HMICFRS

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

National Child Protection Inspection Post-Inspection Review

Hampshire Constabulary

13–17 June 2022

Contents

Introduction

In June 2021, HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) inspected how well Hampshire Constabulary keeps children safe. We made six recommendations in the Hampshire – National child protection inspection report.

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

During this inspection we:

- examined force policies, strategies and other documents;
- interviewed senior leaders, managers and supervisors; and
- audited 30 child protection cases (12 cases were good, 14 required improvement and 4 were inadequate).

Summary of findings from the post-inspection review

The constabulary has committed a great deal of resources, time and energy to improving outcomes for children and making improvements in line with our recommendations. Existing constabulary governance processes have been used well to oversee improvement activity. There is a clear commitment from senior officers to child protection and this was evident throughout our inspection.

The constabulary has taken steps to better understand the service it provides to children. A range of qualitative audits regularly take place throughout the constabulary to determine themes and areas of strength and areas for development. Feedback is given to individual officers and teams. The reports inform the senior leaders about the findings from the audits to assist their understanding of any issues requiring attention, which then informs any required strategic response. But there would be some benefit to central co-ordination of the quality assurance work to ensure similar themes are identified and responded to in a consistent way. This assurance work is further enhanced by a quarterly multi-agency scrutiny group who analyse the joint response to a small number of child (and adult) safeguarding cases. Learning points are discussed with individual officers and supervisors and mitigating actions are completed. Wider learning is shared throughout the constabulary and, where relevant, statutory safeguarding partners are invited to participate through safeguarding partnerships activities to improve multi-agency practice.

There has been wide-ranging investment in learning and development throughout the organisation. Frontline officers and specialist teams are given the skills they need to recognise vulnerability and risk and to provide an appropriate response. This gives officers a firm foundation to consistently make the best decisions for children.

The constabulary has increased resources in key areas. This shows a commitment to ensuring that the service children receive from the constabulary is responsive to the level of need and risk. Despite this, we found problems with capacity in some departments and teams. In some areas this is undermining the good work completed by the constabulary since the 2021 inspection. But it is positive that work is underway through the demand and capacity review to further consider how services can be implemented more efficiently. Work is also underway through Operation Olympus to improve the capacity and capability of investigative functions.

Initial contact

Recommendations from the 2021 inspection report

We recommend that Hampshire Constabulary immediately reviews its processes within the contact management centre, control room and resolution team. This is so it can make sure that:

- risk is regularly assessed when attending incidents is delayed; and
- only appropriate cases are dealt with over the phone.

We recommend that, within three months, Hampshire Constabulary acts to make sure that children's concerns and views are gathered and recorded. This includes noting their behaviour and demeanour.

Summary of post-inspection review findings

Contact management centre staff have received more training and there is better scrutiny of the way calls are dealt with. But the demand from calls for service is outstripping capacity. This means that incidents involving children are often delayed, which could put them at risk.

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

Detailed post-inspection review findings

Constabulary staff have received further training

Since the 2021 inspection, the constabulary has provided substantial levels of training to many of its staff, including the contact management centre. This has included child centred policing, the importance of the voice of the child (VOC), adverse childhood experiences and the submission of public protection notices (PPNs) – that is, how information about vulnerable people is recorded and shared with partner organisations. Where appropriate, partner organisations have been involved in providing and receiving the training.

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

Oversight of call handling has also improved through the control room quality assurance department. At least two calls per month from each call taker are reviewed. This includes consideration of their professional curiosity when taking details from callers. Feedback is given to individuals and their supervisor. Identified themes are included in briefings and training days. In most of the cases we reviewed, call takers and enquiry office staff had followed structured risk assessments and asked appropriate questions, for example, whether children were present at an incident.

There are delays in the constabulary attending and dealing with incidents involving children

The constabulary has a target to attend 75 percent of priority incidents within an hour. During the inspection, we found that this target wasn't being met. Only 54 percent of priority incidents were attended within an hour. However, to monitor and mitigate risk when attendance is delayed, the constabulary has introduced several processes. These include an escalation policy, a flexible resourcing approach and scrutiny applied through daily management meetings. And we did see supervisors within contact management monitoring incidents considering escalation to the force incident manager, and those managers reviewing incidents on occasion.

