HMICFRS

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

National Child Protection Inspections

Hertfordshire Constabulary

2–13 September 2019

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 still 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 meeting their needs.

Protecting children is one of the most important things the police do. Police officers investigate suspected crimes involving children and arrest perpetrators, and they have a significant role in monitoring sex offenders. They can take a child in danger to a place of safety, and 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 wellbeing 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, 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 and Fire & Rescue Services (HMICFRS) 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 the police protect children and secure improvements for the future.

Contents

Summary

This report is a summary of the findings of our inspection of police child protection services in Hertfordshire, which took place in September 2019.

We examined the effectiveness of the decisions made by the police at each stage of their interactions with or for children – that is, those under 18 – from initial contact through to the investigation of offences against them. We also scrutinised the treatment of children in custody and assessed how the constabulary is structured, led and governed, in relation to its child protection services.[1]

Main findings from the inspection

We found that the chief constable, his senior team and the police and crime commissioner (PCC) are committed to protecting vulnerable people, including children. This is reflected in Everybody's Business, the PCC's community safety and criminal justice plan.

'Putting victims at the centre' is one of the plan's main themes. The way the police force is organised reflects this. Hertfordshire Constabulary has invested in a specialist command dedicated to child protection and safeguarding. Its strengths include an impressive collaboration with children's social care (CSC) services to form a multi-agency joint child protection investigation team (JCPIT), which is based at police headquarters.

Despite significant challenges in recruiting and retaining detectives, there are good staffing levels in the safeguarding command. Several specialist teams (sometimes called 'units') manage areas of risk including online offending, domestic abuse and offender management.

Throughout our inspection, we encountered highly motivated staff and managers who were working tirelessly to help children and disrupt those who were a risk to them. For example, senior leaders are working to improve the ways the constabulary manages risks to children and meets the increasing demand for child protection.

Safeguarding partner organisations told us about strong and effective joint working arrangements with the constabulary. Some are innovative. There is a clear intention to use problem-solving methods to deal with risk and vulnerability, rather than short-term interventions such as arresting offenders or relying on the criminal justice system.

[1] For more information on HMICFRS's rolling programme of child protection inspections, see our website.

The workforce is aware of the threat of organised crime, including county lines and exposure to gang activity. They work hard across teams and areas to disrupt and mitigate child exploitation of all types.

We also found examples of good work by frontline officers responding to incidents involving children. However, they often lacked experience or weren't fully trained.

Within the public protection unit (PPU) that deals with the management of registered sex offenders (RSOs) we found concerning backlogs in completing home visits, delays in updating risk management plans and inconsistent recording of information on offender management systems.

The case audits that formed part of this inspection highlight the need to improve some of the constabulary's responses to children in need of help and protection. The recognition of vulnerability and risk, even within specialist safeguarding teams, is inconsistent, and decisions to reduce risks to children aren't always made with enough information. Consequently, too many children remain at risk when opportunities to support them at an early stage are missed.

Specific areas for improvement include:

- speaking to children, particularly the very young, recording their behaviour and demeanour, and making sure their concerns and views are heard and inform decisions made about their welfare;
- considering the wider risks posed to children when they are missing or living in homes where domestic abuse features, to enhance protective planning;
- reducing delays in referrals to CSC and making sure that consideration is given to the presence of cumulative and repeat low-level risk;
- recognising that to neglect a child is a serious criminal offence in itself, but that the consequences of neglect mean that children are even more vulnerable to other forms of abuse and exploitation;
- supervising investigations more consistently to make sure opportunities are pursued and cases aren't unnecessarily delayed;
- reducing delays in holding strategy discussions and/or multi-agency management meetings, and recording the outcomes;
- making sure children aren't inappropriately kept in police detention or brought to police stations as a place of safety for prolonged periods; and
- supervising the management of RSOs so that risk is identified and mitigated by effective referrals and enforcement.

During our inspection, we examined 79 cases where the police had identified children at risk. We assessed the constabulary's child protection practice as good in 12 cases, as requiring improvement in 33 cases, and as inadequate in 34 cases. This shows that the constabulary needs to do more to make sure it provides a consistently good service for all children.

Conclusion

Hertfordshire Constabulary is clear in its commitment to protecting vulnerable children. It has established a safeguarding command with specialist capabilities to tackle those who are a risk to children and to investigate – with sensitivity – some of the most complex offences. The threat of gangs and county lines drug trafficking to children is understood and being tackled in innovative ways.

Senior leaders understand what safeguarding means. They have contributed to an effective multi-agency partnership that is well governed and enables the frontline workforce to work closely together to protect children.

Our inspection found that the officers and staff who manage demanding child abuse investigations are committed and dedicated. However, we have concerns about some aspects of child protection practice:

- the consistency of practice and decision making in child protection and safeguarding matters;
- the welfare of children while they are in police detention;
- the current processes for referring child protection concerns to the local authority;
- how the constabulary records the use of its powers for taking children into police protection; and
- an underdeveloped ability to recognise child neglect.

We were encouraged to note that the constabulary was recruiting more detectives and that a force-wide crime review is under way. This includes the safeguarding command working with partner organisations to improve the arrangements of multi-agency risk meetings for domestic abuse, missing children, and children at risk of exploitation.

We have made recommendations that will help improve outcomes for children if the constabulary acts on them. We will revisit Hertfordshire Constabulary no later than six months after the publication of this report to assess how it is responding to them.

1. Introduction

The police's responsibility to keep children safe

Under the Children Act 1989, a constable is responsible for taking into police protection any child whom they have reasonable cause to believe would otherwise be likely to suffer significant harm. The police have an additional duty to enquire into that child's case. They also have a duty, under the Children Act 2004, to ensure that when carrying out their functions they have regard to the need to safeguard and promote the welfare of children.

Every officer and member of police staff should understand that it is their duty to protect children as part of day-to-day policing. Officers going into people's homes for any policing matter must recognise the needs of the children they may meet, and understand what they can and should do to protect them. This is particularly important when they are dealing with domestic abuse or other incidents that may involve violence. The duty to protect children also covers children detained in police custody.

In 2018, the National Crime Agency's strategic assessment of serious and organised crime established that child sexual exploitation (CSE) and abuse is one of the highest serious and organised crime risks. Child sexual abuse is also one of the six national threats specified by the Home Secretary in the Strategic Policing Requirement.

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*, sets out what is expected of all partner agencies involved in child protection (such as the local authority, clinical commissioning groups, police, schools and the voluntary sector).

The specific police roles set out in the guidance are:

- identifying children who might be at risk from abuse and neglect;
- investigating 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 our child protection inspections.

2. Context for the force

Hertfordshire Constabulary has a workforce of approximately[2]:

- 2,025 police officers;
- 1,406 police staff;
- 214 police and community support officers (PCSOs).

The constabulary serves a population of approximately 1.18m people across a county area of 634 square miles.

The standard of living is mostly high, with low levels of unemployment and many workers commuting into the capital. However, there are areas of deprivation and social exclusion. As the cost of renting housing in London has risen, many vulnerable people have moved to the relatively less expensive towns in the county.

Organisation

The constabulary has a variety of specialist teams to direct and manage its response to various forms of threat, harm and risk:

- The domestic abuse investigation and safeguarding unit (DAISU) deals with domestic abuse and notifies partner organisations when children are thought to be vulnerable.
- The Halo team investigates serious and complex cases of child sexual exploitation.
- The child online safeguarding team (COST) investigates online child abuse images, working closely with the force's digital forensics investigation unit (DFIU).
- The missing persons unit (MPU) co-ordinates the response to children missing from home.
- The Locate team makes enquiries about children who are reported as missing from home.
- The JCPIT is a co-located team of police and social workers responsible for child abuse investigations. It manages child protection conferences and is responsible for assessing and sharing information to safeguard children via the constabulary's referral and multi-agency safeguarding hub (MASH).

The PPU manages high-risk offenders, including violent and sex offenders.

Outside these teams, the constabulary expects its workforce to respond to child protection and safeguarding demand as it arises.

[2] Figures accurate as of 13 September 2019.

Hertfordshire Constabulary has formed a strategic alliance with Bedfordshire Police and Cambridgeshire Constabulary called BCH. The three forces work closely together and share operational and support functions, such as training. This helps them meet the increasing demand from cross-border activity.

Hertfordshire has a two-tier local authority arrangement, with a county council and ten district councils. The constabulary maintains a strong local policing focus through ten community safety partnerships aligned to local authority areas. Each has dedicated neighbourhood, local response and crime teams supported by inter-agency partnership staff and centralised specialist support.

The police, along with CSC and the local clinical commissioning groups, are early adopters of the new statutory safeguarding arrangements[3]. The local safeguarding children board has been replaced by the Hertfordshire Safeguarding Children Partnership (HSCP).

The most recent Ofsted judgment of CSC services in Hertfordshire (15–19 October 2018) graded the overall effectiveness of services for children as **good**.

In May 2018, the force introduced the Athena information system to help manage investigations, intelligence, custody and case preparation.

The constabulary's specialist safeguarding command is responsible for:

- investigating crimes of neglect and abuse committed against vulnerable children and adults;
- managing serious and violent offenders;
- risk-assessing information for the protection and welfare of children; and
- working in partnership with other safeguarding agencies.

It faces particular safeguarding challenges related to the county and its geography. Hertfordshire's proximity to London and its extensive transport links make it an attractive place for drug suppliers. It is home to organised criminal gangs that are active in modern slavery, human trafficking and county lines crime. And the large number of homes for children in care, including many with roots in the London boroughs, increases the risk of criminal exploitation for some children.

[3] *Working Together to Safeguard Children 2018* sets out the guidance that transfers local safeguarding arrangements from local safeguarding children boards to three statutory safeguarding partners: the local authority, clinical commissioning group, and chief police officer.

3. Leadership, management and governance

The chief constable and senior leaders have invested in resources that prioritise safeguarding vulnerable people

Safeguarding vulnerable people is a priority for the chief constable and the PCC. In 2018, they invested substantially in providing additional staff for the safeguarding command, clarifying terms of responsibility for specialist units with clear lines of management responsibility.

Staff told us they believe senior leaders are committed and dedicated to raising the quality of child protection.

The deputy chief constable chairs the constabulary's organisational development board and strategic performance board, which have agendas that include a clear focus on safeguarding. A wider crime review, that includes the safeguarding command as well as future constabulary-wide demand, is also under way.

A monthly operational performance board, chaired by a detective chief superintendent, reviews the performance of the specialist units in the safeguarding command.

The constabulary uses information and data to align its resources and capability to meet safeguarding demand. For example, this has led to the creation of the children, young persons, schools and gangs (CYPSG) team, and recognition that the DFIU needs more investment. It uses national figures to benchmark and review its performance. It has also been able to identify local successes – for example, in the work of the Locate team.

