
# National Child Protection Inspections

## West Mercia Police
## 4-14 November 2014

February 2015



ISBN: 978-1-78246-726-7

www.justiceinspectorates.gov.uk/hmic

# 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, still too many children are abused or neglected by those responsible for their care; they sometimes need to be protected from other adults with whom they come into contact and some occasionally go missing, or are spending time in environments, 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 ensuring that their needs are met.

Protecting children is one of the most important tasks the police undertake. Only the police can investigate suspected crimes and arrest perpetrators, and they have a significant role in monitoring sex offenders. Police officers have the power to take a child who is in danger to a place of safety, or to seek an order to restrict an offender's contact with children. The police service also has a significant role working with other agencies to ensure the child's protection and well-being, longer term.

Police officers are often the eyes and ears of the community as they go about their daily tasks and come across children who may be neglected or abused. They must be alert to, and identify, children who may be at risk.

To protect children well, the police service must undertake all its core duties to a high standard. Police officers must talk with children, listen to them and understand their fears and concerns. The police must also work well with other agencies to ensure that no child slips through the net and that over-intrusion and duplication of effort are avoided.

Her Majesty's Inspectorate of Constabulary (HMIC) 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.

# Contents

# 1. Introduction

This report is a summary of the findings of an inspection of child protection services in West Mercia Police which took place in November 2014. The report comprises nine chapters in three main parts. The first part provides information on the background to the inspection and to West Mercia Police. The second part focuses on the inspection findings, and the third part looks to the future and makes recommendations for improvement.

# 2. Background

Between October 2011 and March 2013, HMIC was involved, on a multi-agency basis, in a number of child protection inspections. Along with evidence of strengths and effective practice, these inspections highlighted areas for improvement, in particular: the quality of joint investigations; the identification of risk; dealing with domestic abuse; and the detention of children in custody.

To address these issues, HMIC decided to conduct a programme of single agency inspections of all police forces in England and Wales. The aims of the inspection programme are to:

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

The focus of the inspection is on the outcomes for, and experiences of, children who come into contact with the police when there are concerns about their safety or well-being.

The inspection methodology builds on the earlier multi-agency inspections. It comprises self-assessment and case audits carried out by the force, and case audits and interviews with police officers and staff and representatives from partner agencies, conducted by HMIC.[1]

[1] Details of how we conduct these inspections can be found at Annex A.

# 3. Context for the force

West Mercia Police has approximately 3,550 staff. The workforce includes:

- 1,915 police officers;
- 1,405 police staff; and
- 226 police community support officers.[2]

The force area comprises a mix of rural communities and medium-sized county towns with greater urbanisation towards the West Midlands conurbation. It covers 2,860 square miles and has a population of 1.2 million. The force has five territorial policing areas which match the boundaries of its four constituent local authorities: Herefordshire, Shropshire, Telford and Wrekin, and Worcestershire.

The four local authorities are responsible for child protection within their boundaries. Each has a local safeguarding children board (LSCB)[3].

The most recent Office for Standards in Education, Children's Services and Skills judgments for each of the local authorities are set out below.

| **Local authority** | **Judgment** | **Date** |
|---|---|---|
| Hereford | Inadequate | May 2014 |
| Shropshire | Adequate | November 2012 |
| Telford and Wrekin | Adequate | July 2012 |
| Worcester | Adequate | March 2012 |

West Mercia Police formed an alliance with Warwickshire Police in 2011. Under this arrangement, assistant chief constables, the director of finance and the director of enabling services have shared responsibilities across both forces.

An assistant chief constable has overall responsibility for protective services across West Mercia and Warwickshire; this includes protecting vulnerable people (PVP). The PVP department (PVPD) is responsible for child protection, domestic abuse,

[2] Police workforce, England and Wales, 30 September 2014. Home Office, www.gov.uk/government/statistics/police-workforce-england-and-wales-30-september-2014

[3] LSCBs have a statutory duty, under the Children Act 2004, to co-ordinate how agencies work together to safeguard and promote the welfare of children and ensure that safeguarding arrangements are effective.

vulnerable adult abuse and registered sex offender management, and is led by a superintendent.

Superintendents (managed by the assistant chief constable – local policing) are responsible for local policing including safer neighbourhood teams and youth inclusion teams, as well as locally-based crime investigation departments (CIDs) who have responsibility for the investigation of rape and serious sexual offences that are not dealt with by the PVPD.

At the time of the inspection, in November 2014, West Mercia Police had developed a multi-agency safeguarding hub (MASH) in Hereford and two single-agency harm assessment units (HAUs) to cover the rest of the force area.

# 4. The police role in child protection

Under the Children Act 1989, the police service, working with partner agencies such as local authority children's social care services, health services and education services, is responsible for making enquiries to safeguard and secure the welfare of any child within their area who is suffering (or is likely to suffer) significant harm.[4] The police are duty-bound to refer to the local authority those children in need they find in the course of their work.[5] Government guidance[6] outlines how these duties and responsibilities should be exercised.

The specified police roles set out in the guidance relate to:

- the identification of children who might be at risk from abuse and neglect;
- the investigation of alleged offences against children;
- their work with other agencies, particularly the requirement to share information that is relevant to child protection issues; and
- the exercise of emergency powers to protect children.