Despite this, we also saw numerous cases where response times weren't met, and evident risk wasn't being managed sufficiently. However, we did see, on some occasions, callers being recontacted to check if there had been any change or escalation in risk and to explain the delays.

Case study: delayed response to a domestic abuse incident

A 16-year-old boy reported that his mother had attacked him, and a fight developed as the child tried to defend himself. The child said that his mum has bi-polar disorder and hadn't been taking her medication for five months. At the time of our review, two days after the incident had been reported, the boy hadn't been seen and a PPN hadn't been completed.

When incidents are less urgent, the triage hub reviews them to decide who should deal with the incident. They refer some cases to the resolution centre if they can be dealt with over the phone. And they refer some to neighbourhood policing teams (NPTs).

But we also found that both the triage hub and resolution centre also faced high demand. During the inspection, staff in the triage hub were in the process of reviewing 400 incidents to assess how they should be dealt with. We reviewed 20 incidents from within this triage list. We found that the queue was generally well managed and of the 20 incidents only 2 were found to relate to children. But, in both cases, there was a delay before they were allocated.

The resolution centre had 696 open incidents; the oldest unallocated incident was 23 days old, and callers were waiting 5 days for initial contact. We reviewed 10 incidents from this list, 2 of which related to children. Despite the delays, we found that these cases were suitable to be dealt with over the phone and therefore did not require a police officer to be deployed. Staff were routinely monitoring queues to prioritise cases involving children. Following review, we also saw cases being returned for physical deployment as they weren't deemed suitable for telephone resolution. However, among the high number of incidents awaiting allocation, there is unknown risk as full enquiries have yet to commence. Delays in contacting callers to gather further details and submit PPNs means that information-sharing with partner organisations is delayed and children won't always get the help they need.

The constabulary has a focus on improving the recording of the voice of the child

The multi-agency PPN scrutiny group is a quarterly meeting chaired by the multi-agency safeguarding hub (MASH) chief inspector. Children's social care services, the youth offending team and health partners are represented. This forum is used to identify any organisational learning that might be needed and to consider how children have been dealt with. It is also used to identify whether children have been spoken to and observed, and considers how information has been recorded on PPNs. This is good practice and shows a keenness to work with partner organisations to improve outcomes for children.

The constabulary has introduced over 200 child-centred policing champions throughout the organisation. They have received extra child protection training from the wider workforce and are used to provide additional training to their colleagues.

They also conduct bi-monthly samples of child protection cases on a thematic basis. Subjects have included missing children and children present when premises are searched by the police. A feedback form for each case is shared with the officer concerned and their supervisor if appropriate. The child-centred policing team monitors the feedback and creates learning points from the areas identified, which informs future training opportunities. A report is produced with the findings from the scrutiny, and this is shared with senior officers and in a child-centred policing newsletter.

In the cases we examined during the inspection, we found an improvement in the quality of the recording of the voice of the child in PPNs

A continued focus on training and assurance should lead to further improvements to improve consistency in this area.

Assessment and help

Recommendations from the 2021 inspection report

We recommend that, within six months, Hampshire Constabulary works with its safeguarding partners to review its assessment and information-sharing practices. It needs to make sure that those responsible for making decisions have the skills they need, and that all relevant information is shared at the earliest opportunity when vulnerable children are involved.

We recommend that, within three months, Hampshire Constabulary improves its practices in relation to missing children. It needs to make sure that its response is consistently effective and appropriate to the risks identified to missing children.

Summary of post-inspection review findings

Staff within the MASHs have received more training and a dedicated training resource has been created. But backlogs of work mean there are some delays in risk assessing and sharing information with partner organisations.

There is an inconsistent response when children are reported missing. But we saw some good longer-term work when children are reported missing regularly.

Detailed post-inspection review findings

The constabulary has worked well with safeguarding partners following the 2021 inspection

There is good representation by the constabulary at an executive level at the four safeguarding children's boards. Findings from the 2021 inspection were shared with safeguarding partners, and findings from other inspections have also contributed to multi-agency improvement plans. As mentioned earlier, safeguarding partners have also been involved in developing and providing training to multi-agency workers to address areas for improvement.

