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

National Child Protection Inspections

Northamptonshire Police
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Foreword

All children deserve to grow up in a safe environment, cared for and protected from harm. Most children thrive in loving families and grow to adulthood unharmed. Unfortunately, though, too many children are still abused or neglected by those responsible for their care; they sometimes need to be protected from other adults with whom they come into contact. Some of them occasionally go missing, or end up spending time in places, or with people, harmful to them.

While it is everyone's responsibility to look out for vulnerable children, police forces, working together and with other agencies, have a particular role in protecting children and making sure that, in relation to their safety, their needs are met.

Protecting children is one of the most important tasks the police undertake. Police officers investigate suspected crimes and arrest perpetrators, and they have a significant role in monitoring sex offenders. They have the powers to take a child in danger to a place of safety, and to seek restrictions on offenders' contact with children. The police service also has a significant role, working with other agencies, in ensuring children's protection and well-being in the longer term.

As they go about their daily tasks, police officers must be alert to, and identify, children who may be at risk. To protect children effectively, officers must talk to children, listen to them, and understand their fears and concerns. The police must also work well with other agencies to play their part in ensuring that, as far as possible, no child slips through the net, and to avoid both over-intrusiveness and duplication of effort.

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) is inspecting the child protection work of every police force in England and Wales. The reports are intended to provide information for the police, the police and crime commissioner (PCC), and the public on how well children are protected and their needs are met, and to secure improvements for the future.

Summary

This report is a summary of the findings of an inspection of child protection services in Northamptonshire Police, which took place in March 2018.[1]

HMICFRS's inspection comprised an examination of the effectiveness of police action at each stage of their interactions with or for children, from initial contact through to the investigation of offences against them. It also scrutinised the treatment of children in custody, and assessed how the force is structured, led and governed in relation to its child protection services.[2]

Main findings from the inspection

The chief constable, his command team, and the police and crime commissioner (PCC) have a clear commitment to child protection, reflected in both the police and crime plan and the force's priorities.

Inspectors found that the force has an effective system for referring children to the multi-agency safeguarding hub, which means all children identified as vulnerable by the police can be assessed jointly with partner safeguarding agencies. However, the force often fails to provide sufficient details on these referrals. This can lead to a failure to provide the full picture of risk relating to a child.

We found that officers within its dedicated child protection team are well-trained and highly-motivated. Their caseloads are manageable and we found evidence of effective investigations. Equally, the responding to incidents of sexual exploitation (RISE) team's work to protect vulnerable children in Northamptonshire who are at risk of child sexual exploitation, is innovative and effective.

However, HMICFRS also identified a number of areas where the force needs to improve if it is to ensure the service it provides to children in need of help and protection is of a consistently high standard. In particular, we had significant concerns about the management of sexual and violent offenders, which is not currently in line with national guidance. Improvements are also required in the response to missing children, and in the quality of investigations involving children

[1] 'Child' in the report refers to a person under the age of 18. See annex B for this and other definitions.

[2] For more information on HMICFRS's rolling programme of child protection inspections, see: www.justiceinspectorates.gov.uk/hmic/our-work/child-abuse-and-child-protection-issues/national-child-protection-inspection/

allocated to non-specialist teams. We also found that significant backlogs of electronic devices awaiting examination within the hi-tech crime unit is leading to delays in investigations.

During the inspection, HIMCFRS examined a total of 81 cases in which children were identified as being at risk. Of these, the practice in 22 cases was rated as good, in 25 as requiring improvement, and in 34 as inadequate. This demonstrates that there are significant areas where the force needs to improve if it is to ensure the quality and consistency of the service it provides to those children in need of help and protection.

Conclusion

The chief constable, his senior team, and the PCC have made a clear commitment to protecting vulnerable children, and made it central to the force's values and strategic objectives. This is in turn widely recognised by the staff, officers and partner agencies HMICFRS consulted as part of this inspection. Throughout the inspection, we found that specialist officers and staff who manage child abuse investigations are demonstrably committed and dedicated, often working in difficult and demanding circumstances.

Despite this we were extremely troubled by some of the weaknesses we identified – specifically the management of sexual and violent offenders and the quality and timeliness of investigations.

However, it is clear the force has a culture of continuous improvement, and we were pleased to note it responded promptly and positively to the areas we identified. We have made a number of recommendations, and will revisit the force within six months of publication of this report to assess how it is managing the implementation of those recommendations. We will also continue to work with the force to support its ongoing improvement activity.

1. Introduction

The police's responsibility to keep children safe

Under the Children Act 1989, a police constable is responsible for taking into police protection any child whom he has reasonable cause to believe would otherwise be likely to suffer significant harm, and the police have a duty to inquire into that child's case.[3] The police also have a duty, under the Children Act 2004, to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children.[4]

Every officer and member of police staff should understand his or her duty to protect children as part of the day-to-day business of policing. It is essential that officers going into people's homes on any policing matter recognise the needs of the children they may encounter, and understand the steps they can and should take in relation to their protection. This is particularly important when they are dealing with domestic abuse or other incidents in which violence may be a factor. The duty to protect children extends to children detained in police custody.

In 2018, the National Crime Agency's strategic assessment of serious and organised crime established that child sexual exploitation and abuse represents one of the highest serious and organised crime risks.[5] Child sexual exploitation is also one of the six national threats specified in the *Strategic Policing Requirement*.[6]

[3] Children Act 1989, section 46.

[4] Children Act 2004, section 11.

[5] *National Strategic Assessment of Serious and Organised Crime*, National Crime Agency, May 2018. Available at: www.nationalcrimeagency.gov.uk

[6] The *Strategic Policing Requirement* was first issued in 2012 in execution of the Home Secretary's statutory duty (in accordance with section 37A of the Police Act 1996, as amended by section 77 of the Police Reform and Social Responsibility Act 2011) to set out the national threats at the time of writing, and the appropriate national policing capabilities needed to counter those threats. Five threats were identified: terrorism; civil emergencies; organised crime; threats to public order; and a national cyber security incident. In 2015, the *Strategic Policing Requirement* was reissued to include child sexual abuse as an additional national threat. See *Strategic Policing Requirement, Home Office, March 2015.* Available at www.gov.uk

Expectations set out in *Working Together*

The statutory guidance, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*,[7] sets out the expectations of all partner agencies involved in child protection (such as the local authority, clinical commissioning groups, schools and the voluntary sector). The specific police roles set out in the guidance are:

- the identification of children who might be at risk from abuse and neglect;
- investigation of alleged offences against children;
- inter-agency working and information-sharing to protect children; and
- the use of emergency powers to protect children.

These areas of practice are the focus of HMICFRS's child protection inspections.[8]

[7] *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, February 2017 (latest update). Available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

[8] Details of how HMICFRS conducts these inspections can be found at annex A.

2. Context for the force

Northamptonshire Police has approximately 2,050 people in its workforce (as at September 2017). This includes:

- 1,209 police officers;
- 753 police staff; and
- 92 police community support officers.

The force provides policing services to a population of around 700,000 people over an area of 913 square miles. The resident population is increased by university students and the large numbers who visit or travel through the county each year.

The force provides policing services to the county of Northamptonshire across 16 geographical neighbourhoods: rural Corby; Corby Town; rural Daventry; Daventry Town; East Northants Central; East Northants North; East Northants South; rural Kettering; Kettering Town; Northampton Central; Northampton North East; Northampton South West; South Northants Brackley; South Northants Towcester; rural Wellingborough; and Wellingborough Town.

There is one local authority in the county, Northamptonshire County Council, and one local safeguarding children board (LSCB). Neighbourhood, response, and investigation police services are provided through a single local policing command. The force's operating model is currently under review as part of the service delivery model programme, and changes to the workforce profile are being implemented. The force's child protection teams are based at two sites in Northamptonshire.

Deprivation in England is determined through various social factors, resulting in a national rank for each of the 326 local authorities;[9] the local authority ranked at number one is determined as being the most deprived. Northamptonshire is in the mid-upper range for overall deprivation, ranking at 108 out of 326 local authorities (Kettering is ranked at 168; Corby at 75; Daventry at 238; and Wellingborough at 133).

The most recent Ofsted judgment for the local authority is set out below.

[9] For more information see www.gov.uk/government/statistics/police-workforce-england-and-wales-30-september-2017

Local authority	Judgement	Date
Northamptonshire County Council	Requires improvement	08/02/2016

An assistant chief constable is Northamptonshire Police's overall lead for public protection and is supported by a detective chief superintendent who is the overall head of crime. A detective superintendent oversees the units responsible for the public protection both of children and adults.

Northamptonshire Police is part of a multi-agency safeguarding hub (MASH), responsible for using and sharing information with partner agencies to ensure that all interventions with a child and their family are appropriate, timely, and effective. For all cases involving an identified victim of child abuse, part of the investigation is liaison with agencies within the MASH.

