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

National Child Protection Inspection

Wiltshire Police

7–18 March 2022

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 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 organisations – have a particular role in protecting children and meeting their needs.

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

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

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

Contents

Summary

This report is a summary of the findings of our inspection of police child protection services in Wiltshire, which took place in March 2022.

We examined how effective the police's decisions were at each stage of their interactions with or for children. This was from initial contact through to the investigation of offences against them. We also scrutinised how the force treated children in custody. And we assessed how the force is structured, led and governed, in relation to its child protection services.

Main findings from the inspection

Wiltshire Police has clear governance arrangements for its child protection services. But the force provides its leaders with mostly quantitative performance data rather than information that would help them understand the quality of its responses to vulnerability and risk.

We found some areas of effective practice, and there are dedicated officers and staff who are committed to keeping children safe. But, overall, we found that the force's child protection arrangements weren't consistently providing a good enough response to effectively safeguard children in Wiltshire.

Chief officers and senior leaders take part in multi-agency safeguarding partnership arrangements. They attend and contribute to multi-agency meetings and activities. But we found limited evidence of the force escalating cases or challenging other organisations when child protection arrangements weren't benefiting children.

Leaders have recognised the increasing risk to children from online sexual abuse and changed how the force works to safeguard them from this risk. Officers now jointly assess risk to children with multi-agency partner organisations. They act quickly to arrest offenders, seize digital evidence, and protect children.

But there are significant delays in the time it takes the digital forensic unit to provide evidence to investigators. There are also delays in the time taken for investigators to get third-party disclosure of children's health, education and social care records, transcriptions of evidential recordings and charging decisions for court proceedings. These delays add to investigators' caseloads and weaken the force's support for children.

The force's response to missing children isn't good enough. Assessments of the risk faced by missing children aren't consistent, and many reports aren't responded to quickly enough. Many cases aren't effectively supervised and lack enough direction of actions to find children and reduce risks. And the force doesn't consistently compile relevant information on its systems or use this information to help frontline responders find missing children.

Encouragingly, the force has recruited to the full strength that its budget allows and increased staffing levels in some teams, such as the child abuse investigation team. But it doesn't have enough detectives or specialist trained staff in its public protection department. Many frontline staff and supervisors are very inexperienced and haven't been given the training they need to be able to always respond appropriately to incidents affecting vulnerable children.

Throughout the force, officers don't always understand the importance of speaking to children, listening to them, and recording their vulnerability. We saw this from the variable quality of information officers recorded about their concerns in both public protection notices (PPNs) and referrals to children's social care (CSC) services.

The force's assessment of information about vulnerability, whether by itself or together with its safeguarding partners, isn't always effective. Relevant information from other incidents or other agencies isn't always used to form a comprehensive picture of risk. This means that some crimes, abuse, and child welfare concerns aren't being identified when they should be.

We found that supervision was often ineffective. This results in delays in the force's response to missing children and incidents, with risk to children not being fully investigated. It can also lead to inexperienced officers risk-assessing domestic abuse incidents without reference to previous events.

We saw evidence of some effective work by the team that managed the risk from registered sex offenders in the community. But we are concerned about the number of visits and assessments being made by officers acting alone. Two offender managers working together would provide more robust management of this high-risk responsibility.

While there are good facilities for children in police detention, there can be delays in the time it takes for some to receive healthcare and other support from appropriate adults. The force appeared to accept without challenge the lack of local authority alternative accommodation provision for children denied bail after charge.

During our inspection, we examined 70 cases in which Wiltshire Police identified children at risk. We assessed the force's child protection practice as good in 16 cases, requiring improvement in 29 cases, and inadequate in 25 cases. This shows that the force needs to do more to give a consistently good service for all children.

Specific areas for improvement we identified include:

- improving the capacity and capability of investigators and supervisors to respond effectively to vulnerability;
- improving data-management and performance-management processes to better understand the quality of service and improve end results for children;
- speaking to children, recording their behaviour and demeanour, listening to their concerns and views, and using that information to make decisions about their welfare;
- making appropriate referrals to CSC services and early help practitioners;
- reducing investigation delays;
- supervising incidents and investigations more consistently to make sure opportunities are pursued to help children; and
- making sure children in police detention are supported by appropriate adults and have timely access to healthcare professionals.

Conclusion

Wiltshire Police needs to make some fundamental changes to improve many areas of its child protection arrangements and practices.

We have therefore made a series of recommendations. If the force acts on them, these will help improve end results for children.

1. Introduction

The police's responsibility to keep children safe

Under section 46 of the Children Act 1989, a constable is responsible for taking into police protection any child they have reasonable cause to believe would otherwise be likely to suffer significant harm. The same Act also requires the police to inquire into that child's case. Under section 11 of the Children Act 2004, the police must also keep in mind the need to safeguard and promote the welfare of children.

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

The National Crime Agency's (NCA) strategic assessment of serious and organised crime (2021) established that the risk of child sexual abuse continues to grow, and is one of the gravest serious and organised crime risks. Child sexual abuse is also one of the six national threats specified in the *Strategic Policing Requirement*.

Expectations set out in the *Working Together* guidance

The statutory guidance published in 2018, *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*, sets out what is expected of all organisations involved in child protection. This includes local authorities, clinical commissioning groups, schools and voluntary organisations.

The specific police roles set out in the guidance are:

- identifying children who might be at risk from abuse and neglect;
- investigating alleged offences against children;
- inter-agency working and information sharing to protect children; and
- using emergency powers to protect children.

These areas are the focus of our child protection inspections. Details of how we carry out these inspections are in Annex A of this report.

2. Context for the force

Wiltshire Police is responsible for policing the county of Wiltshire. It has a workforce of 2,298, comprising:

- 1,096 police officers;
- 1,070 police staff;
- 132 police community support officers; and
- 150 special constables.

The force serves a population of 696,000 people in an area of 3,500 square miles, including the large urban area of Swindon Borough Council and the more rural areas and smaller population centres covered by Wiltshire Council.

There are eight community policing team areas in the force area: Amesbury, Chippenham, Devizes, Royal Wootton Bassett, Swindon, Salisbury, Trowbridge and Warminster.

The force control room is located at the headquarters in Devizes. There are two custody facilities, in Melksham and Swindon.

The Wiltshire and Swindon PCC introduced a revised Police and Crime Plan 2022–2025 during our inspection. This includes a commitment to protecting children from violence and serious harm, the Police and Crime Plan 2022–2025.

Safeguarding partnerships are required by the Children and Social Work Act 2017. The force works closely with other organisations to safeguard children. Its statutory partners are the local authorities of Swindon and Wiltshire, and the NHS Bath and North East Somerset, Swindon and Wiltshire clinical commissioning group.

The assistant chief constable has responsibility for the force's public protection services and represents the force in the Swindon Safeguarding Partnership and Wiltshire Safeguarding Vulnerable People Partnership.

Recent Inspections

The most recent Ofsted inspection (July 2019) of children's social care services provided by Swindon Borough Council reported:

Judgment	Grade
Overall effectiveness	Good

Ofsted continues to monitor the progress of the council.

The most recent Ofsted inspection (June 2019) of children's social care services provided by Wiltshire Council reported:

Judgment	Grade
Overall effectiveness	Good

3. Leadership, management and governance

There is a good governance structure, but leaders aren't provided with the qualitative data they need to understand performance

The force has a clear structure of governance for its public protection activity, which helps leaders and staff understand demand and responsibility. An assistant chief constable is responsible for public protection services. Chief officers and senior managers are actively involved in a range of meetings overseeing the force's responses to crime, risk and vulnerability.

These meetings are informed by substantial quantitative data, such as information on crime types, which helps highlight any potential performance problems. For example, the force's operations and vulnerability board receives monthly updates about the full range of public protection department areas of responsibility. Exceptions to expected trends and changes in demand are highlighted by analysts.

But the force has limited qualitative information to give context to this. For example, data tells the force that there has been a reduction in reports of child sexual exploitation (CSE), but the force doesn't fully understand why this is the case and hasn't analysed the problem. This means that leaders lack insight into trends relating to CSE, which reduces their ability to improve performance and reduce risks for children.

The force does produce some intelligence profiles, on subjects such as CSE and child criminal exploitation. But these profiles aren't widely accessed by the force's staff and partner organisations, and don't effectively support operational activity to reduce the impact of harm from these crimes.

Data about risk and vulnerability isn't recorded well enough in the force's systems to improve the quality of these profiles. There is inconsistency in the recording of some crime types and incidents, such as sexual offences and missing children. And the workforce often doesn't make accurate records of the ethnicity or cultural heritage of victims, witnesses and offenders. Managers need to improve the force's data-recording standards if they want to use intelligence-led policing methods to disrupt offenders more effectively.

The force's performance data and its scrutiny processes don't focus enough on critical vulnerability. For example, repeat victims who are known to the force through PPNs rather than as crime victims may not be assessed as being vulnerable. And some crime types aren't identified by frontline responders or their supervisors.

We found several cases where child neglect and assaults weren't identified and recorded within domestic abuse incidents. So golden hour investigations weren't completed, and safeguarding was ineffective, for those children.

This also means that the force is unaware of the full extent of these types of crime, making it difficult for it to respond appropriately.

Leaders need to quickly improve the significant under-recording of information about people's ethnicity and cultural heritage. If not, this is likely to undermine the force's understanding of vulnerability and may reduce the quality of its responses aimed at reducing risk to some vulnerable children.

An inexperienced workforce doesn't yet have the capability and skills to respond effectively to vulnerability and risk

The force has recruited to the full strength allowed by its budget, which is positive. But the capability of its workforce is limited by inexperience and a lack of specialist training. About 70 percent of the force's officers have fewer than five years' experience.