Staff within the MASH have received more training aimed at improving information-sharing processes

The constabulary has introduced a dedicated training sergeant post within the MASH. All staff within the MASH have received vulnerability training, which includes a focus on the importance of PPNs, the recording of the voice of the child, and the effect of domestic abuse on children. They have also received risk assessment training. The training is refreshed annually for staff within the MASHs and ensures that they receive continuing professional development.

We found some delays in sharing information with partner organisations about the risk to children

During the inspection, we were told that PPNs relating to children at risk and high-risk domestic abuse are prioritised and reviewed within 24 hours. However, we found that this wasn't always the case.

Case study: a delay in reviewing a PPN indicating risk to children

During routine monitoring, it was discovered that a registered sex offender was having contact with his grandchildren. There was a delay of five days in submitting the PPN. But, when it was submitted, we found that a further five days later it hadn't been reviewed in the MASH and the information hadn't been shared with partner organisations. This had left these children potentially at risk.

There has been an increase of 13 percent in the submission of PPNs in the last year. This could be viewed as positive as it means that following the increased training received by officers and staff, they are better able to determine risk. However, the increase in PPN submissions has led to backlogs of PPNs waiting to be processed in the MASHs. During the inspection, we found 694 PPNs yet to be processed. We sampled 11 of these. All of them had children linked to the family. The oldest was received in a MASH 11 days earlier. This means that there is a considerable delay before research, secondary risk assessment and information-sharing processes are carried out. In domestic abuse cases, it means that for children affected by domestic abuse, information isn't shared via the Operation Encompass process as it is too late. Children have been left exposed to risk by these delays.

Strategy meetings aren't always requested when it would be appropriate to do so

Safeguarding co-ordinators in the MASH review PPNs and assess whether a strategy meeting may be required. In such cases, they escalate this to the MASH sergeants so that a strategy meeting can be requested. During our inspection, we found several cases where a strategy meeting should have been held, but this wasn't recognised by the safeguarding co-ordinators and the PPN was filed after sharing.

There is some dip sampling to test the quality of decision-making by the safeguarding co-ordinators but due to the current demand in the MASHs this hasn't been taking place as regularly as the constabulary would like. A review of quality assurance processes in this area would be beneficial.

But we did see, in the cases we looked at, good recording of decisions made at strategy and other multi-agency meetings, and the minutes were uploaded onto police systems. This means that information is visible to the wider workforce so that they can understand a child's current situation and make better decisions.

When children are reported missing from home or care there is often a delay in officers attending

When a child is reported missing through the control room, call takers complete a comprehensive assessment to determine how quickly the police should respond. As part of this process, police IT systems are checked to identify previous incidents and known risks relating to the child. Trigger plans are also viewed for children who are regularly missing and at high risk of harm. Following this assessment, the case is allocated to a response team to attend and complete the missing report.

The attending officer completes a missing person risk assessment, which is ratified by the officer's supervisors. But, in the cases we looked at, there was often a delay in officers attending to take the report and conduct the risk assessment. We saw delays of up to six hours. In the intervening period, we didn't see sufficient evidence of enquiries being conducted to find the children.

Following initial attendance, we found an inconsistent level of response to the missing person investigation

Children assessed to be at high risk had a much better service with an officer allocated to the case, regular reviews from supervisors and documented investigation plans. However, for children recorded as medium risk, we found, conversely, limited supervision and little activity generated to try to locate them. Missing children are discussed at the local daily management meetings. We observed one such meeting and saw that updates were given to a senior officer and resources allocated to a high-risk missing child. A strategy meeting with children's social care services was also requested. However, from the cases we have seen, it isn't clear that this oversight has improved the response in lower-risk cases.

When children are found or return home, officers attend and conduct a prevention interview. In the cases we looked at, we saw that PPNs had been completed and good detail was recorded, including the voice of the child. But we didn't see any evidence of information being updated in police systems following local authority independent return home interviews. Information from these could be vital in assessing risk and starting enquiries should the child be reported missing again.