3. Leadership, management and governance

Safeguarding is a priority for both the force and the office of the police and crime commissioner. Particular emphasis is placed on protecting children from the risks of child sexual exploitation and online crime, and on using multi-agency early interventions to prevent vulnerable children and families being exposed to crime. This strong commitment to keeping children safe was evident throughout the inspection, clearly understood by officers and staff, and reflected in the work undertaken to develop the force's new service delivery model.

Internally, the force monitors and seeks to improve its performance through its monthly performance and improvement group meeting. This examines the force's performance in several areas, including public protection from dangerous offenders and domestic abuse. Externally, the force interacts effectively with partner agencies through regular attendance at the Northamptonshire Safeguarding Children Board.[10] Officers also attend the various sub-groups that feed into this board, which include those focused on: child sexual exploitation; missing people; and vulnerable children and adults. However, while engagement with partners is positive, senior leaders described the significant challenges being faced by Northamptonshire County Council and the difficulties this presents for effective partnership working. Major organisational restructuring in a climate of significant financial challenge means that senior leaders across the partnership must give careful consideration to ensuring that safeguarding and protective planning for vulnerable children continue to be prioritised.

The force has invested in safeguarding training for frontline officers and staff and has recently developed a number of online training modules on protecting vulnerable people, which are presented by supervisors to their teams. So far, these have covered topics such as mental health, missing people, hate crime, and child sexual exploitation. These interactive modules have received good feedback from officers and staff, and are considered by recipients to be better than national online packages. Moreover, a number of local neighbourhood police teams throughout Northamptonshire have arranged for child protection experts from within the force to provide training, including inputs from externally-sourced speakers (most recently from the disability and learning alliance, and from a survivor of child sexual exploitation).

Leadership across the force is generally good and child protection is recognised as a priority within all areas of the organisation. However, HMICFRS did find some reluctance by frontline supervisors at sergeant and inspector levels to challenge decisions made by the local authority, specifically those relating to refusals to take

[10] A statutory multi-agency board made up of representatives from the local authority, police, health services, probation trust, youth offending services, the voluntary sector, and others.

children into its care (including when they are arrested and detained in police custody, and when taken into police protection). Although processes exist to escalate such matters, these are used too infrequently. This may be due in part to the significant number of officers undertaking these roles on a temporary basis, who may not have accrued the knowledge of the procedures for escalating problems.

The force runs a daily protecting people from harm management meeting, which aims to identify and prioritise activity against those incidents or individuals perceived to pose the biggest risk. Although the meeting is well-represented by all departments (both in person and via videolink), we found the structure of the meeting was inconsistent, often being determined by the chair on a particular day. The consequence of this was a lack of emphasis on the protection of vulnerable people – including children.

4. Case file analysis

Results of case file reviews

To determine how well Northamptonshire Police deals with specific cases, HMICFRS asked the force to self-assess the effectiveness of its practice in 33 child protection cases. The force used HMICFRS criteria[11] to grade its practice in each case as 'good', 'requiring improvement', or 'inadequate'.

Of the 33 which were self assessed, practice was rated by the force as good in 25 cases; requiring improvement in 8 cases; and inadequate in none.[12]

HMICFRS also assessed these cases. The findings were significantly different from that of the force: practice was rated as good in 6 cases; requiring improvement in 12 cases; and inadequate in 15 cases.

Figure 1: Cases assessed by both Northamptonshire Police and HMICFRS

	Good	Requiring improvement	Inadequate
Force assessment	25	8	0
HMICFRS assessment	6	12	15

[11] The assessment criteria for and indicators of effective practice used in this report are taken from *National Child Protection Inspection: Criteria Assessment*, HMIC, London, 2014. Available at: www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/ncpi-assessment-criteria.pdf

[12] The case types and inspection methodology are set out in annex A.

Below is an example of a case in which the force self-assessed its practice as good, in contrast to HMICFRS's rating of the force's practice as inadequate.

A care home reported a child staying there missing after she failed to return at the agreed time. Before the police could locate her she returned sometime later of her own volition. A return interview was completed, as per force policy, and the incident was closed.

The assessment conducted by HMICFRS found that despite obvious risk factors indicating a vulnerability to sexual exploitation, no one attended the care home to begin an investigation to locate the girl for some five hours. No flag indicating an increased risk of sexual exploitation had been placed on force systems and there was no record of a notification being sent to children's social care services to inform the development of a longer-term protective plan. Despite being reported missing on numerous occasions in the past there was no evidence that the escalating or cumulative risk to the child was being considered or addressed. Each missing episode was dealt with in isolation leading to an inconsistent (and often inappropriate) assessment of the risk faced by the child. This in turn undermined the development of longer-term protective plans to reduce the risks and vulnerabilities faced by the girl.

HMICFRS selected and examined a further 48 cases: in 16 the force's practice was assessed as good; in 13 as requiring improvement; and in 19 as inadequate.

Figure 2: Additional cases assessed only by HMICFRS

	Good	Requiring improvement	Inadequate
HMICFRS assessment	16	13	19

HMICFRS referred eight cases back to the force because they were considered to contain evidence of a serious problem – for example, failure to follow child protection procedures and/or a child at immediate risk of significant harm. The force responded to the referrals by providing an updated assessment or by taking action relevant to the problems identified.

The following are examples of two cases referred back to the force:

- A 10-year-old girl told her teacher that she had been sending and receiving indecent images to and from three older men via social media. There was a timely initial response by the force and a strategy discussion took place. However, at the time of our inspection the investigation was more than 100 days old, and there was no evidence of any investigative activity to identify and trace the perpetrators (who may be of risk to other vulnerable children).
- HMICFRS noted that in the case of a registered sex offender wanted for an offence there had been no management oversight nor supervision of this case since 2014. Although some superficial enquiries had been completed there was very little information to indicate what investigative activity (if any) had taken place to locate and arrest the offender. We also found that information about the offender being wanted had been removed from the Police National Computer. This meant that if the offender were to come to the attention of officers they would be unaware of the need to make an arrest.

Breakdown of case file audit results by area of child protection

Figure 3: Cases assessed involving enquiries under section 47 of the Children Act 1989

Case type	Good	Requiring improvement	Inadequate
Enquiries under section 47 of the Children Act 1989[13]	3	5	5

These are cases where a child has been identified as in need of protection, i.e., is suffering or likely to suffer significant harm. HMICFRS found that:

[13] Local authorities, with the help of other organisations as appropriate, have a duty to make enquiries under section 47 of the Children Act 1989 if they have reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm.

- There is generally a swift response to calls for assistance where children are said to be at risk.
- Although police protection notices (PPNs) are generally completed for all children coming to notice in this manner, their quality of completion is inconsistent and many do not contain evidence of officers speaking directly to the relevant children.
- Such cases should result in a strategy meeting and joint visit between child protection team officers and children's social care services, however, details of such visits are often not recorded or they do not occur.
- Where a strategy meeting is recorded the detail is often poor, at most providing a summary of recent events, with no clear plan to safeguard the child.

Figure 4: Cases assessed involving referrals relating to domestic abuse incidents or crimes

Case type	Good	Requiring improvement	Inadequate
Cases relating to domestic abuse incidents	3	5	2

Further detail for some of these individual cases, relating to domestic abuse incidents, is given in the chapters that follow.

Common themes include:

- Protecting vulnerable people training modules provided to all departments have a strong emphasis on domestic abuse, including stalking and harassment, so-called honour-based violence, and coercion and control.
- Those within the force control room understand the risks and recognise the indicators of domestic abuse, using an effective and standardised risk assessment.
- Where a call is graded as 'immediate', there is a fast and effective intervention that ensures safeguarding and investigative opportunities are addressed.
- Where a call is graded as 'prompt', deployment varies and is rarely in a prompt fashion; too often it occurs the following day or is given a scheduled appointment. In these cases the momentum is lost and delays occur in both the safeguarding and investigation activity.

- Crime allocation for domestic abuse cases is organised via a formal document; investigations are allocated to different units based on their gravity and complexity.
- Supervision and practice is much better within specialist departments.
- The consistency of domestic abuse, stalking and harassment and honour-based violence (DASH) risk assessment completion is good. HMICFRS did not review any cases where the assessment of risk had been underestimated, and all forms are subject to supervisor endorsement.
- PPN completion is less good; the quality and details included are often lacking, with wider safeguarding observations generally brief or altogether absent. This weakness indicates a reluctance to engage with affected children.
- Use of body-worn video is mandatory for attendance at all incidents of domestic abuse and its use was evident during the inspection.

Figure 5: Cases assessed involving referrals arising from incidents other than domestic abuse

Case type	Good	Requiring improvement	Inadequate
Referrals arising from incidents other than domestic abuse	0	3	5

Further detail for some of these individual cases, relating to non-domestic abuse incidents, is given in the chapters that follow.