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

Many teams throughout police forces perform important roles in protecting children from harm, including those who analyse computers to establish whether they hold indecent images of children and others who manage registered sex offenders and dangerous people living in communities. They must visit sex offenders regularly, establish the nature of risk these offenders currently pose and put in place any necessary measures to mitigate that risk.

---

[4] Section 47 of the Children Act 1989.

[5] Section 17 of the Children Act 1989 places a general duty on the local authority to safeguard and promote the welfare of children in their area who are believed to be 'in need'. Police may find children who are 'in need' when they attend incidents and should refer these cases to the local authority. A child is 'in need' if he or she is disabled, unlikely to achieve or have the opportunity to achieve a reasonable standard of health or development, or if their health and development is likely to be impaired without local authority service provision.

[6] *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2013.

To ensure that agencies co-operate to keep children safe and look after their welfare, each local authority must establish an LSCB. The four LSCBs in the West Mercia Police area are made up of senior representatives from all agencies (including the police). They promote safeguarding activities, ensure that the protection of children remains a high priority across their area, and hold each other to account.

# 5. Findings: the experiences, progress and outcomes for children who need help and protection

Prior to the inspection visit, West Mercia Police audited 33 cases in accordance with criteria provided by HMIC. Although the force was not asked to rate each of the 33 self-assessed cases individually, practice was viewed as good by the West Mercia Police assessors in 10 of the cases, 11 were assessed as adequate and 12 as inadequate[7]. HMIC also assessed these cases, rating 7 as good, 9 as adequate and 17 as inadequate. In addition, inspectors reviewed another 38 cases of which 13 were assessed as good, 8 as adequate and 17 as inadequate. Although the ratings were different, inspectors' and self-assessors' views about the cases were very similar.

The force's self-assessments were of a very high quality with good analysis, identification and descriptions of good and poor practice, and sound reasoning for judgments.

## Initial contact

Inspectors found that when concerns about a child were reported to the police as a 'child protection' matter the police response was generally good. Officers and control room staff sought information from police and other sources, consulted with children's social care services about the best way to proceed and usually attended incidents quickly, although some delays were apparent. Specialist child protection officers who interviewed children were usually skilled in their roles and engaged with the children well. When officers anticipated communication difficulties they used an intermediary (an accredited communications specialist) and they had ready access to interpreting services.

For example:

- The action taken in a case of alleged sexual abuse by a father of his 4-year-old daughter. The referral went directly to specialist child protection staff who first checked the immediate safety of the child before planning the investigation with children's social care services. They used an intermediary and interviews were conducted in the sexual assault referral centre.

[7] The case types and inspection methodology are set out in Annex A

- The response to two brothers aged 12 and 13 infested with lice and living in squalor. The police spoke with the boys at school, undertook a home visit, interviewed the parents with children's social care services and quickly gathered evidence.

- The case of a very vulnerable and immature 15-year-old girl with mental health problems and at high risk of sexual exploitation who was reported missing from home. The police used all the means at their disposal to try and locate her. They arranged media coverage, used social media, scanned closed circuit television footage and searched railway stations.

Initial responses to domestic abuse incidents were also good. Police attended promptly, checked on the well-being of children and formed a view about the level of police intervention required. Their responses were proportionate.

However, if not initially allocated to a specialist team, reports might be dealt with by insufficiently skilled or experienced staff, or be transferred from team to team. In these cases a child's initial experience of the police was poor and risks were not identified or managed:

- Thirty boys aged 13-15 in one school were approached online for sexually explicit photos. The case was allocated to a response officer who did not know what action to take. The boys were not interviewed or their parents contacted, nor enquiries made as to whom the suspect might be. Communication with the boys and their parents and the management of the boys' safety was undertaken by the school.

- A 14-year-old girl was sexually assaulted by a known offender with a mental health problem. She and her family were very afraid of the alleged perpetrator. Against the family's wishes, the police sent a uniformed officer to the home to investigate the allegation.

Errors such as these were attributed by staff within the HAUs to their own lack of training and experience.

**We recommend that within three months West Mercia Police ensures that all child protection allegations are referred to and assessed by knowledgeable and experienced staff.**

## Assessment and help

The force had systems in place for checking incident logs to establish whether a report raised a child protection concern. It also had systems for checking police information and reviewing initial responses to domestic abuse cases. Those who undertook the checks had access to all relevant police information. Staff in the HAUs and the Hereford MASH undertook these initial assessments and alerted staff to particular concerns such as domestic abuse or sexual exploitation, and passed information on to children's social care services and other agencies.

Although inspectors saw a few examples of these initial assessments that were not as good as they should have been, the systems and infrastructure for identifying and assessing those children at greatest risk were in place and, for the most part, worked well. There was evidence that initial errors of judgment were being picked up by more senior staff. However, in the HAUs domestic abuse cases that were not initially assessed as high risk joined a backlog of cases for further assessment. The backlog was about 200 at the time of the inspection. Many of these cases are likely to be low risk and they may not involve children, but it is also likely that there are some cases about which the force should be concerned and on which it should be taking action. The MASH in Hereford, with a slightly different remit and dealing only with cases involving children, had no backlog.

