HMICFRS

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

National child protection inspection – assessment of progress

Northamptonshire Police

30 November–4 December 2020

Contents

Introduction

This report sets out findings from our 2020 assessment of the progress made by Northamptonshire Police against recommendations and findings from our 2018 and 2019 child protection inspections.

The 2018 inspection

In March 2018, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) conducted a child protection inspection of Northamptonshire Police.

This inspection found that senior leaders had a clear commitment to child protection. There was also evidence of the force's readiness to engage and work with other organisations that work to keep children safe across the force area.

The commitment to protecting children was evident throughout the force. We found that specialist officers and staff managing child abuse investigations were committed and dedicated, often working in difficult and demanding circumstances.

However, we also we identified a number of areas where the force needed to improve to ensure children in need of help and protection receive the right support. In particular, we had significant concerns about:

- managing sexual and violent offenders;
- responding to missing children;
- the quality of investigations involving children allocated to non-specialist teams; and
- significant backlogs of electronic devices awaiting examination, leading to delays in investigations.

We published a report on our findings in July 2018. This included a series of recommendations aimed at improving the service provided to children under the age of 18 in Northamptonshire.

The 2019 post-inspection review

In March 2019, we conducted a post-inspection review to assess progress. The review included:

- examining documents, including policies and action plans;
- interviewing officers, managers (including senior managers) and staff; and
- auditing 21 child protection cases (specifically on the areas for improvement set out in the 2018 report).

Although the force had made a number of changes, we found that overall progress since our initial inspection was slow. As a result, in some areas, the force was not yet effectively managing risk.

The force had changed its approach to child protection work to meet the demand. It was prioritising improving joint working, the scrutiny and oversight of child protection, and better ways of monitoring and managing the policing response. But even where changes had already been made, the results for children were not always better. The force still needed to make sure the new processes worked effectively.

The force relied too much on numerical data to measure how well it was looking after children's interests. It needed to look for better ways to measure the quality, as well as the quantity, of outcomes for children.

In some investigations, supervisors were not consistently challenging the progress of enquiries or adding value by giving direction that helped to focus and drive officers' activity forward. We also found that officers were still not sufficiently challenging or escalating matters when local authorities did not provide alternative accommodation for children who were remanded in custody.

Officers and staff were taking on some work that partner agencies should be doing. This included, assisting social care staff to find accommodation for children detained in police custody from outside the Northamptonshire area and placing assessments about sexual or violent offenders on the national violent and sex offender register (ViSOR) database on behalf of the National Probation Service.

Despite this, as we reported in 2018, specialist officers and staff who managed child-related investigations were committed and dedicated to their work. Senior leaders were focused on child protection, and on improving the police response to all vulnerable people.

As a result of this sustained focus, we found a significant decrease in the number of outstanding visits to registered sex offenders (RSOs). The force had also improved its understanding of the reasons why children go missing by completing a problem profile. This was positive and helped the force identify and reduce the risks vulnerable children face.

We audited the force's work in 21 case files. No cases were assessed as good. We found that the force's practice required improvement in 10 cases and was inadequate in 11.

We were concerned about delays and backlogs in several critical areas of child protection work:

- delays in investigating online cases, with frequent drift in investigations;
- a significant backlog of electronic devices awaiting examination by the hi-tech crime unit (HTCU);
- information about missing children obtained from return home interviews not recorded on police systems promptly;
- a significant backlog of risk management plans for sex offenders awaiting supervision; and
- cases dealt with by the non-specialist force investigation team (FIT) taking longer than they should, with a frequent failure to recognise the wider risks children face.

We were also particularly concerned about some of the decisions regarding RSOs who breach the restrictions placed upon them. A breach of these restrictions is likely to be a criminal offence and the offender could be arrested and prosecuted. However, we found that where the breach was deemed to be relatively low level, the force routinely issued warning letters, taking the view that formal action was not in the public interest. We made a new recommendation to the force about this.

Overall, Northamptonshire Police recognised the challenges it faced. It also understood what it must do to provide consistently good outcomes for children. But significant risks remained, due to limited progress since our 2018 inspection.

Methodology for the revisit, and impact of COVID-19

The methodology for this inspection was adapted because of the COVID-19 pandemic. We agreed arrangements with the force, to conduct the inspection both safely and effectively while working within national 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 supervisors; and
- audited 37 child protection cases (these were graded: 10 cases as good, 12 as requiring improvement and 15 as inadequate).

Summary of findings from the 2020 assessment

Northamptonshire police has taken action to improve its ability to protect vulnerable children

It is clear that senior leaders are determined to improve the quality of safeguarding for vulnerable children. The force's strategic plan, Futures Project 25, has, at its core, activity that focuses on reducing vulnerability and dealing effectively with those whose activities present a risk of harm to children.

Senior leaders had reviewed the existing arrangements and are implementing organisational changes. They are aligning resources and capability to support their strategic aims of improving safeguarding practice and achieving better outcomes for children.

This has meant some significant restructuring and additional investment in senior manager positions and establishing a prevention and intervention command. This will support the refocusing of the force's approach by combining some existing specialist units that manage risk, with newly-formed teams that will work closely with other agencies. For example, the Missing Persons Unit (MPU) and the Reducing Incidents of Sexual Exploitation (RISE) team are merging to form a Missing and Vulnerability Identification Team (MAVIT) that recognises the complexity of sources of risk to children.

The force has effective governance arrangements in place for child protection. An assistant chief constable (ACC) chairs a vulnerability board that monitors performance and provides a clear structure for accountability.

Each senior officer is required to complete monthly case audits of their unit's work and report back on their findings. This activity is designed to inform the force of the quality of investigations and the outcomes of incidents such as missing episodes so that concerns can be identified, and improvements made.

The force has invested in developing a strong culture that prioritises reducing vulnerability and improving the outcomes for children after police involvement. It has targeted training at frontline officers and staff to improve capability and competence. Approximately 400 officers have received a 2-day investigator training course, which includes content on responding to vulnerability.