We found some good work and innovation when children are regularly missing

When a child is identified as being particularly vulnerable and goes missing regularly, the missing, exploited, and trafficked team (METT) take responsibility for managing the case. Multi-agency monthly meetings are held, and risk management plans drawn up to try and mitigate the risks faced by these children. At the time of the inspection, we found that the 174 children in the METT cohort had risk management plans that were being updated regularly. This means that when they go missing again, officers know the current risks and where they should start looking for them. This is positive practice.

Operation Endeavour has been in place in Portsmouth and the Isle of Wight since 2021 and also began in Southampton in May 2022. When a child is reported missing the school that the child attends is notified (in a similar way to Operation Encompass in domestic abuse cases). This means that school staff are aware of the risks and can better support the child.

Investigation

Recommendation from the 2021 inspection report

We recommend that, within three months, Hampshire Constabulary improves its approach to investigations related to the exploitation and abuse of children via the internet. It is important to pay particular attention to:

- understanding the circumstances in which children share images of themselves;
- making better use of the intelligence system available to locate offenders;
- its risk assessment processes; and
- sharing information with safeguarding partners sooner when risk to children is known.

Summary of post-inspection review findings

The constabulary has improved its response to online child sexual abuse and exploitation (CSAE).

Detailed post-inspection review findings

The constabulary introduced an online images improvement plan in November 2021 with the aim of improving its response to CSAE.

The constabulary reviewed how they respond to incidents where children have shared images of themselves

The organisational learning development team audited CSAE cases that had been allocated to the resolution centre. Findings showed that resolution centre staff were speaking to the children in most cases and advice was given in all appropriate cases to delete the images from devices. But it was also found that wider risk to children and risk from perpetrators may be missed through this approach. We were told that the constabulary is considering whether a change in policy is required.

Although the number of cases allocated to the resolution centre is relatively small, approximately 25 a month, there is also a risk that this approach leads to delays. Invariably, the child will need to be seen in person to assess the information, potentially view and/or delete images from devices and submit a PPN. This means that the case will need to be allocated after the resolution centre have been involved, adding a delay. Children may not receive the help they need as soon as they should.

It is positive, however, that when a case is allocated to a non-specialist team for investigation, education or visit, detailed guidance is added to the investigation log by a detective sergeant in the specialist internet child abuse team (ICAT).

The ICAT provide an effective response to online CSAE

All referrals from the National Crime Agency, other forces and intelligence from peer-to-peer networks are updated in the Niche system in a timely way. This means that risk is visible to the wider workforce as research and attribution processes are being completed. KIRAT risk assessments are consistently used by intelligence staff in ICAT. Should further information come to light, risk will be reviewed and documented by supervision, meaning that any escalation in risk can be effectively dealt with.

The ICAT team are regularly using a peer-to-peer system to safeguard children and identify those who pose a risk to them. Staff within ICAT have been appropriately trained on the system and further training is planned for new members of the team. Backlogs that we had previously identified have been actioned.

In the cases we have looked at, we have seen effective processes in the ICAT team from initial research, to identifying suspects and addresses, the allocation of cases to the relevant team, the supervision, planning and execution of search warrants, the arrest of suspects and the conducting of child protection visits.

The constabulary has improved processes for the sharing of information in online CSAE cases

When a risk to a child is identified by the ICAT team, there are effective early information-sharing processes in place. An initial pilot in Southampton has now been rolled out throughout the other local authority areas. A PPN is submitted quickly, and we saw strategy meetings taking place to share information, decide on next steps and formulate safety plans. This was completed before the arrest of suspects. This is positive practice and rarely seen in other areas. This also shows the maturity of relationships with partner organisations throughout the county.

Case study: Effective information sharing and child safeguarding in an online CSAE case

The constabulary received information that indecent images of children had been uploaded to the internet by a Hampshire resident. A timely KIRAT risk assessment was conducted, which identified a medium risk. Research established that a two-year-old child lived at the address. A PPN was quickly submitted, and a strategy discussion requested. This took place the following day, with minutes and decisions uploaded to Niche.

