HMICFRS

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

National Child Protection Inspection – assessment of progress

Lincolnshire Police

12–16 October 2020

Contents

Introduction

The 2018 inspection

In September 2018, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) inspected how well Lincolnshire Police was keeping children under the age of 18 safe.

In February 2019, we published our findings. We concluded that the chief constable, his senior team, and the police and crime commissioner were committed to protecting vulnerable people, including children.

However, improvements were needed, and we made a series of recommendations in our 2018 inspection report, aimed at improving Lincolnshire Police's child protection practice.

The 2019 post-inspection review

In October 2019, we assessed the force's progress in a post-inspection review.

Although improvements had been made, some work was yet to be completed and some yet to be started. We remained concerned about the standard of investigations.

As a result, we committed to revisiting the force within 12 months to carry out a further assessment of its progress. This report sets out our findings.

Impact of the pandemic on our revisit

The methodology for this inspection was adapted because of COVID-19. We agreed arrangements with the force to deliver the inspection safely and effectively while working within national and local guidelines.

It was carried out remotely, using video calls for discussions with police officers and staff, their managers and leaders, together with online reviews of incidents and investigations.

During this inspection, we:

- examined force policies, strategies and other documents;
- interviewed senior leaders, managers and frontline officers and staff, with some interviews planned and some unannounced; and
- audited 37 child protection cases (related specifically to the areas for improvement set out in the 2018 inspection report). We graded 13 cases as good, 11 as requiring improvement and 13 as inadequate.

The 2020 assessment

Staffing in units dealing with child protection is now at the levels the force intended

Following our inspection in 2018, the force committed significant time, energy and resources to make sure that officers and staff working in the new protecting vulnerable people units (PVPUs) had the necessary skills to investigate child abuse. The force intended to have completed the training of those staff by January 2020.

During the post-inspection review in 2019, we found that the standard of investigations was being affected by the many absences from the PVPU teams that this training had caused. Sickness absence, along with annual leave that had been authorised when officers and staff were in previous roles, compounded this problem.

The training has now been completed. Although there are some vacancies and sickness absences, staffing is within the levels senior leaders anticipated.

During the inspection, we spoke to several officers working in the PVPUs. They were committed and enthusiastic individuals, eager to do the best job they could. They confirmed that staff levels had improved, and generally thought that they had sufficient resources and the necessary support.

All those we spoke to had completed their initial specialist child abuse investigation development programme (SCAIDP) course, but none had yet completed the accreditation process. The force should now focus on making sure that officers complete the programme.

Some officers expressed a degree of concern that demand could be high from enquiries needing immediate attention, making it harder to spend enough time on longer, more complex investigations.

Senior leaders are aware of this. They have plans to create a team to deal with non-recent sexual abuse. This will reduce the number of complex investigations within the PVPUs.

The force has improved its understanding of standards of practice but more needs to be done

During our post-inspection review in 2019, we saw that the force had developed a more comprehensive performance pack. This provided better oversight of its child protection activities, workloads in different teams and potential associated risks. We noted then that the data didn't include qualitative information about the standards of practice and outcomes for children.

The force was developing a process for a crime scrutiny panel to review cases.

These scrutiny panels were held in the first quarter of 2020. Sergeants working within the PVPUs conducted the review, with the findings discussed at PVP managers' meetings.

It is encouraging that the force has continued to develop this process to provide a more objective view of performance. Two PVP quality auditors are now responsible for scheduled audits based on particular areas of business. They look at investigative standards, standards of supervision and continued safeguarding.

This new audit function began on 1 October 2020. Therefore, outcomes are still awaited.

While the new process was being established, the force completed some other audit activity. These audits were of cases that were still under investigation after six months. This demonstrated that investigative activity slowed after that time. As a result, the force has worked with managers to speed up investigations and reduce the number that exceed six months.

The new process now needs to find its place alongside other audit activity, such as that in the force control room (FCR).