Generally, staff liaised well with other agencies, exchanged information appropriately and conferred with them early in an enquiry about the need for joint working. Police attended every initial child protection case conference[8] – a significant achievement.

When an initial assessment indicated that a low level of police involvement was most appropriate (for example, a simple referral to children's social care services, the issuing of a harassment notice or no further action) the police took action promptly and proportionately. In more serious or complex cases that required more thought, often on an inter-agency basis, action was limited. There were some indications that recognising risk and exchanging information was an end in itself rather than the means of arriving at a plan to protect children. For example:

[8] "Following section 47 enquiries [see chapter 4 above], an initial child protection conference brings together family members (and the child where appropriate), with the supporters, advocates and professionals most involved with the child and family, to make decisions about the child's future safety, health and development. If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth." *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2013, chapter 1, page 40.

- In a domestic abuse case, a flag on the file was changed from domestic abuse to 'harassment' (continued harassment is a strong sign of increasing risk). This would alert officers to the need to respond quickly should another incident occur. However, this new assessment of increased risk did not lead to consideration of new measures that might be needed to protect the mother and her child or prevent a serious incident.

- In another case, harassment of an ex-partner started after police made the decision to take no further action against the father of a 4-year-old girl who disclosed sexual abuse by him. Although the harassment information was collated, it did not result in a reappraisal of the risk or changes to the safeguarding plan.

Young people who were reported as missing lacked an assessment of their needs and a longer-term plan to meet them. For example:

- A 14-year-old boy was found in the home of a 17-year-old and a woman whose children had been removed from her following neglect. The occupants were known to misuse drugs and alcohol. The boy said that if he was taken home he would return again to this house. He was held in custody overnight and returned home the next day. There were no indications on the record of agencies coming together with the boy to consider the best course of action, longer term.

Inspectors examined five cases of children reported as being at risk of child sexual exploitation. Four were considered inadequately handled. There were also a number of other cases – for example, involving missing children or internet related offences – that appeared to have an element of child sexual exploitation; these, too, were not handled well. In the section below, we address a lack of investigative action in these cases. Had the force conducted more robust enquiries, they might have gathered information that could have contributed to inter-agency assessments and plans to protect children. Although the police were involved in some planning meetings, their contribution to future risk management and help was minimal.

In part, the lack of assessments and plans stemmed from a lack of co-operation by many young people. But, even in those cases where young people had disclosed information either to the police or to a trusted worker in another agency, officers did not necessarily incorporate that information into their thinking or into protective plans. For example:

- A 15-year-old girl witnessed her friend being sexually assaulted while both had gone missing. The girl was taken into police custody for her immediate safety, but there was no longer-term plan to try and reduce risk or support her as a witness to the assault.

Although inspectors were concerned that assessing risk did not necessarily lead to protective help being provided by the police or on an inter-agency basis, help was often provided to children and young people through the voluntary sector.

Following concerns about radicalisation and child sexual exploitation, one superintendent had engaged well with the local Muslim community to help them work with boys who were beginning to disengage from school and who were on the fringes of criminality. We welcome this preventative approach.

A force-wide problem profile (September 2014) identified 280 children at risk of child sexual exploitation, but only 32 of these had been identified, 'flagged' on police information systems, and even fewer had risk management plans. Evidence from this inspection confirms the force's weakness in this area.

**We recommend that within three months West Mercia Police takes steps to eradicate the backlog in the HAUs and puts in place systems to ensure that all cases can be assessed promptly.**

**We recommend that West Mercia Police immediately reviews cases where children have been identified as being at risk and, with partner agencies, takes appropriate action to safeguard the children.**

## Investigation

Investigations of less serious concerns and those that were straightforward were handled well. For example, there were two cases of parents reporting their child's behaviour (towards them) to the police where officers focused on calming the situation and mediating between the parents and child rather than pursuing evidence and apportioning responsibility.

Investigations into sexual or physical assault by a family member on a child where there was clear forensic evidence were also usually handled well, although, as addressed later, there were some delays in the system. In cases of sexual or physical assault, the child was interviewed by specialist officers, usually jointly with children's social care services; medical examinations were arranged when appropriate; the suspect was arrested; materials were taken for forensic analysis; and the scenes of crimes were established and photographed. There were also other examples of good investigations, quickly and thoroughly undertaken, such as the one of neglect of two brothers noted earlier.

However, investigations where the evidence was less clear-cut, where young people did not co-operate or where there were a number of aspects that needed to be investigated before decisions could be reached about the right course of action, were handled less well. For example:

- Five-year-old twins independently told staff at school that they had been hit by their father. On the day it was reported, because of a poorly planned investigation, the boy repeated his story three times. Each time he consistently explained how his father had 'kneed' him in the face and 'kicked' him. The following day, when telling his story to the paediatrician and after his father had been interviewed, he said the injuries (bruising and grazing to the face) were caused by a friend. His mother supported this story. No further investigatory activity was undertaken and the matter was dealt with by way of a behavioural agreement between the parents and children's social care services.

Poor investigations were particularly noticeable in cases of child sexual exploitation. Examples include the boys approached for sexually explicit photographs (discussed earlier) and a 15-year-old girl who was thought to be sexually active with a registered sex offender (RSO). There was little investigative activity and the offender was later found to be abusing other young people.