Common themes include:

- Officers respond to incidents quickly in which there are children at immediate risk.
- There are good examples of safeguarding and investigations for cases in which specialist child protection teams are involved from the outset.

Strategy discussions and meetings either do not take place or documented evidence of their occurrence is often absent.

Figure 6: Cases assessed involving children at risk from child sexual exploitation

Case type	Good	Requiring improvement	Inadequate
Cases involving children at risk of child sexual exploitation both online and offline	13	5	3

Further detail for some of these individual cases, relating to child sexual exploitation, is given in the chapters that follow.

Common themes include:

- Despite a generally inconsistent quality of investigations, there are examples of some exceptional investigations that safeguard victims and target perpetrator offending (both civilly and criminally), through joint work between the RISE team and partner agencies.
- Those who do not meet the threshold required for a RISE team response are instead referred for support from the drug and alcohol support service (Aquarious).
- Although the return-home interviews are conducted by RISE engagement officers (which we regard as positive), these often fail to be recorded on police systems.
- Multi-agency meetings occur regularly via RISE to review the risk for each relevant child; of those viewed by HMICFRS, effective and positive professional challenge was observed, and each agency was held to account.

Figure 7: Cases assessed involving missing and absent children

Case type	Good	Requiring improvement	Inadequate
Cases involving missing and absent children	0	1	6

Further detail for some of these individual cases, relating to missing and absent children, is given in the chapters that follow.

Common themes include:

- Poor risk assessment processes used in the force control room often result in underestimated risks to children who are reported missing. This can lead to children previously identified as at high risk of child sexual exploitation being assessed as absent (i.e., at no apparent risk) or of medium risk.
- Subsequent risk assessment processes conducted by response supervisors also lead to minimisation of risk, or can perpetuate poor risk-assessment processes.
- The quality of most missing children investigations is poor, with little evidence of sufficient pursuance and urgency relating to the completion of investigative tasks.
- The force's missing persons unit (MPU) performs primarily administrative tasks; it does not quality assure either its risk-assessment processes or decision-making in relation to current missing children cases.
- Return-home interviews are conducted by a social work team located alongside the RISE team; there are no processes to monitor the rates of completion of these interviews.

Figure 8: Cases assessed involving children taken to a place of safety under section 46 of the Children Act 1989

Case type	Good	Requiring improvement	Inadequate
Children taken to a place of safety by police officers using section 46 of the Children Act 1989[14] powers	1	2	4

Further detail for some of these individual cases, relating to the use of powers under section 46 of the Children Act 1989, is given in the chapters that follow.

Common themes include:

- When it is clear that a child is at risk of significant harm, the response by frontline officers is generally appropriate in using these powers.

[14] Under section 46 of the Children Act 1989, the police may remove a child to suitable accommodation if they have reasonable cause to believe that the child is at risk of significant harm. A child in these circumstances is referred to as 'having been taken into police protection'.

- Although children should only be taken to a police station as a place of safety in exceptional circumstances, examined cases provide evidence that this is happening as a matter of routine.
- There is generally poor recording of the justification for use of these powers and subsequent management by designated officers, and for when the use of the power ceases.
- There is a lack of appropriate challenge made to social care services when the advice is to return the child to the same location from which they were taken under police protection powers.
- Officers display compassionate behaviours towards children taken into police protection.
- There is inconsistency in recording the 'voice of the child'.
- There is a lack of recorded plans made in the strategy and multi-agency meetings following use of police protection powers.

Figure 9: Cases assessed involving sex offender management where children have been assessed as at risk from the person being managed

Case type	Good	Requiring improvement	Inadequate
Sex offender management where children have been assessed as at risk from the person being managed	0	1	5

Further detail for some of these individual cases, relating to sex offender management, is given in the chapters that follow.

Common themes include:

- The managed-offenders-to-staff ratio is notably high and far over the nationally-recommended guidance levels.
- Multi-agency public protection arrangements (MAPPA) level 3 meetings are attended at sufficiently senior rank in accordance with MAPPA guidance, but attendance at level 2 meetings does not comply with this guidance.

- The management of sexual offenders and violent offenders (MOSOVO) unit conducts initial active risk management system (ARMS[15]) assessments on 82 percent of relevant offenders. However, it fails to conduct the required yearly reviews consistently, which compromises the accuracy of the assessments and therefore the risk-management levels.
- There is a high backlog of overdue visits to sex offenders (40 of which we found had not being visited by officers since 2015).
- There is a lack of understanding within the MOSOVO unit regarding proper use of the violent and sex offender register (ViSOR) database, to identify and manage overdue visits and to identify failures to comply with restrictions imposed on offenders.
- F and Thompson reviews are not being undertaken (see chapter 10 below).

[15] ARMS is a structured assessment process to assess dynamic risk factors known to be associated with sexual re-offending, and protective factors known to be associated with reduced offending. It is intended to provide police and probation services with information to plan the management of convicted sex offenders in the community.

Figure 10: Cases assessed involving children detained in police custody

Case type	Good	Requiring improvement	Inadequate
Sex offender management where children have been assessed as at risk from the person being managed	2	3	4

Further detail for some of these individual cases, relating to children detained in police custody, is given in the chapters that follow.

Common themes include:

- Custody officers and staff regularly challenge the necessity to arrest and are effective at refusing detention where appropriate.
- Too often there are long delays in appropriate adults attending and, in the majority of cases audited, their attendance generally appears to coincide with the timings of interviews of the child (as opposed to being for the purpose of assessing their welfare).
- Although requests are made to children's social care services to transfer detained children from custody, requests for secure accommodation often fail to include details of the serious risk of harm the child poses to the public or to themselves.
- Although there is some evidence of custody officers and staff notifying inspectors of the inability to source alternative accommodation, there is a lack of documented evidence of further action taken by inspectors in response.
- There is inconsistency in relation to the completion of PPNs for arrested children.

5. Initial contact

Northamptonshire Police has invested in training both its frontline and specialist officers and staff about their roles in safeguarding children. We found that this training has translated into an increased sense of awareness and responsibility when children who may be vulnerable are encountered.

Police received a report of a couple who were apparently drunkenly arguing, in the course of which a child had been seriously hurt. Officers attended promptly and took swift action to safeguard the child and arrest the suspects. A co-ordinated response between police and partner organisations followed and ensured that both investigation activity and safeguarding were carried out in tandem. Although the criminal matter was not progressed (following a decision made by the Crown Prosecution Service), a strategy meeting between partner agencies within the MASH ensured that appropriate help and support was offered to the family to mitigate future risks to the child.

Officers and staff in the force control room use the threat, harm, risk, investigation, vulnerability and engagement (THRIVE) risk assessment model, in addition to question sets which support the assessment of call prioritisation. Where calls are assessed as requiring attendance from officers, they are categorised as: 'immediate' (attendance is required within 20 minutes); 'prompt' (attendance is required within an hour); or for an arranged appointment at a time convenient to the victim. We found supervisors to be available and proactively reviewing calls to verify the accuracy of initial risk assessments, in order to enable the correct level of police response.

However, the system is less effective at the point where calls initially graded as requiring a prompt response are not attended within the hour target. HMICFRS found examples of such calls – involving victims of domestic abuse where children were present, or children were themselves victims – being downgraded to a scheduled appointment. This approach places emphasis on the management of demand rather than the mitigation of risk and harm. The risks identified during the original assessment have not changed, yet attendance by the police is delayed (possibly by hours or days), and so too the development of a protective plan. The consequence of this is that victims may not be sufficiently protected, suspects not properly managed, and evidential opportunities potentially lost. In addition, the lack of assurance owing to delayed police attendance may weaken victims' resolve to pursue cases against perpetrators. This may also reduce the force's ability properly to assess the domestic environments and to speak to children to consider their behaviour and demeanour (for example, if scheduled appointments take place during school or nursery hours, or when the children are not present).

A woman contacted police to report that she had been assaulted by her partner while their two-year-old daughter was present. Staff in the control room made a timely assessment of the risk and a decision was made for a prompt response. However, officers failed to attend within the required timeframe (an hour) and the call was subsequently downgraded to a scheduled appointment. The victim was not visited by officers until five days after the incident had occurred; this limited opportunities to provide early reassurance and engage with the victim, make an assessment of the child, and gather evidence (such as acquiring CCTV footage and making witness enquiries). The investigation was subsequently closed because of the lack of evidence to support a prosecution.

It is clear that response officers attending calls relating to domestic abuse use their vulnerability training to help identify the signs and symptoms of vulnerability, and that they have good knowledge of a range of related crimes (including coercion and control, stalking and harassment, and so-called honour-based violence). The mandatory use of body-worn video supports evidence gathering, and officers use the footage to provide evidence from the scene and to record injures and comments made by perpetrators, victims and witnesses (both adult and child). DASH risk assessment completion rates are good, and assessments of risk are both effective and endorsed by supervisors.