The force also needs to think about how to achieve consistency in its audit function, how to bring findings together to identify themes and how to measure improvement.

We were told that there are plans to develop a force-wide audit framework by March 2021.

Some of the force's improvement plans have been implemented

In 2019, we heard that the head of PVP had introduced a vulnerability delivery group. This group includes representatives from the media, IT, performance and audit teams, and PVP managers who are subject matter leads.

The group now meets quarterly. We reviewed the minutes from their meetings. These are well attended by a good cross-section of managers and there is evidence of open discussion. The group provides the force with the ability to track progress against recommendations, deliver messages to staff and drive improvement.

In 2019, the force also intended to introduce Vulnerability: Everyone's Business – a web- and app-based guide for officers dealing with problems involving vulnerable people.

This was about to be launched at the time of our last visit and an app was added to mobile data terminals shortly afterwards. It contains a wealth of advice and guidance. However, there hasn't yet been an evaluation of its impact on practice. Unfortunately, the IT doesn't record how often it is used.

The force planned to launch Operation Encompass, a partnership with schools to share early information on domestic abuse, throughout the county in January 2020. We were pleased to see this is now in place. In spite of the pandemic, the force continued to send alerts to schools so that further support could be considered for children affected by domestic abuse.

2020 findings: Initial contact

Recommendation from the 2018 inspection report

> We recommend that Lincolnshire Police should immediately review its processes regarding incidents relating to child protection, paying particular attention to the response decided on by staff in the FCR.

2019 findings

The force had improved training, oversight and quality assurance within the FCR. As a result, initial response to incidents involving vulnerable children was better.

We also saw better oversight of the diary system. This meant that inappropriate appointments weren't created for cases involving vulnerable people. We saw risk assessment tools being used well, and incidents were usually graded correctly. We didn't see any significant delays in responding to incidents involving vulnerable children.

2020 findings

The force control room remains good at identifying risk

In this inspection, we continued to see that staff working within the FCR are good at identifying risk and at grading responses in line with that risk.

Recommendation from the 2018 inspection report

> Lincolnshire Police should act within three months to make sure that officers obtain and record children's concerns and views (including observations of their behaviour and demeanour), to help influence decisions made about them.

2019 findings

The force had gone to some effort to encourage officers and staff to record children's concerns and views, and to explain their importance.

2020 findings

The force has provided further training

The force has introduced more guidance through the Vulnerability: Everyone's Business app.

Inspectors have also briefed each local policing team and custody team, including showing them a video that informs them about adverse childhood experiences and the potential of these to have a huge effect on a person's later life.

Officers and staff still don't gather and record children's views enough

The force's own research shows that, in around one-third of incidents involving children, officers and staff either don't speak to the children themselves or aren't recording their views and concerns.

We found a similar proportion in our audit sample.

The force hasn't yet been able to make improvements to its public protection notices (PPNs), which are used to make referrals to agencies such as children's social care. Extra questions to remind officers to speak to children and record their views, concerns, demeanour and behaviour are yet to be added.

Plans to survey staff in relation to online abuse, including questions about speaking to children, were suspended during the force's response to the pandemic. A survey would help the force understand why performance hasn't improved in line with its expectations, and to gauge the impact of its training and other initiatives.

Body-worn video isn't used often enough

Body-worn video was used once in the five domestic abuse cases we audited. Officers didn't record the reason for not using body-worn video, although this is expected by the force when officers attend domestic abuse incidents.

The force is aware of reliability issues with this equipment, which means it is not always available. New equipment should be available for March 2021.

2020 findings: Assessment and help

Recommendation from the 2018 inspection report

Immediately, Lincolnshire Police should improve practice in cases of children who go missing from home. As a minimum, this should include a review of how missing episodes are recorded, and making officers and staff more aware of:

- their responsibilities for protecting children who are reported missing from home, especially where this happens regularly;
- the importance of investigating where a child has been, and who with;
- their responsibilities for conducting and recording prevention interviews when children return home; and
- the importance of sharing information with partner organisations.