Constabulary analysts recently completed a set of problem profiles to help police and partner organisations take a more strategic approach to tackling organised crime. There is a culture of multi-agency working with partner organisations to jointly understand demand and review performance. This activity is also helpful in identifying themes for training.

However, the constabulary isn't yet managing data and information in ways that provide the bigger picture of a situation or risk – for example, being able to see all of a child's vulnerabilities or reasons why they may have gone missing. This can result in delayed or missed opportunities to intervene when a child is at risk.

Existing safeguarding partnerships continue to develop

The constabulary contributes to and benefits from the HSCP, which is a highly effective new partnership with the local authority, NHS organisations and other agencies that work to safeguard children. Staff from other sectors spoke positively about working with the police and are eager for closer integration.

The early adoption of the new safeguarding arrangements at executive level is already successful. It has clearly been built on an existing, mature partnership that has support and appropriate challenge.

The new structure means that the three statutory safeguarding agencies – the police, NHS (through Hertfordshire's clinical commissioning groups) and local authority (through CSC services) – annually rotate chairing responsibility for the executive group. These arrangements are subject to review and challenge from an independent scrutineer.

The partnership maintains a safeguarding procedures manual that is regularly updated and available online to their workforce.

The constabulary has appropriate representation on various partnership groups. It also participates in operational groups that focus on high risk, vulnerability and intervention, such as the multi-agency risk management (MARM)[4] meetings and the sexual exploitation and runaway children (SEARCH) meeting.

The director and senior managers of CSC, and the independent scrutineer, spoke highly of the constabulary's contribution and engagement at all levels to the safeguarding arrangements for children in Hertfordshire. They reflected that the existing relationship encouraged open dialogue, including constructive challenge. They also mentioned improvements that had been made – for example, finding appropriate alternative accommodation for children held in police detention before a court appearance.

The constabulary is committed to increasing the number of detectives it has available to investigate child abuse

Police leaders are aware of difficulties in recruiting and retaining staff for specialist investigation roles. This is a national problem and a priority concern for managers with safeguarding responsibilities. There is currently a shortfall of approximately 130 trained detectives across the constabulary, which is affecting safeguarding units.

The constabulary is managing the situation by placing trainee detective constables and police constables in detective roles within investigation units.

[4] MARMs are multi-agency risk management meetings that are convened by children's services when a child or young person is missing, at risk of repeated missing episodes, subject to exploitation or vulnerable to exploitation. They are attended by the police, a children services practitioner and their manager and any other professionals involved. Roles, responsibilities and actions are agreed to strengthen risk management planning.

There is a recruitment drive for detective transferees. Since May 2018, 25 officers have joined the constabulary through the accelerated detective programme. It is hoped that this will become a mainstream pathway into the organisation, with the recruitment of two more cohorts planned.

Training is inconsistent and doesn't always support the constabulary's priorities

Managers and staff told us that, despite the force's training ambition, officers were placed in specialist roles without being trained – sometimes for long periods. Senior leaders recognised that continuous professional development (CPD) was desirable for their staff to maintain and develop their skills. Shift patterns have been reviewed to build in regular development days. However, teams often choose their own training courses and activity, which don't always focus on the constabulary's priorities.

Staff from specialist safeguarding units told us it was an important part of their role to provide CPD training for the wider force and its partner organisations. However, the approach in Hertfordshire is often ad hoc and not centrally co-ordinated.

Supervisors of specialist safeguarding teams are mostly high-ranking and had been trained. However, frontline personnel in a variety of roles told us that it was commonplace for relatively 'young-in-service' officers to carry out supervisory responsibilities without any training. Such training is often delayed until a selection process had been passed. These young and/or untrained officers told us they would seek advice from the specialist safeguarding teams such as the domestic abuse investigation and safeguarding unit if they felt it necessary.

Some officers have received vulnerability training as part of their initial training or CPD. They know that safeguarding children is a constabulary priority and have been trained to use body-worn video (BWV) when attending domestic abuse incidents to record evidence and the voice of the child.

Leaders and managers support workforce health and wellbeing

The constabulary's issue register includes the mental health wellbeing and welfare of staff in the safeguarding command. The constabulary recognises that those working in the public protection and safeguarding arena are repeatedly exposed to high levels of emotional, psychological and physical risk. The nature of the work, along with increasing demand and complexity, places extraordinary pressures on them.

Managers consider the risk in Hertfordshire is made greater by a lack of trained detectives and high numbers of inexperienced staff on safeguarding teams. They aren't able to introduce time limits or tenure to high-risk posts.

The constabulary has its own occupational health and wellbeing service. It publicises support groups and a chaplaincy service to its workforce. All safeguarding units have wellbeing champions, and CPD events include wellbeing days.

Staff told us they found their work challenging and sometimes stressful. They acknowledged the constabulary's interest in their wellbeing, but not all were convinced they could access help before reaching a crisis. Some had returned an annual health questionnaire in which they asked for support and hadn't received a reply. Others spoke positively about their experience of cognitive coaching, which is available to support staff in various ranks and roles when line managers or the constabulary psychologist think it might be of benefit.

Recommendation

We recommend that, within three months, Hertfordshire Constabulary should carry out a skills audit to assess the training required for those undertaking specialist child protection work with no previous detective or child protection experience.

4. Case file analysis

Results of case file reviews

For our inspection, Hertfordshire Constabulary selected and self-assessed the effectiveness of its practice in 33 child protection cases. In accordance with our criteria, the cases selected were a random sample from across the county.

Of these 33 cases, constabulary assessors graded the practice in 28 as good, in five as requiring improvement and in none as inadequate. We assessed the same cases. We graded the constabulary's practice in six as good, in 15 as requiring improvement and in 12 as inadequate.

Cases assessed by both Hertfordshire Constabulary and HMICFRS

Constabulary assessment:

- 28 good
- 5 requiring improvement
- 0 inadequate.

HMICFRS assessment:

- 6 good
- 16 requiring improvement
- 11 inadequate.

Additional 46 cases assessed only by HMICFRS

HMICFRS assessment:

- 6 good
- 17 requiring improvement
- 23 inadequate.

There was a significant difference in the gradings given by the constabulary in its self-audits and the same audits completed by our inspection team. Our audits identified many more cases where investigations required improvement or were inadequate.

Our analysis of the difference in grading considers evidence from all the case subject areas. The constabulary auditors focused only on initial response, supervision and process. We also considered:

- safeguarding activity beyond the immediate risks or incident;
- timeliness of partnership engagement;
- the effectiveness of continuous supervision; and
- the outcomes for children.

Of the 79 cases assessed, we referred 11 back to the constabulary, because our analysis of the evidence in its records was that there remained serious problems. Examples included failures to make sure children were being protected by police or partner agency activity, or where it appeared that a child might still be at risk of significant harm from an offender because there hadn't been a meaningful intervention.

The constabulary responded to all of our referrals. Senior managers reviewed the cases, updated risk assessments and/or acted to resolve the problems highlighted.

Breakdown of case file audit results by area of child protection

Cases assessed involving enquiries under section 47 of the Children Act 1989[5]

- 4 good
- 2 requiring improvement
- 6 inadequate.

Common themes include:

- evidence of joint visits and initial action in cases; but
- poor recognition of the voice of the child;
- inconsistent recognition of neglect;
- inconsistent records of further working with other authorities once a case was past its initial stage, or what the outcomes were; and
- missing wider safeguarding concerns for other children.

Cases assessed involving referrals relating to domestic abuse incidents or crimes

- 2 good
- 4 requiring improvement
- 4 inadequate.

[5] 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.

Common themes include:

- good recognition and initial direction from the force control room (FCR);
- consistent use of BWV at scenes, although the voice of the child wasn't consistently sought or recorded during investigations;
- child neglect not being recognised frequently enough in domestic abuse incidents;
- referrals for children affected by domestic abuse being frequently delayed or missed; and
- supervision beyond initial investigation stages being inconsistent and not always setting clear plans to prioritise crime investigation or progress safeguarding activity.

Cases assessed involving referrals arising from incidents other than domestic abuse

- 2 good
- 5 requiring improvement
- 2 inadequate.

Common themes include:

- the constabulary responding well initially when contact is through the FCR; but
- the voice of the child and wider safeguarding issues not always being considered;
- limited and sometimes ineffective supervisory oversight; and
- frequent unnecessary delays in investigations.

Cases assessed involving children at risk from child sexual exploitation

- 2 good
- 2 requiring improvement
- 12 inadequate.

Common themes include:

- a usually good initial response, but wider risks and safeguarding activities not always being identified;
- some evidence of effective joint working but, in many cases, referrals being delayed and not supporting joint planning for proactivity;
- strategy meetings not always being held;
- actions and plans not always being recorded on police records;
- risks to other children not always being considered;
- the child's voice not being clear enough within records;
- a lack of effective supervision of cases, leading to drift and delay; and
- enquiries to identify and locate potential perpetrators sometimes being overlooked, and the consequences of delays not being considered in strategy meetings.

Cases assessed involving missing and absent children

- 1 good
- 7 requiring improvement
- 3 inadequate.

Common themes include:

- the FCR consistently using THRIVE to assess and grade the risk to a child;
- information from the constabulary's records being available to initial responders to help them locate missing children;
- the FCR risk assessments being accurate; but
- some initial frontline response being delayed or superficial, awaiting assistance from specialists;
- the voice of the child being inconsistently sought and recorded by responding officers;
- supervision of activity and records being inconsistent; and
- frontline officers and supervisors not always fully understanding the risk of being missing in increasing child vulnerability, and gathering intelligence to help in reducing that risk.

Cases assessed involving children taken to a place of safety under section 46 of the Children Act 1989[6]

- 0 good
- 6 requiring improvement
- 0 inadequate.

Common themes include:

- responding officers considering the circumstances of vulnerable children and making effective decisions to remove children with appropriate use of section 46 powers; and liaising well with emergency CSC services; but
- officers not always holding strategy discussions or recording outcomes and joint plans;
- officers sometimes inappropriately using police stations as places of safety; and
- inspectors not consistently supervising cases or recording the end of the use of section 46 powers.

[6] Section 46(1) of the Children Act 1989 empowers a police officer who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm to (a) remove the child to suitable accommodation and keep him/her there, or (b) take such steps as are reasonable to ensure that the child's removal from any hospital, or other place in which he/she is then being accommodated, is prevented. A child in these circumstances is referred to as 'having been taken into police protection'.

Cases assessed involving sex offender management in which children have been assessed as at risk from the person being managed

- 1 good
- 3 requiring improvement
- 5 inadequate.

Common themes include:

- supervision often being superficial and not sufficiently directing investigations;
- risk to children and vulnerable adults not being consistently identified and recorded;
- referrals to safeguarding partner organisations being delayed and insufficient; and
- wanted offenders not being appropriately risk assessed or sufficiently prioritised.