Supervisors have also been trained with a focus on specific areas the force wanted to improve, including missing children, the voice of the child, using protective powers, challenging the use of exclusionary language, and information sharing.

A team member is now designated as the safeguarding officer for all planned operations. This is making a positive impact and supports the culture change that promotes safeguarding activity as a major consideration in all police activity.

The force also supports its workforce with communication campaigns, such as Operation Marvel and #LookCloser. These focus on safeguarding and encouraging staff to be professionally curious when dealing with all incidents where there may be potential child protection or safeguarding opportunities.

More needs to be done to complete the improvements made to how the force identifies and manages those who pose a risk to children

The force has begun addressing our previous recommendations. However, some of this activity needs to be reinforced to improve the consistency and depth of the improvements and actions in progress.

There is still inconsistency in recording practice, particularly in cases involving separated families and multiple siblings. This is despite training that has increased the numbers of referrals made to safeguarding partner agencies, and improved the overall

quality of records on vulnerability and risk. We also saw cases where relevant information about ethnicity and cultural heritage was not recorded. Missing or inaccurate data can undermine the quality of the information about risk to responders, and may affect outcomes.

The force has reviewed and improved some processes. It has developed a vulnerability matrix and established a multi-agency daily risk assessment (MADRA) meeting that supports decision making. The MADRA meeting has real potential to support victims. However, its decisions are not currently recorded on police systems and cannot be accessed by officers. This critically undermines the safeguarding benefits of MADRA.

The multi-agency safeguarding hub (MASH) team, which brings together children's social care and other agencies with responsibilities for the safety of vulnerable people, is located within police premises. It shares information about promoting children's welfare and allows timely strategy discussions to be held for child protection referrals.

Despite this established partnership arrangement, not all the force's safeguarding information and research is routed through the MASH. Information about online offending against children is researched separately. Some is held for long periods on standalone systems before it is finalised and included within the main force intelligence systems. This means that important information about vulnerability and risk may not be available to frontline staff dealing with other concerns affecting children or the perpetrators of abuse.

The force has yet to fully address the level of demand associated with managing registered sex offenders and those who commit online crime

There is a higher workload for the unit responsible for the management of sexual and violent offenders (MOSOVO). The level of online offending, involving the abuse of children by distributing indecent images, also continues to grow. In response, the force has adjusted the way it works and increased staff numbers and specialist resources.

However, demand on the MOSOVO team and HTCU is still rising. The force expects this trend to continue. Even with the latest substantial investment, there are significant backlogs in supervising offenders, in forensically examining digital devices and in investigating intelligence about online offenders.

Supervision in the MOSOVO unit is not sufficient to effectively manage and direct the team's work. Senior officers were not considering or authorising decisions on case management. The force sometimes did not respond quickly enough or correctly refer to partner agencies those cases where the risks offenders posed to children had significantly changed.

HTCU managers have reviewed the risks posed by the backlog for forensic investigation. Their plan is to balance cases that have been in the system for some time, whilst prioritising new cases that pose a high risk. Despite this review, many cases await forensic examination and the current service level agreement (SLA) to complete examinations is 12 months. These delays are a barrier that reduces the effectiveness of some investigations.

The force has invested in specialist equipment to examine and retrieve evidence from digital devices. But the force has yet to provide a facility to assist non-specialist investigators who deal with cases such as sexting, where indecent images of children are contained on devices such as phones.

We were told that the examination of phones is likely to require a minimum of 8 weeks (the force SLA is within 9 months for the HTCU and 28 days for the less complex case examinations). Delays mean that children and their families who are left without a phone for such periods are unlikely to support investigations. Delays also reduce the ability of officers to understand the full extent of the offending behaviour and to implement appropriate and timely safeguarding measures.

There are significant delays in researching, risk assessment and investigation of cases referred to the specialist police online investigation team (POLIT). Some cases come from within the force area, but many are sent as intelligence by the National Crime Agency or from internationally-based policing organisations.

POLIT does not have enough trained staff for the timely processing of the referrals it receives. We were told that cases containing high risk were prioritised and allocated for investigation. But in the majority of cases there is an unacceptable delay in assessing and potentially mitigating the risk to children from offenders.

In our 2018 and 2019 reports we expressed our concern about delays, backlogs and oversight in these areas and the risk that these can create. We are therefore disappointed to find that these problems still remain.

Next steps

Northamptonshire Police still needs to make improvements to some areas of its activity to provide consistently better outcomes for children.

Some progress has been made, particularly in the way frontline officers and staff respond to vulnerable children who are reported as missing from home. However, the force has yet to ensure that all its systems and staff are sufficiently focused on achieving better outcomes for children.

The force has a credible improvement plan and is developing its performance monitoring and auditing capability to inform leaders of what still needs to be done. But this inspection has revealed that force leaders must intervene even more to achieve the sustained improvement in all the areas where we have made recommendations.

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 where required.

Initial contact

Recommendation from the 2018 inspection report

Northamptonshire Police should immediately review its processes:

- to ensure that its staff can easily draw together all available information from police systems in order to better inform their responses and risk assessments; and
- for supervision of the decisions made when police attend incidents where children are at risk or vulnerable.

2019 findings

The force was raising awareness and training staff to recognise vulnerability and prioritise safeguarding. But more work was needed to ensure they could draw together all available information to inform assessments and decision making.

It was taking too long to update police systems with information from return home interviews of children who had been missing from home. This reduces the availability of potentially important information to help responses to future incidents.

There was an improved response to incidents of domestic abuse where children were present. Our concerns that the force was inappropriately scheduling appointments to respond to these incidents (rather than assigning an immediate or prompt response) were reduced. We saw good evidence of research and intelligence assisting decision making. But referrals made to the multi-agency risk assessment conference (MARAC) were not always updated with a record of the minutes or actions from the meeting.

There remained inconsistency and omissions in the way the force used flags and vulnerability markers to highlight important information about risk or vulnerability.