In frontline community policing teams (CPTs), about 50 percent of officers have fewer than two years' service. This means that student officers are often mentored and guided by inexperienced colleagues. Frontline supervision is similarly affected by inexperience. And trainee officers are sometimes taken away from their duties to complete training.

Because CPTs lack resilience and experience, they don't always respond to incidents as well as the force would like. We found several incidents where, despite a good initial response, officers didn't appropriately identify or address vulnerability and supervision was ineffective. For example, several domestic abuse incidents were graded as standard risk when there was clearly a high risk, such as the presence of repeat perpetrators.

There is a skills and capability deficit in specialist public protection departments (PPDs). While the force has added staff to increase the capacity of some teams, overall, not enough officers are trained as detectives or have completed the specialist child abuse investigation development programme (SCAIDP). This means some officers aren't skilled enough to manage more complex investigations. As a result, they sometimes make poor decisions, especially when dealing with high caseloads and complex multi-agency enquiries with vulnerable victims. For example, we saw delays to interviews with child sexual abuse victims and suspects, which meant opportunities to safeguard and gather collaborative evidence were missed.

The force hasn't trained all its PPD supervisors and managers to perform their duties. This means that some teams within PPD don't have enough staff with the right skills and experience to effectively manage workloads. For example, the exploitation and missing team (EMT) has little investigative capacity and the multi-agency safeguarding hub (MASH) team currently has no PIP2/SCAIDP-trained supervisors or staff. Both units play an important role in identifying vulnerability and making decisions about risk management.

Some frontline and specialist staff told us they lacked understanding of the crime allocation policy and the remit of many of the PPD units. This results in inconsistency and inefficiency in the response to reported crime and the management of incidents where vulnerability and risk are factors. A lack of clarity over processes and responsibilities means that inexperienced officers are unable to hand over some serious and/or challenging investigations to specialist teams or trained detectives.

The force's response to missing children is ineffective

We found that the force wasn't following authorised professional practice (APP) for missing children.

The force and its partners don't engage well enough with these children to understand why they go missing and what needs to change to keep them safe. The information the force collects doesn't provide the detail needed; either to quickly find the children in future incidents, or to deal with any abuse or exploitation risk. The force hasn't assigned enough personnel and supervision to reduce vulnerability for missing children.

The force participates in several multi-agency meetings where vulnerable children are discussed and safeguarding activity is managed. Multi-agency safeguarding arrangements can be vital to reducing risk to children. Leaders should make sure that these meetings complement each other to enhance the effectiveness of the response and not duplicate or confuse activity.

Arrangements for assessing risk and referring concerns to other organisations are ineffective

To contribute effectively to multi-agency safeguarding, police forces must efficiently assess information about risk and send it to partner organisations. Although the force assigns a substantial number of staff to the MASHs, its process is ineffective.

The force doesn't research or triage any PPNs before sending these individually to the local authority. Most of the force's PPNs only record single incidents. So they're often below the threshold for statutory intervention by children's social care (CSC) services. As a result, CSC typically doesn't act on these referrals.

MASH processes don't always identify and record all crimes within referrals from other agencies, or crimes that aren't recorded by responding officers within PPNs.

Force leaders understand the benefits to children of providing early help and intervention to prevent the escalation of risk. So they should have a process to assess PPNs and direct them to the right local safeguarding organisation. This would allow children to get the help they need without delay.

Most strategy meetings are held in the MASH. But in the MASH, police supervisors without child protection investigation training are making decisions on behalf of the force.

In addition, sometimes investigations begin before information sharing and joint planning takes place in the MASH.

The problems highlighted in this section relate to working in partnership. The force needs to work with other safeguarding organisations to improve arrangements for assessing information about children's welfare and child protection referrals.

The force's approach to multi-agency governance arrangements for safeguarding isn't fully effective

The force engages with, and contributes to, statutory partnerships in both of its local authority areas to provide multi-agency governance to safeguard children. Police leaders and senior partners describe cordial and professional relationships within these, that support multi-agency operational activity.

Both local authority areas have MASHs, with arrangements to tackle the risk to children from exploitation. There is some joint training and communication to inform the staff in the participating agencies about lessons learned from serious incidents affecting children.

But the force doesn't effectively challenge its partners when there are strategic or operational problems. More information about these problems is contained later in this report. But in summary, the problems where leaders should be escalating concerns within the safeguarding partnership are:`

- delays in receiving third-party material for disclosure in criminal proceedings. A protocol for this is in place, but its timescales are often not met;
- the lack of support for children in police detention, including timely access to appropriate adults, the availability of healthcare professionals and the provision of alternative and secure accommodation for children detained after charge; and
- ineffective MASH arrangements for addressing concerns about the welfare of children, as well as referrals for child abuse.

There is inconsistent understanding of the voice of the child

We saw some encouraging examples of officers engaging well with children and recording a child's vulnerability. But there were too many other occasions when this wasn't the case and officers and their supervisors failed to record the voice of the child (VoC). The force needs to constantly reinforce the importance of seeing and speaking to vulnerable children, and then recording their concerns so they can be supported. This underpins the effectiveness of the response from police and their partner organisations to children who need help and protection.

Recommendations

- We recommend that Wiltshire Police immediately works with its multi-agency safeguarding partners to escalate and resolve problems that are reducing the effectiveness of arrangements to safeguard children.
- We recommend that within three months Wiltshire Police reviews how it collects, assesses, and presents information about crime, vulnerability, and risk. This is to make sure that leaders and managers are given good-quality data to support their decision-making for effective safeguarding responses.
- We recommend that within three months Wiltshire Police reviews the training it gives its workforce. This is to make sure all staff have the right skills to support them in their duties to investigate crime and protect vulnerable children.
- We recommend that within three months Wiltshire Police reviews the VoC training it gives its personnel in all roles. This is to develop awareness of the importance of engaging with children and understanding their perspectives. This is designed to improve safeguarding activities and support better end results for those children.

4. Case file analysis

Results of case file reviews

For our inspection, Wiltshire Police selected and self-assessed the effectiveness of its work in 33 child protection cases. Under HMICFRS criteria, the cases selected were a random sample from across the area.

Our inspectors also assessed the same 33 cases.

Cases assessed by both Wiltshire Police and us

Force assessment:

- 13 good
- 14 require improvement
- 6 inadequate.

Our assessment:

- 6 good
- 14 require improvement
- 13 inadequate.

Our inspectors selected and assessed 37 more cases during the inspection.

Additional 37 cases assessed only by us

- 10 good
- 15 require improvement
- 12 inadequate.

Total 70 cases assessed by us

- 16 good
- 29 require improvement
- 25 inadequate.

Breakdown of case file audit results by area of child protection

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

- 3 good
- 3 require improvement
- 4 inadequate.

Common themes include:

- in most investigations, there are strategy discussions with CSC;
- but the force doesn't record investigation plans well (including actions and updates);
- the force does make joint visits with CSC;
- officers are inconsistently recording the VoC;
- officers don't always identify and address wider safeguarding risks;
- officers and supervisors don't always identify and record crimes against children;
- officers don't often record ethnicity; and
- investigations often lack the right supervision.

Cases assessed involving referrals relating to domestic abuse incidents or crimes

- 2 good
- 3 require improvement
- 4 inadequate.

Common themes include:

- most responses are prompt;
- the force sometimes gives officers information about risk and vulnerability to help their approach;
- some officers don't speak to children, or record their demeanour and accounts;
- other officers use body-worn video to record children's voices and gather evidence;
- officers don't often record ethnicity;
- the force makes referrals via Operation Encompass;
- officers sometimes miss offences of neglect, and sometimes don't hold strategy meetings with CSC to plan safeguarding arrangements; and
- supervisory guidance and endorsement of plans are inconsistent.

Cases assessed involving referrals arising from incidents other than domestic abuse

- 3 good
- 6 require improvement
- 1 inadequate.

Common themes include:

- generally there was a prompt response;
- officers don't always submit PPNs or make referrals for children quickly enough;
- supervision is inconsistent;
- officers fail to speak to some children, or to record their demeanour and wishes;
- officers generally use powers to protect children appropriately; and
- crimes against children aren't always identified or recorded.

Cases assessed involving children at risk from child sexual exploitation

- 6 good
- 1 requires improvement
- 7 inadequate.

Common themes include:

- control room staff don't always recognise risk and prioritise responses;
- officers don't always speak or listen to children;
- officers don't always complete PPNs;
- officers often miss golden hour opportunities to gather evidence;
- in some instances, we found that there were delays to making arrests and that opportunities for disruption activity were missed;
- there are often delays to actions that would benefit investigations or safeguarding;
- in online abuse investigations, we saw evidence of good initial research and prompt responses; later case management often suffered from delays and a lack of focus on the best end result for the child; and
- officers don't always identify crimes against children and record these on force systems.

Cases assessed involving missing children

- 0 good
- 0 require improvement
- 7 inadequate.

Common themes include:

- control room staff don't always record a THRIVE risk assessment;
- some incidents are wrongly graded, and managers' decisions are delayed;
- supervision is often unclear and doesn't always escalate activity to find children;
- supervision of high-risk missing children incidents is often delayed;
- staff complete PPNs and trigger plans inconsistently;
- staff often use warning markers and intelligence poorly; and.
- there are often delays in sending officers to find vulnerable children.

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

- 1 good
- 4 require improvement
- 1 inadequate.