Cases assessed involving children detained in police custody

- 0 good
- 5 requiring improvement
- 1 inadequate.

Common themes include:

- custody records being inconsistently completed and not always updated with relevant information;
- custody staff not always fully understanding their responsibility to seek appropriate alternative accommodation for detained children;
- not all staff in the custody suite environment being aware of their responsibility towards detained children;
- the attendance of appropriate adults at the custody suite being timed to coincide with other events, such as interviews, rather than to promote the welfare of the detained child; and
- some confusion and inconsistency about who is responsible for submitting referrals about children's vulnerability when they are arrested.

5. Initial contact

The constabulary has effective systems in its control room to identify risk and prioritise its response to the most vulnerable

Hertfordshire Constabulary has invested in its control room and trained its staff to complete THRIVE risk assessments and recognise vulnerability. It responds in a timely and appropriate way to calls when there is high risk.

Police intelligence systems provide information to officers assigned to incidents. This information is passed on in a timely way and assists in identifying vulnerable people. The constabulary's systems are regularly updated so that the addresses of children subject to child protection plans and those of repeat sex offenders are flagged up on Athena to alert operational staff and officers.

When the constabulary and its safeguarding partner organisations find that children in care from other areas are being placed in accommodation and care homes in Hertfordshire, they write to the local authorities that place them. They ask for information about the children to add to police intelligence systems to help staff attending any incidents.

Other prompts and flags on police systems remind officers to activate BWV when responding to domestic abuse incidents, and to capture the voice of the child where there are concerns for their safety.

There is good supervision in the FCR. Supervisors routinely dip-sample incident logs to satisfy themselves that responses are timely and appropriate. The FCR also identifies to responding officers any incidents where concerns for children's welfare and safety should be recorded and referred to other agencies.

The incident resolution team (IRT) and the investigation management unit (IMU) resolve outstanding cases in the FCR. They assess call recordings to decide on the most appropriate police response or referral to other services. However, cases can stay with them for prolonged periods and their supervision process doesn't always recognise high risk.

A teacher of a 15-year-old girl reported that the child had been asked to send indecent images of herself and videos of herself engaging in sexual acts via her phone. The suspect had sent the victim indecent images of himself and became abusive when she refused to do the same. He was believed to be in contact with other children.

The incident wasn't investigated for over a month. No safeguarding referral was made.

The constabulary has robust systems to record allegations of crime and update its intelligence records

The IMU has an important role in identifying allegations of crime. Where children are involved in cases that won't be investigated by specialists, the unit notifies the safeguarding command to 'register an interest'. This means that referrals to CSC for children in non-specialist safeguarding situations are also progressed.

Incidents should be dealt with within 24 hours. A supervisor completes daily searches for incidents involving the most serious crimes and related to child protection, and prioritises them. On the day of our visit, the IMU workload was 382 incidents, of which only three were child protection incidents (all three were within the past 24 hours). This indicates that the workforce effectively recognises and prioritises child protection incidents.

The constabulary recognises the vulnerability of those suffering from mental ill health and provides an emergency triage service

The constabulary and its health service partner organisations provide an emergency response mental health triage service. Although the service is primarily focused on adult mental health, it also attends and assists with advice when a child needs help.

Despite some good practice, the overall response to missing children is inconsistent

The initial response for children missing from home, directed by the FCR risk assessment, is good. Frontline staff go to COMPACT, a police database containing information on missing people, and the force intelligence system for information that will help find a child. This process is known as devising a trigger plan. The MPU has oversight of all children reported missing, and once the child is located, works with them to develop a problem-solving plan to reduce their risk and protect them from harm.

Children reported missing are risk assessed and assigned a minimum risk grading of medium. We are encouraged that the constabulary recognises that all missing children are vulnerable and doesn't use an 'absent' or 'no apparent risk' category to manage demand.

Missing person investigations are allocated to individual officers to action. However, demand can dictate whether these cases get an appropriate response (although high-risk missing children are prioritised). Frontline officers told us they were aware of the vulnerability of children reported missing, but their ability to respond appropriately is sometimes hampered by other demands. Supervisory direction doesn't always focus on missing children.

An 11-year-old boy, who had previously been reported to police as missing, had been told him to come home by 9pm and was reported missing by his mother at 10.30pm. He told her he was staying with a friend and didn't return home.

His mother told police that he had been spending time with a group of older children. She also said that he was being bullied, had attempted self-harm, was eager to please and easily led, and was at risk of being brought into a gang. She gave a name and an address of where he could be.

Despite this information being recorded on the force system, officers only searched the area in which the boy was found the last time he went missing. At 5.25am the following morning, the COMPACT record was endorsed by a supervisor as follows: "Although the subject is 11 years old, he is relatively streetwise for his age".

At 9.15am, police eventually visited the address the child's mother had provided and found him safe and well.

Neighbours of a nine-year-old boy called the police with concerns about his welfare. They said his mother and her partner appeared intoxicated.

The FCR assigned officers to check on the child's welfare.

Initially, the officers found it difficult to gain access to the house. Once inside, the parents were obstructive and abusive, and officers found evidence they had been using illegal drugs. They saw the boy and noted that he appeared scared. However, they decided he wasn't at immediate risk and left him at the house.

They didn't record the child's voice or any other information about his demeanour on the report. They did state that there was possible neglect, which might have been emotional or physical. No further investigation took place and the incident was closed with a referral to CSC.

The Locate team is also notified, along with frontline staff and the MPU, when a child is reported as missing.

Frontline officers praised the staff on the Locate team, saying they provide excellent support and are skilled in establishing successful lines of enquiry to find children.

Officers should hold intervention interviews with missing children when they return home. MPU staff told us that the quality of these interviews was inconsistent because officers didn't always find ways to engage with a child, observe their demeanour or record their voice. They said the interviews remained superficial, even though they regularly advised officers' teams on how to interview children. Officers are therefore missing opportunities to engage, obtain intelligence and provide children with the environment and support to disclose abuse or crime.

The constabulary undertakes some good work to protect newly arrived migrant children

The constabulary recognises that the number of unaccompanied migrant children arriving in its area is increasing. Children are going missing before they can be fully assessed and protected with safeguarding interventions.

The MPU worked with local and national partner organisations, such as the Border Agency, to develop a standard operating procedure to guide staff dealing with these children. Guidance includes the use of a specially designed migrant CYP pack to take biometric details from a child, to reduce lengthy missing persons investigations should they go missing.

While this operating procedure has been in effect, there have been no reports of missing migrant children in Hertfordshire.

The constabulary recognises that it needs to tackle child criminal exploitation more holistically

Frontline staff told us that they were aware of the county lines issues affecting their local areas and felt able to recognise and respond to child protection risks. They described their approach as prioritising safeguarding, rather than focusing on criminal issues. Their briefings refer to individuals at risk who may need reassurance, rather than targets for police action. Officers use their knowledge to patrol places where those at risk were regularly seen, as hotspot information relevant to child sexual and criminal exploitation isn't provided in their briefings.

Despite the efforts of the partnership and senior leaders, frontline staff said that local officers weren't routinely informed about the risks when children vulnerable to London gangs were placed in local care homes. It is only when called to deal with incidents – for example, a missing child – that they get to know. Those officers believed the constabulary had more to learn about the implications of organised and cross-border crime and that intelligence briefings could be further developed to help them tackle the problem more effectively.

Intervention officers understood when to complete a safeguarding referral for children, although they were less clear about the need to make referrals for children suspected of committing crimes. For those who are vulnerable to child criminal exploitation, involvement in crime is often simultaneous with being a victim of crime.

The constabulary recognises there is more to do to fully embed frontline understanding of vulnerability and risk, particularly that associated with child criminal and sexual exploitation. It is developing its approach internally through new units such as the CYPSG team. It is also working with partner organisations to fund external capability, including the St Giles Trust, which works with schools and young people.

The CYPSG team works with internal and external partners to help reduce threat, harm and risk from serious violence, gangs, county lines and all forms of criminal exploitation. The team provides an important link between police operations and targeted youth support workers from CSC.

Officers receive no feedback on the quality of their child safeguarding referrals or the outcomes for the child

Frontline officers advised that they routinely made safeguarding referrals using the child protection referral template on Athena. However, they never received feedback about the quality of their referrals or information on the outcomes for children. This is concerning. Without feedback, the constabulary cannot demonstrate that it has a learning culture or let its staff know when they have completed good work.

The workforce has been trained to capture the voice of the child, but there is inconsistency in how it deals with children affected by domestic abuse

A child's behaviour provides important information about how an incident has affected them. This is especially true when they are too young to speak to officers, or where having a parent present might present a risk. The police should carefully observe a child's behaviour and demeanour to inform their initial assessment of the child's needs. Additional training to reinforce the importance of capturing the voice of the child at incidents, especially those where domestic abuse is a concern, has been provided.

Officers told us they understood their role at domestic abuse incidents to deal with everyone present and support children's welfare. Those we spoke to had a good understanding of the need to consider children's circumstances by speaking to them alone, waking them if necessary and considering their emotional response to the presence of police.

The domestic abuse, stalking, harassment and honour-based violence (DASH) risk assessment reminds officers to capture the voice of the child. Constabulary control room staff also remind them to use BWV when attending incidents. The constabulary had invested in promotional material to emphasise the benefits of using BWV as part of its 'make a movie' campaign.

Police were called to a family home by a neighbour who heard shouting and screaming. A female was saying, “Stop hitting the kids!” The caller told the FCR force control room that four children aged between 12 and five lived there.

The police attended promptly. They recorded that they spoke with the male, female and children, but no offences were disclosed. The male left the premises.

Despite speaking to the children, no record of what they said or their demeanour was added to the report. The officers recorded their check of the house – it was extremely untidy, the fridge didn’t work, there was very little food and the children’s bedrooms were a mess. There were old dog faeces next to a child’s bed.

No rationale was given as to why it was felt safe for the children to stay in that environment, even though there had been a previous domestic abuse incident and there were signs of neglect. The constabulary had no record of any referral being made to other agencies to consider the wider risks to the children in the household.

A man reported a domestic incident between himself and his female ex-partner. Police attended the address promptly and the officers saw two girls aged about nine. No offences were disclosed and it was agreed that he could leave, taking both girls with him.

The officers didn’t enter and check the premises or speak with the girls. They did submit a DASH assessment. However, this only contained the details of one child. A referral was made to CSC five days later, but supervision by domestic abuse investigation support didn’t identify the safeguarding omissions and that the referral was for only one child.

Consideration of risks to these children was delayed and clear signs of vulnerability were missed.

Athena records told us that officers routinely used BWV but weren’t including the voice of the child in their reports. These omissions should be identified by supervisors at the frontline or in the DAISU, and corrective action taken. The lack of supervisory activity in many of the cases we saw meant that reports that did capture the voice of the child didn’t do so effectively.