Completion rates of police protection notices (PPNs) – used when vulnerable children are encountered to share information with partners in order to develop a protective plan – are not as good. The force recognises this, and in response has made changes to its main computer system to ensure improved completion rates. Where an incident involves a child the computer record on the force system should no longer be closed until a PPN has been completed and supervised. This is positive; but our case audits revealed many instances where PPNs had not been completed for children in circumstances where one was required. Moreover, we found the quality of those that were completed to be inconsistent; too often lacking details of the child's demeanour and their opinions, especially at incidents of domestic abuse. A child's demeanour, especially in those cases where a child is too young to speak to officers, or where to do so with a parent present might present a risk, provides important information about the effects of the incident on the child. Information about their demeanour should inform both the initial assessment of the child's needs and the decision as to whether a referral made to children's social care services is required.

Many officers expressed to us a lack of confidence in interacting with children. More work needs to be done to improve the awareness of children's needs, and to ensure that officers record effectively details of children's behaviour, in order to support the referral process.

Recommendations

Immediately, Northamptonshire Police should:

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

6. Assessment and help

The single MASH is the focal point for information exchange and inter-agency planning across the force area. The force and its partners have invested significant time and resources in the development of the MASH and we found a clear commitment to improved joint working. The MASH currently houses representatives from the police, children's social care services, targeted prevention and education organisations, the NHS, youth offending services, probation, and the fire service. We found examples of organisations working well together, identifying risks, making plans to reduce these risks and supporting children and families.

However, inspectors are concerned about the effectiveness of the referral and assessment processes within the MASH and the impact that this can have on the development of appropriate protective plans. Inspectors found evidence that MASH staff routinely passed information from PPNs to the local authority. However, in a significant number of the cases reviewed there was no record of any additional assessment of risk being made about a child (by completing a search of force systems) before the information was passed to partners. Instead, PPNs are predominantly forwarded to the MASH without additional information about previous incidents or an assessment of the overall risk posed to that child. Current processes place the emphasis on the timely and efficient management of large volumes of information as opposed to prioritising the reduction and mitigation of risk. This undermines the development of effective longer-term protective plans.

Information was received by police that the mother of a young child was using illegal drugs. Although this information was submitted on a PPN, it was not reviewed fully by police working within the MASH before the form was shared for assessment by all agencies. As a result, further existing intelligence was not made available to police and partner organisations within the MASH. This intelligence indicated that both parents were involved in not only the use but also the supply of Class A drugs. The information therefore did not form part of the full assessment of risk to the child.

However, HMICFRS acknowledges that the force recognises it needs to increase its capacity and capability to review PPNs effectively, to ensure intelligence shared provides an effective assessment of risk, and that only those referrals which require a multi-agency response are shared.

We were also pleased to find that the force is working to identify risk and vulnerability at an earlier stage than would otherwise have been the case. The force is currently supporting a pilot scheme of an early intervention hub in Northampton North East, where police and partner organisations work with schools to identify those pupils and families exhibiting early signs of risk or vulnerability, and who are in need of help and

support. The hub works with families to assess the situation and develop an agreed intervention plan. While presently it is too early to assess the effectiveness of the hub, this innovative approach is positive and demonstrates the force's commitment to continuous improvement and more effective joint working.

HMICFRS was similarly encouraged by two other innovative projects, aimed at early engagement with children to identify risk at an earlier stage and divert them from criminal behaviour. The force uses the Blue Butterfly programme to engage with children aged between 7 and 11 years. This helps them understand the feelings (likened to butterflies in the stomach) they might have experienced as a result of witnessing domestic abuse or other adverse childhood experiences. It is sometimes the first indication of an environment of domestic abuse previously unknown to relevant authorities.

Secondly, the Northamptonshire emergency services cadets launched in 2016 brings together the fire, police and ambulance services. It encourages children aged between 13 and 18 years who may have negative perceptions of authority – particularly the police – to join. A minimum of 25 percent of cadets must be criteria-assessed vulnerable children. At time of inspection there were 261 cadets in its cohort, including 18 looked-after children, and 28 percent were assessed as vulnerable.

Six multi-agency risk assessment conferences (MARACs) are held in Northamptonshire: two per month for Northampton, and one per month for the areas of Corby, Kettering, Daventry, and Wellingborough. Around 16 domestic abuse cases are reviewed at each meeting. During the inspection, HMICFRS attended a MARAC at Northampton and reviewed the minutes from recent meetings at the other MARAC locations. We found that attendance at MARACs is satisfactory; all statutory agencies and relevant voluntary sectors are represented, thereby enabling a holistic approach to safeguarding support and intervention. Although as an information-sharing forum the MARAC is adequate, it is not always apparent whether agencies have communicated with one another or researched their own information prior to the meeting.

Very few pro-active actions are decided at the MARACs. Most actions are to update other agencies; police actions are mainly to undertake reassurance visits and compliance checks. Only the Northampton MARAC is police-chaired, and while this provides opportunity for other agencies to take the lead in the other MARACS, no police officer above the rank of constable attends them. This may be the cause of the lack of proactive police intervention, as the officer attending does not have the authority to make decisions relating to police resources.

Additionally, there are often delays in cases being heard, particularly in Northampton which has a two-month lag before cases come to MARAC. This can create delays in the development and implementation of appropriate protective interventions and

services. Decisions made at MARACs to undertake joint visits by agencies are also rare. Such visits are an effective means of providing victim reassurance, lead to evidence gathering opportunities, and send out a strong, committed message to domestic abuse perpetrators.

Recommendations

Within three months, Northamptonshire Police should undertake a review to ensure that the force is fulfilling its statutory responsibilities as set out in *Working Together to Safeguard Children*. 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.

7. Investigation

HMICFRS found some good individual (and isolated) examples of investigating officers demonstrating an appropriate mix of investigative and protective approaches. This ensures that the safeguarding of children remains central to the force's efforts while criminal investigative opportunities are pursued.

Domestic abuse often has a significant and detrimental effect on children within a family who witness acts of violence, aggression, coercion, or control. The force has used different processes to manage its response to domestic abuse cases. Currently it uses a process whereby the most complex cases are dealt with by a specialist team: the domestic abuse prevention and investigative team (DAPIT). Other serious, but less complex, cases are dealt with within the criminal investigation department (CID); the remaining cases are dealt with by the force investigation team (FIT), which is staffed by uniformed officers and supervisors.

FIT officers and supervisors have access to specialist advice from the DAPIT when dealing with cases of domestic abuse or violence. However, the effectiveness of the process is undermined by the frequent and significant delays in allocating crimes within FIT. Moreover, once crime investigations are allocated, the progression of cases occurs against a background of high existing caseloads and a continual influx of new cases into the unit. Although a triage process is in place to prioritise cases based on risk, it is not used effectively nor consistently by FIT supervisors. As a result, vulnerable victims often receive a poor service. Moreover, this weakness goes beyond cases of domestic abuse: the FIT also takes cases involving children as both victims and suspects, and HMICFRS found evidence of significant delays in both new and progressing cases involving children.

A report was made following a domestic argument and allegations that the victim's partner had removed their young children from the family home to a friend's house and demanded that she leave the house. The victim subsequently alleged that her partner had recently assaulted her. However, the matter was never investigated and was subsequently finalised some five months after the allegation. The report stated that the victim had withdrawn her allegation, and that it was being dealt with by partner organisations as a matter of child access.

The force has a dedicated child protection team (CPT) whose remit includes the majority of crimes committed against children. All officers within the team are detectives (or working towards that status) and SCAIDP[16] trained. Those within the team have manageable workloads, are well supervised and receive regular, mandatory welfare assessments, as well as ready access to the trauma risk

[16] Specialist child abuse investigation development programme.

management (TRIM) process. Although the quality of investigations is generally good, HMICFRS found a lack of detail of safeguarding activity, in addition to a general failure to assess properly the risks to those children on care plans. Strategy discussions and meetings either did not take place or were often not recorded for these children. Moreover, we found that where they did exist the records for such strategy meetings contained few details, at most providing a summary of recent events, without a definitive plan for safeguarding the children involved.

A mother called the police to report that she had discovered marks on her young child and believed the child had been assaulted by her ex-partner (the child's father). The child was subject to a protection plan which stipulated limited access for the mother.

The case was jointly investigated by CPT officers and children's social care services. They attended the child's home and were concerned that the marks they observed were different from those in the photographs. They believed the marks they saw were consistent with a minor skin irritation. No consideration was given to involving health services or a medical practitioner to provide definitive and expert guidance and no further enquiries were undertaken with the child's mother about the marks.

Given the discrepancies identified and considering the conditions of the child protection plan further investigation should have been undertaken to ascertain if the allegation was genuine or a deliberate attempt to dishonestly manipulate the conditions of the child protection plan and her access to her child.