Common themes include:

- in most cases, police attend incidents quickly and safeguard children well;
- designated officer entries are inconsistent, but we did see some good supervision and decision-making;
- the end of the use of police protection powers isn't always recorded;
- in some cases, officers don't recognise crimes (in particular, neglect);
- in some cases, officers don't record crimes correctly; and
- officers don't always submit PPNs.

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

- 0 good
- 7 require improvement
- 1 inadequate.

Common themes include:

- officers work well with probation officers to assess offender risk;
- officers don't always act consistently when offenders commit offences;
- officers make referrals to CSC when they have concerns for children, but sometimes safeguarding is delayed without explanation; and
- supervision isn't consistently in place.

Cases assessed involving children detained in police custody

- 1 good
- 5 require improvement
- 0 inadequate.

Common themes include:

- officers explain to detained children their rights and entitlements when they enter custody;
- there are long delays in appropriate adults attending to see detained children;
- the VoC principle isn't fully understood;
- there is inconsistency in when health care professionals see children;
- officers don't always complete PPNs to refer children to CSC; and
- when alternative accommodation isn't available for some children after they're charged, custody officers don't escalate the problem to senior officers.

5. Initial contact

Risk assessment in the force control room is inconsistent

The force has a single control room that receives all calls for police assistance in its area.

Police forces use the THRIVE (threat, harm, risk, investigation opportunities, vulnerability) model to decide on their level of response to new and continuing incidents. They should record these assessments to support their decisions about the response a call should get. And supervisors should record reassessments of continuing incidents and cases in which responses were delayed.

The force told us it had recently re-trained its control room staff to risk assess calls using an updated version of this model, called THRIVE+. For the incidents we examined, staff had recorded very few THRIVE assessments. But better use of the model was evident in more recent incidents.

If incident records don't contain clear THRIVE assessments, it is difficult for supervisors to understand the call-takers' decisions and determine whether responses are appropriate.

We saw these problems in the way control room staff responded to reports of missing children.

The force's control room practices delayed and confused its responses to missing children

Control room police inspectors, in their role as force incident managers (FIMs), introduced a process to manage responses to missing children. Control room staff didn't delay entering information about missing children on the force system. But these incidents were designated as 'concerns for safety' rather than missing person incidents for up to four hours. The incident reports weren't recorded and risk assessed in accordance with national guidance and the college of policing's APP for missing persons.

Instead, the 'concerns for safety' incidents were held by the FIMs on a separate area of the force's system.

Like other police forces, the force uses trigger plans to hold information about children who are frequently reported missing, so it can find them more quickly. It is vital that forces regularly update these plans, so they accurately reflect the risks and vulnerability of the children concerned. We found some incidents where the force used trigger plans to help find missing children. But in other cases, although a trigger plan was in place, it wasn't used to assess the child's risk or set priority actions to find them quickly.

FIM assessments were often superficial, without reference to relevant intelligence, warning markers and existing medical or welfare conditions affecting the child. And many assessments were incorrect. This way of working means that risks to children aren't adequately researched, and that in too many cases the force doesn't understand the extent of the child's vulnerability.

We found that the force didn't recognise high risk well enough. This delayed the appropriate level of supervisory direction and operational activity being carried out by up to four hours.

FIMs allocate missing children reports to duty inspectors once they are received. We found that delays were often occurring before the relevant duty inspector acknowledged responsibility, reviewed risks and assigned actions. These delays may expose children to further risk before an effective investigation finds them.

Case study: ineffective response to a missing child

A mother called police because she discovered her 15-year-old son was missing from home when she went into his room in the morning. He had taken toiletries and extra clothing.

There were reports for six recent previous missing incidents. The child is autistic and affected by attention deficit hyperactivity disorder and had self-harmed in the past. He had been prescribed medication for his conditions, which needed to be taken twice daily. The force knew that he was vulnerable to exploitation.

The call handler completed the missing person questionnaire and established that a trigger plan was available. But no THRIVE assessment was made. The incident remained open as a concern for safety.

The FIM assessed the incident three hours after it was reported and decided that it was a medium-risk missing person investigation. It was allocated to community policing team officers to take forward.

There was no clear supervisory direction to encourage officers to find the child quickly. The first review of the investigation took place 12 hours after the initial call. The review identified that the child might be with a man in another county.

The inspector assigned actions to officers to locate the child. The next morning, officers from the force covering that county found the child and he was returned home safely.

The force's records don't specify whether a return-to-home interview was ever completed with the child. And no multi-agency meeting or strategy discussion was held to discuss risks to the child or plan future safeguarding.

The categorisation of incidents as 'concerns for safety' has meant that the force's records of missing children are inaccurate. This is because many children who are found before an incident is assessed aren't recorded as missing. This means that ways to support vulnerable children (such as the high-risk cohort who are reported missing three times in 90 days) may not be engaged early enough.

The force stopped its practice of recording missing children as 'concerns for safety' during our inspection.

Training for frontline staff needs to improve to help them better respond to risk and vulnerability

New and student officers carry out training modules about vulnerability and safeguarding as part of their formal initial training.

The force understands that it needs to support its inexperienced frontline responders. We found that it had made some electronic guides and links to force policy available for officers to see on their issued personal devices. Officers responding to incidents can access the force's online systems to get the information about what to do if specialist advice is needed.

Case study: the force's mnemonic for mobile devices to inform and prompt staff about child neglect

N – not looked after, poor hygiene

E – environmental concerns

G – giving unexpected attention to others

L – left alone

E – evidence of lack of medical care

C – changes in behaviour

T – times of poor health/development

But many staff we spoke with didn't have a clear understanding of the VoC approach, or the need to be professionally curious and think about risks to children beyond the immediate incident they were responding to. This finding was reflected in many of the cases we reviewed. Officers didn't always make sure that they recorded information about children's welfare on PPNs.

Frontline supervisors don't make sure their staff consistently record vulnerability and risk

Supervisors aren't consistently checking how well their staff complete reports of incidents. This means the force can't always be sure that investigations follow golden hour principles, that crimes are recorded, and that any victims, scenes, and witnesses identified and protected.

Although some officers take the time to speak with children and record their words and demeanours, this isn't always the case. But we did see some very good responses showing that some officers understood how they should approach children.

Case study: exemplary focus on the voice of the child

Control room staff identified a repeat high-risk domestic abuse incident. Two young children were at home and saw their mother being abused.

The responding officers turned on their body-worn video to record how they dealt with the family. Their approach was professional and compassionate, with a clear focus on the welfare of the children. They recorded information on a PPN about the effects of the incident on the children's welfare, which was sent to the MASH.

The force began investigations in relation to the violence against the mother and the abuse of the children. A strategy discussion was held promptly with CSC services, and the children were given child protection plans because they were being emotionally harmed by the domestic abuse. The force made a timely referral to the multi-agency risk assessment conference (MARAC) to co-ordinate support for the family.

The offender was arrested. A successful evidence-based prosecution using the material gathered by the officers resulted in a criminal conviction.

Frontline staff aren't routinely recording information about the ethnicity and cultural heritage of children affected by incidents. We saw some cases where although officers had met children, the children's ethnicity was recorded on force systems as "unknown".

The force should always record information about victims' and suspects' ethnicity and cultural heritage – particularly if this is a factor in the incident they are involved in. Some individuals and communities are more vulnerable to harm from specific risks because of their cultural heritage. Examples of this are so-called honour-based violence and female genital mutilation.

We didn't see evidence of supervisors reviewing reports and instructing officers to record the voices of children or complete PPNs before incidents were closed. This includes force control room supervisors. This finding means the force has an incomplete record of children's vulnerability, and that it doesn't always make the referrals to other organisations to help children that it should.

All PPNs and risk assessments for domestic abuse incidents are supervised. But we saw instances where supervision assessments were superficial or not specific enough.

These are potentially unsafe ways of working. They indicate a lack of understanding of the importance of reviewing every incident to make sure the police response is good enough. Without effective supervision to check the quality of junior staff's work, there is potential that victims and their children may be left at risk.

Case study: risk missed by response officers and their supervisor

Officers assigned a high priority to their response to a domestic incident involving a woman and her husband. It was the fourth report within six months involving this couple.

The incident was a verbal argument, caused when the man became angry after returning home from work and finding the couple's 18-month-old child unsupervised in the bath upstairs while the man's wife was sitting downstairs using her phone.

The force had records about the woman's vulnerability. She experienced difficulties with her mental health and had previously attempted self-harm.

Officers dealt with the situation by offering words of advice after the man agreed to leave the home and stay elsewhere overnight.

The risk to the child wasn't dealt with appropriately. The force's records didn't include the risk to the child due to the mother's neglect, and no investigation was recorded.

The domestic abuse incident was assessed as standard risk. A PPN was submitted because the child was present at the incident, but not because the child was neglected.

The officers involved didn't contact CSC services for advice or support while dealing with the incident, and they left the child alone with its mother.

Despite a supervisor review being carried out, the risk to the child and the escalating risk in the parents' relationship weren't fully identified.

The force is improving its control room systems to help its staff respond better to risk

Control room staff told us they had recently received updated THRIVE assessment training. We saw that this had led to an improvement in the quality of the response given to recent calls. This training had helped staff to recognise vulnerability and assign the appropriate response priority to incidents to reduce risk.

The force has also introduced a new set of questions to ask callers who report domestic abuse incidents.

Case study: the force's revised control room 'domestic abuse incident question set'

1. Is the informant able to speak freely?
2. Where is the suspect now? Where are they likely to go?
3. Is violence involved and does the victim have any injuries?
4. Are any weapons involved?
5. Are there children/vulnerable adults in the house? Are they safe?
6. Are drink/drugs involved?
7. Can police gain entry to the premises?
8. Is there any allegation of stalking/harassment?