Recommendation

We recommend that, within three months, Hertfordshire Constabulary should make sure that children’s concerns and views are obtained and recorded, including noting their behaviour and demeanour. This will help influence decisions made about them.

6. Assessment and help

The constabulary's referrals processes are inconsistent and don't always identify risk in a timely way

Hertfordshire Constabulary has established two main channels to refer concerns about vulnerable people to partner agencies:

- via the referral's hub; and
- the domestic abuse referral team (DART).

The referrals hub, part of the JCPIT, is linked to the local authority-based MASH. Staff in the hub supervise and assess referrals about risk and vulnerability to children before passing them to other agencies:

- open case referrals are passed directly to the social worker managing them; and
- all other referrals below the level of high risk are sent from the hub to the MASH without further research or additional assessment of the child's needs and risk.

In high-risk cases, or where there are concerns about child protection, the hub researcher has a strategy discussion with the JCPIT's CSC manager. For other incidents, they transfer the referral with some basic information from local police systems on to a new referral form (the first referral form differs slightly) using an automated function within the Athena system that passes the referral to the MASH.

The DART, part of the DAISU, receives all the DASH reports. Officers submitting DASH reports assess incidents as high, medium or standard-risk. DART staff review each report against referral threshold criteria agreed with CSC. Standard and medium-risk incidents aren't referred on unless certain additional criteria apply.

Managers told us that these referral criteria are in place because of local authority 'front door' arrangements (the initial contact and assessment local authorities make when professionals or members of the public notify them with concerns), and the MASH's capacity to manage all police notifications about children.

DART staff complete limited local research on police systems before making referrals. The absence of comprehensive intelligence research on cases that meet the threshold for referral means the current system is inherently weak, with delays in identifying risks to children who may continue to be exposed to harm. For example, the effects of cumulative risk for a child who lives in a household where there have been repeated incidents of domestic abuse or concerns of neglect that were individually reported as low-level.

There is a backlog of approximately 900 standard-risk DASH referrals awaiting review. We were told that police and CSC managers dip-sample cases to satisfy themselves that those where children are at risk aren't overlooked by the current practice.

We reviewed ten standard-risk domestic abuse cases, dated 11–14 July 2019, from the DART backlog. Children were linked to eight of these incidents (80 percent). Of these, three (30 percent) were eventually shared with CSC. The DART review for all the cases was delayed by at least eight weeks, meaning that the risk for children was left unassessed during this time.

We sampled another ten standard and ten medium-risk cases that hadn't been reviewed. These were cases where children had been affected by an incident but were unlikely to be referred using the current DART threshold policy. We considered the children would potentially benefit from a referral being made in three of the standard and five of the medium-risk cases.

We found that in 40 percent of the 20 cases we sampled, children would have benefited from a referral to CSC.

The threshold that is currently applied to decide if a domestic abuse referral is shared with CSC means that, for a large group of children, risk is unassessed and potentially unaddressed.

MASH referral pathways for police information are inefficient

Two members of police staff are co-located within Hertfordshire's MASH. All referrals are reviewed by a social work manager to determine if further information and analysis are needed. Cases 'open to' social workers are sent directly without delay, bypassing this system. Once the CSC MASH staff have reviewed a police referral, these referrals are either completed on the local authority system or the MASH manager requests additional information from the police and other agencies.

The police MASH function is to research referrals sent to it by the MASH manager. Some of this research will be on information previously referred on by police officers, but without comprehensive research or assessment of information beyond the incident prompting the referral. This MASH-generated research can often be carried out a long time after the initial presentation of risk, meaning that vital information on police systems isn't always available to support timely safeguarding interventions.

The constabulary doesn't have any process in place or data by which safeguarding managers can identify repeat victims, perpetrators or locations. Assessing the effect on children of escalating and cumulative risks is undermined by this omission. Children can suffer significant trauma from exposure to standard-risk domestic abuse. An effective police response requires the ability to identify these situations and escalate safeguarding activity without delay.

Clear information on numbers of referrals, and referrals related to investigations, wasn't readily accessible to safeguarding managers. We were told Athena recorded that 542 referrals were made, but this information was only for cases that hadn't been closed. The total number of JCPIT investigations for the same period was 1,774, but it was known that some of those investigations wouldn't have an associated referral.

This situation means that managers weren't fully aware of the volume of work that safeguarding teams were dealing with. And adjustments to staffing levels to prevent or reduce backlogs were only made once these reached high levels. An example of this was in the arrangements to inform schools of children affected by high-risk domestic abuse.

The HSCP informs schools when police find their pupils in a household where domestic abuse is assessed as high or medium-risk. The referrals are intended to benefit children by providing school staff with timely information to help safeguard and support them.

The agreed process is for the police to identify the incidents and pass referrals to the MASH. The MASH then identifies the child's school and shares relevant details with the school's safeguarding contact. However, 149 of these referrals hadn't been made to the MASH at the end of the 2019 summer term.

Some other referral pathways are in use and feedback about outcomes of referrals isn't routinely provided

Some units have retained or created ways of passing information for the purposes of safeguarding or promoting a child's welfare outside the constabulary's referrals hub. For example, the CYPSG team, and sometimes the specialist child sexual exploitation Halo team, pass and receive referral information by email. We were told this practice had arisen due to a previous difficulty with using the Athena system for referrals. This has now been rectified. The use of these additional pathways introduces potential gaps in the constabulary's intelligence records, with the possibility that subsequent risk assessments and decisions will be less effective owing to missing information.

We were consistently told by staff across various roles and teams that they never received feedback about the safeguarding referrals they made. This meant that staff who took responsibility for notifying safeguarding concerns were never updated with outcomes for the children or encouraged to submit further information. The implication is that some of the context of vulnerability and risk in referrals remains unknown to the constabulary, and feedback isn't being used to guide and improve future responses.

The constabulary reviews and continues to develop the arrangements that support those affected by domestic abuse

The constabulary recognises that vulnerable adults and children are at high risk from domestic abuse. It also recognises the linked issues of stalking, harassment and so-called honour-based violence, including forced marriage. It has invested in the DAISU, a central resource to investigate and co-ordinate activity to tackle such abuse.

The DAISU has a dedicated multi-agency risk assessment conference (MARAC) team. We spoke with them and reviewed ten sets of MARAC minutes, for meetings held during July and August 2019.

Meetings were held monthly and chaired by the MARAC manager from Hertfordshire police, with generally good attendance and contribution from a wide range of agencies. The actions raised were meaningful and based on risk, with due consideration to the impact on children within a family. The number of cases

discussed varied depending on the area, ranging between a manageable ten and an excessive 27.

The frequency of MARAC meetings and the number of cases mean there are sometimes delays before a case is considered. When this happens, the risks to children can be overlooked if the focus of the referral is on the adults. This is particularly so when repeated incidents aren't considered together during assessment, and cumulative risk is neither considered nor addressed, as we saw in some cases in the DART backlog.

The timeliness of MARACs has been recognised as a risk and the partnership has agreed to start a pilot of fortnightly meetings from October 2019.

Not all DAISU officers attend MARACs and those who don't were unable to access the meeting records relevant to the cases they were investigating. This meant they were unaware of safeguarding actions agreed at MARAC and, without this information, were operating in isolation. Managers acknowledged this was the case and stated an intention to immediately change their practice so relevant safeguarding information from MARAC was available on Athena.

Effective safeguarding activity is in place to deal with domestic abuse risk

The specialist safeguarding unit manages the safeguarding of domestic abuse victims and their children. There is no backlog in its management of the domestic violence disclosure scheme (DVDS), which is also known as Clare's Law. We dip-sampled DVDS records and found evidence of good safeguarding practice and excellent supervisory decision making.

The constabulary is also proactive in its use of domestic violence prevention notices (DVPNs) and domestic violence prevention orders (DVPOs). The specialist safeguarding unit operates a robust system that maintains contact with victims throughout the lifetime of a DVPO, reassuring them and reacting promptly to any breaches by the offender.

A multi-agency risk assessment tool is used to identify children's vulnerability to sexual exploitation, but staff have concerns about its accuracy

Officers within the specialist Halo team dealing with child sexual exploitation use a scored risk assessment tool that is available to all staff. The risk assessment is attached to a child's record on Athena as a child sexual exploitation tracker. Information from partner agencies is gathered and included on the record to create a risk level based on an overall score.

However, the risk score may not represent the real level of risk because operational activity may not be focused enough on the children at highest risk. The child sexual exploitation tracker wasn't used to select the high-risk cases that are managed by the SEARCH panel. Staff told us that, although the tool was useful, they felt it could be improved. Managers had commenced a review of its format and use – to include,

for example, the use of professional judgment to determine case management, particularly when a child's circumstances changed or interventions mitigated risk.

Halo's child sexual exploitation co-ordinator works with schools, taxi firms, hotels, football clubs and other organisations in which there is a risk of sexual exploitation. This activity is linked to a Halo-branded campaign: 'Say something if you see something'. There is a calendar of campaign activity to reinforce messages. Work has started on the next message – 'positions of trust' – in conjunction with the local authority and national sporting organisations including the Football Association and British Gymnastics.

Community safety partnerships tackle the exploitation of children, but activity isn't fully co-ordinated across Hertfordshire

Managers and staff of various ranks and roles were unaware of any overarching county-wide plan to co-ordinate activity to tackle child sexual and criminal exploitation. Halo staff recognised that more work is needed across the ten community safety partnerships in Hertfordshire to raise awareness about child protection.

One of the community safety partnerships is planning a pilot to tackle gangs and those who are identified as a risk to vulnerable children. The plan would benefit from a clear reference to the current Hertfordshire child sexual and criminal exploitation profile. For example, including detail about targeting, disruption and investigation in the context of the local and wider areas would help frontline officers and their safeguarding partner organisations co-ordinate and evaluate their work.

A good example of how to raise awareness in the community is the CYPSG work on the 'Lives not knives' campaign. This is more structured and benefits from regular senior leadership oversight.

The Halo team benefits from working closely with specialist professionals and having strong multi-agency links

The constabulary and its partner organisations have implemented a contextual safeguarding[7] approach to meet the needs of children at risk of sexual and criminal exploitation. They believe it is a more appropriate way to engage with children than the statutory Children Act practices. This means that instead of convening strategy discussions that may lead to section 47 investigations, and initial child protection conferences that may result in a child protection plan (CPP), they hold 'professionals meetings' in which they assess information and co-ordinate activity to protect the child.

[7] Contextual safeguarding is an approach to understanding and responding to young people's experiences of significant harm beyond their families. It recognises that the different relationships young people form in their neighbourhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships.

Halo officers participate in these meetings with professionals from other agencies, including mental health specialists and those who care for children. The team is also supported by specialists including independent sexual violence advisers, missing persons support organisations and school pastoral staff.