2019 findings

The force had improved its procedures when children were reported missing. When these were followed, the response was generally good. However, they weren't always followed.

In 2019, the force still wasn't good at conducting prevention interviews when children returned home. Independent return-home interviews completed by the local authority – opportunities to uncover information that can help protect children from the risk of going missing again – weren't available to the force.

These issues meant that risks to children weren't fully understood and longer-term safety planning wasn't effective.

2020 findings

The force is better at gathering information and making plans for children who repeatedly go missing

The force has worked with its partners and now receives information from return-home interviews. This is a positive step. The information gives a rich picture of the child's experience. This is reviewed and added to COMPACT, the police database of missing people.

We were encouraged that officers usually carry out prevention interviews. These interviews make sure that a child is safe and well. Their purpose is to identify any ongoing risk or factors that may contribute to the child going missing again.

At times, however, further investigation of what the child said would have improved future risk assessment or safety planning.

In cases of children who frequently go missing, we saw some good examples of the force contributing to longer-term safety planning with its partners. These related to those children who had been discussed at multi-agency child exploitation (MACE) meetings.

In these cases, plans were developed drawing together information from return-home interviews, prevention interviews and other sources. The plans were visible on the COMPACT system and used whenever those children were again reported missing.

Initial assessment of risk is good, but activity to find children often doesn't match that risk

When a child is reported missing, FCR staff grade most, but not all, reports appropriately. In most of the cases we assessed, COMPACT records were opened within half an hour of the report.

However, we also saw examples when, although the risk was identified by the FCR, activity to trace children in line with that risk was delayed (in one case for 24 hours) or didn't take place because of conflicting demands.

Recommendation from the 2018 inspection report

> Within six months, Lincolnshire Police, along with its partner organisations, should undertake a review to examine its referral processes and supervisory oversight, to make sure that risk to children is identified effectively and the necessary information shared appropriately. Particular attention should be paid to:
>
> - the cumulative risk to children experiencing domestic abuse; and
> - children going missing from home or care.

2019 findings

The force had begun to work more closely with other agencies involved in child protection to improve information sharing.

However, opportunities to intervene were still being missed when children were exposed to domestic abuse and those children were repeatedly going missing.

2020 findings

The force is better at recording and sharing information when children go missing

Most missing child reports are now recorded on COMPACT, making the automated sharing process more effective.

Officers and staff can more accurately assess risk thanks to better recording of prevention interviews, return-home interviews, trigger plans[1] and action agreed at MACE meetings.

But there remain too many examples of when COMPACT records weren't created, especially when children were missing for a short time. This may affect the force's understanding of escalating risk, and may result in prevention and return-home interviews not happening when they should.

Supervisors check public protection notices but don't always intervene when they should

Supervisors regularly endorse PPN reports to say they have reviewed them. However, we saw little evidence of meaningful intervention when it was needed, such as spotting cumulative risk in domestic abuse incidents.

The Police Safeguarding Hub (PSH) staff sometimes recognised escalating risk when they checked the reports. They regraded them accordingly, making multi-agency risk assessment conference (MARAC) referrals when appropriate.

Decision making needs to be more consistent in the Police Safeguarding Hub

We saw two cases that had been reviewed by the PSH staff when serious offences had been disclosed but not recorded or investigated.

Recent data also shows that only around 60 percent of PPNs are shared with children's social care services. This data is yet to be properly understood by the force. No checks are in place to make sure that PSH decisions meet force expectations.

The force should reassure itself that those reviewing the material have the necessary skills and experience to recognise offences and escalate as necessary. Sufficient governance should also be in place to monitor staff decision making.

[1] A plan to locate a child quickly when they go missing.

2020 findings: Investigation

Recommendation from the 2018 inspection report

> We recommend that Lincolnshire Police review its approach to risk assessment and allocation of cases concerning those suspected of viewing, downloading and distributing indecent images of children.