With a couple of exceptions, inspectors noted that computers and phones were seized promptly from alleged offenders who had been reported for sexual offences, but analysis might take several months. At the time of the inspection, the high-tech crime unit had 142 computers and 165 phones awaiting analysis, some going back to April 2014. An initial risk assessment had been made and cases were being prioritised according to the assessed level of risk. The force is now putting additional resources into this area of work.

There were cases of alleged child sexual exploitation where the identification of an offender might have been made through analysis of data held on a victim's mobile phone or computer. Analysis did not always happen. Failing to pursue this line of enquiry was particularly noticeable in those cases of young people initially reported as 'missing' rather than those reported as ‘victims of sexual abuse'. Inspectors judged as inadequate five of the six 'missing' cases they examined because of the superficial nature of the enquiries undertaken following the return of the child.

Poorly planned and managed investigations led to officers undertaking tasks at a late stage, or to serious delays. For example:

- Photographing the scene of a crime some 16 weeks after the crime was reported.

- The response to a suspected sexual offender who had regular access to his grandchildren. The force's self-assessor found that the timescales for executing warrants, informing the local authority designated officer (the man's wife was a council employee with access to children), the examination of computers and the charging of the suspect (15 months after the warrant was executed) were all unnecessarily long.

- In the case of a 12-year-old girl who reported sexual abuse by an uncle. There were sporadic investigative activities over a period of several months and, at the time of the inspection, 15 months after the first report, a charging decision was awaited.

- Dealing with an allegation of sexual assault on a girl by her grandfather with the last entry on the file being January 2014.

Systems in place to encourage oversight, including alerting an inspector to investigations over 12 weeks old, had not improved timeliness, even in cases that had been reviewed by supervisors. This suggests that supervision was not as effective as it should have been in improving practice. In contrast, the inspectors noted the high quality of supervision in 9 of the 12 cases involving investigations or enquiries assessed as 'good'. In these cases, investigations proceeded quickly, in a co-ordinated manner and with attention to the child's welfare as well as the obtaining of evidence.

Inspectors noted some tension between investigation and safeguarding roles in the child protection teams. Officers spoke highly of their supervisors' efforts to support them and oversee their work, but many also commented that sergeants were heavily committed to inter-agency safeguarding discussions arranged by the HAUs and inspectors were committed to inter-agency meetings such as the LSCB subgroups or PVP meetings, leaving less time for case supervision.

In the earlier section of this report, ‘Assessment and help’, we noted how poor investigations were limiting police contributions to assessment and safeguarding.

**We recommend that within three months West Mercia Police takes action to improve child protection investigations, including those of suspected child sexual exploitation. This should include ensuring:**

- **every referral received by the police is allocated to a team with the skills, capacity and competence to undertake the investigation;**

- **investigations are planned (with partner agencies when appropriate). Plans should include consideration of all the likely evidential requirements and when evidence gathering activities should be instigated; and**

- **investigations are supervised and monitored and, at each check, the supervisor reviews the evidence and any further enquiries/ evidence gathering that may need to be done.**

**Until such time as West Mercia Police is assured of these changes being embedded, the force should conduct regular reviews of practice that include the quality and timeliness of investigations.**

## Decision making

As already noted, the service has sound systems in place for initial assessments and decision making. When an early decision was made not to pursue a case because of lack of evidence, or the case was not a very serious one, the decisions to take no further action, offer advice or issue a warning were made promptly and were proportionate. Parents and children were informed of the decision quickly. However, in the earlier section on investigations, we raised concerns that the police did not always pursue evidence as assiduously as they should. Lack of evidence was a factor in decisions not to pursue cases, particularly in cases of suspected child sexual exploitation.

Inspectors found that, in cases where the alleged perpetrator was a child or young person, decisions were expedited and the needs of both victim and offender were considered.

Decisions to take a child into police protection for their own safety were also carefully considered and based on good information and the needs of the child. However, in these cases, while the decision was the right one in the circumstances, there was no follow-up action to prevent a recurrence. In many cases, in the absence of child detention certificates (see section below), it was not clear whether the decision to detain a child, brought into custody on offending grounds, was the right one.

Good record keeping is key to good decision making, particularly in child protection cases where a pattern of concerns is usually indicative of greater risk and need. Staff gave a number of examples to inspectors of dip-sampling by managers, and there was evidence of cases being referred back to officers who had not kept satisfactory records. In addition, the work of the HAUs and the MASH enabled good oversight of the quality and flow of information. However, inspectors found that the quality of recording across the force was very variable, and in some cases it was not clear whether essential tasks had been undertaken. For example:

- An adult woman reported having been sexually abused by her stepfather as a child. The reason for her report at that time was her concern that he was living in another family with children. The assault on her was investigated appropriately but there was no record on the file as to whether the suspect was living with children who might be at risk from him.

Routine considerations – for example, referral for a paediatric examination or assessment of need – were not always noted as having taken place. Consequently it was difficult to know if all investigative avenues had been considered, or if due regard had been given to a child's healthcare needs when decisions were made.

## Trusted adult

There were some excellent examples of police officers behaving as a trustworthy adult. For example:

- Officers' response to a girl in foster care who 'kicked off'. Police intervened to bring her back home. They consulted with the foster carer, social worker and the girl, and reached an agreement as to how both parties would behave for the rest of the night until the situation could be reassessed and the difficulties resolved. Both the foster carer and the girl trusted the police in these negotiations and both parties did as they agreed.