Control room staff record the responses to these questions and make the information immediately available to support responding officers in their approach to victims and suspects.

Warning markers and flags are added to force systems to inform responses to domestic abuse victims and perpetrators. Other markers can be used to highlight children on child protection plans, and MARAC safeguarding plans for families at risk.

We also saw that the force used flags to alert officers about the risks of some offenders in the community, such as registered sex offenders who may be a risk to children. But some frontline staff told us they found the force's use of flags and warning markers inconsistent, and they weren't always sure what they should do after getting these alerts.

Recommendations

We recommend that Wiltshire Police immediately improves its arrangements and ways of working for responding to incidents of missing children so that:

- control room staff identify risk and vulnerability, and assign the correct response priority to incidents involving these;
- flags, warning markers and trigger plans are accurate and used appropriately;
- supervisors review decisions and open incidents, and escalate responses when necessary; and
- an audit process is in place to identify concerns and ways to improve.

6. Assessment and help

The force and its safeguarding partners don't agree about what information should be shared in the MASHs

There are two MASHs in the force area – one covering Swindon and the other covering the county of Wiltshire.

The police work with other safeguarding organisations to risk assess information about children and decide which service is needed to help them.

Assessing information about children's vulnerability and acting on it without delay is the cornerstone of effective multi-agency safeguarding.

Statutory guidance in *Working together to safeguard children 2018* states:

> "Everyone who works with children has a responsibility for keeping them safe. No single practitioner can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.
>
> Anyone who has concerns about a child's welfare should make a referral to local authority children's social care and should do so immediately if there is a concern that the child is suffering significant harm or is likely to do so. Practitioners who make a referral should always follow up their concerns if they are not satisfied with the response.
>
> The force sends all its PPNs to the MASH. But the force and its safeguarding partners don't fully agree about what information should be sent to the MASH. The force encourages its staff to record concerns they have about the welfare of children on PPNs and send these electronically to be assessed in the MASH. But the local authorities have told the force that they only want to receive information about serious concerns for children."

The Children Acts of 1989 and 2004 promote the benefits of multi-agency contributions to child protection. Different organisations hold information about children, their families and those who are a risk to them. Children may need help from various organisations across a spectrum of risks and vulnerabilities. Some activity is urgent – particularly when a child is at risk. But other support will be less intensive and longer term.

MASH arrangements for assessing information should be clear and have clear referral pathways to protect children or to provide information without delay to those who can help a child to thrive.

The force doesn't have an effective process to assess the quality of information within PPNs and other force records

The main role of the force's MASH staff is to research police systems and provide information for strategy discussions called by CSC services under section 47 of the Children Act 1989. This helps safeguarding organisations to share information and carry out joint investigations to protect children.

Where children are at risk of abuse or neglect, the organisations need to hold strategy discussions quickly. This is so they can understand the risks and plan together to protect children and investigate the incident effectively. A police MASH supervisor attends strategy discussions. Decisions made at these are recorded on police systems and, where applicable, notified to investigating officers.

But police MASH supervisors aren't detectives, and they haven't been given specialist child protection training. They don't always fully understand the information they are given and sometimes they don't identify instances when crimes should be recorded. This means that action to safeguard children is sometimes delayed until they become repeat victims, or the level of abuse is greater and more apparent to responding officers.

It also means that partnership safeguarding arrangements may not be triggered early enough.

Case study: ineffective risk assessment and supervision leaves children at risk

Officers responded to an incident of harassment against a mother of four children. The risk was recognised in the control room and officers were quickly deployed. But the perpetrator, a male ex-partner, left the home before officers arrived.

The four children were seen by officers. But the officers didn't speak to them, use body-worn video, or make a record about the effect the incident had on these children.

This was the fourth time within two months the woman had reported she had been abused by her former partner.

According to police records, the male was a multiple domestic abuse perpetrator, with six previous partners who were victims of his abuse. One of these was still being protected by a restraining order against him.

The officers assessed the incident as standard risk. It was supervised by a sergeant and sent to the MASH.

MASH processes didn't identify the vulnerability of the family or the risk from the suspect. Police in the MASH decided not to share the PPN with any other agencies as they assessed that the children hadn't been directly affected by the incident. This meant that schools, who could have offered support to the children, weren't told about the incident.

The force's own policy, which required 5 incidents of domestic abuse to take place within a 12-month period before assessment by the MARAC, meant that this family was excluded from automatic inclusion in this safeguarding forum.

We brought this to the attention of the force, and it began a review.

Police MASH staff aren't child protection specialists, and they aren't trained for their roles

Police staff within the MASH aren't formally trained for their roles there. Instead, they learn on the job. This is a significant weakness. And the development of these staff has been worsened by staff working online during the pandemic.

The lack of a well-trained and organised specialist capability to process PPNs means that there isn't an effective risk assessment process in MASH. It also means that the MASH lacks a clear understanding about how to use other information from the force's systems to get a better understanding of a child's vulnerability. Having this understanding is vital to help supervisors decide what information needs to be provided to other safeguarding organisations to help children. Officers and supervisors in many of the cases we inspected hadn't properly assessed the available information.

MASH staff don't routinely check new PPNs in a triage process. This lack of MASH triage means that intelligence about child exploitation and other vulnerabilities (such as child neglect or other incidents) isn't always identified, recorded and where necessary escalated to a strategy discussion. The force told us that its staff did make reports about child exploitation – particularly in relation to drugs supply and county lines. But it is concerned about the lack of intelligence its officers record about CSE.

The College of Policing has issued approved professional practice (APP) guidance for forces, which states:

> "Information sharing enables early intervention and preventative work to safeguard and promote welfare, as well as for wider public protection. The public needs to be confident that their personal information is kept safe and secure. All members of the police service are responsible for ensuring that we share information appropriately as part of our day-to-day practice and do so confidently, proportionately and lawfully."

Not every child seen in an incident by police needs to be referred to be considered for a child protection investigation. But it is likely that there is some form of help that will benefit vulnerable children. For example, children affected by domestic abuse can be supported by staff in schools who are informed of the incidents by the force's Operation Encompass scheme.

The force works with other organisations to understand vulnerability and reduce the risk to those affected by domestic abuse

MARACs are held regularly by the force and other safeguarding organisations in Swindon and the county of Wiltshire. These are supported by independent domestic violence advisors.

For the cases discussed at MARAC, the force keeps records of case summaries, updates, risks, safety measures, information shared and agreed actions on its systems. This means that it can assess risk and appropriate responses if it is called back to help victims.

MARACs consider risks to children in families affected by domestic abuse. We reviewed records that showed some MARAC meetings were trying to deal with up to 30 cases. Such large numbers of cases can make it difficult to effectively manage complex domestic abuse risk.

We saw that the MARACs had a high threshold (5 repeat incidents in 12 months) before they would review cases. Nationally, most MARACs follow guidance from the charity SafeLives that cases are automatically referred to a MARAC after 3 incidents in 12 months. We are concerned that the local policy has been set primarily to reduce demand on MARAC, and that as a result some families may not get the help they need to be safe soon enough.

The specialist safeguarding team co-ordinates the force's response to domestic abuse

The specialist safeguarding team works with community policing teams to protect vulnerable families. It also works closely with independent domestic violence advisors, local authority staff and local domestic abuse charities. It is clear that the force and the PCC prioritise multi-agency activity in seeking to reduce the amount of domestic abuse in Swindon and Wiltshire.

The force's safeguarding team carries out victim safeguarding and provides support for investigations into high-risk and medium-risk domestic abuse crimes.

But the force's long-standing shortage of trained detectives severely reduces the capability of this team. It means that investigations are sometimes delayed, and that offenders aren't always arrested quickly enough.

The team supports the force's domestic abuse prevention and intervention strategies. It co-ordinates the domestic violence disclosure scheme (often called 'Clare's Law') where police tell vulnerable people about domestic abuse offenders who may harm them.

The force also works with its partners to identify offenders who would benefit from attending the Wiltshire domestic violence perpetrator programme.

The force told us it was inconsistent in its use of domestic violence prevention notices and didn't make enough applications to the courts for domestic violence prevention orders (which last longer than the notices). More clarity in the force's approach and its guidance to officers would provide better levels of protection for victims and their children.

The force doesn't have the capability to support effective arrangements for missing children

Staff within the force's EMT are responsible for co-ordinating arrangements for missing children. But this team is very small and works during standard office hours from Monday to Friday.

According to the force's policy, two missing from home co-ordinators should work with two full-time missing prevention operational support (MPOS) officers, but we found there was only one MPOS officer in place. And there is no dedicated supervision to review and endorse decisions made by EMT staff in relation to missing children. The staff make decisions based on their own professional judgement and their capacity to deal with individual cases.

The co-ordinators review all missing incidents, as well as 'concerns for safety' incidents where the child was reported as missing, and prompt officers to complete PPNs for missing children.

MPOS officers and missing from home co-ordinators are responsible for making sure warning markers for missing children are up to date, and for updating information on trigger plans to help find children quickly if they go missing again. But we found that information about missing children wasn't recorded systematically. Instead, this information is scattered among various trigger plans, PPNs and other records. Some risk assessments are simply copied directly from earlier entries. And children's ethnicity isn't recorded accurately in many of the force's records.

The missing from home co-ordinators keep their own records about the children they are helping. This includes information on numbers of missing episodes and trigger plans completed, and where there are child abduction warning notices (CAWNs). The force has 14 CAWNs aimed at safeguarding children in its area. But it doesn't have a process to review whether these are helping reduce the risk from people who are a threat to the child. We found that the CAWNs weren't all linked to children on the force's systems, meaning it was sometimes difficult to access accurate intelligence about children's vulnerability.