The force wasn't flagging the addresses of RSOs on the command and control system. This potentially meant lost opportunities to act or identify significant changes in an RSO's risk level. Neighbourhood beat profiles contained information about RSOs, but these were not updated sufficiently regularly.

2020 findings

The force control room (FCR) is good at identifying risk

Call handlers have a dropdown checklist of questions, which helps build a complete picture of history and circumstances from the caller.

Flags and warning markers are present on police systems for children who are the most vulnerable when missing from home. This informs the risk assessment, ensuring that action is taken as soon as possible on the correct response to locate the child.

Staff in the FCR are very well supervised and they assess incidents to understand risk and support decisions on prioritisation and level of response. We also saw occasions when the risk assessment changed from medium to high when circumstances changed. This is good evidence of supervisors being dynamic and adapting the priority of the response.

Information from return home interviews with missing children is recorded in a timely way on force systems and 'trigger plans', that hold information about the children's circumstances, are updated to help officers to quickly find the most vulnerable missing children.

The frontline response for vulnerable children has improved but some aspects are yet to be fully effective

Frontline officers are supported with vulnerability guidance, which is on the force intranet and also available via an app on their mobile devices.

The frontline response to reports of missing children is excellent. The investment in training, and strong messages about the risks associated with vulnerability, capturing the voice of the child and not using exclusionary language has meant that staff understand the need to prioritise missing children.

As a result, many more missing cases are now assessed as high risk. Force analysis shows that the average time taken to find children has reduced by 25 percent. When children are found, officers take time to speak with them, attempting to establish rapport and gather intelligence for inclusion within public protection notices (PPNs) so that it is available to others on the force systems.

The FCR assigned an immediate response to most incidents of domestic abuse where children were present. Responding officers completed domestic abuse risk assessments to a good standard in most cases. However, the quality of PPNs was less consistent, with some officers recording the voice and demeanour of children to a high standard, while others recorded little information about the effects of the incident on the children.

The new MADRA is held to focus the response to incidents of domestic abuse. This is a positive initiative, but the meeting records and decisions are not recorded on police systems. As a result, vital information is unavailable to responders if there are repeat incidents.

It was clear that responders are more confident in recognising the risk of significant harm when officers used protective powers to safeguard children. The records we saw showed officers had a good understanding of children's vulnerability, which greatly assisted communication with emergency social workers.

Better availability of information about the presence of those who pose a risk to children

Staff from the MOSOVO unit regularly update force systems and provide information within neighbourhood profiles, with updates on RSOs. This improves the awareness of officers responding to incidents of potential risk and also encourages officers to provide intelligence to assist offender managers.

Senior managers are updated about incidents assessed as high risk and direct resources to reduce vulnerability and risk

Northamptonshire Police has introduced daily pacesetter meetings at key points of the day. These meetings are told about significant incidents, crimes and cases where there is high risk or vulnerability. Senior managers attend and chair the meetings and task work robustly, giving clear focus and direction for the force's response.

Assessment and help

Recommendation from the 2018 inspection report

Northamptonshire Police should undertake a review within three months to ensure that the force is fulfilling its statutory responsibilities as set out in *Working Together to Safeguard Children*, the guide published by HM Government in 2018. As a minimum, this should include:

- examining the referral processes to ensure that risk is being identified effectively and shared in a timely manner with external agencies when appropriate; and
- providing guidance to frontline staff that identifies the range of responses and actions that the police can take to ensure immediate safeguarding concerns are addressed which contribute to multi-agency plans for protecting children in these cases.

2019 findings

Although the completion of PPNs had improved, we found some cases in which this essential activity had not taken place. Despite the importance of recording concerns for vulnerable children and sharing this information within safeguarding arrangements, there was no requirement for supervisors to oversee PPNs.

The force's referral unit screened all PPNs and decided if the information should be shared with other agencies or no further action taken. PPNs that were assessed to meet the safeguarding partnership's higher threshold for statutory intervention by children's social care, were forwarded to the MASH. Those with lower levels of concern were routed to be considered for multi-agency early-help provision.

We were told that discord between agencies had led to pressure to reduce the number of PPNs being submitted by police to the MASH.

The force assessment of PPNs was insufficient because staff were not including intelligence or information from either the police national computer (PNC) or the police national database (PND). Neither were these decisions taken jointly or with the benefit of other agencies' inputs. Consequently, potential opportunities were being missed to intervene and safeguard children at an earlier stage.

2020 findings

Further work is needed to improve the effectiveness of decision making for safeguarding referrals

The main workload of police referral unit staff is to complete research and checks on referrals made to children's social care and in support of strategy discussions held in the MASH.

The force processes remained similar to our previous inspections. All PPNs are reviewed by referral unit staff who decide whether the concern within the PPN meets the threshold for a MASH referral, or to staff within early help, or to take no further action. Staff have now been trained and have access to the PNC. PND checks are also requested when needed to help inform decisions.

Changes have been made to improve the effectiveness of the unit and staff now work in the same offices as colleagues from other agencies. Three detective sergeants are now assigned to the MASH to increase both supervisory oversight and the capacity to hold child protection strategy discussions.

However, the force and its safeguarding partners still hold different views on understanding and applying local referral thresholds. This means that significant numbers of police referrals are not accepted for assessment or further enquiries by children's social care.

The force and its partner agencies work together at the strategic level and have established a MASH steering group. However, there is not enough performance data to allow managers to understand the quality of single and multi-agency contributions to the MASH. Northamptonshire Police has developed a strong culture of case auditing but there is no joint auditing of the MASH by the safeguarding partnership. This reduces the opportunities to identify either strong or weak practice.

We are concerned about the quality of police decision making in strategy discussions for cases referred to the MASH from schools and health settings. Several cases where children had disclosed assaults and abuse to professionals were given to social workers to assess rather than being investigated by police.