- Action taken to protect the welfare of two brothers experiencing severe neglect – this was done in a way that supported the whole family.

- In the case of a 9-year-old boy who was placed under police protection. A police officer sat with him for the whole night in a police station because the local authority could not find accommodation for him. While neither the child nor the police officer should have been in this situation, the safety and well-being of the child was clearly prioritised by those on duty at the time.

In some cases, however, police behaviour did not inspire confidence. For example:

- When a 15-year-old girl who retracted allegations (possibly under duress from her mother) of inappropriate sexual behaviour by her stepfather was called in to be interviewed about her 'lying'. (The stepfather was subsequently convicted of the offence).

- In the case of a 15-year-old girl who made a rape allegation about a (previous) care worker. The police concluded she was lying and she was cautioned for perverting the course of justice. (No criminal charges were made against the worker but he was disciplined for inappropriate behaviour.)

- In a case of a uniformed police officer attending the home of a victim against the family's expressed wishes (see the earlier 'Initial contact' section).

The force has recognised the need to improve its response to child sexual exploitation and additional resources have been committed to fund a police child sexual exploitation team. This specialist team should be better equipped to communicate with children and young people, and to forge more positive relationships with them, including how best to deal with conflicting accounts and the reasons for these. At the time of the inspection, the new team had not yet been recruited.

In many cases, delays would have had an impact on a victim's confidence in the police, especially in those cases where families were separated until the case was concluded. For example:

- A baby just a month old when taken into foster care with leg fractures had spent six months away from home (at the time of the inspection in November 2014).
- A girl of 15 had been denied contact with her mother from the beginning of enquiries in February 2013. The girl was suffering severe mental health difficulties and such a long delay in concluding the case was likely to be detrimental to her health.

In a number of cases there were delays in receipt of charging advice from the Crown Prosecution Service (CPS). For example, the case of the baby above, and another case involving a number of children that had been awaiting charging advice since July 2014 (at the time of the inspection in November 2014).

In most of the cases seen by inspectors and in the self-assessed cases, police communicated promptly with children and families about the progress of their case.

**We recommend that within six months West Mercia Police evaluates the impact of its investment in tackling child sexual exploitation – in particular, the extent to which the new approaches lead to improved investigations, improved protective plans and greater levels of confidence in the police and partner agencies shown by children at risk.**

**We recommend that within three months West Mercia Police takes action to improve the timeliness of submissions to the CPS and works with the CPS to reduce timescales for charging decisions.**

## Managing those posing a risk to children

All the cases of sex offender management in both the self-assessment sample and those seen by inspectors were of a good quality. Specialist police teams undertook all the appropriate checks, actively sought information about offenders, worked well with other agencies (primarily probation and social work) and liaised appropriately and sensitively with parents who were in contact with offenders and needed to understand the risks. They were open and clear in their dealings with offenders and, in one specific instance, firm in their management of an articulate, knowledgeable and challenging offender.

In one case, the police became aware of a sex offender released from immigration detention without prior warning from immigration services or any checks having been made (or requested) about his proposed accommodation and area of residence. The police responded to the information immediately, undertook a home visit, interviewed the offender and other household members, and formed a plan for his management that included carefully informing the victims of his offence of his return to the community.

Understanding the importance of addressing risk posed by offenders (and acting on that understanding) was more mixed in those teams without specialist expertise in working with sex offenders or other offenders who posed a high risk. Officers generally considered the risks a suspect might pose to children in a family but there was often no assessment of the risks they might pose to extended family members or the wider community. Notifications to the local authority designated officer were required in two cases but both were delayed. In addition, the force did not make sufficient attempts to try and find out the identity of men approaching children for sex via mobile phones or the internet.

**We recommend that within three months West Mercia Police extends the knowledge and skills of staff working with RSOs to those investigating cases of sexual abuse. Those investigating cases of sexual abuse should be knowledgeable about how offenders operate, how to conduct effective enquiries into offenders' activities and what action can be taken to reduce the risk they pose.**

## Police detention

Inspectors examined 15 cases of children remanded overnight. There were 10 boys and 5 girls. Two were aged 13, 5 aged 14, 7 aged 15 and 1 aged 16.

Case details indicate that police custody staff had a good understanding of child vulnerability and took steps to minimise the negative impact of a custodial remand – for example, by keeping young people in a detention room rather than a cell or ensuring that police officers spent time with them (not just checking on them) to reassure them and explain what was happening. There were also cases where neighbourhood officers had worked well to prevent incidents escalating into situations that might have required arrest and detention.

Inspectors were told that it was rare for a child detained for mental health reasons to be taken to a police station, although the child and adolescent mental health services were also said to be under pressure.

Following the 2011 report, *Who's looking out for the children?*[9], action was taken to improve the conditions for children in custody and to increase staff awareness about their responsibilities towards children. This has had some success. Inspectors found that custody staff were attuned to the needs of children, ensured that there was an 'appropriate adult', had some 'Safer custody' leaflets for children and (to an extent) sought alternative accommodation.