These meetings are essential to protect children at high risk. Often, they don't understand their own vulnerability. A feature of county lines is that criminals will coerce and traffic children into drug supply or sexual activities. In these circumstances, the police and partner organisations are aware that they must balance the need to tackle criminal activity and to promote the welfare of every child. They don't want to criminalise vulnerable children.

The assessment of risk and its discussion in professionals meetings can lead to proactive and disruptive activity. We saw that child abduction warning notices (CAWNs) are used appropriately – 21 were issued between January and August 2019 that resulted in arrests for child abduction. Halo officers also consider and use sexual harm prevention orders (SHPOs) and other legal measures to reduce vulnerability and offending opportunities.

Each month, police and CSC managers meet the missing-from-home co-ordinator to decide which children will benefit most from inclusion at the monthly SEARCH panel. The children discussed are those who have the greatest vulnerabilities and are considered at the highest level of risk.

The police also join MARM meetings, which can be attended by the parents, key worker, social worker, school staff, and occasionally, a representative from child and adolescent mental health services. These meetings are usually held for children considered as vulnerable but below the level of risk for a SEARCH panel. They are operationally focused to establish plans to safeguard individual children. They focus on information sharing and resourcing, rather than identifying perpetrators, hotspots and community disruptions.

As well as close working with youth justice workers, the police also make referrals to the National Referral Mechanism when they identify a potential victim of modern slavery.

Specialist teams work effectively to reduce risk for missing children

The Locate team assesses and co-ordinates all missing-from-home enquiries, following a first response by intervention officers. Some of the team are multi-lingual. They engage with children and clearly understand the importance of capturing the voice of the child. This is seen in the quality of prevention interviews, during which the team gathers information to understand a child's vulnerabilities. This information later helps social workers hold return-home interviews. Some of the children assessed as high risk will be assigned to a specialist missing-from-home worker from a funded but independent charity for additional support.

The MPU works to reduce the vulnerability of and risk to children who are frequently reported as missing. When high risk concerns are present for children, they may be escalated at a MARM or SEARCH meeting for additional activity or support.

The constabulary and its partner organisations understand the benefits of using problem-solving approaches to tackle situations where children are likely to be at increased risk. Staff in many roles are trained to consider how they can disrupt the behaviour of those who prey on vulnerability and/or cause risk. MPU officers identify hotspots and have the confidence to challenge partner organisations and others – for example, care providers – when situations arise that present risk to children.

There are approximately 120 providers of residential care for children in Hertfordshire. The police described many having good links with CSC and other safeguarding agencies. When children are missing from home, staff follow agreed guidance and maintain two-way communication that helps safeguard the child. This support continues after they return home.

Unfortunately, this isn't the situation for every looked-after child. Some children and young adults are placed in accommodation that isn't regulated as a children's home and where the staff aren't carers. This is known as the semi-independent sector, and the providers are private businesses. Some of these locations have proved to be highly unsuitable for vulnerable children to be accommodated in, as they can increase exposure to risk and harm. This, in turn, creates additional demand on the services, as the police and safeguarding partner organisations repeatedly need to respond to requests to support these children.

The MPU identified that a semi-independent residential home was the top missing-from location in Hertfordshire. During an 11-month period, there were 124 missing reports for 16 young people and the FCR received 285 calls to incidents at the home.

The young people were placed there by other local authorities without notifying Hertfordshire of their presence or their associated vulnerabilities and risks. It emerged that a local authority had placed a young person who was a county lines gang member and on bail in connection with murder by shooting. Another young person who had previously been exploited and trafficked was placed in the home at the same time by another local authority. The gang member recruited the second young person to transport drugs while they were both residents in the home.

The MPU initially attempted to work with the managers of the home to improve the support that children were receiving and to reduce their vulnerability. An agreement to make changes was made and this resulted in a significant reduction in missing reports being made. However, other concerns were being raised about anti-social behaviour. It was decided to make a joint visit with the local authority to check on the suitability of the premises. This revealed that it hadn't been licensed as a house in multiple occupancy. The management was increasingly uncooperative and further unannounced visits were made.

Contact was made with the local authorities that were funding the placements and they were informed of the existing concerns. The local authorities withdrew their placements and, following meetings between police, CSC and the home's directors, the premises was closed and put up for sale.

The HSCP has written to other local authorities to advise them of the risks of placing young people in this type of accommodation without completing full assessments.

The police and children's safeguarding partner organisations have agreed to review the arrangements for assessing and co-ordinating safeguarding

We saw inefficiencies in some of the systems and structures for assessing and dealing with vulnerability. These create risks of siloed working and duplication.

The safeguarding partner organisations have identified that, although they have invested in resources and built up specialist capability, further work and organisational change are needed to effectively tackle child sexual and criminal exploitation.

They have a plan to review and rationalise risk panels for issues such as missing children and sexual exploitation, criminal exploitation, youth offending and a wider set of behaviours. It builds on the desire to embed a more co-ordinated approach to contextual safeguarding. It shows that the partnership has recognised the importance of streamlining the referral and assessment process for young people at risk.

There are robust systems to support children at risk of significant harm

A team of four staff, based within the MASH, helps assess and protect children who need a CPP because they are at risk of significant harm.

The team is effective and efficient. Staff attend all initial child protection conferences, sharing information and contributing to the child's risk assessment. They update systems to flag the children to frontline officers, and also provide reports to update CPP review conferences.

Recommendation

We recommend that, within six months, Hertfordshire Constabulary should review its referral pathways used for sharing police information to ensure they are both efficient and effective.

7. Investigation

The JCPIT is a collaborative partnership arrangement between Hertfordshire CSC and the constabulary. It is responsible for investigating:

- allegations of child abuse and cruelty within a family;
- abuse of positions of trust; and
- incidents in which a child has abused another child.

The team also responds to any sudden and unexpected death of a child.

Our audits of the quality of JCPIT investigations revealed inconsistency. Some of the investigations received meaningful and authoritative supervision, while others didn't. Those that progressed well with multi-agency involvement had clearly recorded strategy decisions, offenders were arrested, and there was a clear focus on the welfare and needs of the child. Investigations that drifted highlighted offenders that weren't always quickly arrested and questioned. The records of some of these inadequate investigations contained clear evidence that children were suffering from neglect and that this wasn't being addressed by investigation.

A nine-year-old girl told school staff that she had been injured in an assault by her mother. The school nurse saw that she had bruising and scratches on her wrist and her finger appeared to be broken. The girl also complained that she was hungry, there was no food at home, and that she and her siblings were often left home alone.

Police and CSC made a joint visit to the school and held a strategy meeting. The girl said that she was still scared and didn't feel safe at home because she thought her mother might hurt her again and had said she wanted her to go into care.

When the police and CSC met with the mother, she said her daughter was "evil and a liar" and that she should be taken into care. A medical examination showed that the child's finger wasn't broken.

The investigation was closed at this point, with no further action taken. A supervisory comment was: "It is no longer being treated as a GBH [grievous bodily harm] and would amount to a battery at most." The police didn't record if any action had been agreed with CSC or the school about future support for the children and family. There was no record of the decision being explained to the child, or her views being gathered before closing the investigation.

The girl and her siblings were not put at the centre of the investigation.

There are delays in providing specialist training

Some officers told us they didn't feel fully equipped for their specialist child protection roles. They said they were reliant on colleagues to guide them through difficult investigations because they had yet to receive training.

Despite this, they were investigating significant numbers of child abuse cases, including sexual assaults, rapes and other complex physical assaults. One officer was acting as a family liaison officer in a child death investigation without any formal training for this specialist role.

Staff in other safeguarding units also lacked training to carry out complex work.

It is concerning that some members of safeguarding teams are repeatedly assigned to deal with high-risk and complex matters without the necessary technical knowledge and training.

The Halo team investigates the most serious cases of child sexual exploitation

Halo investigates the most serious cases of child sexual exploitation. The team works with multi-agency partners using professionals meetings, rather than following section 47 Children's Act joint investigation arrangements.

In Hertfordshire, the highest-risk cases are discussed monthly at the SEARCH panel and during MARM. These arrangements have merit and show the partnership has

thought about how to involve children, families and carers in planning achievable safeguarding strategies. However, we found that this approach can be undermined if the arrangements aren't timely and decisions aren't recorded, and supervision isn't consistently in place to challenge and drive investigative activity.

The constabulary recognises that proactive investigation is necessary in tackling child sexual exploitation. It has increased its investigative capability by increasing the number of officers in its Halo team.

Officers target, and work to disrupt, those suspected of child sexual and criminal exploitation. They interview children who are believed to be at risk of exploitation following missing episodes. Intelligence is gathered to support investigations where child sexual exploitation isn't disclosed but there are other concerns, such as a suspect being involved in drug, theft or driving offences.

This proactive investigation is designed to enhance the intelligence available to the constabulary and its partner organisations, so they can identify perpetrators at an early stage and act to prevent or reduce the threat they pose. It includes work to support potential victims, alongside staff from community safety partnerships, and to progress civil or community orders such as CAWNs when criminal prosecution thresholds aren't met.

The police identified a child sexual exploitation hotspot from intelligence about the behaviour of some adult males towards girls in a Hertfordshire town. They started a proactive operation to tackle the problem.

An analyst was tasked with developing intelligence that would help officers understand the type and scale of risk. A low-cost hotel, a fast-food outlet and a graveyard were identified as key venues. More than 20 girls were thought to be vulnerable to exploitation.

A number of separate investigations progressed under the direction of a senior detective. Staff from various Hertfordshire units, supported by eastern region serious and organised crime unit officers, carried out surveillance, disruptions and undercover investigations.

The investigations centred on certain vulnerable children and suspects. Close working with the Crown Prosecution Service led to several arrests and prosecutions. In other cases, restraining orders and a SHPO were used.

The tactics allowed police to disrupt the activities of those who presented a high risk to children.

Halo officers understand the importance of engaging with child victims of sexual exploitation. This helps to build rapport with a child and gain their trust, which is vital to securing evidence in interviews.

Officers from all safeguarding units told us they had access to intermediaries and interpreters. Our case audits indicated that these essential supports for investigation were being used.

Some officers have been trained in the forensic questioning of children to identify the best way for investigators to communicate with them. This approach supports the child and reduces investigative delays. Supervisors regularly dip-sample cases to maintain the quality of interviews.

Where organised criminal gangs operate across police borders, the constabulary requests additional specialist investigative support from its east region special operations unit. An example of this positive work is its modern-slavery unit, Operation Tropic.

In July 2019, Operation Tropic linked Hertfordshire Constabulary's Europe-wide trafficking operation with its child criminal and sexual exploitation operation.

During a week of activity, 25 search warrants were executed across the county and six arrests were made for:

- online grooming of children;
- possessing indecent images of children; and
- immigration offences.

