involving child sexual exploitation that HMIC reviewed.

HMIC found a much better picture in cases referred to children's social care services when there were other concerns for a child. We assessed all seven such investigations as good. In most cases officers responded quickly, children were spoken to sensitively and immediate safeguarding measures were put in place. We saw good evidence of information-sharing and joint-working with children's social care services. Strategy meetings were timely and children were listened to. Officers had recorded the children's demeanour and how they had been affected in five of seven cases where this was relevant.

For example, during a search of a house for drugs a large quantity of cannabis was found drying in the children's bedroom wardrobe. The mother was arrested and police and children's social care services held a strategy discussion. A joint visit to see the children was agreed by police and children's social care services; they were staying with their father. The views and needs of the children were recorded as "lovely, well mannered, well presented, talkative and switched on". The children did not like their mother using drugs or that the house smelled. The mother was later interviewed by police. The CPS decided subsequently to prosecute the mother for drugs offences but concluded that there was insufficient evidence to support a prosecution for child neglect.

3. Recommendations

Immediately

We recommend that Greater Manchester Police immediately

- complies with its statutory obligations in completing and producing detention certificates before the court, in relation to children under 17 detained in custody post-charge.

Within three months

We recommend that, within three months, Greater Manchester Police

- ensures that the effect of exposure to domestic abuse on a child's welfare is recorded in every case and the information is used to inform risk assessment.
- undertakes a review with children's social care services to ensure that children in custody are given early access to appropriate adults.