Some officers and supervisors told us that they didn't fully understand the force's policy about applying for CAWNs and recognising when children would benefit from their protection.

There are missed opportunities to reduce risk to children who go missing

MPOS staff should engage with missing children who are assessed as being vulnerable to exploitation. This should include multi-agency preventative work with children and their carers to divert them from risk and harm.

The force and its safeguarding partners should speak with children to understand the reasons causing them to run away from home, so they can identify and reduce risk. But we found that EMT staff didn't have time to complete all their work, such as attending strategy meetings with partner organisations. In addition, information in EMT records wasn't always reflected in markers on the force's systems. This means the most up-to-date intelligence isn't always immediately available to responding officers.

CSC staff conduct return-to-home interviews with children. But these interviews are inconsistently recorded on force systems and intelligence isn't effectively shared. This means information that may help find the child or reduce their risk from exploitation isn't always available when it should be.

The quality of trigger plan records for frequently missing children is also inconsistent. Some cases have inaccurate information and out-of-date intelligence and warning markers. It was clear to us that these trigger plans weren't being systematically reviewed. This means that some of the force's risk assessments may be inaccurate, or that some of the information it holds may mislead rather than assist frontline responders.

The force isn't recording all reports about missing children. We found that some were closed as incidents of 'concerns for safety' if the child was found within a period of up to four hours (before any missing record was made).

This means the force doesn't have accurate records of missing episodes for some children. It also affects the timeliness of when the force mobilises support for children who are reported missing three times in 90 days. And it means that some police prevention interviews or local authority return-to-home interviews aren't being carried out when they should be.

The force hasn't done enough to reduce missing children incidents

The force hasn't yet introduced the Philomena Protocol. This is a project widely used by other forces and safeguarding partnerships to help find and return children as quickly as possible when they are missing. The basis of the scheme is for vital information about the child to be gathered and recorded so that this can be used by responders to help find them quickly.

Under the scheme, police also talk to carers, particularly those involved with children's homes, about their responsibilities to make reasonable enquiries themselves to find the child before contacting the police. Nationally, there is evidence of significant reductions in the numbers of looked-after children reported as missing following implementation of the protocol.

The daily management meeting informs leaders of high-risk and critical incidents

The force holds a daily management meeting (DMM) every morning with representatives from its departments and policing areas. The agenda includes information and updates about notable and critical incidents to allow senior managers to review responses. This helps leaders have confidence in existing responses, or task additional resources or specialist capability to priority incidents.

During our inspection we joined a DMM, where we saw that the force had responded positively to our feedback and added incidents where children were taken into police protection to the agenda. Managers discussed one of these incidents and were satisfied with the action taken to protect the children.

But another incident within the missing person section of the meeting raised concerns for us about how the force understood what its response to vulnerability and risk should be.

Case study: DMM scrutiny should identify risk and escalate responses

Foster carers reported a 16-year-old boy as missing. Control room staff assessed the report as a 'concern for safety'.

Since October 2021, the force had recorded 33 missing reports for the boy. Nine of the missing incidents were recorded as 'concerns for safety'. The force systems also held warning markers and information about his vulnerability, including self-harm and criminal exploitation linked to drugs supply.

There was a trigger plan for the boy. But this was out of date and didn't hold information from previous incidents, or a link to intelligence about risks to him.

While still missing, the boy returned to the foster carers' home and stole their car. He and another vulnerable child sent messages on social media suggesting they were in another police force area involved in drugs supply.

The following morning the child was discussed in the DMM. The meeting was told that it still wasn't a missing child investigation because the boy was now wanted as an offender – for stealing the car.

Following feedback provided to inspectors about vulnerability, this case was discussed by the DMM attendees, and they decided to treat the boy as both a wanted and missing child.

The force participates in multi-agency arrangements to reduce child exploitation, but they aren't as effective for CSE risk

The local safeguarding partnership uses an exploitation tracker to help staff manage their response to children vulnerable to criminal and sexual exploitation. Partnership-funded analysts assess the risk of exploitation for each child so they can be placed on a tracker to indicate the risk level. This helps professionals manage the level of intervention and support needed for each vulnerable child.

But the force and its partners don't have qualitative performance measures to help inform leaders about the impact of these arrangements.

Of the 93 children on the tracker, 20 are girls – 14 of whom are at risk of CSE. Most of the children on the tracker are vulnerable boys involved in county lines-type drug supply.

Officers attend several multi-agency safeguarding meetings to manage risk and vulnerability for victims and offenders. These include meetings relating to knife crime and child exploitation, and panels to discuss risks to children from outside the home.

Monthly multi-agency mapping meetings in both local authority areas are attended by police officers, youth offending services and local authority staff including CSC services. Children assessed as being at risk of exploitation are mapped by analysts using association charts, to help the meeting identify people who may be criminal associates and a risk to the child.

But the records of some of these meetings showed that decisions about which cases would be prioritised or discussed were made based on professional judgment rather than by using intelligence or a consistent assessment method. This means there are sometimes different risk assessments for the same child. It also creates some duplication of effort and uncertainty about which organisation or professional is leading the safeguarding response. And it means that CSE risk may not be identified for some children.

We saw, and heard from staff, that the force's intelligence profiles for child exploitation didn't contain enough information. The profiles don't benefit from rich multi-agency information, which would provide the safeguarding partners with a better understanding of victims, offenders, locations and timings. And the force knows that its own information (for example, ethnicity data) doesn't reach the standard needed to benefit strategic and operational planning.

Senior leaders told us they knew the force's approach to CSE wasn't good enough. Officers and staff aren't recognising and recording concerns about CSE. There are few CSE investigations, and little relevant intelligence is recorded on force systems. This means the force doesn't fully understand the risk of CSE to children in its area. Child sexual abuse is one of the threats specified in the Strategic Policing Requirement.

Recommendations

- We recommend that within three months Wiltshire Police reviews its assessment and information-sharing practices so it can more effectively:
    - identify vulnerable children at the earliest possible stage; and
    - refer those children without delay to the most appropriate level of support.
- We recommend that within three months Wiltshire Police reviews with its partners its ways for identifying children at risk of CSE. This is so that there are effective strategic and operational responses to reduce this risk for those children.
- We recommend that Wiltshire Police engages with its partners and community to reduce the risks to children who go missing, including:
    - implementing the Philomena Protocol; and
    - making sure all children are quickly contacted after they are found, for return-to-home and prevention interviews so that the VoC is clearly recorded.
- We recommend that within six months Wiltshire Police introduces a process to review all its PPNs:
    - to check the information is complete;
    - to check that any immediate safeguarding action is in place;
    - to include any other relevant information from police systems for context;
    - to check that crimes are recorded; and
    - to check that it is necessary and proportionate to forward the information to the other organisations.

7. Investigation

The force prioritises child abuse investigation

Three child abuse investigation teams (CAITs) cover the force area. They provide a specialist seven-days-a-week response for children affected by intra-familial abuse, abuse from perpetrators in positions of trust or where serious sexual assaults are committed against any child.

The force has good facilities for interviewing children and vulnerable witnesses. Investigating officers have good access to intermediaries to support communication with some vulnerable victims.

The force has worked with its safeguarding partners to make sure that sexual assault referral centres (SARCs) are in place for forensic medical examinations.

CAIT officers have a good relationship with crown prosecutors, so they are able to seek early advice and direction.

CAIT officers should be detectives or trainee detectives and have received specialist training for this role. Force leaders understand that the CAITs are vital to how effectively the force investigates serious crime against children. The force has increased the size of the CAIT teams. But it struggles to recruit and retain CAIT officers to keep its response fully effective. CAIT should have 1 detective inspector, 5 detective sergeants and 30 detective constables. We found that there were significant numbers of vacancies for investigation staff and that not all the force's CAIT officers were fully trained.

CAIT investigations aren't always effective

The CAIT officers are highly committed and passionate about their work, but they told us they had large investigative caseloads which their supervisors struggled to manage.

Many CAIT staff are inexperienced. Despite this, they are sometimes assigned complex investigations. They don't always have the skills or training needed to help them take these investigations forward effectively. More experienced CAIT staff are expected to mentor and assist their less-experienced colleagues, while also having large numbers of their own open cases. This means that CAIT doesn't always have the capability to fully investigate all the cases assigned to it.

We found that there were some CAIT cases without records of investigation or safeguarding plans. Actions from strategy meetings aren't always updated, and there are some significant unexplained delays. Investigating officers don't often record the VoC to make clear what end results the victims wanted. Supervisory reviews are inconsistent and don't always record and direct investigative action.

Working together with CSC services isn't recorded consistently within CAIT investigations. We saw some investigations where officers spoke with children to understand their views and demeanour, and assess what needed to be done to safeguard them. But in other cases, social workers visited families alone. In these cases, there wasn't a full evidential assessment of criminal offences.

We saw some investigations being closed prematurely by supervisors when lines of enquiry were still available. In several cases, named suspects weren't interviewed and investigations to prove or disprove the suspects' involvement in serious sexual offences weren't progressed. Some suspects were children, and others were parents who still had full access to their victims.

Some of the closure decisions were made when child victims didn't wish to give evidence. But we were concerned that the force wasn't promoting evidence-led prosecutions for these cases or recording why this wasn't done. Without this rationale being recorded, opportunities to reopen proceedings in the future if victims change their minds are less likely.

Case study: ineffective child protection investigations

Two sisters aged 15 and 16 made separate reports that they had been sexually assaulted by their father.

When the first sister reported the abuse, she was interviewed by police and said her father assaulted her on several occasions. Despite knowing that the suspect had immediate access to other children, the investigating officers didn't immediately arrest him, but asked him to attend the police station for a voluntary interview.