The force (with partners from social care and health services) has made a significant investment in the establishment of the RISE team, to safeguard and support those children most at risk of child sexual exploitation. The RISE team manages a cohort of around 50 children who are believed to be at particular risk of child sexual exploitation. Each child is the subject of an individual risk-management plan, which is discussed in a multi-agency forum every seven weeks. The plans are reviewed if significant incidents occur – such as the child being involved in crime or going missing – to consider if new or additional interventions are needed to support the longer-term protective plan.

Children who are believed to be at risk of child sexual exploitation can be referred to the RISE team by any agency. A decision is then made by all agencies as to whether the case should be adopted by RISE to provide a multi-agency response. For cases that are declined, agencies are invited to provide their expert opinion on work needed to benefit the child, and this is sent back to the referring agency and recorded on the children's social care service's database. Those children who do not

meet the RISE threshold can also receive effective support from the Aquarius service, a third-sector organisation located alongside RISE, which provides specialist drug and alcohol prevention services.

Child sexual exploitation investigations are generally effective. Some are exceptional, using a proactive and multi-agency response to tackle the relevant aspects of perpetrator offending, both civil and criminal.

A 16-year-old girl told her social worker that a friend had taken her to a takeaway food outlet, where she had sex with a man she did not know. She stated she felt set up; that as soon as they entered, two men had accosted them, and that she was very drunk and would not have consented to sex.

The social worker reported the incident to the police, who began a rape investigation. A referral was also made to the RISE team, who adopted the girl into its cohort, and a partnership engagement officer began working with her. Throughout the investigation the child's needs were prioritised, and she was allocated a trusted adult with whom she was able to discuss details of the case and seek support. Despite her unwillingness to provide evidence to the police, the RISE team continued to work with the girl to reduce her risk of child sexual exploitation.

The force has established a police online investigation team (POLIT), whose primary function is to identify and arrest those who seek to abuse or exploit children online. The unit prioritises those investigations where suspects are actively attempting to meet or engage with children for sexual abuse and investigations are managed in collaboration with the force's cyber-crime unit and hi-tech crime unit (HTCU). At the time of inspection, each officer within the POLIT was responsible for between 20 and 27 cases. Given the complex and time-consuming nature of these investigations, this is a significant caseload and can contribute to delays. However, HMICFRS found the quality of investigations to be good.

An adult male engaged inappropriately online with an undercover officer, in the belief he was communicating with an 11-year-old girl. This information was shared with the force and the suspect was promptly arrested.

Following his arrest, the man was released pending the completion of the examination of computers in his possession. A PPN was submitted appropriately in relation to a child within in his extended family. There was evidence of good supervisory oversight and investigation of the case. At the time of inspection, the devices seized were awaiting examination by the force's HTCU.

Digital media investigators (DMIs) located within the force's HTCU use specialist software to track the distribution of child abuse images. At the end of January, some 38 cases were being built against suspects. The DMIs respond to all referrals from the national child exploitation and online protection centre (CEOP) and outside forces. They conduct background checks, use the standard assessment tool (KIRAT), and – if a suspect is identified – obtain a warrant. Any case that is risk assessed as very high or high is ordinarily responded to within 48 hours by the DMIs. This leads to lower-risk tasks moving down the queue; there is no required timescale within which to action medium and low-risk cases. The completed information package is then passed to the POLIT where it is recorded as a crime, and efforts are made to locate the perpetrator through execution of the warrant. At the time of inspection there were 13 warrants awaiting execution at addresses where it was suspected that indecent images of children were being accessed – with one of these being three months old.

Early safeguarding disclosures to children's social care services may be considered but usually are not carried out until the warrant is executed, meaning that children living in an at-risk household could be exposed to further risk – especially where there are delays in executing warrants. HMICFRS found that HTCU officers will occasionally attend a high-risk warrant to conduct an immediate initial examination of computers and other electronic equipment, but this is rare owing to caseload pressures. The force does not currently have the capability or capacity to carry out immediate examinations of devices routinely, which could lead to the earlier conclusion of an investigation. For example, officers within the HTCU executed a warrant in the presence of an HMICFRS inspector; although they obtained a full admission from the perpetrator that was recorded by body-worn video cameras, there was no triage of devices at the scene in order to provide evidence of illegal images sufficient for an early charge.

The force's lack of a triage system means that the HTCU struggles to manage the demand placed on it. At the time of inspection there were delays on device examination averaging 12 to 18 months on some 144 computers and over 200 mobile phones. The detective sergeant in charge of the unit has developed a risk matrix, which provides an effective process for prioritising device examination. However, such delays mean that victims' trauma is prolonged, the identification of previously unknown victims is delayed, and the risk of self-harm by suspects is increased.

The delays in device examination have further adverse effects, including: the potential loss of evidence through the expiry of data-storage time limits; loss of confidence by victims who are often unwilling to hand over devices when told of the delays; and detrimental effects on the welfare of suspects subjected to waiting despite not having been charged with an offence. The force is investing in the HTCU

with an increase in staffing levels to deal with the backlog, in addition to the introduction of kiosks to enable phones to be examined without recourse to the HTCU.

Offences of online child abuse which are reported by a victim or their family (rather than being identified through an offender) are not dealt with by the POLIT. Instead they are dealt with by the RISE team, CID, or the FIT for minor offences (such as sending sexually inappropriate text messages). Within these units, HMICFRS was pleased to find similarly good examples of investigations.

A teenage boy with learning difficulties was contacted by a man, who asked him to send naked images of himself. CID officers were deployed quickly to speak to the boy and gain more information. They ascertained that the suspect and boy had previously been in contact and that they had exchanged indecent images with one another. However, following the initial disclosure, the boy refused to engage with officers or supply evidence such as the gaming devices and phone on which contact had taken place.

Officers were able to identify the offender and where he lived, which was outside Northamptonshire. They recorded the offence as a crime of distribution of indecent images, and transferred the case to the suspect's local force to continue the investigation. They also recognised the case as a matter of safeguarding, and made appropriate referrals to children's social care services.

An allegation was received by police that a 15-year-old boy had been sending indecent images of himself and highly sexualised messages to a 12-year-old girl. The force responded promptly and early investigative advice was obtained from the Crown Prosecution Service. Both children were spoken to in the presence of parents. The girl was fully supported and her wishes were taken into account. The boy was extremely upset and remorseful. Appropriate referrals were made to children's social care services. The decision not to take further legal action against the boy was appropriate in the circumstances.

Reports of missing children go through the same review process as other calls into the force control room, and are subject to a THRIVE risk assessment. A supervisor within the force control room reviews the assessment and then grades the child as either high, medium, or low risk, or at no apparent risk (i.e. they are believed to absent rather than missing and there is no apparent risk of harm to either themselves or the public).[17] Those who are graded high, medium or low risk are subject to a formal investigative process. The level of response reflects the level of

[17] College of Policing Missing Persons Authorised Professional Practice, November 2016

assessed risk: high-risk cases are investigated by the force's CID, and low and medium-risk cases by uniformed response teams. Those matters graded as no apparent risk remain within the force control room, where they are periodically reviewed in consultation with the informant – to detect changing circumstances – but receive little by way of police activity to trace the missing child.

HMICFRS was troubled to find examples where those within the force control room had either underestimated or failed to recognise the presence of risks to children reported as missing. This led to children who had previously been identified as being at high risk of child sexual exploitation, being graded incorrectly as medium risk or even at no apparent risk. Similarly, subsequent supervisory reviews of cases dealt with by uniformed response teams often minimised risk. As a result, these investigations were poor quality, with little evidence of activity to locate the child.

During a period of extremely cold weather, a 14-year-old boy was reported missing overnight by his parents. The initial risk assessment graded the child as of medium risk, and this remained as such until the case was examined by HMICFRS inspectors and returned to the force for urgent attention (some 36 hours after the child's disappearance).

The case was further reviewed by the force and then immediately raised to high risk. This led to an extensive investigation by CID and a referral to the MASH. The child returned home of his own accord the next day, by which time it had become apparent that he may have been involved in criminal activity and potentially been exploited by adult criminals.

Although the force has a missing persons unit (MPU), it is relatively small and lacks the capacity to review each individual missing person enquiry. It performs more of a consultative and problem-solving role. In particular circumstances it is also responsible for triggering strategy meetings for children missing from home (these circumstances are: missing more than 24 hours, and either three missing episodes in 90 days, or two or more in 30 days). However, evidence obtained through the case audits indicates that this does not routinely occur. The majority of cases examined demonstrated little evidence of strategy discussions being held or the development of longer-term protective plans to reduce the overall vulnerability of children who are routinely missing.

A 15-year-old girl, who was flagged on force databases as at high risk of child sexual exploitation, was reported missing from home on two occasions within a week. For both reports she was graded as medium risk. On the first occasion, there was no force deployment and the child returned home of her own accord. On the second occasion, she was missing with a friend and was believed to have gone to meet two unknown men.