Force systems recorded these as allegations of crime but no police investigative activity – such as medical examinations, forensic questioning, scene visits or witness interviews – took place. Officers didn't fully assess the risks to the child, their siblings or other children in contact with the alleged perpetrators. In situations where there is potential for the abuse to repeat or get worse, the opportunity to prevent or mitigate this risk could be missed.

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

Frontline staff were habitually submitting PPNs containing information about the missing episode and also the circumstances in which they found the child, including details of the demeanour and voice of the child. Officers are making time to try and engage with the missing children to gain an understanding of where they have been and to identify any additional safeguarding concerns.

Officers were contributing to multi-agency meetings to evaluate the vulnerability of missing children and to plan support and interventions to keep them safe.

The group of most vulnerable 'missing from home' children is discussed in detail at a monthly multi-agency meeting. In addition, escalating risk for vulnerable children is assessed through a dynamic process. Police officers and managers from the missing and adolescent social care team discuss information about risk gathered in the return home interviews of missing children. This process supports and can trigger effective partnership activity at an early stage without waiting for the formal monthly meeting.

Resources are being provided to reduce crime and vulnerability

A prevention and intervention command is now in place, which focuses on missing persons, those at risk of exploitation, and also on managing known offenders who pose a risk to children and other vulnerable people.

The force and its partner agencies have established an early intervention hub where police and staff from other agencies work together to reduce serious youth crime and other concerns that are a risk to vulnerable people. Analysis of police and partner agencies' data is used to decide where these hubs are based (for example, in areas with higher levels of knife and gang-related crime).

There are significant delays in referring and assessing the risk posed by online offenders

There are significant delays in the research, risk assessment and investigation of cases where the force receives intelligence about offenders accessing and distributing indecent images of children.

At the time of this inspection, only one member of staff was undertaking the intelligence officer role within the POLIT.

There were 111 cases waiting for the development of intelligence. Only 16 of these cases were being worked on. Some cases in this queue had been allocated for research by an experienced HTCU staff member in an attempt to reduce these delays.

The cases in the POLIT development queue are held on standalone systems that are not accessible to others. The current POLIT staffing arrangement and capability means that it can take several months to research, risk assess, allocate and investigate these serious crimes. During this time the intelligence is withheld from the wider workforce and partners. This means that the levels of risk to children are unknown and unmitigated for too long.

When case development does begin, a request for information to inform the risk assessment is made directly to other agency staff. However, at present, these requests are not systematically routed within an established multi-agency information-sharing protocol. Such a protocol would enable a robust multi-agency assessment to inform the investigative strategy.

Investigation

Recommendation from the 2018 inspection report

Within three months, the force should take action to improve child protection investigations by ensuring that:

- investigations are allocated to teams and individuals with the skills and experience necessary to manage them effectively;
- investigations are supervised and monitored, with supervisor reviews recording clearly any further work that may need to be done;
- decisions reached at meetings are recorded on police systems to ensure that staff are aware of all relevant developments to assist in future risk management; and
- regular audits of practice are conducted, which include assessments of the quality, timeliness and supervision of investigations.

2019 findings

Significant delays continued in the work of the FIT. The backlog had been reduced, but some cases were unallocated. Many of the team were inexperienced and were also deployed to other force activity, taking them away from their investigations.

High workloads meant that supervisors didn't always have enough time to support or direct the progress, or challenge whether officers were following identified lines of enquiry.

Specialist officers within the child protection team were working with partner agencies but there were delays in recording information on police systems.

The force needs to do more work to improve the consistency of decision making, risk management and outcomes for children.

2020 findings

The force has reviewed and restructured investigative capability to better support victims

The force has disbanded the FIT which previously dealt with low risk and less complex crime allegations. These crimes are now allocated to named officers within response and neighbourhood teams. Complex and serious crime investigations are the responsibility of criminal investigation teams (CID) based across two local policing areas and specialist units within the crime and justice command.

There are more detectives and the force has invested in training other staff as investigators within the frontline units and CID.

We saw some good initial investigation and supervision when officers responded to child protection incidents, such as neglect and domestic incidents, where children were present in the household. But there were other cases where the investigative actions were less effective and existing vulnerability and previous incidents were not fully considered. This meant that some offenders were not being arrested and robust child protection investigations were not always pursued without delay.

The supervision of investigations and recording of activity remains inconsistent

We saw investigations where officers and supervisors made timely and insightful entries on the records. In these cases, investigation plans were clear and purposeful, and contained information and decisions from strategy meetings. Vulnerability was understood and realistic plans to reduce risk to victims were visible. These investigations did not drift and were regularly updated by the officers.

However, in other cases, we found a lack of timely updates or records of multi-agency meetings, and unexplained delays. Some officers had not taken sufficient investigative action to support victims' accounts and gather evidence from scenes, or interview other potential victims/witnesses. Investigative activity drifted. In some of these cases, supervisors' input did not ensure that the focus was on achieving the best outcomes for children.

The force expects senior managers to identify deficiencies within child protection investigations and take action to improve practice

The force has introduced a policy that requires senior officers to audit incidents and investigations in their areas of responsibility. These managers are required to review five cases in depth each month, using an audit template with set areas including investigation plans, supervisory oversight, safeguarding, voice of the victim/children and decision making. The intention is to improve the quality of investigative practice and outcomes for victims. This is positive.

However, in some cases, despite supervision and auditing, safeguarding activity was insufficiently considered and prioritised. We are concerned that managers are not intervening sufficiently to address poor practice in all types of child protection investigations.

Child protection investigation is more complex than other crime types. Officers should receive specialist training to help them in this role. There is a statutory requirement to investigate jointly with other agencies so that the best interests of the child are kept at the forefront of decision making. All investigators are responsible for sharing and updating information about vulnerability and risk. Good supervision is vital so that the force is confident that its investigations are sufficient to protect children.

Some of the specialist team investigations failed to focus on the safeguarding risk presented by the suspects. This was particularly evident in cases where MOSOVO offenders were potentially breaching notification requirements and also in POLIT investigations. We saw no evidence that the audit process had identified these

concerns and prompted officers to appropriately challenge offenders and make additional referrals.