The suspect didn't admit to committing any offences against his daughter. He was released under investigation without formal bail restrictions. But the officer advised him not to contact his children.

The officer later recorded that the suspect was in contact with the children but took no action to stop this.

An evidence review officer decided that as there was only the victim's word against her father's, the investigation should be closed. No further investigation was initiated to support the victim's complaint.

When the victim's sister came forward and made a similar complaint, the original complaint wasn't reopened.

The investigating officers and their supervisors didn't fully consider safeguarding for these children, or others whom the offender was in contact with. Officers could have applied for a sexual harm prevention order or a sexual risk order to restrict his access to children.

We asked the force to review this case and the safety of the children and it responded appropriately.

Investigations are frequently delayed

Supervisors told us about frequent causes of delays to serious investigations they routinely faced. Typically, these delays are:

- forensic examination results – 6 months;
- third-party disclosure (usually CSC, education and health records) – 9–12 months;
- transcribing evidential recordings – 6–8 months;
- digital forensics examination results – 6–8 months; and
- criminal justice charging decisions – 2 months.

Staff are confused about the crime allocation policy for CSE

Staff and supervisors from both CAIT and the EMT told us that they didn't think their teams should have responsibility for investigating CSE crimes. CAIT officers said they were at capacity with other types of child protection investigations, and that they didn't have enough experienced detectives to manage the case load. The EMT said they only had a small investigative capacity and that due to demand, their investigative focus was on crimes against adult victims.

This friction negatively affects professional relationships and staff motivation. It also affects the force's ability to move CSE investigations forward. So CSE isn't prioritised, and victims aren't given the service they need.

CSE investigations can be complex, and may need to be assigned to specialist teams with the capability and terms of reference to support long-term operations. National experience indicates that victims or groups of victims vulnerable to CSE are often trafficked by groups of offenders.

Wiltshire Police has a proactive investigative team called Operation Fortitude, which can be tasked to deal with some child exploitation investigations. The team has specialist detective capability but, like other force teams, it isn't fully staffed. Managers told us that most of its child exploitation investigations related to county lines drug supply.

Ineffective CSE investigations

The force's approach to CSE investigations concerned us because supervisors weren't making sure that officers took forward all investigative opportunities. We found that initial investigations didn't always secure vital evidence and officers didn't always instigate golden hour actions. There is an over-reliance on children making verbal disclosures to move CSE investigations forward.

Child victims of CSE are vulnerable. An effective response will often require complex investigative strategies and intensive support for victims. But we saw cases where strategy meetings between officers and CSC services weren't held or were excessively delayed. This meant that safeguarding planning was ineffective for some CSE victims. Opportunities for evidence-led prosecutions aren't being sufficiently considered or identified by officers and their supervisors.

We found examples where serious CSE crimes hadn't been recorded correctly on the force's systems. In other cases, supervisors had closed investigations prematurely, before all the crimes and suspects had been fully investigated. This meant the force wasn't recording the full extent of CSE crime and that vulnerable children weren't being given the opportunity for justice. Below is an example of a very poor response and a failure to recognise and respond appropriately to the needs of a child.

Case study: ineffective response and investigation

A 16-year-old girl with mental health vulnerability and at risk of CSE returned home after going missing. Her mother had reported her as missing from home, but the force didn't make a missing person record of the incident, or record it on a PPN, and CSC services weren't informed.

Later that day, the child told her mother and social worker that she had been raped by three males, and that they had filmed the events and sent her the images online. She complained of internal bleeding and injuries to her head and lip.

A detective constable was assigned to investigate and spoke with the victim. But there wasn't a child-centred investigation. The officer didn't record what she said on the force's investigation system. And they didn't arrange medical care or a forensic medical examination. The child's phone wasn't examined for evidence. There was no video interview to obtain her account for evidence. And there was no assessment of the risk from the three suspects who were in touch with the victim.

Both the investigating officer and the supervisor who reviewed the case recorded their opinion that they thought the victim had consented to sex and that there was no offence of rape.

A decision to close the investigation was recorded.

Despite a clear allegation and evidence on the victim's phone, the force didn't record or investigate offences of making and distributing indecent images of a child.

We asked the force to review this incident and it accepted that it needed to change its response. All the offences are now recorded, and investigations and safeguarding plans are in action.

The force has improved the way it investigates online sexual abuse of children

The force has been proactive about improving the effectiveness of its CIET (child internet exploitation team). It has recently introduced new procedures to make sure the team prioritises safeguarding children.

CIET staff have reduced delays in the time they take to record and research the intelligence they get from the National Crime Agency (NCA), other forces, or law enforcement agencies such as the Child Protection System (CPSys). These referrals are recorded on the force's intelligence system. So the information is available to inform other staff if the need arises.

Five CIET staff have been trained to access the CPSys. This allows them to routinely draw intelligence about offenders in the force area from the system and act without delay to protect children.

The new procedures include recording any risk to children on PPNs and sending this information via MASH to CSC services. For example, this could be when police get intelligence that children may be present at an online offence suspect's address. The force no longer delays multi-agency safeguarding until after a warrant is executed or they arrest a suspect. Procedures relating to the MASH are still being developed with partner agencies to make sure that the information provided by police is shared appropriately and that timely strategy meetings are held.

In January 2022, CIET had a backlog of over 100 referrals from the NCA, and wasn't accessing the CPSys. But sustained activity using the new methodology has reduced this backlog to about 30. These outstanding cases are triaged to prioritise investigations where the force identifies vulnerable children.

CIET staff have high workloads, averaging 15 to 20 investigations per officer. Overtime is needed to help the team to meet the demand: many CIET staff work two weekend overtime days per month. The force has agreed to increase the number of CIET staff and supervisors so that the team has the capability and capacity to manage its investigations.

Officers arrest suspects and apply police bail conditions. These help them to protect children while they carry out investigations and evidential forensic examinations.

Some aspects of the force's online investigation response still need to improve

The force has a desktop link to the national child abuse image database (CAID), which allows trained officers to view images and add images to the system. This can help officers identify victims faster when they're researching intelligence or investigating offences. Forces should use this system to help identify children and offenders. By adding confirmed information to CAID, forces help officers (locally, nationally and internationally) identify new indecent images and children who are at risk.

The force isn't currently fully contributing to CAID. It has only recently assigned and trained a victim identification officer. This officer's role is to upload images onto CAID. But the force is experiencing some problems accessing the system. CIET is attempting to resolve these problems through the national police governance structure.

This means the force isn't using victim identification tools, such as facial and crime scene identification, effectively to help investigations. And it isn't adding to CAID all the details of victims it identifies in images its officers seize. The force should be doing this for all its investigations.

The force's investigators don't have enough equipment or training to triage digital devices when they search offenders' premises. This means officers can't prioritise suspect devices, which may increase workloads and cause investigation delays. It also means that some devices with no illegal images will be unnecessarily examined.

Triage during the early stages of investigations allows the force to quickly identify 'first-generation' images, which are likely to have been created by the offender. This information is vital to identifying victims, gathering evidence and safeguarding children. The current system without triage means there can be delays before investigating officers get this information.

There are inefficiencies and delays in obtaining digital evidence

There are significant delays before the force's digital forensic unit (DFU) completes device examinations. CIET investigators told us they often waited 12 months before receiving these results. We saw the force's February 2022 DFU examination backlog records. They included 95 phones (with the oldest examination request from 9 months ago); and 28 computers (with the oldest examination request 6 months ago).

CIET officers told us they weren't aware of the time targets for device examination in the force's service level agreements and hadn't escalated the problem of delays to senior leaders.

Many staff were also uncertain about whose responsibility it was to view and grade indecent images.

Improved communication and discussions between personnel in CIET, DFU and the force's digital investigation intelligence unit would improve their knowledge and understanding of process, demand, and timescales.

The force supports its staff to respond effectively to risk from online child abuse

The force has clear guidance to help staff respond to cases of self-produced sexual images sent on digital devices (often known as 'sexting'). This means that frontline responders know how to investigate this crime, and that they understand their responsibility to prioritise safeguarding where children are affected.

We found a good standard of supervision within CIET investigations. Supervisors provide clear case direction and make sure officers implement appropriate safeguarding measures. The rationale for decisions taken is clearly recorded.

Managers and force leaders understand that CIET staff are highly likely to be affected by the images of child abuse they see. Three monthly mandatory referrals for psychological support are in place for staff and supervisors. And after consulting colleagues in other areas of the force, managers have decided to create a 'wellbeing room' to provide a place where CIET staff can substantially step away from the job during their breaks.

Recommendations

- We recommend that Wiltshire Police immediately improves child protection investigations by making sure:
    - it effectively supervises investigations, with reviews clearly recording any further work needed;
    - the VoC is clearly recorded and included in decision-making;
    - it appropriately supports joint multi-agency investigations;
    - it assigns investigations to officers with the skills, capacity and competence to take them forward effectively;
    - it regularly audits the quality of its ways of working, including how effective safeguarding measures are; and
    - it focuses on achieving the best end results for children.
- We recommend that within three months Wiltshire Police establishes clear terms of reference for all its investigation capability, so all its staff are certain about which team is responsible for investigating the crime allegation being made.
- We recommend that within three months Wiltshire Police reviews the staffing levels of its investigation teams so that they have the capacity to effectively investigate the crimes they are allocated.

8. Decision-making

The force used police protection powers well in all the cases we audited, but record-keeping is often inconsistent

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

In the cases we examined, decisions to take a child to a place of safety were well-considered and made in the best interests of the child.