Safeguarding measures were put in place for several children found to be at risk.

A media strategy linked this operational activity to information that would make the community more aware of signs that a child may have been trafficked. It encouraged those with concerns to contact the police.

The constabulary has reacted positively to the increasing demand created by online offending

The COST proactively uses the Child Protection System. This is an international intelligence system that assists police to identify and trace the owners of computers that are used for the distribution of indecent images of children. COST investigates every report of offenders in the area accessing and distributing such images. It uses the Kent Internet Risk Assessment Tool to prioritise its activity.

After a review of its caseload and demand, senior leaders gave the COST team additional resources. More managers, personnel and equipment will increase the timeliness and improve the quality of the team's work. They have also looked for new, more efficient ways for the team to deal with large volumes of indecent images. They have attended demonstrations using Qumodo, an image search platform to optimise evidence-gathering accuracy being piloted by the Home Office, and keenly await its roll out.

A dedicated victim identification officer works to identify new victims from first-time-seen photographs found on suspects' devices and using information from other agencies. This information is added to a national system, the child abuse identification database, and assists other investigations in cases where images have been shared.

Joint working between police units takes place, but this doesn't always extend to partner organisations

The COST team prioritises cases and makes timely referrals to local authority designated officers (LADO) when a suspect is identified in a profession or position where they are likely to have contact with children.

However, our case audits and discussions with staff revealed that CSC is unlikely to be involved in the planning or invited to join the team when a search warrant is obtained, even when there are concerns that a suspect lived with or had access to children. Instead, officers make referrals only after these events. This means that there are potentially missed opportunities to identify risk and safeguard children in a timely way.

The constabulary's investigations into those who access and distribute indecent images of children don't show the same level of close, operational multi-agency working as that in other parts of the organisation.

We saw examples of COST officers participating in strategy meetings, but inconsistently, and often weeks after CSC arranged them. There was little in the cases we saw to suggest that COST was investigating jointly with CSC and speaking to children to understand the child's situation in partnership with social workers. Officers we spoke to were clear that if children were living or present in a home being searched, the suspect would always be arrested. But this wasn't always the case.

Supervisors aren't consistently recording investigative direction in a timely way

Although supervisors interact with their officers and hold one-to-one meetings, detectives were often expected to manage their own investigations with little routine support or supervision. This means only limited investigative reviews were being recorded on force systems after the initial allocation for investigation. We saw the consequences of this in some of the cases we reviewed: there were investigative delays and some referrals to CSC lacked detail. Children at potential risk weren't fully assessed, with offenders' activities not being investigated beyond immediate concerns.

The COST and Halo team supervisors have a reciprocal arrangement to cover for each other, but we saw that for these teams' cases, the investigation reviews were frequently delayed.

In some investigations, the reasons for delays were beyond the control of supervisors. Cases awaiting evidence from the DFIU were particularly affected by delay and, in these cases, supervisors had to extend review periods. This was despite a prioritisation process in which investigating officers submit an online form on the day a device is seized.

Frontline officers and specialist investigators told us they could get evidence from phones in good time, but for other devices needing to be examined, such as computers, there were often delays of about a year. Managers had tried outsourcing this work to the private sector, but stopped after a review raised concerns with the

quality and timeliness of the work. These delays mean that some investigations cannot be completed in a timely way and the full risk that suspects present isn't immediately understood or known.

The constabulary introduced supervisor contracts to document individuals' responsibilities and improve the quality of supervision of investigations. Senior managers are expected to dip-sample supervisors' inputs and address any deficiencies. However, some of the supervisors we spoke to were unaware of these contracts.

An adult male who was pretending to be 13 years old was attempting to meet children for sexual purposes.

COST investigated, obtained a search warrant and seized several devices from the suspect's home. He was not arrested. Instead, officers interviewed him by voluntary agreement. They advised him not to return home to his wife and daughters, but to stay with other family members. There were no bail conditions.

After 13 days, the girls told social workers that they had been repeatedly sexually assaulted by their father. This was reported to police and the father was arrested. He was charged with committing serious sexual offences and remanded in custody after the girls and other witnesses were interviewed.

Although the initial research and activity to tackle the suspect was timely, the police investigation wasn't planned with the vulnerability of his immediate family in mind. There were no records of safeguarding referrals being made or the police involving social workers. CSC was informed after the warrant was executed and later contacted the children and their mother itself.

Despite the involvement of CSC, following the children's disclosures and the father's arrest, the police records weren't updated with information about plans to safeguard the family.

Domestic abuse investigations are initially well supervised, but lack meaningful inputs thereafter

The initial supervision and case direction on investigations by DAISU supervisors is authoritative and timely. Investigations where high risk has been identified are supervised by detective inspectors and can only be closed with their authority. However, the longer-term management of investigations isn't regularly supervised. Detective sergeants told us they have little capacity to supervise investigations and have to trust their staff to progress investigations.

We reviewed the caseload of two DAISU investigators. They lacked supervisory oversight. One officer had 51 live investigations on Athena. On closer inspection, it was clear they weren't all live cases – many were ready for completion but hadn't been attended to.

The detective sergeants didn't know how many of their officers' investigations were live. On the day of one review, there were 436 outstanding review tasks for one

of the supervisors. Some of these tasks included managing high-risk cases where delays place vulnerable children at further risk.

A lack of authoritative supervision can lead to investigative delay, missed opportunity and loss of victim confidence. Victims may also suffer increased risk from repeated assaults and abuse when offenders aren't managed sufficiently.

The DAISU safeguarding support unit offers support to the victim and their family until the suspect is arrested. There is close oversight of outstanding suspects and the risk is considered at the decision making and tasking meetings.

The DAISU provided training to all response and neighbourhood officers between January and March 2019 to enhance the workforce's understanding of domestic abuse. The intention was to improve investigative outcomes. It included input on:

- child risk assessment;
- the importance of the voice of the child;
- coercive control, stalking and harassment;
- using BWV; and
- evidence-led investigations.

These messages have been reinforced with material on the constabulary's intranet.

The HSCP is developing its own sexual assault referral centre

The HSCP realises the importance of supporting victims of sexual assault with first-class facilities. It has established a sexual assault referral centre (SARC) that is jointly funded by the police, the PCC, NHS England and innovation funding. A recent expansion in April 2019 now allows the SARC to offer full paediatric services. The SARC also takes self-referrals and referrals from other agencies. It has four independent sexual violence advisers, two of whom are trained to support young children through the medical phase and beyond.

Recommendation

We recommend that, within six months, Hertfordshire Constabulary should 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 effectively to multi-agency strategy discussions and plans for protecting children;
- every referral the police receives is allocated to those with the skills, capacity and competence to carry out 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.

8. Decision making

The use of police protection powers was appropriate in all the cases we audited, but record keeping was often poor

It is a very serious step to remove a child from a family by way of police protection. When there are significant concerns about the safety of children, such as parents leaving young children at home alone or being intoxicated while looking after them, officers handle incidents well. When assessing the need to take immediate action they use their powers appropriately to remove children from harm's way.

In the cases we examined, decisions to take a child to a place of safety were well considered and made in the best interests of the child. When we spoke with CSC managers and the independent scrutineer for the HSCP, they said they considered that police officers used these powers appropriately.

Although we saw cases where officers made enquiries to safeguard children promptly and effectively, there wasn't always a full record of it on police systems. There weren't always details of strategy discussions with CSC, including agreed actions to safeguard and promote the welfare of the child. Police protection powers may be used for a maximum of 72 hours and a record should be made when they end. However, when the power was rescinded before the maximum time had elapsed – such as when a child is passed to the care of a family member – these details were rarely entered. Nor were there any details of what the longer-term protective plan was likely to be.

The records we saw of children in police protection showed that it was often some hours before designated officers reviewed the use of the power and the need for it to remain in place. Often, we found only one review recorded, despite the child being at a police station for a significant period. This means that the constabulary is insufficiently reviewing the welfare of children against the proportionality and necessity of continued use of the power.

Children remained at police stations for inappropriate periods of time

This lack of oversight can mean there is an absence of appropriate challenge to CSC to urgently accommodate a child somewhere more appropriate than a police station. Statutory and professional guidance states that a child should only be taken to a police station as a place of safety in exceptional circumstances. However, the constabulary's records show that children are invariably taken to police stations, sometimes for several hours overnight. Children would fall asleep on chairs in police canteen areas.

Frontline officers knew of the inspectors' role as designated officers[8], but were unsure what records they were expected to make or where to put them. We found officers recording actions on Athena, while inspectors used an FCR system called Storm for their entries.

During our inspection (and partially because of our emerging findings, which reinforced existing concerns) the constabulary introduced a quality assurance process for police protection cases, which are now reviewed daily.

Two siblings aged 12 months and two years were living with their estranged father because of concerns about maternal neglect. The children's mother told her social worker that she had been raped and assaulted by their father in front of them.

CSC couldn't get an emergency protection order as the court wasn't sitting, so it held a strategy discussion with police specialists.

Police and social workers went to the father's house. The police exercised police protection powers and the children were placed with foster carers. However, the police records lack any entry by or on behalf of the designated officer. This raises questions as to whether there was any form of police management oversight on behalf of the children affected by this situation.

A 15-year-old girl who was in local authority care and at risk of sexual exploitation reported that she had been assaulted.

When police officers arrived, they spoke with her and checked her injuries. Their assessment of her responses and demeanour was that she was at risk of significant harm. They took her into police protection.

The social care emergency duty team social worker was contacted promptly and an out-of-area emergency foster placement was identified for the child. A follow-up strategy discussion took place three days later.

Although police records (from the computer-aided dispatch and Athena systems) indicate that an inspector was aware of this incident, no entries were made by or on behalf of the designated officer.

Despite the good practice where we saw police making decisions to use their protective powers, we also saw cases where response officers didn't respond sufficiently to acute and chronic child neglect. As a result, children had been left with those who were a risk to them and without an immediate referral to CSC or other meaningful interventions.

[8] The designated officer must be of at least the rank of inspector. The role is to ensure police protection has been invoked appropriately; to have responsibility for enquiring into cases in which police protection has been invoked; to have oversight of the process throughout; to ensure that the necessary actions are completed; and to ensure that the accommodation where the child is placed is appropriate and does not place the child at further risk.

Recommendation

We recommend that, within three months, Hertfordshire Constabulary should issue guidance and take steps so that, in incidents where children are taken into police protection, designated officers take an active responsibility for overseeing activity, ensuring:

- the voice of the child is sought, and their wishes and concerns are listened to;
- strategy discussions are held;
- records are made of all relevant information, and;
- police stations are not improperly used as places of safety for children.

9. Trusted adult

It is important that children can trust the police. We saw that, in some child protection cases, officers carefully consider how best to approach a child and/or their parents or carers and explore the most effective ways in which to communicate with them. Such sensitivity builds confidence and creates stronger relationships between the police and the child, parents and/or carers. The constabulary works well with partner organisations and professionals to protect children when they need immediate safeguarding.