2019 findings

Following our 2018 inspection, the force reviewed all the outstanding cases and acted on them. The force had also worked hard to maintain the numbers of outstanding cases at manageable levels.

2020 findings

The force continues to carry out regular risk assessment of cases and manage demand

Cases awaiting action are now reviewed every month to judge whether the level of risk has changed and whether more prompt action is required.

Although the numbers are increasing – 74 were awaiting action at the time of this inspection – none was graded as high risk.

We are also reassured that the force is conscious that demand is continuing to increase. The force intends to use the national rise in police officer numbers to increase staffing levels within the units dealing with these cases.

Recommendation from the 2018 inspection report

> Lincolnshire Police should improve its child protection and exploitation investigations, paying particular attention to:
>
> - improving staff awareness, knowledge and skills in this area of work;
> - ensuring a prompt response to any concern raised;
> - undertaking risk assessments that consider the full range of a child's circumstances and the risk to other children; and
> - improving the oversight and management of cases.

2019 findings

We were concerned about the standard of investigations. The restructure of the PVPUs, associated training and other absences were having a detrimental effect on the quality of investigations.

2020 findings

We saw some improvement in the standard of investigations

Staff levels in the PVPUs are now where the force intended when the restructure was planned. All staff in the teams have attended the initial SCAIDP course. This was a significant undertaking.

Our case audits demonstrate some improvement in the standard of investigations. We saw examples of good joint working, early strategy discussions and prompt responses to concerns. The better cases had clear supervisory oversight from the outset with regular meaningful reviews to give further direction or support.

Supervision of investigations remains inconsistent

The force expects supervisors to review an investigation and set an initial plan with the investigating officer, then review progress within 28 days. Some supervisors allocated investigations to their staff without clear guidance or instruction. Many also did not have a meaningful review within the 28-day period.

Some of the good cases we saw were due to the actions, knowledge and skill of the allocated officer, rather than guidance from their supervisor.

In some cases, investigative activity was either not recorded or not completed.

Senior leaders are aware of the need to improve supervision of investigations. Unfortunately, additional training for supervisors was suspended in March 2020 because of the pandemic. Plans are in place to restart that training before March 2021.

Investigative opportunities are still being overlooked

Investigations are still either not progressing or being closed too soon, before investigative opportunities have been followed up. This was particularly so in cases where child abuse images were shared. The risks posed by the offender to others wasn't recognised or acted upon. We saw cases where sexually harmful behaviour by children wasn't recognised or referred to partners.

Media devices are still not always examined when they should be. This includes cases where child abuse images may have remained on the devices.

Kiosks are available in local police stations to quickly examine some media devices. Some staff are frustrated by the inability of the kiosks to retrieve evidence, especially from new devices. This may explain the decisions they make.

The force needs to take action in these areas.

2020 findings: Decision making

Recommendation from the 2018 inspection report

We recommend that Lincolnshire Police ensure that it accurately records all relevant information and makes it readily accessible in all cases where there are concerns about the welfare of children. Guidance to staff should include:

- what information they should record (and in what form) on their systems to enable good-quality decisions; and
- an emphasis on the importance of ensuring that records are made promptly and kept up to date.

2019 findings

We found little improvement in recording practices. Officers and staff did not have access to all the available information to assist in making better decisions.

2020 findings

The force is better at recording some information

Recording has improved in some areas:

- Missing reports are usually recorded properly on the COMPACT system, albeit with some exceptions.
- The force receives and records return-home interview information.
- Trigger plans for children who go missing are clearly visible.
- Outcomes of strategy discussions are usually recorded.

Officers and staff still don't have access to important information

During our revisit in 2019, the force intended to improve its form for recording the use of protective powers. This has not happened.

Authorising officers still don't record ongoing reviews of the use of the power. When and in what circumstances the power has been retracted are also not recorded.

This means that officers attending later incidents involving the family won't know what decisions were made, why they were made and what protective measures are in place.

We reviewed recent MARAC minutes. We were pleased to see that these meetings continued by video conference through the pandemic. Attendance is from a variety

of organisations. They share information and agree a variety of actions to reduce risk to victims and children.