The suspect was arrested the following day and a social worker attended to speak to the suspect's wife and child. There were good updates documented about the investigation and good supervisory oversight. The suspect was bailed with conditions to safeguard children while an assessment was conducted by children's social care services. The local authority designated officer was informed as it was discovered that the suspect's wife worked in a nursery. There has been continuous contact with the family's social worker and a copy of the safety plan is attached to Niche. The case was ongoing at the time of our inspection.

Managing those posing a risk to children

Recommendation from the 2021 inspection report

> We recommend that Hampshire Constabulary immediately reviews its MOSOVO arrangements and practices. It needs to make sure that the risk from offenders in the community is managed effectively.

Summary of post-inspection review findings

The management of offenders in the community has improved and there are better governance processes in place. But there are some backlogs of work in some areas.

Detailed post-inspection review findings

At the time of this inspection, there were 2,346 registered sex offenders (RSOs) in the community in Hampshire. The average number of RSOs each offender manager is managing is 60. But they also manage other types of offenders. This means that the average number is 80. The constabulary accepts that this figure is high, and recognises that reduced cohort sizes would provide greater capacity for intrusive offender management.

The management of RSOs in the community has improved

Following the 2021 inspection, the constabulary formulated a 28-day improvement plan to quickly respond to the findings and monitor the required improvements. This led to the creation of several standard operating procedures which have brought clarity to staff about what is expected of them. The intention is to provide a consistent service throughout the four teams in the constabulary, and we saw that this approach is working as practice has developed and improved.

We saw active risk management system assessments and risk management plans being well written with good details of the risks highlighted. Bespoke actions are recorded in most cases. The four pillars model (supervision, monitoring and control, interventions and treatment, victim safety) outlined in multi-agency public protection arrangements is being used for risk management plans and this adds structure and consistency. This is positive practice.

All visits to RSOs are double crewed and most are unannounced – which is in line with national policing practice. We saw that during their work, offender managers are considering wider safeguarding and are confident to intervene to safeguard children. However, we also saw that PPNs aren't always submitted in a timely way. And PPNs are rarely followed up with children's social care services to see what decisions have been made and what plans have been put in place to safeguard children. This means that the management of those offenders is then based on incomplete information.

Visits to the majority of newly convicted RSOs are conducted quickly, and before they are sentenced in applicable cases. This is good practice, and something not always seen in other forces. This means the risk from these RSOs can be managed quickly.

The recording of information about RSOs has also improved

There have been improvements made to the way that information about RSOs is recorded. The secure folders that were previously used are now read-only. The information in them can still be viewed by offender managers but can't be added to. A pragmatic decision was made at chief officer level to not place information from the secure folders onto other police data systems. While not ideal, this is reasonable in these circumstances. Officers are now using ViSOR as the primary system to record information. But we found that the quality of information recorded was inconsistent.

There are some backlogs of tasks relating to the management of RSOs

We found a backlog of 195 tasks waiting to be processed in the ViSOR hub. These include registration notifications, foreign travel notifications and offenders transferring in from other forces. This means that the records aren't up to date in these cases. We also found one case where an offender had been released from custody, but this wasn't updated in ViSOR. This means that the risk from these RSOs is unknown. We were told that this situation is improving, but more work needs to be done to clear the backlog.

There is also a backlog of 993 supervisor approval tasks in the ViSOR system. We were told that when sergeants are on leave or abstracted, their work isn't looked at in their absence. This will exacerbate the problem and this process should be reviewed and improved.

Performance management and quality assurance processes in the ViSOR team have been improved

Since the 2021 inspection, a comprehensive performance dashboard is produced monthly. This is complemented by regular fortnightly peer scrutiny of records by team managers and daily ViSOR team management meetings. While this is positive, further improvements could be made by considering more qualitative elements of the work.

Next steps

Hampshire Constabulary has made good progress in response to our 2021 recommendations. But the force recognises that it still needs to improve in some areas to provide consistently better outcomes for children.

We are, however, confident that the force understands where it needs to improve. We are also satisfied that senior leaders have plans to make these improvements and to monitor progress.

As part of our routine monitoring of all police forces, we will continue to evaluate Hampshire Constabulary's performance in relation to these recommendations and instigate closer scrutiny if necessary.

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