The police online investigation team should focus more on safeguarding children

POLIT has a high workload with approximately 300 open investigations and a backlog of 115 cases awaiting allocation and investigation. A lack of staff to research and risk assess cases in a timely way has created the backlog.

Investigations against offenders who are a potential risk to children were being routinely delayed. There were also delays in taking action to protect the children to whom these suspects had access. The force told us it intended to assign additional staff to support the team.

We were told that POLIT officers were not routinely obtaining search warrants before attending premises where intelligence indicated that offences involving indecent images of children were being committed. Without a search warrant, officers may not be able to systematically search all the places where evidence may be present. Police could also be denied entry, or suspects alerted, meaning that evidence is lost or opportunities to safeguard children are missed.

Computers and devices seized are forensically examined for indecent image files. For most cases this means lengthy delays in the HTCU queue. Without the digital evidence, decisions on case disposal options cannot be made and suspects are usually released under investigation (RUI) or on police bail.

RUI is often used by POLIT, rather than bail, due to the length of time digital examinations take. However, this practice reduces the protective measures bail conditions could provide when children are potentially at risk.

POLIT had good practice in place to support the welfare of suspects. This required investigating officers referring suspects to support organisations and also maintaining monthly contact with them for the duration of the investigation, or until this was no longer wanted.

A different approach is taken towards vulnerable children. Following the initial investigative activity, the responsibility for officers appears to end with the submission of a PPN. We found a template (see below) on the force system that was being used by POLIT officers endorsing this practice.

Safeguarding strategy at scene

Identify a safeguarding officer to speak to those present, ideally not the suspect. Try and establish what children are in the family, along with their parents' details in order for a PPN to be submitted to the MASH. Once the PPN is submitted to MASH, then social services will take lead on safeguarding, allowing police to focus on the investigation.

POLIT officers are not sufficiently focused on the risks to children in some investigations.

In one investigation about a two-year-old child, the PPN that was submitted stated: "purely for procedural purposes as the child is never left alone with the suspect, and the grandparents, with whom he resides, are aware of his offending history". It was unclear if the child's parents knew about this risk and, if not, whether disclosure to them had been considered.

In another case, the safeguarding officer decided not to submit a PPN about an eight-year-old autistic child, because they were told he was never alone with the suspect, and that the suspect's mother would contact the child's mother once police left. This was not followed up by the police.

In another case, there was a record mentioning the presence of a ten-year-old child, but no PPN for this child was submitted.

Vulnerable children and risks posed by offenders should be identified by officers during child protection investigations. These concerns require assessment, and this means referral and discussion with other safeguarding professionals so that effective plans can be put in place to mitigate the risks. Reassessment is also required when situations change, or periodically during protracted investigations. We expect to see this activity within investigations that seek the best outcomes for children. But this does not happen often enough.

Recommendation from the 2018 inspection report

Within three months, the force should improve its practice in cases of children who go missing from home. As a minimum, this should include:

- improving officer and staff awareness of their responsibilities for protecting children who are reported missing from home, in particular, those cases where it is a regular occurrence;
- improving supervisory oversight required to drive activity to trace children who are reported missing from home; and
- ensuring there is consistency in how information obtained from return home interviews conducted with children is being relayed to the force, to assist in the formulation of plans to reduce the frequency and risk of future episodes.

2019 findings

The response to missing children remained inconsistent. There was improving joint working between the force and social care services missing teams.

There was a missing person problem profile which clearly identified the threat, risk and harm associated with missing children. The force had identified where it needed to make improvements, including the need to draw all information from systems to inform risk assessments and police responses. However, some missing children, particularly those in the care of the local authority, sometimes received no police response, despite the presence of risk indicators. Some calls remained outstanding without a timely response.

The rationale within records did not recognise risk sufficiently. In addition, minimising language reflected a lack of understanding of the vulnerability of missing children.

This led to delayed responses and ineffective investigations to find children, leaving them exposed to risk for long periods.

The missing team was unable to see cases of missing children being held on FCR systems which had not been allocated for investigation. Investigation plans were not evident within the missing person case management system – COMPACT and missing episodes were not viewed as an investigation to find a child.

Reviews were not routinely completed, apart from a 24-hour COMPACT entry by an inspector, which often didn't prioritise tasks to locate the missing child. The force had only recently started to use trigger plans to help find vulnerable children who were frequently reporting as missing.

2020 findings

Systems and practice have significantly improved, providing a highly effective response for children missing from home

Missing investigations start promptly, following sound decision making in the FCR that is supported by good quality trigger plans for some of the most vulnerable children. Initial investigative activity by frontline staff is treated as priority activity and is well supervised.

In high-risk cases, specialist investigators are involved without delay and the missing person unit (MPU) is involved in the majority of investigations. Force pacesetter meetings are updated about high-risk missing cases, meaning that senior leaders can direct additional resources to assist these investigations.

Officers are confident to take children into police protection when they felt this was appropriate. These decisions are made to reduce the risk of significant harm to the child, to keep them safe. We saw evidence of clear rationale and appropriate explanation to others when the use of police protection powers was questioned.

We saw no incidences of officers using inappropriate, exclusionary or judgmental language within reports about children. In fact, we saw strong evidence of staff taking time to engage with and hear the voices of these children. This enabled them to gather information about a child going missing to help understand their vulnerability, any safeguarding concerns and information that could inform future responses. This information also helped to update trigger plans and was included within PPNs.

MPU staff update and review trigger plans, ensuring that force systems have current information to help frontline responders locate missing children. They also engage with these children outside the missing episodes to build trust and reduce the frequency of a child going missing. This information informs a monthly multi-agency meeting which reviews the plans to help the most vulnerable group of children who regularly going missing. This work is proving successful.

Recommendation from the 2018 inspection report

> Within six months, the force must take steps to reduce delays in the high-tech crime unit (HTCU).