Responding officers record information on the force's systems. They say why they needed to use the power, explaining:

- the scenario;
- the parents' attitude;
- the child's demeanour, behaviour and appearance; and
- the risks they feel are likely to cause harm.

But we found some records where the decision to end the use of the police protection power wasn't recorded by the designated officer. This means that that the force can't be certain that the children concerned are in a safe and suitable place where the risk of significant harm has been reduced.

Officers used several different logs and forms within the force's system, so records of a given incident weren't always consistent. This practice is unhelpful to the people reviewing the incident as it progresses. It means decisions can't easily be reviewed and understood by those checking that safeguarding is in place.

There is an effective system for reviewing the use of police powers

The force's duty inspector is responsible for authorising and reviewing cases when police protection powers are used. They take the role and responsibilities of the designated officer. We saw records of their rationale for invoking the powers, including details of the risk to children they were concerned about.

In most cases, handovers between designated officers were recorded. This included reviewing the continuing use of the power to make sure it remained necessary.

In its daily management meetings, the force now reviews incidents when police protection powers are used. This is so that senior managers have knowledge and oversight of the use of powers and the safeguarding activity of frontline staff.

There is good early communication between frontline officers at incidents, and officers make timely referrals to CSC

In every case we reviewed, officers had submitted PPNs, and there were records of prompt and effective liaison with emergency duty social workers to reduce delays in jointly safeguarding the children.

Strategy meetings regarding the cases had been held promptly, and the minutes of these were attached to the force's records of the incident. We saw evidence that officers record some of these incidents on their body-worn video cameras. This material is made available to those who continue investigations and helps to inform planning with other organisations in relation to the children's safety.

We found that officers protected children and took them to appropriate places of safety. On occasions where a place of safety couldn't immediately be found, officers remained at the home address with children until children's social care arrived. We found no instances of officers inappropriately taking children to police stations.

Neglect is a serious risk for children, which officers often don't recognise

In many of the incidents we reviewed, we found that officers protected children effectively, such as by taking them to a place of safety.

After this, a joint-agency child protection investigation should start, including a strategy discussion held promptly with CSC services. Trained child abuse investigation officers should take these investigations forward.

But the force's officers don't always identify incidents as crimes when they should do, particularly in cases of neglect. They don't always effectively pursue child protection investigations, and they don't always hold strategy meetings. We are concerned about these findings. As well as representing weaknesses in the frontline response and a failure to fully understand the VoC, they also indicate a lack of effective supervision.

Case study: officers act decisively to protect children, but don't record or investigate child neglect

After a call from a neighbour, officers responded quickly to a domestic abuse incident where two children aged two and seven were at risk from their drunk mother.

Force records showed warning markers and information about the woman's previous arrest for child neglect.

The officers acted decisively, arrested the woman for being "drunk in charge of a child" and took the children into police protection. They contacted CSC services and agreed to stay with the children at the home address until emergency foster carers collected them.

The officers didn't gather evidence about the more serious offence of child neglect and didn't record it as a crime on the force system.

The evidence review officer didn't consider neglect when they decided not to charge the woman with being "drunk in charge of a child".

And later, the MASH officers who received the PPN on the incident and held a strategy discussion with CSC services also failed to identify and start investigating the offence of neglect.

9. Trusted adult

There is a structured multi-agency approach to early intervention, crime prevention and restorative justice

Experienced managers lead the force's early intervention team in working closely with staff from other organisations to help children receive services for crime prevention, early intervention and restorative justice. This team benefits from trauma-informed training and mental health first aid training, to help it better communicate with and support vulnerable children. The team works closely with colleagues from the force's community policing teams.

The relationship between specialist early intervention officers and community officers helps them to jointly provide well-structured help for children thought to be at risk of criminalisation or vulnerable to exploitation.

Officers make sure that children and families thought to be vulnerable are referred to the multi-agency Swindon and Wiltshire Intervention for Families to Thrive (SWIFT) programme. Staff in MASHs also identify these children and refer them for assessment and support.

Case study: SWIFT programme

The programme is available to children aged 8 to 15 who are invited to participate.

It is aimed at children who don't have any criminal convictions and who aren't allocated a social worker or a children and adolescent mental health worker. The other criteria is concerned with a child's vulnerability, such as from low-level anti-social behaviour, living in homes with disruption and disorder, going missing from home or where there is potential for sexual or criminal exploitation.

Participating children are assigned a trusted adult who will engage with them and work to support practical interventions to reduce risks.

Police constables and community support officers act as trusted adults, and the work is monitored and supported by the force's early intervention team.

We noted that there were 60 children being supported across Wiltshire – 44 in the county and 16 in Swindon. Staff told us that they could support a further 60 children in the programme.

The force works directly with schools and other groups of children to involve them in policing

The force encourages young people aged between 13 and 16 to join its voluntary cadet units.

The Mini Police programme allows police community support officers to engage with groups of up to 20 primary school children in years 5 and 6 in their local schools. They lead the children through a funded seven-week programme. Police officers and staff also co-ordinate targeted lesson plans in secondary schools to educate children about the risks of exploitation.

Under a programme called ‘People who help us’, community officers also work with nursery school children to develop their understanding about who they can trust and how to contact police, ambulance and fire services in times of emergency. The lesson plans for this programme are carefully assessed by the early intervention team before use to make sure the messages are consistent.

Community-based officers liaise and engage with school communities to build trust and relationships so that children and school staff know who to approach if they are concerned about risk or vulnerability. They lead lessons and give information and advice on current threats to children from exploitation, weapons and online abuse.

Community officers are encouraged to identify any children who may be particularly vulnerable to exploitation to receive support from diversion schemes. One scheme is the DIVERT programme, which provides funding for children to receive therapy by spending time outdoors with animals on a farm.

Community officers actively build relationships with several community schemes in the force’s area so they can make referrals for children. This includes organisations that provide football coaching and boxing training for young people identified as being at risk of criminality, for example.

These are positive interactions with children, and demonstrate the force’s commitment to promoting welfare and child protection.

10. Managing those who pose a risk to children

A dedicated specialist team manages the risk from registered sex offenders

At the time of this inspection, Wiltshire Police's management of sexual or violent offenders (MOSOVO) team was managing 744 registered sex offenders in the community. The number of offenders being managed increases yearly. But the force has acceptable ratios of managers to registered sex offenders, which means that staff have realistic workloads and enough time to assess the complex risks presented by this cohort.

A detective inspector and two supervisors manage this team. The staff have had specialist training. They make good use of the force's intelligence systems and the national Violent and Sex Offender Register (ViSOR) system to record their work to reduce risks to the community.

The MOSOVO unit also supports multi-agency public protection arrangements (MAPPA). Representatives from all appropriate agencies attend and contribute effectively to MAPPA meetings. MOSOVO officers work closely with probation officers from the National Probation Service, who manage offenders subject to court-imposed licence restrictions.

MOSOVO staff generally work well with other policing teams and multi-agency partners, but communication isn't always effective

We saw some encouraging examples of MOSOVO staff acting quickly when they received information that registered sex offenders were a risk to children. This included offender managers promptly notifying CSC services and the National Probation Service about changes in offenders' circumstances.

We saw records indicating effective work with probation officers to jointly manage offenders' risk. Staff also worked and shared information productively with housing and mental health service providers to support offenders and reduce their risk to the community.

The MOSOVO team induct student officers into their work so that these new colleagues have a better understanding of what to do when responding to incidents involving registered sex offenders.

MOSOVO subjects are included within the force's intelligence briefings. But this information is removed after a few days and staff don't upload it to the offender's Niche record. This means officers can't use it in the future. Losing this information could make the force's response to future incidents involving offenders less effective.

Officers make sure disclosures about offender risk are made to the parents and carers of any children who they are in contact with. This provides these responsible adults with the information they need to decide how to safeguard their children. The force's policy is that MOSOVO staff should also record this information on PPNs to alert other officers and inform other partners, including CSC services, about registered sex offender risks.

But we saw delays and inconsistency in officers doing this.

Case study: delays and poor recording of information about offender risk

A registered sex offender told his offender manager about his new relationship with a mother of two young children.

There was a delay of three days until the offender manager spoke to the woman and told her about the risk. She said that she hadn't introduced her children to the registered sex offender, as it was too early in their relationship.

The offender manager didn't assess the risk, record it on a PPN or share it with CSC services.

Two months later, the registered sex offender told the offender manager that he was going to meet the children. The offender manager recorded the information on a PPN and shared it with CSC services. But rather than carrying out a new assessment, the officer inappropriately categorised the report as 'for information only' because the force had already disclosed the registered sex offender's situation to the woman.

A further record was made of the offender manager's unannounced visit to the registered sex offender after he and the family began to live together.

But supervisors didn't identify the delays in passing information to CSC services for joint safeguarding action or put appropriate measures in place, such as visiting the family with two officers to increase the robustness of the risk assessment.

We found other instances where there had been delays in PPNs being submitted after officers became aware of potential risks to children. In one case there was an unexplained two-week delay. And there were some cases where disclosures to potential victims or carers of children weren't recorded on ViSOR.

The force makes timely risk assessment visits to offenders, but more visits should be unannounced and with two officers present

Offender managers use the active risk management system (ARMS) to determine how they manage registered sex offenders in the community. This approach focuses more resources on the offenders causing greatest concern. It can mean the police visit these offenders more often than those it assesses as a lower risk. But ARMS assessments aren't always reviewed after a significant event.

There are no significant delays to the force seeing and assessing offenders' risk. We saw good records of visits to, and interaction with, offenders, including an appropriate level of detail and with a structure that allowed the force to understand the reasons for the assessed risk.