Information that a family has been discussed at a MARAC is now recorded on the Niche records management system.

Senior leaders again believed that MARAC actions were also being recorded on Niche. We found this still wasn't happening. This means that officers and staff still don't have access to important information that would help them make better decisions.

2020 findings: Managing those posing a risk to children

Recommendation from the 2018 inspection report

We recommend that Lincolnshire Police act to reduce the number of outstanding visits to registered sex offenders and, within three months:

- review its approach to providing appropriate information on registered sex offenders to response and neighbourhood officers; and
- make sure there is adequate management oversight of performance and risk.

2019 findings

The force was better at overseeing the way it manages offenders. Key staff had been trained, managers had access to better performance information and there was evidence of better supervision of teams.

2020 findings

The approach to managing those who pose a risk continues to develop

An offender management unit now supplements the work of the management of sexual offenders and violent offenders (MOSOVO) unit. It aims to draw together information about all offenders who pose a risk, not just sex offenders. Local officers can now receive briefings and information to improve the monitoring and policing of those individuals.

We have not assessed the unit's work, but this is an interesting initiative. The force hopes it will increase neighbourhood involvement in managing those who pose a risk to communities.

More work is needed to brief neighbourhood police teams to enhance intelligence gathering

The force continues to work on an IT-based system that will help brief local officers about offenders in their area. Senior leaders decided to discontinue the planned intranet-based system because it duplicated information already held in Niche.

Pre-set searches are to be made available so that officers can draw information directly from Niche. Entries for managed offenders do not currently differentiate between risk levels and do not summarise risk management plans. Therefore, a

significant amount of work is needed to bring these records up to a standard that will make these searches useful.

We were assured that this would be complete by the end of 2020.

2020 findings: Police detention

Recommendation from the 2018 inspection report

We recommend that Lincolnshire Police should undertake a joint review with children's social care services and other relevant organisations of how it manages the detention of children. This review should include, as a minimum, how best to:

- make sure that children are only detained when necessary and for the absolute minimum amount of time;
- make sure that an appropriate adult attends the police station promptly;
- make sure officers consider the needs of the child and make referrals to children's social care when necessary;
- assess, at an early stage, the need for alternative accommodation (secure or otherwise) and work with children's social care services to achieve the best option for the child; and
- when alternative accommodation cannot be found, escalate the issue so as to seek a resolution.

2019 findings

Children were usually treated well and fewer were now detained. But timely attendance of appropriate adults, referral to children's social care, and ways to find other places to stay still needed improvement.

2020 findings

The force continues to work with its partners to improve outcomes for children detained in custody

Those agencies responsible for the care of children who are detained, including Lincolnshire Police, meet regularly. They discuss specific issues, such as amendments to procedures and protocols or to solve problems.

The meetings also examine the treatment of all children detained overnight after charge. We were encouraged that those numbers are very low.

However, we were shown data that included relatively high numbers of children detained overnight before charge. The force should work to understand why this happens and reassure itself that children aren't being detained for longer than is absolutely necessary.

Appropriate adults are usually contacted promptly. When the appropriate adult service is responsible for attending, this usually happens, with a focus on the child's wellbeing.

When attendance of adults was delayed, it was usually when a family member was the appropriate adult, or it was thought that they would be.

Opportunities to contribute to longer-term safeguarding are still being missed

The submission of referral forms to alert the local authority of safeguarding problems remains inconsistent. In two cases we audited, referral forms weren't submitted when there were clear safeguarding concerns.

The force knows it needs to do better. At the time of this assessment, it was working to accurately retrieve information from its systems to determine whether referrals are being made when they should be.

The force's planned audit framework can be used to better understand quality of practice when children are detained.

Next steps

The force recognises that it still needs to improve in some areas to provide consistently better outcomes for children.

The pace of progress has been impeded partly, but not exclusively, by the impact of the pandemic.

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

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

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