[9] *Who's looking out for the children? A joint inspection of Appropriate Adult provision and children in detention after charge*, Criminal Justice Joint Inspection, December 2011, available from: www.justiceinspectorates.gov.uk/hmic/media/whos-looking-out-for-the-children-20111215.pdf.

A report for the four LCSBs indicated that between November 2013 and May 2014 there were 689 arrests of juveniles of whom 25 (3.6 percent) were detained overnight – a drop from 6 percent of arrests in 2011. However, only one child was transferred to local authority care.

Detention certificates, which outline to a court the reason for a custodial remand, are essential for police accountability and enable forces to monitor how well they are doing in terms of their responsibilities under the Police and Criminal Evidence Act 1984. There were nine cases where a detention certificate should have been presented to court and a copy retained on the police file, but a certificate was copied and recorded in only one case.

Of the 15 children detained in police custody for all or part of the night, accommodation was sought and provided in 5 cases. In one case, a young person was arrested in the early hours of the morning and the police expedited proceedings to enable an early court appearance the same day, and in another case the young person was re-bailed.

In four cases inspectors found there had been no attempt to seek alternative accommodation (although as two of the children were looked after, the local authority was aware that the children had been taken into custody). In four cases, an approach was made to the local authority but no bed was forthcoming. In one of these cases, the approach had been made to the local authority far too late in the night for a transfer to have been appropriate, and in two of the cases a further approach should have been made the following day when the young people continued to be detained.

However, the situation is complex. In the inspectors' sample of 15 cases of children detained in custody, 6 young people looked after by the local authority were arrested following incidents in a residential home. Offences included breach of the peace, criminal damage, threats and assault. In all 6 cases, no alternative accommodation was found for the young people. In the self-assessed sample, there were three young people who were arrested following incidents at a care home. All were held in police custody overnight. In other words, every young person in this sample who was involved in an incident in a children's home was remanded in police custody, even though they were in the care of the local authority.

**We recommend that West Mercia Police engages immediately with local authorities and LCSBs to:**

- **develop strategies to equip frontline staff to manage difficult behaviour by young people looked after by the local authority so that detention is a last resort;**
- **ensure that no child who is looked after by the local authority is denied accommodation by them;**

- **record and report to the LSCB the number of children held in custody (and their legal status), the efforts made to secure alternative accommodation and the reasons for failing to do so (with plans to address them).**

**We recommend that West Mercia Police immediately ensures that all detention certificates are completed with full details of the length of time a young person has spent in custody and the efforts made to find alternative accommodation. West Mercia Police should engage with the West Mercia Criminal Justice Board to discuss establishing collective oversight of this statutory requirement.**

# 6. Findings: leadership, management and governance

"Protecting communities from harm" is one of the four aims of the West Mercia PCC's Police and Crime Plan for 2013–2017[10]. This includes protecting vulnerable people and working in partnership with other agencies to achieve this.

West Mercia Police's commitment to protecting vulnerable people is evidenced by the new organisational arrangements designed to give greater focus to, and investment in, protecting vulnerable people. However, operational staff were not always aware of who was responsible for what area of practice, both at a practical and at a more senior level.

Following the success of Operation Chalice which resulted in a number of men being convicted of sexual and trafficking offences against teenage girls, the force and partner agencies had invested in improving their response to child sexual exploitation, including by providing awareness training for all frontline staff. The force had also made a commitment to invest in a specialist police team to combat child sexual exploitation; this has the full approval of the PCC.

The force has funded two missing person co-ordinator posts, developed the use of intermediaries in work with young children, increased the funding for the high-tech crime unit and developed the HAUs.

No structure is perfect, but inspectors consider that bringing together the responsibility for all vulnerable people in the PVPD and the development of the HAUs are steps in the right direction. Already, the service has developed methods of checking crime reports for concerns about children, and a system for flagging incidents that suggest a high risk. It is taking steps to increase the skills of those working in the HAUs, and to resolve structural and resourcing problems across the PVPD. Inspectors recognise that this is a relatively new development, not yet a year old. It will take time to become established, and to work effectively and consistently across the force. While the changes are taking shape and staff skills in the HAUs are, as yet, not yet fully developed, more management attention needs to be given to checking and assuring the quality of the unit's work.

While staff and other agencies welcomed the new developments, concerns were expressed to inspectors about how they have been managed. Inspectors consider that the HAUs had been introduced without sufficient attention being paid to their purpose and remit. Consequently, practices had developed in an ad hoc manner and

[10] *The Police and Crime Plan for West Mercia 1 April 2013 – 31 March 2017*, the Police and Crime Commissioner for West Mercia, March 2013, available from: www.westmercia-pcc.gov.uk/Document-Library/Publications/POLICE--CRIME-PLAN-PUBLISHED-VERSION.pdf

this had contributed to lack of consistency across the force. Lack of a distinct remit for the HAUs and a clear understanding of responsibilities between the various teams across the force had also led to gaps in the oversight and management of cases. In addition, insufficient attention had been paid to the anticipated volume of work and required staffing, or their need for training. The force's management was well aware of all these difficulties and was taking appropriate steps to resolve them.

It was evident to inspectors that senior managers were highly committed to protecting vulnerable people, had introduced a number of measures to improve the force's response and were actively working to reduce the adverse impact of change. However, it was also evident to inspectors that frontline staff, especially those in the most-hard pressed teams, were not always aware of what was being done on their behalf or when improvements might bear fruit, and so they felt undervalued.