The force's ARMS assessments and risk management plans highlight risks appropriately and usually contain bespoke actions to deal with these. They are well supervised, and it is clear that supervisors read and understand the plans and assessments.

Offender managers routinely make unannounced home visits to offenders. This practice is a vital tool to check on offenders' compliance with their risk management plans.

The force's visits to registered sex offenders are mostly carried out by a single offender manager. This isn't generally considered to be a good way of working, either for officer safety or to prevent registered sex offenders from grooming and manipulating their managers. The supervisors told us they hadn't fully considered the risk of their staff being groomed. The force isn't training its staff to be more aware and resilient against this operational risk.

There isn't consistency in applying control orders to offenders or responding to incidents where offenders fail to comply with supervision

The force should have a clear policy for dealing with offenders who breach control orders or the conditions of their registration notifications. This helps the force to understand the extent of offences being committed and the performance of its staff. But there is inconsistent practice within the MOSOVO team when dealing with registered sex offenders who breach the terms of their notifications and risk management plans.

We found that supervisors had different approaches. One regularly issued warning letters to offenders who breached conditions – approximately one letter a month. But another supervisor told us they had only issued one warning letter in four years. The force should clarify its policy for issuing warning letters so that staff know what they are required to do.

Officers aren't always clear about their responsibility to apply for sexual harm prevention orders (SHPOs) and sexual risk orders (SROs) when they have concerns about an offender's behaviour. These orders help officers manage the risk of some offenders, and their presence on force systems alerts responding officers to risk.

The risk to a child isn't always recognised and PPNs are often not submitted in a timely manner.

Case study: ineffective management of an offender

A mother of a child reported that a registered sex offender was approaching local children.

But officers delayed for nearly a month before they interviewed the offender about breaching a sexual harm prevention order (SHPO). And they didn't record the risks to children on a PPN.

No other action was taken because supervisors thought the offence was minor. Two months after the incident they issued the offender with a warning letter for breaching the order.

When the complainant was updated about the offender's risk by officers, she told them that the offender had also spoken to other children outside his house, and that he offered to build one child a tree house.

But despite officers recording this information, no further action to investigate additional offences was taken. This included no action in response to a further breach of the offender's conditions (failing to notify a change to his name).

The force management's decisions weren't appropriate to the information known about the level of risk from this offender.

Recommendation

- We recommend that within three months Wiltshire Police reviews its arrangements for supervising sex offenders. This is to improve the consistency of decision-making for registered sex offender management, and the resilience and effectiveness of home visits to risk assess offenders.

11. Police detention

The force understands that children should only be detained in custody when absolutely necessary

Officers should arrest a child only when it is absolutely necessary. The force's officers arrest and detain fewer children than they did in previous years because they now find other ways of dealing with some children who commit offences.

Before children enter the force's custody facilities, police assess them for risk and whether they need to be detained. Supervisors scrutinise each situation. They consider whether the arrest is necessary, and whether there are alternative ways of dealing with the investigation.

In five of the six cases we reviewed, the arrest and detention of the child was necessary and appropriate.

Many children in custody have complex needs. They're often vulnerable and need support to keep them safe. The custody facilities in Wiltshire have some bespoke child detention rooms. If there are children in detention, then custody staff try to keep the number of adult detainees to a minimum to reduce contact.

Custody staff have dedicated training days throughout the year. Staff told us that this training was mostly about first aid and officer safety. But they said they had received some vulnerability training. We saw evidence of custody staff taking into account the welfare of children in police detention, such as by providing them with child-friendly distraction items.

Custody officers typically complete juvenile detention certificates on force systems appropriately, and include a detailed rationale about why it was necessary for the child to be kept in police detention after being charged.

The force's custody inspector dip-samples cases to identify good ways of working and ways of working that need to improve.

Appropriate adults aren't seeing detained children quickly enough

Children detained in the force's area don't always receive early support from an appropriate adult. Guidance under the Police and Criminal Evidence Act 1984 states that police should ask appropriate adults to come to the custody facility as soon as possible.

In some cases we examined there were long delays before an appropriate adult was called, or attended to support detained children. Sometimes they arrived just before officers interviewed the child. But they often weren't there early enough to make sure the child's welfare needs, rights and entitlements were met.

In 3 of the 6 cases we reviewed, there were substantial delays (of 3.5 hours, 6 hours, and 16 hours) before appropriate adults saw the detained child. This meant that very vulnerable children had to wait too long before they were given support and advocacy.

Case study: long delays before a vulnerable child received support from an appropriate adult

A very vulnerable 11-year-old girl with severe behavioural and medical problems was arrested for seriously assaulting a relative in her family home.

The force had over 70 incident records for this child on its system, including over 40 PPNs that were shared with CSC services. But this was the first time she had been arrested and brought into custody.

The custody staff partially identified the child's vulnerability, and that she had attempted to seriously harm herself. At one stage they took her from custody to be assessed in hospital, but after five hours there she was returned to police detention.

After she had been in custody for 15 hours her legal representative formally asked for her to be released on bail. But the force refused the request.

Overall, it took six hours before an appropriate adult was contacted. And there were a further 11 hours before an appropriate adult from the CSC emergency duty service attended the custody suite and saw her. But this visit was timed to facilitate her interview about the assault rather than to support the child's welfare needs.

The interview lasted for seven minutes. The child was then released under investigation. She wasn't ever charged with a criminal offence.

The force is inconsistent in providing support for detained children

The force offers mental health services to people in custody, supported by the local liaison and diversion service. But we found that this service wasn't always available for children who were in police detention.

In January 2022, the force and its safeguarding partners implemented a project known as Engage, aimed at reducing the unnecessary criminalisation of children and young people who are in police detention. This is a positive development, but the scheme isn't yet fully staffed and implemented at both the force's custody sites. It runs from Monday to Friday between 8.00am and 4.00pm.

Children in custody aren't routinely seen by healthcare professionals. Custody staff told us they would ask for a medical assessment if a specific medical need was identified. This way of working doesn't provide enough support for vulnerable children in custody, because staff without healthcare training may not recognise a child's needs.

Officers don't always submit PPNs for detained children, and there isn't a supervisory process in place to make sure that this always happens. We found no records of the MASH researching PPNs for children who had been in custody to identify vulnerability and risk for these children, who may benefit from being referred to multi-agency safeguarding services.

Custody officers request alternative or secure accommodation for children, but this isn't always available

A local authority is responsible for giving suitable alternative accommodation to a child charged with offences and denied bail, under statutory guidance in the Concordat on children in custody. Only in exceptional circumstances is this not in a child's best interest (for example, if bad weather makes it impossible to transport them). In rare cases, such as when a child is at high risk of causing serious harm to others, they may need secure accommodation.

Custody staff at the force know when they should ask the local authority to provide alternative accommodation. However, in the two cases we reviewed where secure accommodation was appropriately requested, none was available. This meant that the children stayed in police detention until they were taken to court.

When local authority accommodation isn't available, custody officers typically don't ask their managers for help finding an immediate solution. And leaders don't escalate these cases with the local authorities. Officials from the two Wiltshire local authorities and the children's safeguarding partnerships told us that in recent meetings, the force hadn't asked why alternative accommodation hadn't been provided.

12. Conclusion

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

Wiltshire Police needs to make fundamental changes to improve many of its child protection arrangements and practices. The inexperience of many of its officers means that they don't have all the skills needed to respond to, assess and investigate all aspects of child protection and safeguarding demand. The force needs to make sure its leaders have good-quality performance information. This is so they can understand the effectiveness of the force's workforce and what needs to change to improve its child protection arrangements.

We found that the officers and staff who managed demanding child abuse investigations were committed and dedicated. But we're concerned that some frontline and specialist officers don't have enough knowledge or understanding of good child protection practice.

While we recognise that it will take time to build an experienced workforce, there is also a need for the force to focus on training staff and supporting them with more effective systems and processes.

Specific areas for improvement include:

- improving data-management and performance-management processes to better understand the quality of service and improve end results for children;
- a focus on providing better training to increase the force's capability to respond effectively to vulnerability;
- speaking to children, recording their behaviour and demeanour, listening to their concerns and views, and using that information to make decisions about their welfare;
- making appropriate referrals to CSC services and early help practitioners;
- reducing delays in investigations;
- supervising incidents and investigations to make sure opportunities are pursued to help children; and
- making sure children in police detention are appropriately supported.

We have therefore made a series of recommendations. If the force acts on these, they will help improve end results for children.

Next steps

Within six weeks of the publication of this report, we require an update of the action the force has taken to respond to the recommendations where we have asked for immediate action.

Wiltshire Police should also provide an action plan, within six weeks of the publication of this report, setting out how it intends to respond to our other recommendations.

Subject to the update and action plan received, we 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 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 organisations are set out in the statutory guidance *Working together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children.*

The specific police roles set out in the guidance are:

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

These areas of practice are the focus of the inspection.

Inspection approach

Inspections focus on the experience of, and outcomes for, children following their journey through the child protection and criminal investigation processes. They assess how well the police service has helped and protected children and investigated alleged criminal acts, taking account of, but not measuring compliance with, policies and guidance.

The inspections consider how the arrangements for protecting children, and the leadership and management of the police service, contribute to and support effective practice on the ground. The team considers how well management responsibilities for child protection, as set out in the statutory guidance, have been met.

Methods

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

The purpose of the self-assessment is to:

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

Self-assessment and case inspection

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

- domestic abuse;
- incidents in which police officers and staff identify children who are in need of help and protection (for example, children being neglected);
- information sharing and discussions about children who are 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.

www.justiceinspectorates.gov.uk/hmicfrs