The constabulary supports the work of Fearless, which is the youth service of the Crimestoppers charity. A Fearless outreach worker works with children and young adults to provide information about:

- the dangers of crime;
- how to report information about crime anonymously; and
- how to keep themselves safe from sexual and criminal exploitation.

When children become victims of crime, those crimes should be reported and investigated as robustly as crimes committed against adults.

In March 2019, the constabulary implemented a victims' code of practice (VCOP) performance dashboard to track and monitor compliance at individual, team and departmental level. (The constabulary had realised that its prior compliance with VCOP was low – 69 percent in April 2019.) VCOP training has since been delivered to frontline staff and investigators. This has raised compliance to 90 percent, which means that more crimes committed against children are reported and victims are provided with updates.

Senior leaders have acknowledged that adverse childhood experiences have an impact on children and that enforcement isn't always the most appropriate way to deal with a troubled child. They support the principle that 'The child is a victim first, an offender second'. Officers' mindsets and language are changing, with many more considering alternative case disposals for children such as restorative justice outcomes.

The constabulary works closely with partner organisations to engage with children

The CYPSG team was set up in January 2019 to tackle cross-cutting themes of gangs and child criminal exploitation. It works closely with partner organisations to tackle criminality and divert children away from the criminal justice system whenever appropriate. Its recent activity includes:

- a 'Lives not knives' event in March 2019, for young people at risk of county lines and other gang activity; and
- the multi-agency Broxbourne Youth Crime Intervention Project, a response to increasing concerns about children being involved with criminal gangs.

This project is now being rolled out county-wide and linked to other activity including:

- 'Spot the signs', a gang and knife campaign in East Hertfordshire;
- Operation Starboard, tackling the rise in serious youth crime, including county lines, in Stevenage;
- Operation Edge, a film-making competition for secondary schools about carrying knives; and
- a hate crime event for 90 school children at the constabulary's headquarters.

The constabulary also supports the National Volunteer Police Cadets (NVPC) programme. The purpose of the NVPC is to encourage good citizenship among its members and to inspire young people to participate positively in their communities. There are currently approximately 285 volunteer cadets in Hertfordshire.

10. Managing those posing a risk to children

There are good staffing levels and constructive partnership arrangements

Hertfordshire Constabulary's PPU deals with the management of sex offenders and violent offenders (MOSOVO). The unit is dedicated to supporting multi-agency public protection arrangements (MAPPA). Representatives from all appropriate agencies attend and contribute to MAPPA meetings. PPU staff work closely with the MAPPA manager to co-ordinate the agendas and make sure that actions are completed. We spoke with the MAPPA chair and reviewed ten sets of minutes and conclude that there are effective arrangements in place in which risks to children are identified and assigned appropriately for action.

The MOSOVO team is evenly split between police officers and specialist police staff. All staff are trained in the active risk management system (ARMS), the violent and sex offender register (ViSOR) and MOSOVO. Two of the team manage the polygraph – the lie detector test. A detective chief inspector has oversight of the PPU and the structure of the team corresponds with the probation service's areas. The average offender manager's workload was approximately 55 RSOs, with 45 of those in the community (as opposed to in custody). Hertfordshire's PPU has relatively low ratios compared nationally and to neighbouring police forces.

The constabulary has invested in technology called E-Safe that enables offender managers to monitor RSOs' electronic devices. It is currently installed on 339 registered devices to deter inappropriate browsing and allow offender managers to review an offender's online activity during monitoring visits. Offender managers also regularly use polygraph testing to help assess RSOs' verbal responses and GPS tags to monitor their compliance with the restrictions on their movement.

The public protection unit has a significant backlog

A vital activity within offender management is for officers to make home visits to check on an RSO's compliance with orders and that they aren't a risk to other people in the community. The PPU completes visits on a frequency determined by an RSO's risk assessment. These visits are generally unannounced and completed by pairs of officers working together. We were provided with performance data that indicated a significant backlog of outstanding visits and risk management plans.

Managers are aware of this situation. However, at the time of our inspection, no robust plan had been made to deal with the situation or its underlying causes. We saw

missed visits in high-risk cases – one from July 2019 was still outstanding. In another case, the offender was released from prison in June 2019 but not visited until August.

In 2017, the National Police Chiefs' Council issued guidance that forces may use either active or reactive management approaches for RSOs. Active management requires visiting the offender. National practice is for officers to complete ARMS assessments at least every 12 months, or when something happens that may result in a major change to the current overall assessment and risk management plan for the offender. A force may move individuals from active to reactive management. This can be done if an ARMS assessment suggests that an RSO presents a low level of risk, and the offender manager is satisfied that the offender hasn't committed offences or presented any risk for a three-year period. The use of both active and reactive management, effectively carried out, should allow the force to focus on those RSOs posing the greatest risk.

Police received a call from a grandparent concerned about a man who had moved into their daughter and grandchildren's home.

Officers went to the home to establish the man's identity and found him to be an RSO. He was arrested for breaching his notification requirements and later released with bail conditions to protect the children. Police made a referral to CSC.

The police were subsequently informed that the offender was returning to the house. A joint home visit with CSC services was made two months after the initial contact. The children were assessed at that point as being at risk, taken into police protection and placed into foster care.

The risk management plan was updated seven weeks later.

Some public protection unit staff haven't received specialist training

All PPU staff have received ARMS training. We were told that eight had yet to be MOSOVO trained, and that one officer who had worked in the PPU for three years had never attended a MOSOVO course. Our audit of PPU cases, the majority of which were assessed as inadequate, showed that this inconsistency in training undermined the quality of work of some staff.

Frontline and neighbourhood staff receive briefings on PPU-managed offenders

RSOs' home addresses are mapped on Athena. They are also available on briefing and tasking documents to make staff aware of their presence and the risk they pose. This means that local officers are aware of the RSOs in their area and can obtain information about their activity. The PPU produces individual briefings when an offender isn't engaging with offender managers, or it is suspected they may be preparing for or committing offences.

However, despite this positive approach, we heard of intelligence gaps because PPU staff didn't always input information that was on the ViSOR system on to Athena

where it could be seen by other officers – for example, intelligence that an offender was supplying drugs.

The public protection unit has an inconsistent approach to enforcement

There are currently 369 SHPOs and 257 sexual offences prevention orders in place. In 2018-19, there were 150 breaches of orders or registration requirements in Hertfordshire. The force management statement is unclear how these breaches of orders were dealt with. We were told by PPU managers that all breaches should be recorded on Athena. They said that outcomes for offenders are discretionary and managed on a case-by-case basis, and decisions are made by team sergeants.

> An RSO convicted of sexual exploitation of a child online and managed as a high-risk offender was regularly breaching his early release licence conditions, a SHPO and notification requirements.
>
> Only one breach was dealt with by PPU officers, when they discovered that he had deleted his internet browsing history.
>
> The offender was interviewed using a polygraph and admitted that he had contact with the children of his family and friends. He also admitted being alone with them for short periods of time. This breach wasn't referred to CSC and there was no strategy discussion to consider whether the children had been harmed. And the risk management plan wasn't updated with this vital information about the offender's non-compliance and the risk he presented.
>
> PPU staff didn't fully consider the welfare of the children he knew or any other children, or robustly tackle the offending behaviour of a high-risk offender.

The PPU didn't gather performance data on enforcement. When the offenders they managed were wanted for committing offences, suspects would be flagged on the Police National Computer and Athena. However, there is no prioritisation process to grade the risk and priority for these wanted cases.

We found inconsistency in the public protection unit's recording practices

The risk management plans we saw on ViSOR were generally of a good standard. However, they weren't always updated, despite there being several changes in an RSO's circumstances. We also found that PPU staff weren't recording information fully on ViSOR, even though they held information that could assist decision making for safeguarding purposes. Officers expressed concerns that sensitive information might be disclosed inappropriately by partner organisations. This approach means that important information about managing offenders' risk is being recorded and retained only in officers' daybooks.

The cases we looked at gave us concerns about a lack of understanding of child protection and safeguarding within the PPU. The voice of the child isn't considered or

recorded in relation to the management of offenders. Referrals to CSC aren't always made in a timely way and strategy discussions aren't used to share information with partner agencies. This means that staff are insufficiently focused on safeguarding, which can leave children at risk from those who are already considered to present a risk.

An RSO convicted in 2014 for sexual activity with a neighbour's child breached a SHPO in July 2107 and was returned to prison. On his release, it was discovered he was living in a house where three children lived next door on one side, while his neighbours on the other side were regularly visited by their grandchildren.

A MAPPA meeting was held, but it wasn't attended by CSC. Minutes of the meeting weren't added to ViSOR. The probation officer completed a risk management plan, but it wasn't updated. No ARMS assessment was completed.

There is no record of CSC being consulted before police made disclosures to the RSO's neighbours, and no subsequent referral about any of the children. Despite the ViSOR records being supervised in the PPU, the intelligence isn't available on Athena.

The risk presented by this offender in the community is insufficiently assessed, and there is no record of activity to mitigate risk.

Public protection unit supervision and management are ineffective

The backlogs in home visits, delays in updating risk management plans and inconsistent recording of information and intelligence on ViSOR and Athena are highly concerning.

There is not currently an effective performance management regime to fully understand the level of risk presented by the offenders being managed. Supervisors don't know about individual staff performance – only team outputs. As a result, the workforce isn't being developed or increasing its capacity. Staff had received some training, but not always in the areas that would improve their contribution to safeguarding.

A consequence is that there isn't a culture of actively considering the vulnerability of children at risk from RSOs and working effectively with partner organisations such as CSC to understand and tackle risk in a timely way. Managers didn't know that referrals to CSC weren't being made promptly and consistently.

Recommendation

We recommend that Hertfordshire Constabulary should immediately review the arrangements within its public protection unit, including its supervision and management information systems, so that it is satisfied that the unit is fully effective within its terms of reference.

11. Police detention

The numbers of children being arrested have reduced, but we found delays in the attendance of appropriate adults[9] to support children in custody

Many children suspected of committing criminal offences have complex needs and are likely to be vulnerable and in need of safeguarding support. Hertfordshire Constabulary has been successful in reducing the number of children arrested and brought into police detention. This has resulted in significantly fewer children being detained across the force area. Frontline officers told us they face increased scrutiny from custody officers when they bring a child into custody. They expect to be challenged about the necessity to arrest and said that this meant they now deal with most children outside custody. This is positive – it isn't in a child's best interests to be kept in custody.

However, the constabulary has yet to achieve a comprehensive approach that prioritises safeguarding and a child's welfare throughout the detention process. Guidance in the Police and Criminal Evidence Act 1984 (PACE) states that once an appropriate adult is identified, officers should ask that person to attend the custody suite as soon as practicable. In some of the cases we examined, there was evidence of long delays in the attendance of appropriate adults. Their attendance generally coincided with the interview of the child, rather than providing early support for their overall welfare needs, rights and entitlements.