A strategy meeting was held in relation to this episode, but appeared to have no positive effects on the way the case was dealt with. There was very little investigative activity undertaken to trace the child. She eventually reported to a police station with gifts in her possessions, when she clearly had no means to purchase them herself.

Inspectors found that return interviews[18] for children missing from home are used across the force area, although details of whether they were in fact conducted and what was said are not always recorded on police systems. While the MPU routinely reviews completed return interviews, inspectors could find no evidence in the cases assessed of them being used to inform the development of protective plans. Interviews with children at this stage can provide a wealth of information about the reasons why they are running away, particularly where this is becoming more frequent and the child is reluctant to speak to police or other organisations. A better understanding of why a child has run away can provide vital information to partners and support more effective risk management, and should inform planning and decision-making about future safeguarding action.

Recently, Northamptonshire Police expanded the size of its MPU on a trial basis, enabling greater capacity to review investigations and assess risk. However, the unit was reduced back to its original size as part of the review of the new service delivery model. The force is aware of HMICFRS's findings, and is evaluating how the MPU can be remodelled to improve its capability and approach to missing people – in particular, children.

[18] When children are found, they must be offered an independent return interview. These interviews provide an opportunity to uncover information that can help protect children from the risk of going missing again, from risks they may have been exposed to while missing, or from risk factors in their homes. For further information see *Statutory guidance on children who run away or go missing from home or care*, Department for Education, January 2014. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf

Recommendations

- Within three months, Northamptonshire Police 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.
- Within three months, Northamptonshire Police 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.
- Within six months, Northamptonshire Police should take steps to reduce delays in the hi-tech crime unit.

8. Decision-making

HMICFRS found that, when a case is clearly defined as a child protection matter from the outset, the police response is generally appropriate, and there were examples of effective decision-making to protect children. When there are significant concerns about the safety of children, officers handle incidents well, using their powers appropriately to remove children from harm's way. It is a very serious step to remove a child from their family by way of police protection. In the cases examined, decisions to take a child to a place of safety were well considered and in the best interests of the child.

The estranged parents of an infant girl had a history of domestic abuse and had been referred though the MARAC process. The father contacted police to report that he had taken the child from the mother's care owing to her drug use and her having left the child unattended. Within the force control room, a number of checks were made on information systems and with specialist officers in the CPT to assess the potential risks of the father to the child. From these checks it was clear that he was unsuitable to have the child in his care, and a strategy meeting with children's social care services was held within 20 minutes of receiving the initial call. It was decided that the child was in immediate need of protection. Officers attended the father's address and exercised their s.46 powers. Effective work with social care services enabled an assessment of suitability of the child's maternal grandmother, and the child was placed in her care.

While we found examples of officers taking appropriate protective action for children, HMICFRS is concerned about the poor standard of record keeping on police systems. Accurate and timely recording of information is essential for good decision-making in child protection matters. In the cases examined, HMICFRS found that information, particularly relating to decisions to take children into protection, is often absent. Very often, it is unclear whether or not strategy meetings have taken place once children have been taken into police protection.

On too many occasions, children are taken to the police station as a place of safety. This is not in a child's best interests and should only occur in exceptional circumstances. Moreover, we found examples where children's social care services had advised the force that children in police protection should be returned to the address from which they were earlier removed. We were concerned that despite no apparent change to the risks faced by the children, the force had adhered to this advice without considering whether any challenge or escalation was appropriate.

The mother of a young girl reported to police that her daughter was smashing up the house and assaulting her younger siblings. All three children in the household were the subjects of child protection plans. Officers attended shortly after the initial report and took the girl into police protection. Following consultation with children's social care services, the child was returned home. However, there is no evidence to indicate that the younger siblings were visited by the force or social care services to establish whether they were safe; it appears that officers accepted the word of the mother. Moreover, there is no evidence that the circumstances of the incident were investigated in order to inform future safeguarding planning. Finally, there is no evidence of a strategy discussion having taken place, nor of joint work with other safeguarding organisations to establish any intervention activity which should take place with the family.

Recommendation

- Immediately, Northamptonshire Police should take steps to ensure that all information relevant to the use of powers under section 46 of the Children's 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.

9. Trusted adult

HMICFRS found that child protection officers consider carefully how best to approach a child and their parents, and explore the most effective ways in which to communicate with them. Such sensitivity builds confidence and creates demonstrably stronger relationships between the child (their parents) and police.

A child at potential risk of sexual exploitation was part of the cohort overseen by the RISE team. During a discussion with the RISE officer, the child's social worker reported that the child had a new boyfriend (also a child, aged between 16 and 18 years), who had previously come to police attention for sending text messages of a sexual nature to young girls. However, RISE officers found no records of any actual offences by the boy.

The girl's mother disclosed that her daughter had problems with 'attachment', and that she would harass the boy (on the basis that she had demonstrated such behaviour with others in the past). RISE officers visited the boy and advised him verbally regarding his involvement with the girl, given that she was under sixteen. This safeguarded the boy in relation to the girl's attachment behaviours and also ensured that his parents were made aware of the situation. Both the girl and her mother received significant social care support, in addition to regular contact from the RISE team.

The safeguarding of this child was good and every opportunity was taken to protect her through a multi-agency approach. Social care services were fully engaged with the family and the force demonstrated efforts to minimise the risk to her.

However, we found inconsistencies in this approach when non-specialist officers were responding to an incident, particularly those occasions where children are exposed to or the victim of domestic abuse. Nevertheless, we found officers in Northamptonshire Police to be acutely aware of the needs of the child and the potential for neglect and trauma. They usually record their findings on a PPN and seek advice where necessary.

The force is committed to countering violent extremism and the significant risks of radicalisation faced by some children in Northamptonshire. There is a good working relationship between the police team working in the MASH and officers working within the force's counter terrorist department, who frequently refer into the MASH children who have come to their attention in relation to terrorism-related enquiries. Similarly, the MASH provides details to the special branch of those children who demonstrate radical attitudes and where there is worry that this behaviour may be an early indicator of extremist activity.

The force works closely with partner agencies to highlight and enhance the mutual awareness of the potential for radicalisation of children. Operation Explorer is an event that has been run four times (most recently at Corby School), and involves police, schools and other organisations working together to respond to fictional scenarios in which children and families are reported as missing, and the possibility that they may join overseas terrorist groups.

10. Managing those posing a risk to children

Northamptonshire Police has a dedicated management of sexual and violent offenders team (MOSOVO) to manage local registered sex offenders (RSOs). At the time of the inspection, of the RSOs located in Northamptonshire, 797 were residing within the community and 314 in custody.

The force's IT system enables neighbourhood officers to be made aware of RSOs living in their areas. However, we found the knowledge of officers and teams to be inconsistent: some officers had a good awareness, while others had little or no knowledge of RSOs living within their areas. The force also has a facility for RSOs to be flagged on the IT system. This should ensure that if an RSO comes to notice by the force, the offender's manager will be informed, and allows for swift risk-assessment processes to be conducted. Flagging is particularly important in enabling the force to conduct the reactive management of RSOs effectively. However, HMICFRS found that while all the cases of RSOs which we examined were flagged on the Niche crime-recording system, their addresses were not flagged on the STORM command and control system. As a result, calls for police assistance made from these addresses would not immediately indicate heightened risk as the systems do not communicate with one another to link addresses with the people who live there.

RSOs are risk assessed against standardised criteria and range from low and medium, to high and very high risk. Workloads relating to RSO management must be manageable and take account of the risk levels. Nationally-approved guidelines recommend a maximum of 50 RSOs per offender manager, and that no more than 20 percent of the caseload should be high or very high risk. The Northamptonshire Police MOSOVO team comprises both police officers and civilian risk management officers. Police officers manage the very high and high-risk RSOs, while civilian risk management officers manage medium and low-risk RSOs. At the time of the inspection, the team was managing a caseload that HMICFRS considered to be too high according to guidelines: each police officer managed approximately 80 higher-risk offenders, and each civilian risk management officer between 80 and 90 lower-risk offenders. HMICFRS was concerned to find that at the time of the inspection there were 279 outstanding mandatory visits to RSOs.

The Criminal Justice Act 2003 requires the police, probation and prison services to work jointly for the purposes of establishing and reviewing arrangements for the assessment and management of risks posed by relevant violent and sexual offenders and potentially violent persons. These arrangements are commonly known as multi-agency public protection arrangements (MAPPA), and include multi-agency meetings at different levels according to the risk the individual poses.

Northamptonshire Police attend all level 3 MAPPA meetings at sufficiently senior rank in accordance with MAPPA guidance. However, attendance at MAPPA level 2 meetings by the detective constable overseeing an offender does not comply with the guidelines, which state that it should be an inspector or person with sufficient specialist knowledge and authority to allocate resources.