The practice findings in the preceding chapter indicate that West Mercia Police has strengths in the following areas: initial responses to reports of abuse and neglect, making enquiries of police systems and checking welfare and safety concerns, recording initial information and exchanging it with other agencies, and work with RSOs. There is also some evidence of positive relationships with young people, especially young vulnerable offenders, and the service's response to young people in custody is improving.

Service weaknesses are to be found mainly in the investigation of more complex allegations and child sexual exploitation cases where young people are reluctant to engage with the police. Some problems also remain in the area of child detention. The service was actively seeking to improve its work in the areas of child sexual exploitation and child detention, but it will need to give greater focus to the planning and quality of investigations. Inspectors noted that the child protection units were understaffed, with 4 vacancies in a team of 11 staff and officers carrying high caseloads. This will need to be addressed.

The four LSCBs would normally be attended by the head of the PVPD; however, chairs of the boards told us that that task was often delegated to staff who partner agencies perceived as having insufficient seniority or knowledge to make decisions. Attendance by the police at LSCB sub-groups, and their work there, was considered to be better.

Some concerns were raised by LCSB chairs about the police not actively bringing matters to the boards' attention – for example, an HMIC report on domestic abuse. Concern was also raised by chairs that decisions that have an impact on the work of all agencies, such as the development of a child sexual exploitation team or the HAUs, were not always discussed with them prior to decisions being made. Overall, the chairs of LSCBs expressed a view that senior level police engagement in working with other agencies to safeguard children was declining.

The force had invested in some training for specialist staff and those in the recently established HAUs. 'On the job' learning had been supplemented by work shadowing more experienced staff. Specialist staff had access to support and expertise at a more senior level, and knew about other specialist teams or roles. We consider the high level of confidence and competence of the sex offender management team to be a contributory factor in its ability to produce good-quality work. However, the inspection team found pockets of staff, particularly on the front line and in the HAUs, who did not feel competent or confident in some of the tasks they undertook.

Management data were limited to providing information about numbers of incidents, volume of work, staffing levels and vacancies in units. The force had started to produce information on numbers of prosecutions and offences that affect children. However, there was no information that focused on the outcomes for children, the quality of the investigation or service, or the views of children; nor was there information about the time taken to complete an investigation or safeguard a child. Lack of information on race, ethnicity and special needs compromised service planning.

There were LCSB-led multi-agency case audits, often on themes of current concern, and the force participated in serious case reviews. Learning from the reviews was incorporated into training for new staff but the force had no mechanisms in place to ensure learning is passed to the staff already working in this area. We were told of sampling exercises across a number of practice areas to check compliance with recording requirements, but these were ad hoc. They had led to changes in crime recording practice but were not driving improvements in the quality of investigations. We also noted earlier in this report that oversight of cases had not led to improved practice in a number of cases seen by inspectors. Consultation with children was limited to informal contact between youth and neighbourhood teams, and LSCBs' development of policy and procedures in consultation with children. The quality of analysis shown in the self-assessment exercise for this inspection was good and could be built upon.

Some of the areas of concern raised in this report (for example, the police response to child sexual exploitation, backlogs in dealing with referrals in the HAUs and high-tech crime unit) were known to the force and were being addressed. Our recommendations relate only to those areas that were not being addressed, or where we consider more attention is needed. Force leaders and managers should now:

- take note of the findings of this report – in particular, those relating to investigation of cases, delays and lack of oversight in investigations, the high number of looked after children remanded in police custody, and the need to provide better support to the HAUs and local policing teams (in part, by improving their skills) who are faced with either allocating or undertaking child protection investigations;

- ensure that action plans are developed to address these issues, and that progress is reported on (to the LSCB and PCC, as appropriate);
- develop a performance framework that reflects PVP priorities and, in particular, attends to quality of practice and outcomes of police activity for children; and
- take a more active role in establishing alternatives to custodial remands for looked after children.

# 7. Findings: the overall effectiveness of the force and its response to children who need help and protection

In the past few years West Mercia Police has paid considerable attention to the development of structures and approaches to policing to improve its work with vulnerable people. That work is largely complete, although adjustments will continue to need to be made. In addition, as we note in this report, some further work will need to be undertaken to ensure that teams that are not part of the PVPD, but which undertake work with vulnerable people, are appropriately skilled and supported.

The focus now needs to shift towards addressing quality, particularly in the core policing activity of undertaking investigations and making enquiries. One theme of this report is that there were systems in place for overseeing work and preventing cases from falling through gaps and that, on the whole, those systems were being used. However, they were not having the impact that might be expected. Tasks seem to be viewed as largely administrative rather than as an important contribution to improving professional practice. The force should look at this more closely.

Poor investigations and delays run the risk of causing harm rather than doing good. Current performance management systems that focus on compliance with expected processes take no account of the impact of police intervention on children's lives. In refocusing on quality, the force will want to give greater attention to the outcomes of its work.

West Mercia Police's senior managers have expended considerable energy and resources in improving services and the force is heading in the right direction. It now needs to give more priority to engaging with staff, the LSCBs and with other agencies so that shared concerns are understood and action to address them is communicated.