[9] An appropriate adult is a parent, guardian, social worker, or any responsible person over 18 years old, and who is not a police officer or a person employed by the police. Appropriate adults must be called whenever a child is detained or interviewed. An appropriate adult must be present during a range of police processes, including intimate searches and identification procedures, to safeguard the interests of children detained or questioned by police officers.

There is a lack of understanding of the thresholds and requirement to seek alternative accommodation[10]

Custody officers had a reasonable understanding of the child custody concordat[11] between the constabulary and the local authority. Officers could explain the different types of accommodation, but not necessarily the threshold for alternative or secure accommodation. This was despite custody procedures advising that this needed to be considered when the detained child "poses a risk of serious harm to the public between being charged and appearing at court". Custody officers told us they raised concerns with CSC services about the availability of non-secure accommodation and recorded non-availability when it occurred. Custody officers would inform duty inspectors of these situations. However, our case audits didn't confirm that alternative accommodation was being requested or give any detailed rationale as to why it wasn't possible for the detained child to be accommodated prior to their court attendance.

A child detainee was kept in a cell for approximately 32 hours. There was an entry on the custody record about his first night in pre-charge detention. However, it lacked enough detail to justify reaching the exceptional circumstances described within the constabulary's procedures.

After the child was charged with criminal offences, he remained in police custody. The rationale recorded on the custody record and post-charge detention certificate was insufficient. It was unclear why it was necessary to continue to detain him. There was no inspector's endorsement on the custody record post-charge of efforts to secure alternative accommodation.

The child's welfare and vulnerabilities weren't addressed in the inspector's entry, which only dealt with authorising his continued detention.

[10] In 2015, government ministers wrote to children's services highlighting problems in complying with the need to transfer children from police custody to local authority accommodation and reminding them that section 38(6) of the Police and Criminal Evidence Act 1984 applies.

[11] The concordat on children in custody provides guidance for police forces and local authorities in England on their responsibilities towards children in custody. 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.

Following a stop and search, a 15-year-old who was suspected of being involved in gang-related knife crime was arrested. An appropriate adult and lawyer attended promptly and were able to advise him. The investigation wasn't delayed – after five and a half hours in custody, he was charged in the early hours of Sunday morning.

Bail was refused and the child was detained in police detention until court on Monday morning. This meant he was held in custody for 35 hours and the only contact he had with an appropriate adult was before he was charged. The custody record didn't include a rationale as to why the custody officer had refused bail.

The juvenile continued-detention certificate entry said that the local authority had been contacted to arrange for the child to be taken into care pending his court appearance, but no secure accommodation was available. There was no entry by an inspector confirming the decision. The police entries didn't explain why it was necessary to continue to detain the child or why secure accommodation was needed. The records didn't indicate whether his welfare had been discussed with CSC, only that it had been contacted to provide secure accommodation once he had been charged. There is no record of the police making a referral to CSC after the child left police custody.

The constabulary gathers data on children arrested and detained each month that includes information on case outcomes. It also reports on detention that has been refused. It has a constructive relationship with the local authority and alternative accommodation provision is available in Hertfordshire. Obtaining secure accommodation for detained children is more problematic as its provision is very limited. A monthly partnership meeting discusses all children charged and remanded to court.

All children held in police detention overnight are reviewed each morning by senior officers. The constabulary has introduced an online system that allows custody inspectors to dip-sample all custody records to help with quality control and identify training needs. The custody policy and performance review also focuses on the welfare of vulnerable detainees, and asks whether they are sufficiently engaged and informed of the inspector's reviews of their detention. This has led to a more robust process for identifying vulnerability, and actions needed to reduce it, in detained children – for example, calling appropriate adults at an early stage.

There is insufficient child protection training in place, and staff have an inconsistent understanding of their safeguarding responsibilities

Officers and staff, including detention officers within the custody environment, told us that they hadn't received any training on:

- child protection;
- the voice of the child; and
- child sexual and criminal exploitation.

The healthcare professional, an employee of an independent provider, had been provided with some external online training.

The absence of safeguarding training for this group of professionals is concerning – it is highly likely that they don't always recognise vulnerability and risk is not mitigated.

Staff told us they didn't understand the concept of voice of the child, or the impact of adverse childhood experiences. They didn't consider the impact of arrest and being in custody for a child and claimed to treat everyone the same. There was little recognition that children need more support and reassurance, or that their emotional needs are different to adults'. This meant that they were focused on offences and processes as laid out in PACE, rather than seeing a child in custody.

We were told that staff in custody suites hadn't had guidance on how to make a child protection referral and that if they had a concern, they would inform the custody sergeants. Senior managers told us the constabulary's policy made investigating officers responsible for making safeguarding referrals to social care.

The healthcare professional can make referrals for children and adults by sending the information to their line manager. This is generally for health-related safeguarding concerns, which aren't necessarily brought to the attention of the custody officer unless they affect the detention of a prisoner. In these situations, the healthcare professional should make an entry on the custody record – for example, that a detainee is self-harming.

Healthcare professionals don't use Athena to make referrals or pass them to the MASH. Matters they consider to be confidential or not relevant to detention are recorded on their own assessment form and not disclosed to custody officers. This means that it is possible for vulnerabilities affecting children to not be shared with the staff who are directly responsible for their welfare.

Recommendation

We recommend that, within three months, Hertfordshire Constabulary should carry out a review to satisfy itself that its management of children in police detention is appropriate and reflects the standards of current national best practice. This should include:

- the knowledge and understanding of custody staff about how to promote the welfare of children;
- recording the voice of the child;
- making child protection referrals; and
- understanding the requirement for the provision of alternative accommodation.

Conclusion

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

Senior leaders in Hertfordshire Constabulary are highly committed to making the county a safe place for children to live. They have developed innovative safeguarding arrangements with strategic partner organisations in the local authority and NHS clinical commissioning groups that are designed to help staff provide high-quality services to children.

The constabulary has established and continues to invest significant resources in its specialist safeguarding command. There are dedicated units with specialist staff to investigate complex crime, support vulnerable children and tackle high-risk offenders. Information sharing with other agencies to protect and promote the welfare of children is managed by safeguarding command staff.

Partner agency staff are embedded in the JCPIT, which is a beacon for how joint working can be progressed from co-locating to an effective collaborative working arrangement. The processes in the FCR were robust and mostly prioritised the response for vulnerable children, while supporting frontline officers with advice and timely intelligence.

However, during our inspection, we saw that not all of the arrangements and processes were effective for children who need help and protection.

This meant that:

- the voice of the child wasn't captured by significant numbers of the workforce;
- referrals for child protection and to promote welfare concerns weren't always made;
- strategy discussions weren't held, and records weren't always made;
- there were some significant delays in assessing child protection concerns where cumulative or emerging risk was unidentified;
- investigations weren't consistently supervised;
- there were delays and some inefficiencies in multi-agency case management;
- children taken into police protection were taken to police stations, where inspectors didn't take responsibility for decisions;
- some children were held in police detention for long periods without their needs being fully considered; and
- the threats to children from high-risk offenders were inconsistently managed.

It was clear from what staff told us that the workforce is committed and dedicated. But there has been insufficient training for and supervision of young-in-service officers, particularly detectives who are placed on safeguarding investigation teams. Those in specialist roles are expected to conduct complex and challenging enquiries while managing risk, but many haven't received enough training.

Frontline supervisors are under pressure and many of them are inexperienced. They told us they feel confused about the constabulary's priorities. An example is the campaign to reinforce to all staff the importance of listening to the voice of the child. Staff told us that they had heard the expression, but that it hadn't been explained clearly enough in the context of their roles.

We are very concerned that the constabulary doesn't sufficiently recognise the threat and risk of neglect within the family. Understanding neglect and tackling it is vital to child protection and to reducing the vulnerabilities of children to abuse from criminal and sexual exploitation.

Some cases where serious neglect is present are included in DASH referrals, rather than as child protection investigations. When frontline officers attend incidents where there is evidence of serious neglect to children of all ages it isn't recognised as a criminal matter that requires police to investigate, but as a concern for referral to CSC.

The constabulary works well with safeguarding partner organisations. It fully participates in multi-agency operational activity to address vulnerability in areas such as child exploitation, gang membership and children missing from home. This partnership has also recognised that more needs to be done in its response to tackling neglect. It is encouraging that the constabulary will take an active role in neglect-themed training.

Senior leaders know there are inconsistencies and areas that need improvement, and had already instigated substantial reviews at the time of our inspection. We welcome the response of the constabulary and its willingness to work with us, and to act quickly to address the areas of concern we identified through the child protection case audits.

Our recommendations aim to help the constabulary make sustainable improvements in these areas.

Next steps

Within six weeks of the publication of this report, HMICFRS requires an update of the action the constabulary has taken to respond to those recommendations that we have asked to be acted on immediately.

Hertfordshire Constabulary should also provide an action plan within six weeks of the publication of this report to specify how it intends to respond to our other recommendations.

Subject to the update and action plan received, we will revisit Hertfordshire Constabulary no later than six months after the publication of this report to assess how it is managing the implementation of all 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 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 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 police 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 officers and staff from 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 HMICFRS); 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 in which police officers and staff identify children in need of help and protection, e.g. children being neglected;
- information-sharing and discussions about 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 nature and those of a non-criminal nature (section 47 enquiries are those relating to a child ‘in need’ rather than ‘at risk’);
- sex offender management;
- the management of missing children;
- child sexual exploitation; and
- the detention of children in police custody.

Annex B – Definitions and interpretations

In this report, the following words, phrases and expressions in the left-hand column have the meanings assigned to them in the right-hand column. Sometimes, the definition will be followed by a fuller explanation of the matter in question, with references to sources and other material which may be of assistance to the reader.

Term	Meaning
child	person under the age of 18 years
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 throughout England and Wales
multi-agency safeguarding hub (MASH)	working location in which public sector organisations with responsibilities for the safety of vulnerable people collaborate; 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

Term	Meaning
Office for Standards in Education, Children's Services and Skills (Ofsted)	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; 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; established under section 1, Police Reform and Social Responsibility Act 2011
registered sex offender (RSO)	person convicted or cautioned for a sexual offence as set out in Schedule 3 to the Sexual Offences Act 2003, or who has otherwise triggered the notification requirements (for example, by being made subject to a sexual offences prevention order), who is required to provide personal details to the police, including details about movements (for example, if going abroad) and, if homeless, where they can be found; registered details may be accessed by the police, probation and prison service

March 2020 | © HMICFRS 2020 | ISBN: 978-1-78655-914-2

www.justiceinspectorates.gov.uk/hmicfrs