2019 findings

It could take up to two years for electronic devices seized by Northamptonshire police to be examined. We were told that senior leaders were implementing a strategy to address the backlogs by increasing the HTCU's capacity and capability in line with the level of investigations it was required to undertake.

The force was planning to introduce technology outside the HTCU to allow investigators to secure evidence from digital devices such as mobile phones, but these were not yet in place. The force had no system for prioritising such devices to speed up investigations into indecent images of children.

The force didn't have a robust system to ensure that indecent images of children it found were uploaded to the child abuse image database (CAID). This undermined the police's ability, locally and nationally, to quickly identify victims. It also decreased evidential efficiency. Without CAID, officers and staff must repeatedly view and grade images.

Long HTCU delays harm investigations, as victims lose confidence and the workload increases for officers in managing suspects, including providing welfare support.

2020 findings

Despite investment there are still delays in the HTCU, which affect both the timely retrieval of evidence and outcomes for victims

Outdated and obsolete computers and software have been replaced. The force has also provided equipment to allow officers from other investigative units to gather evidence from some digital devices without having to submit these to the HTCU.

Five kiosks where officers can examine files on mobile devices have been introduced. Staff have been trained to use these, rather than submitting devices to the HTCU. This reduces delays. However, where devices are thought to contain images relating to sexual abuse, they must be examined by the HTCU. This can take several months. As a result, victims are less likely to be willing to part with their phones, leaving them potentially in possession of indecent images of children. Evidence of offenders or other victims may be lost.

Non-specialist officers are not always conducting investigations that are sufficiently thorough. They need to understand the importance of seizing mobile devices containing indecent images of children, especially in cases where images were created and shared by children in a peer group.

Ideally, these images should be secured and removed from the devices and considered for uploading to CAID by the force victim identification officer. This action supports the identification of victims and future investigations, should those images be linked with other crimes, both locally and nationally. It also helps to prevent the recirculation of the image on the internet and improves outcomes for victims.

Managers have analysed the caseload and are introducing systems to reduce HTCU backlogs

The HTCU understands that MOSOVO and POLIT officers submit the most items for examination. In a successful pilot, HTCU officers have been conducting an early review of POLIT exhibits, with POLIT officers then viewing the results and prioritising exhibits for full examination. This will be adopted as business as usual.

The HTCU has reviewed the outstanding submissions from 2018, and those from 2019 were in progress. The assessment of the quality of evidence was that it had secured enough evidence to support criminal prosecutions or alternative disposals. In only one case was it decided that no further action should be taken. This shows that the HTCU is actively dealing with its backlog cases.

However, there are still delays. In November 2020, force management data showed:

- the HTCU had 83 outstanding cases, 40 of them older than the 12-month SLA target time;
- there were 84 cases awaiting the completion of mobile data investigation within the 9-month SLA; and
- some 29 kiosk examinations were outstanding, 13 of them over the 28-day SLA.

Overall, this meant 53 cases (27 percent of the total of 196) were overdue, based on the force's own SLA.

Managers had taken steps to identify and prioritise high risk within the case load. They also had some funds to outsource work and to speed up some cases, such as those where retaining a mobile phone would cause disproportionate difficulty for a victim.

This situation has improved since our previous inspections. But it still takes too long for Northamptonshire Police to complete examinations of digital devices, considering the potential consequences of these delays for vulnerable children.

Decision making

Recommendation from the 2018 inspection report

Northamptonshire Police should immediately take steps to ensure that all information relevant to the use of powers under Section 46 of the Children Act 1989 is properly recorded and is readily accessible in all cases where there are concerns about the welfare of children. Guidance to staff should include:

- what information should be recorded on systems to enable good quality decisions;
- the importance of ensuring that records are made promptly and kept up to date and visible to all, to assist in future safeguarding and risk management decisions; and
- the proper process to be followed to appropriately challenge decisions made about children with which the force may disagree.

2019 findings

Officers dealt well with incidents where there were significant concerns about children's safety, using their powers appropriately to remove children from harm's way. In the cases examined, decisions were in the best interests of the child. Frontline officers used body-worn video to gather evidence. Children subject to police protection were taken to designated locations other than police stations.

The force had provided guidance on the actions and oversight designated officers must provide. However, we found that officers did not always record some information relevant to the use of powers. Further work was required.

2020 findings

The force is better at recognising risk to children and taking action to protect them

Frontline officers have a good understanding of when police protection should be used. Where officers attend complex and challenging incidents, they are not distracted from their responsibility to prioritise children's safety. There were good records showing officers taking time to engage with the children. Officers were clearly following their training and capturing the voice of the child. Records showed children's views being considered by both response and specialist investigator officers throughout their investigations.

There is generally good record keeping by the officers instigating police protection. Strategy discussions with social workers were held promptly, with good records of updates and follow-up activity recorded in most cases we saw. The recorded information, including children's demeanour and their wishes, was shared on PPNs to support partner agencies' safeguarding activity.

Designated officers are not routinely recording decisions and rationale

Police inspectors perform a statutory role of 'designated officer' when children are taken into police protection. They are required to actively oversee the enquiries made to find a safe place for the children. A template form on the force system has been designed for designated officers to record details of their management of the incident. The force child protection team also records and monitors the occasions when its officers use this power.

Despite these requirements, designated officers were not routinely recording their activity. Most records did not include the rationale agreeing the use of the power and the need for it to continue or stop. In many cases, details of strategy discussions with local authority staff about care and accommodation were not recorded. Details of the times that interested parties were provided with information and outcomes of reviews, or times of handovers, were also frequently absent.

Unaddressed risks may remain if the rationale supporting decisions to end the use of police protection is not clear and fully understood by all those involved. To reduce the possibility of repeat incidents and the need for additional emergency intervention, the police should be satisfied that the arrangements for the children are sufficient to keep them safe. These should be clearly recorded on police systems.

The quality of oversight for designated officers needs to improve to ensure better outcomes for children.

A fast-time process to resolve disputed decisions between agencies would support frontline officers

We saw some evidence of officers challenging decisions of local authority managers, following the use of police protection powers to safeguard children.