# 8. Recommendations

## Immediately

We recommend that West Mercia Police reviews cases where children have been identified as being at risk and, with partner agencies, takes appropriate action to safeguard the children.

We recommend that West Mercia Police engages with local authorities and LCSBs to:

- develop strategies to equip frontline staff to manage difficult behaviour by young people looked after by the local authority so that detention is a last resort;
- ensure that no child who is looked after by the local authority is denied accommodation by them;
- record and report to the LSCB the number of children held in custody (and their legal status), the efforts made to secure alternative accommodation and the reasons for failing to do so (with plans to address them).

We recommend that West Mercia Police ensures that all detention certificates are completed with full details of the length of time a young person has spent in custody and the efforts made to find alternative accommodation. West Mercia Police should engage with the West Mercia Criminal Justice Board to discuss establishing collective oversight of this statutory requirement.

## Within three months

We recommend that West Mercia Police ensures that all child protection allegations are referred to and assessed by knowledgeable and experienced staff.

We recommend that West Mercia Police takes steps to eradicate the backlog in the HAUs and puts in place systems to ensure that all cases can be assessed promptly.

We recommend that West Mercia Police takes action to improve child protection investigations, including those of suspected child sexual exploitation. This should include ensuring:

- every referral received by the police is allocated to a team with the skills, capacity and competence to undertake the investigation;
- investigations are planned (with partner agencies when appropriate). Plans should include consideration of all the likely evidential requirements and when evidence gathering activities should be instigated; and

- investigations are supervised and monitored and, at each check, the supervisor reviews the evidence and any further enquiries/ evidence gathering that may need to be done.

Until such time as West Mercia Police is assured of these changes being embedded, the force should conduct regular reviews of practice that include the quality and timeliness of investigations.

We recommend that West Mercia Police takes action to improve the timeliness of submissions to the CPS and works with the CPS to reduce timescales for charging decisions.

We recommend that West Mercia Police extends the knowledge and skills of staff working with RSOs to those investigating cases of sexual abuse. Those investigating cases of sexual abuse should be knowledgeable about how offenders operate, how to conduct effective enquiries into offenders' activities and what action can be taken to reduce the risk they pose.

## Within six months

We recommend that West Mercia Police evaluates the impact of its investment in tackling child sexual exploitation – in particular, the extent to which the new approaches lead to improved investigations, improved protective plans and greater levels of confidence in the police and partner agencies shown by children at risk.

# 9. Next steps

Within six weeks of the publication of this report, HMIC will require an update of the action being taken to respond to the recommendations that should be acted upon immediately.

West Mercia Police should also provide an action plan within six weeks to specify how it intends to respond to the other recommendations made in this report.

Subject to the responses received, HMIC will revisit West Mercia Police 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*[11], published in March 2013. 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 focused on the experience of, and outcomes for, the child following its journey through child protection and criminal investigation processes. They assessed 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.

[11] *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children,* HM Government, March 2013. Available from www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf

The inspections considered how the arrangements for protecting children, and the leadership and management of the police service, contributed to and supported effective practice on the ground. The team considered how well management responsibilities for child protection, as set out in the statutory guidance, were 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 within the service about the strengths and weaknesses of current practice (this formed the basis for discussions with HMIC); and
- serve as a driver and benchmark for future service improvements.

## 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 regarding 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 a child ‘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 types of self-assessed cases we examined in West Mercia**.**

| Type of case | Number of cases |
|---|---|
| **Child protection enquiry (s. 47)** | 5 |
| **General concerns with a child where a referral to children's social care services was made** | 5 |
| **Domestic abuse** | 4 |
| **Sex offender enquiry** | 3 |
| **Missing children** | 3 |
| **Police protection** | 3 |
| **At risk of sexual exploitation** | 3 |
| **On-line sexual abuse** | 3 |
| **Child in custody** | 3 |

# Annex B
# Glossary

| | |
|---|---|
| child | person under the age of 18 |
| high-tech crime unit | police computer crimes unit that undertakes examination and retrieval of evidence or intelligence from computers, computer-related media and other digital devices |
| local authority designated officer (LADO) | an officer identified by a local authority to be involved in the management and oversight of individual cases; the LADO should provide advice and guidance to employers and voluntary organisations, liaising with the police and other agencies and monitoring the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process |
| multi-agency safeguarding hub (MASH) | entity in which public sector organisations with common or aligned responsibilities in relation to the safety of vulnerable people work; the hubs comprise staff from organisations such as the police and local authority social services; they 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) | a non-ministerial department, independent of government, that regulates and inspects schools, colleges, work-based learning and skills training, adult and community learning, education and training in prisons and other secure establishments, and the Children and Family Court Advisory Support Service; assesses children's services in local areas, and inspects services for looked-after children, safeguarding and child protection; reports directly to Parliament |
| police and crime commissioner (PCC) | elected entity for a police area, established under section 1, Police Reform and Social Responsibility Act 2011, responsible for securing the maintenance of the police force for that area and securing that the police force is efficient and effective; holds the relevant chief constable to account for the policing of the area; establishes the budget and police and crime plan for the police force; appoints and may, after due process, remove the chief constable from office |

| | |
|---|---|
| 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 (for example, 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 service |