In January 2017, the National Police Chiefs' Council (NPCC) issued guidance that RSOs should be moved towards either active or reactive management approaches. For an RSO who has had an active risk management system (ARMS) assessment indicating low levels of risk, and where the offender manager is satisfied they have committed no offences nor presented any risk for a three-year period, the force may move from active management (where visits are prescribed), to reactive management (for which visits do not occur). The chosen management approach is kept under regular review, and would change if there was a significant shift in circumstances.

All those working in the MOSOVO unit are trained in the use of ARMS. At the time of inspection, HMICFRS noted that the team had a compliance rate of 82 percent of initial ARMS assessments on the RSOs being managed. However, this is a recent development and as a result not all had been through the required 12-month review. This means the force is not yet in a position to assess risk factors dynamically, or to take action to increase or reduce risk-management levels. Although the use of active and reactive styles of management is still in its early stages in the force, it is expected that its effective application will allow more focus on those RSOs posing the highest risk and will, to an extent, ease demand through the reactive management of those who fit the criteria.

ViSOR, the violent offender and sex offender register, is a national multi-agency database containing details of offenders required to register with the police. It is vital to the effective management of RSOs and the protection of the public. Its effectiveness is dependent on the quality and timeliness of information recorded within it and how well those data are used by professionals to make decisions which help to ensure public safety. Use of the system must comply with national guidance; however, during the inspection HMICFRS was concerned to find that record-keeping on the system by the force was poor.

Scrutiny of the database by HMICFRS revealed a number of RSOs who appeared not to have been visited for a number of years. In all we found 40 RSOs who had not been visited since at least 2015 (and in one case, since 2012). We were particularly troubled to find 23 outstanding visits to high-risk offenders.

Furthermore, we found that supervisors and staff within the MOSOVO unit are unable to use ViSOR properly as a case management system; unsuccessful visits are not adequately recorded, and neither are updates made on those who have been

visited. We also found that when non-compliance with notification requirements was identified this was not being acted on in every case. This means that offenders who had committed further offences were not being prosecuted.

An RSO assessed as low risk was convicted of an offence in 2014, at a time when he was living with his partner and her 14-year-old child. His risk factors included alcohol and drug misuse. He subsequently failed to comply with notification requirements on numerous occasions.

Children's social care services were not notified of the RSO's living arrangements following his conviction. Although he provided foreign travel notifications when he travelled abroad with other children, their details were not recorded, nor were children's social care services notified.

A man was convicted of child sexual exploitation offences abroad, and made subject to a notification order in the UK in 2016. He subsequently failed to comply with notification requirements relating to foreign travel. Although this non-compliance was identified by the force, it was not recorded as a crime. No efforts were made to locate or arrest him and his details were not circulated on the Police National Computer. This means that if he were stopped by the police they would have no way of knowing he was wanted for an offence.

Moreover, it is apparent he is also wanted for immigration offences and there is evidence of clear communication between the force and the Home Office. However, the force deferred to the Home Office immigration team to try to locate the suspect, rather than focusing its efforts to investigate and deal with his criminal offences committed in the UK.

Overall, HMICFRS has serious concerns about the ability of the force to manage RSOs within its MOSOVO unit, putting the public – in particular, children – at potential risk of serious harm. The most significant weakness is its failure to record information on ViSOR: activity undertaken is inconsistently documented, which appears due in part to the team's capacity problems.

The force was provided with a report at the time of our inspection, containing details of a number of specific cases (including those outlined above), where we felt that the force needed to take immediate safeguarding action.

The force acknowledged that the backlog of overdue visits is too high, presenting both a risk to the public and the reputation of the force, in addition to undermining morale in the MOSOVO team. It had already taken steps to reduce this backlog at the time of the inspection. The force had also committed to increasing the staffing levels of the unit by adding four additional risk management officers (who were due

to be in post by the end of April). As a consequence, the force was confident that the backlog would be eliminated completely by September 2018. This is something we will rigorously scrutinise when we return to the force to assess their progress.

HMICFRS also found that Northamptonshire Police force does not routinely consider applications made by RSOs to have their details removed from the register (pursuant to the ruling in F and Thompson [2010])[19]. At the time of inspection, we found 17 outstanding reviews, dating from May 2016 to December 2017. This has two potential consequences for the force. First, the ability to reduce the total numbers of RSOs under its management would enable resources to be more effectively deployed to other offenders. Second, there are possible implications for the force for its failure to adhere to its legal duty: under the timescales imposed for the process, the decision-maker (superintendent) should decide within twelve weeks from receipt of the application, whether the offender should be removed from the register.

In response to our immediate findings, and with particular reference to the highlighted cases and others urgently referred back to the force, a MOSOVO management meeting chaired by the detective chief inspector was convened at the first available opportunity. During this meeting, all the urgent cases were discussed and, for each, a series of actions to be completed and reviewed within set time constraints was decided. In relation to the MOSOVO team's poor knowledge and application of the ViSOR system, the force acknowledged that the team requires formal ViSOR training as soon as possible, and this matter has been flagged to the regional ViSOR training lead as a matter of urgency.

Recommendations

- Immediately, the force should undertake a review its management of registered sex offenders to ensure that all necessary action has been taken to mitigate the risk they pose to children.
- Within six months, all staff within the MOSOVO unit should be properly trained to use the ViSOR database used for managing sex offenders.

[19] In December 2008, two convicted sex offenders Thompson (an adult) and F (a child) successfully argued in the UK Supreme Court that the sex offender lifelong notification requirements are incompatible with Article 8 (right to family life) of the ECHR, as there is no opportunity for those offenders to apply for a review of whether they should continue to be subject to those requirements.

11. Police detention

The number of children that enter police custody within Northamptonshire is low, and HMICFRS found good examples of effective use by the force of options other than arrest to deal with children, such as voluntary interviews. Even at the point a decision was made to bring a child into detention, we observed custody supervisors challenging the need for arrest and refusing to authorise detention.

A 13-year-old child was arrested following an incident at the family home where a parent had been physically assaulted, but received no injuries. On arrival at the custody centre, detention was refused by the custody sergeant. The grounds for refusal were that: although the matter needed to be dealt with, it was relatively minor; the child had not previously come to the notice of police; and the potentially detrimental effects on the child's welfare of being in custody outweighed the need for them to be detained for the sake of progressing the investigation.

Children coming into custody often have complex needs, and are likely to be vulnerable and require safeguarding support. Custody officers receive an annual two-day training course that includes elements of vulnerability. Those spoken to during the inspection demonstrated an understanding of the warning signs to look for when children are brought into police custody.

Medical assessment is an important part of this process. However, reports from officers and staff and our own case audits indicate some children experience excessive waits to see a healthcare professional. Such delays can accentuate mental health problems and increase the risk of self-harming.

HMICFRS also found children consistently not receiving early support from appropriate adults. Statutory guidance states that once an appropriate adult is identified, they should be asked to attend the custody centre as soon as practicable.[20] However, in the majority of cases examined, we found evidence of long delays in the attendance of appropriate adults; they generally coincided with the interview of the child, rather than in support of their overall welfare needs.

[20] For more information see: www.gov.uk/government/publications/pace-code-c-2017

A 14-year-old boy was arrested on suspicion of a serious offence and taken to custody, where his detention was authorised. A risk assessment was completed and it was ascertained that the child took medication for a mental health condition, and that he had also consumed alcohol. He was correctly referred to a healthcare practitioner, but was not seen until 12 hours later, when he was described in medical records as being tearful and requesting to speak to a parent. The child's rights and entitlements were also not given until the arrival of the appropriate adult, some 11 hours after his arrival in custody.

A 16-year-old boy was arrested for assaulting his mother and causing criminal damage at their home. He also made threats to harm himself, and there was existing intelligence on police databases about the boy suffering with mental health problems.

Although there was a record on the police detention log that a custody practice nurse had been contacted, and the boy's mother also contacted custody to express concern about her son's mental health, the nurse did not arrive until the following morning. Similarly, the appropriate adult was arranged to coincide with his interview, as opposed to being at the best time to check on his general welfare. As a result, and despite clear concerns about his mental health, the boy was in custody for 18 hours without a medical assessment or appropriate support.

If, when charged with an offence, a child is to be denied bail and detained, the local authority is responsible for providing appropriate accommodation. Only in exceptional circumstances (such as during extreme weather) would the transfer of the child to alternative accommodation not be in the child's best interests. In rare cases – for example, if a child presented a high risk of serious harm to others – secure accommodation might be needed.[21]

HMICFRS's case audits revealed it is generally at the point of charge that requests are made by the force to the local authority for accommodation – usually in the evening – often leading to a delay in contact being made. Moreover, the force's requests for secure accommodation often lack details of the serious risk of harm posed by the child to the public or themselves. In every relevant case examined by HMICFRS where non-custodial accommodation was requested, it was not obtained. Although we found evidence in some cases of custody officers bringing this to the attention of a supervisor, we found no documented evidence of any intervention between inspectors and the local authority to escalate such matters.

[21] s.38(6) Police and Criminal Evidence Act 1984; and s.21 the Children's Act 1989.