One example we saw involved the neglect of young children by a parent who frequently left them alone overnight while they went to work. Frontline officers appropriately took the children into police protection. However, criminal investigations could have been pursued more robustly. The local authority was reluctant to accommodate the children while their vulnerability was fully assessed. Despite police raising concerns to a senior social care manager, the children were returned to the sole care of the parent. Subsequently, the local authority has decided to begin care proceedings to safeguard these children.

We were told that no formal safeguarding partnership process was in place to record and resolve matters where professional disagreement led to incidents or concerns being escalated by managers. These types of arrangements can be useful in identifying organisational learning so that there are better outcomes for all those affected in future incidents.

The Northamptonshire safeguarding children's partnership (NSCP) has an escalation process in place and there is a monthly strategic leads meeting. Other meetings are held between police and children's social care managers. These arrangements are useful in reviewing practice and identifying learning so that there are better outcomes in future incidents.

However, many disputes between agencies occur dynamically while incidents are in progress and an early resolution process may assist in agreeing decisions to achieve the best outcomes for the children.

Managing those posing a risk to children

Recommendation from the 2018 inspection report

The force should immediately undertake a review of its management of RSOs to ensure that all necessary action has been taken to mitigate the risk they pose to children.

Within six months, the force must ensure:

- all staff within the MOSOVO unit should be properly trained to use the ViSOR database used for managing sex offenders.

2019 findings

Those working within MOSOVO, with the exception of the detective inspector, had received training in using ViSOR. As a result, record keeping had improved.

The ratio of staff to offenders had improved but was still insufficient to effectively deal with the caseload.

There was a backlog of risk management plans awaiting supervisory approval. This inhibited the supervisor's ability to check the quality of the proposed plans to manage the known risks and either approve or direct further work.

The force was not collecting sufficient information from the active risk management system (ARMS) because of the way it had previously used ViSOR. This meant there was a lack of information about offender compliance to help focus activity on the RSOs posing the highest risk.

2020 findings

There is insufficient supervision of the MOSOVO team

The force has taken steps to increase MOSOVO staffing levels to meet the caseload and projected increases in the work of the team. A recruitment process for additional staff was under way. Risk management officers (RMOs) were given additional responsibilities and a higher pay grade following a review. The RMOs can now carry out additional activities such as interviewing offenders and file preparation. This improves the agility of the team and supports it to deal more efficiently with cases.

The number of outstanding risk management plans (RMPs) had been reduced from the exceedingly high numbers found in our previous inspections. There were shorter delays in supervisors agreeing the RMOs' assessments.

However, most RMPs on the ViSOR system will wait a month before being reviewed by supervisors. Additionally, if all the outstanding RMPs were to be completed on time (for example, to include changes of circumstances or new intelligence), the timeliness of supervision would be even further delayed.

Due to the number of cases, the two MOSOVO sergeants are unable to complete all the ARMS and the ViSOR supervision in a timely way. The force hadn't addressed this fundamental issue, which we raised in our previous inspections. Such measures could have included assigning extra supervisory posts to the unit on a permanent or temporary basis, and/or identifying and supporting staff to act-up in the short term, to build supervisory resilience.

Despite being in post for approximately one year, the detective inspector (DI), was not fully trained in using ARMS or ViSOR. This meant the DI was not checking the sergeants' work or the quality of the wider team's management of offenders.

MOSOVO staff are insufficiently focused on safeguarding

The information we saw within case records showed an inconsistency in the quality of the team's safeguarding activity. Not all PPNs were fully completed and referred to children's social care in a timely way. These records also indicated that MOSOVO staff were not always professionally curious or challenging about RSO explanations and the risk they posed.

In one case, we saw a record where an RSO had mentioned having large numbers of grandchildren. Relevant details, such as the names and addresses of all these children, were not present and a scant PPN was completed nine days after the home visit.

Six months later, a further PPN was submitted containing the information that some grandchildren were having sleepovers at the RSO's address. There was no record of police investigating this by speaking to the children's parents or to the children themselves. Neither was anything recorded at that stage about actions taken to mitigate this risk.

In another case, an RSO disclosed to officers during a home visit that he had engaged in some concerning sexual behaviour. Despite this disclosure and a separate continuing forensic examination of his previously seized devices, no further investigations to assess his risk took place during that visit.

It is vital that officers follow up and check on RSOs' activities and accounts. They should also make timely and accurate records about the measures to reduce vulnerability and any threat from offenders. Good quality intelligence should be shared without delay to inform staff from relevant agencies that are also involved in protecting the public and safeguarding children.

Recommendation from the 2019 inspection report

> Northamptonshire police should immediately carry out a review of the use of warning letters for RSOs in breach of their notification requirements, when the force assesses that formal action is not in the public interest.

2019 findings

The MOSOVO team had departed from national guidance and introduced a local process for some RSO breaches of notification requirements under the Sexual Offences Act 2003. This meant that investigations of some breaches were recorded and then routinely resolved with a warning letter to the RSO rather than formal action such as a police caution or prosecution.

This approach was outside the College of Policing's national guidance for managing sexual and violent offenders. This stresses that "respectful scepticism" should be central to managing MOSOVO offenders. The routine use of warnings with little or no consideration of the reasons for non-compliance misses important opportunities to identify patterns of behaviour that may indicate increasing risk. It may also undermine future attempts to prosecute, and so protect the public, if previous breaches have not been dealt with robustly.

We saw in some cases that supervisors were issuing warning letters based on incomplete information and without fully considering the wider circumstances and risks.

The approach prioritised caseload demand management over mitigating risk to the community and we recommended that the practice should be reviewed.

2020 findings

Decisions taken about offender breaches of notification requirements are insufficiently supported with clear rationale or supervisory endorsement

Of the six MOSOVO cases we reviewed, four of them provided evidence of RSOs breaching notification requirements. In three of these cases, inappropriate decisions were made to take no further action on these breaches due to "prosecution not being in the public interest".