Recommendation

- 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 absolutely 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.

Conclusion

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

Northamptonshire Police is committed to improving its services for the protection of vulnerable children, and this is visible at all levels of the force – from the chief constable to frontline staff. The chief constable and PCC have prioritised child protection, and it is clear there is a force-wide focus on safeguarding and working to improve outcomes for children.

Inspectors found some good individual examples of the force protecting children who were most in need of help, with good multi-agency work and a child-centred approach that effectively combines investigative and safeguarding approaches. This was particularly the case with those children at risk of or experiencing sexual exploitation. However, the clear strategic intent to improve has not yet translated into consistent improvements in outcomes for all vulnerable children. The consequence of this is that the police are not yet consistently making effective decisions to protect children.

Within the force control room, calls for assistance in situations where children are vulnerable are often downgraded on the basis of demand management rather than risk mitigation. Similarly, we found reports of missing children to be inaccurately assessed at low levels of risk.

We found evidence of good engagement with partner safeguarding organisations from across the force area. Nevertheless, the management and assessment of police protection notices within the MASH requires improvement to ensure that referrals passed to the MASH have been properly assessed in order to support the development of a protective plan. We also found that robust escalation processes for professional challenge were under-developed and under-used. Such processes are essential to ensure that statutory duties to protect children are discharged.

The quality of investigations in the specialist units of CID, RISE, DAPIT and CPT – where children are victims of or affected by domestic abuse – were found to be of an acceptable standard. However, similar but less-complex crimes dealt with by the non-specialist FIT team were of a poorer standard, with frequent delays and decisions made which leave children at continuing risk of harm.

Missing children investigations are of equally poor quality when allocated to non-specialist uniformed officers. The response is often based on the most recent missing episode rather than consideration of all the risks faced by a particular child. HMICFRS examined numerous cases of missing children where they had been exposed unnecessarily to unacceptable levels of risk over a protracted period of time.

HMICFRS was also extremely troubled about the deficiencies identified in relation to the way in which the force manages RSOs. We found that record-keeping was poor and as a result the force could not be sure whether all of the offenders for which it was responsible were being correctly monitored. We were also concerned to find that the clear commission of criminal offences by RSOs was not being investigated, leaving those who pose a risk to children at large in the community unnecessarily.

Overall, although there is an unquestionable commitment to the protection of children and we found some evidence of good work, we also found that in a number areas significant improvements are required in order for the force to be able to reassure itself it is doing everything it can to protect vulnerable children.

Recommendations

Immediately

Northamptonshire Police should:

- review its processes to ensure that its staff can easily draw together all available information from police systems in order better to inform their responses and risk assessments.
- review its processes for the supervision of the decisions made when police attend incidents where children are at risk or vulnerable.
- take steps to ensure that all information relevant to the use of powers under section 46 of the Children's 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.
- undertake a review its management of registered sex offenders to ensure that all necessary action has been taken to mitigate the risk they pose to children.

Within three months

Northamptonshire Police should:

- undertake a review to ensure that the force is fulfilling its statutory responsibilities as set out in *Working Together to Safeguard Children*. 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.

- 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.
- 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.

Within six months

Northamptonshire Police should:

- take steps to reduce delays in the hi-tech crime unit.
- all staff within the MOSOVO unit should be properly trained to use the ViSOR database used for managing sex offenders.
- 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 absolutely 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.

Next steps

Within six weeks of the publication of this report, HMICFRS will require an update of the steps taken by Northamptonshire Police in acting on the immediate recommendations made.

The force should also provide an action plan within six weeks of the publication of this report to specify how it intends to respond to the other recommendations made in this report.

Subject to the updates and action plan received, HMICFRS will revisit the force no later than six months after the publication of this report to assess how it is managing the implementation of all of the recommendations.

Annex A – Child protection inspection methodology

Objectives

The objectives of the inspection are:

- to assess how effectively police forces safeguard children at risk;
- to make recommendations to police forces for improving child protection practice;
- to highlight effective practice in child protection work; and
- to drive improvements in forces' child protection practices.

The expectations of agencies are set out in the statutory guidance *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, the latest version of which was published in February 2017. The specific police roles set out in the guidance are:

- the identification of children who might be at risk from abuse and neglect;
- investigation of alleged offences against children;
- inter-agency working and information-sharing to protect children; and
- the exercise of emergency powers to protect children.
- These areas of practice are the focus of the inspection.

Inspection approach

Inspections focus on the experience of, and outcomes for, children following their journey through the child protection and criminal investigation processes. They assess how well the service has helped and protected children and investigated alleged criminal acts, taking account of, but not measuring compliance with, policies and guidance. The inspections consider how the arrangements for protecting children, and the leadership and management of the police service, contribute to and support effective practice on the ground. The team considers how well management responsibilities for child protection, as set out in the statutory guidance, have been met.

Methods

- Self-assessment – practice, and management and leadership
- Case inspections
- Discussions with staff from within the police and from other agencies
- Examination of reports on significant case reviews or other serious cases
- Examination of service statistics, reports, policies and other relevant written materials.

The purpose of the self-assessment is to:

- raise awareness in the service about the strengths and weaknesses of current practice (this forms the basis for discussions with HMICFRS); and
- initiate future service improvements and establish a baseline against which to measure progress.

Self-assessment and case inspection

In consultation with police services the following areas of practice have been identified for scrutiny:

- domestic abuse;
- incidents where police officers and staff identify children in need of help and protection, e.g. children being neglected;
- information-sharing and discussions about children potentially at risk of harm;
- the exercising of powers of police protection under section 46 of the Children Act 1989 (taking children into a ‘place of safety’);
- the completion of section 47 Children Act 1989 enquiries, including both those of a criminal nature and those of a non-criminal nature (section 47 enquiries are those relating to a child ‘in need’ rather than ‘at risk’);
- sex offender management;
- the management of missing children;
- child sexual exploitation; and
- the detention of children in police custody.

Below is a breakdown of the type of self-assessed cases we examined in Northamptonshire Police.

Type of case	Number of cases
At risk of sexual exploitation	3
Domestic Abuse	5
Child Protection Enquiry S47	5
Child in custody	3
Sex offender enquiry	3
Online sexual abuse	3
Missing children	3
General concerns where a referral to children's social care services was made	5
Police Protection	3

Annex B – Definitions and interpretations

child	person under the age of 18
multi-agency risk assessment conference (MARAC)	locally held meeting of statutory and voluntary agency representatives to share information about high-risk victims of domestic abuse; any agency can refer an adult or child whom they believe to be at high risk of harm; the aim of the meeting is to produce a co-ordinated action plan to increase an adult or child's safety, health and well-being; agencies that attend vary, but are likely to include the police, probation, children's social services, health and housing services; over 250 currently in operation across England and Wales
multi-agency safeguarding hub (MASH)	working location in which public sector organisations with responsibilities for the safety of vulnerable people collaborate; it has staff from organisations such as the police and local authority social services, who work alongside one another, sharing information and co-ordinating activities, to help protect the most vulnerable children and adults from harm, neglect and abuse
Office for Standards in Education, Children's Services and Skills (Ofsted)	non-ministerial department, independent of government; regulates and inspects schools, colleges, work-based learning and skills training, adult and community learning, education and training in prisons and other secure establishments, and the Children and Family Court Advisory Support Service; assesses children's social care in local areas, and inspects services for looked-after children, safeguarding and child protection; reports directly to Parliament
multi-agency public protection arrangements (MAPPA)	mechanism through which local criminal justice agencies (police, prison and probation trusts) and other bodies dealing with offenders work together in partnership to protect the public from serious harm by managing sexual and violent offenders; established in each of the 42 criminal justice areas in England and Wales by sections 325 to 327B of the Criminal Justice Act 2003

police and crime commissioner (PCC)	elected entity for a police area; responsible for securing the maintenance of the police force for that area and ensuring that the police force is efficient and effective; holds the relevant chief constable to account for the policing of the area; establishes the budget and police and crime plan for the police force; appoints and may, after due process, remove the chief constable from office; established under section 1 of the Police Reform and Social Responsibility Act 2011
registered sex offender	a person required to provide his details to the police because he has been convicted or cautioned for a sexual offence as set out in Schedule 3 to the Sexual Offences Act 2003, or because he has otherwise triggered the notification requirements; notification requirements can, for example, be triggered by being made subject to a sexual offences prevention order; as well as personal details, a registered individual must provide the police with details about his movements, for example he must tell the police if he is going abroad and, if homeless, where he can be found; registered details may be accessed by the police, probation and prison services; the notification requirements imposed on such offenders were extended by Sexual Offences Act 2003 (Notification Requirements) (England and Wales) Regulations 2012; the 2012 Regulations introduced requirements including that notification must be provided by offenders to the police in relation to their bank, credit card and passport details, and when they are living with a child under the age of 18 years