One of these cases concerned a breach of notification requirements by an RSO who had been recently released from a prison sentence following his breach of a sexual harm prevention order (SHPO). This offender was described on records as being "manipulative" and "a real risk to children".

Another case contained details of an RSO failing to register his passport, despite being repeatedly reminded to do so by officers. The RSO later also failed to notify changes to his bank account details.

The force told us that "low-level breaches were subject to detective chief inspector (DCI) scrutiny prior to no further action (NFA)". This was not always the situation within the records we saw.

We saw cases where junior MOSOVO staff made decisions on case outcomes where no enforcement action was taken and then recorded and finalised these cases on the force system without any accompanying endorsement from the DCI or other supervisors.

In one case, the RSO had breached notification requirements about a bank card and was given a verbal warning by the offender manager. There was no record of the rationale for this decision, or details of consultation or supervisory authority.

The force has yet to show that it has a robust approach to offender notification breaches. Its use of warnings with little or no consideration of the reasons for non-compliance misses important opportunities to identify patterns of behaviour that may indicate increasing risk. The continuation of poorly supervised, unstructured practice potentially undermines the purpose of protecting the public.

Police detention

Recommendation from the 2018 inspection report

Within six months, Northamptonshire Police should, in conjunction with children's social care services, review how it manages the detention of children. As a minimum, it should:

- ensure that all children are only detained when necessary and for the absolute minimum amount of time;
- ensure that officers and staff in the custody suite assess at an early stage a child's need for alternative accommodation (secure or otherwise) and work with children's social care services to achieve the most appropriate option for the child;
- ensure that custody staff comply with their statutory duties to complete detention certificates if a child is detained for any reason in police custody following charge;
- ensure that custody staff make a record of all actions taken and decisions made on the relevant documentation; and
- improve the timeliness of adequate appropriate adult support for children who are arrested.

2019 findings

Further work was needed to ensure custody staff understood how and why detention certificates should be completed for children refused bail.

Custody officers knew that they needed to find alternative accommodation for children refused bail. But their requests were not always for the right type of accommodation and they were not being made soon enough for all the arrangements to be put in place.

There was little evidence of senior officers escalating the issue with the local authority when accommodation for children wasn't provided. This meant some children were continuing to be held in detention unnecessarily after they had been charged.

We still saw instances of delays in the appropriate adult's arrival at the custody suite, but there was evidence that the situation was improving.

A healthcare professional (HCP) should see all children when they arrive in custody. Although we found that HCPs were available to children in custody, they did not always see them.

The liaison and diversion team in custody provided support to a range of vulnerable groups, including those experiencing mental health problems, alcohol and drug addiction or learning difficulties, as well as children.

The force was using its audit process to better understand its performance when children are detained.

2020 findings

The force is working to improve outcomes for children detained in custody

Arrests were justified and necessary in all the cases we saw where children were detained, as the offences were serious crimes.

Inspectors were informed without delay every time a child was detained in custody. Most of their reviews were completed face to face with the child and recorded on the custody record.

The force policy for all detained children to be seen by an HCP meant that all children were seen promptly after arriving in custody.

Appropriate adults were called without delay. Their attendance was timely and ensured that the child received their rights and entitlements quickly. In one case we saw, an appropriate adult was present where it was necessary to strip search a child.

As part of their core activity, the liaison and diversion staff present in the custody suites saw children who were detained. This is beneficial to children as referrals and assessments to support them are initiated without delay.

There are delays in requesting alternative accommodation and children's vulnerability is insufficiently recognised

Requests for alternative accommodation are not generally made until after the child has been charged. Children are generally arrested only for serious offences. Custody officers should be expected to anticipate the need for alternative accommodation earlier and to start asking the local authority to provide it. Requests made with short notice or at night are less likely to be successful, leaving children in police cells until they are taken to court.

Detention certificates that should be completed by custody officers when refusing a child bail are not detailed enough. In one case, no detention certificate had been completed.

Officers were also not recording sufficient information with supporting rationale when seeking secure accommodation for children. Requests for secure accommodation are appropriate only when the child is thought to present a serious risk to others, rather than on the seriousness of the offence they are charged with.

These omissions and deficits in practice are significant. They indicate that the custody team is not yet sufficiently recognising the vulnerability of children who are involved in serious crime. These children are at high risk of harm. The police need to recognise this and communicate effectively to others who can work to reduce these risks.

Although present, the force's case auditing process had still to have an impact on making sustained improvements across all aspects of the custody system for arrested children.

Next steps

Northamptonshire Police still needs to make improvements to some areas of its activity to provide consistently better outcomes for children.

Some progress has been made, particularly in the way the front line responds to vulnerable children who are reported as missing from home. Officers have made good progress in recognising vulnerability when responding to incidents where children are affected by domestic abuse and in some situations where neglect and abuse is present.

The pandemic does not appear to have impeded the force's work in strengthening its initial response to these areas of activity. The FCR systems ensure strong supervision and direction.

However, the force has yet to ensure that all its systems and staff are sufficiently focused on achieving better outcomes for children. The strategy to safeguard the vulnerable throughout police activity had not been understood or acted upon in some specialist units. Our specific areas of concern are as follows:

- further work is needed to improve the effectiveness of decision making for safeguarding referrals;
- the supervision of investigations and recording of activity remains inconsistent;
- insufficient supervision of the MOSOVO team – the force has yet to show that it has a robust approach to offender notification breaches, with poorly supervised unstructured practice;
- the POLIT team is not focused on safeguarding children;
- significant delays in referring and assessing the risk posed by online offenders;
- delays in the HTCU affecting the timely retrieval of evidence and outcomes for victims; and
- the custody team is not consistently recognising the vulnerability of children who are involved in serious crime.

The force has a credible plan and is developing its performance monitoring and auditing capability to inform leaders of what still needs to be done. But this inspection has revealed that force leaders must intervene even more to achieve the sustained improvement in all the areas where we have made recommendations.

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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