
# National Child Protection Inspections

Bedfordshire Police
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# Foreword

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

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

Protecting children is one of the most important tasks the police undertake. Police officers investigate suspected crimes involving children and arrest perpetrators, and they have a significant role in monitoring sex offenders. They have the powers to take a child in danger to a place of safety, and to seek restrictions on offenders' contact with children. The police service also has a significant role, working with other agencies, in ensuring children's protection and 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 agencies to play their part in ensuring that, as far as possible, no child slips through the net, and to avoid both over-intrusiveness and duplication of effort.

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

# Contents

# Summary

This report is a summary of the findings of an inspection by HMICFRS[1] of child protection services in Bedfordshire, which took place in July 2017.[2]

HMICFRS' inspection examined the effectiveness of police action at each stage of their interactions with or for children, from initial contact through to the investigation of offences against them. It also scrutinised the treatment of children in custody, and assessed how the force is structured, led and governed in relation to its child protection services.[3]

## Main findings from the inspection

Inspectors found that the force is committed to protecting children. In September 2016, the force implemented change as a result of a quality improvement programme which reviewed the demands on its workforce. This led to the investment of additional resources for those departments responsible for child protection work. The review also prompted significant organisational change that reshaped the force's approach to both child protection and vulnerability.

The chief constable, his command team and the police and crime commissioner (PCC) have a clear commitment to child protection, which is reflected in the police and crime plan and the force's priorities. Senior leaders responsible for managing the force's public protection teams provide some effective oversight and active involvement in many areas of its child protection service. HMICFRS found that both recent efforts of the force and its focus on vulnerability are translating into positive child protection work and thereby improving outcomes for some vulnerable children. In particular:

[1] During this inspection, on 19 July 2017, HMIC took on responsibility for fire & rescue service inspections and was renamed HM Inspectorate of Constabulary and Fire & Rescue Services. The methodology underpinning our inspection findings is unaffected by this change. References to HMICFRS in this report may relate to an event that happened before 19 July 2017 when HMICFRS was HMIC. Citations of documents which HMIC published before 19 July 2017 will still cite HMIC as the publisher.

[2] 'Child' in the report refers to a person under the age of 18. See "definitions and interpretations" for this and other definitions.

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

- Extensive training has been given to all officers and staff on child protection and wider vulnerability.
- Work on the PREVENT/CONTEST[4] strategy, to safeguard children from damaging environments in which extremism flourishes, is well co-ordinated and generating positive results.
- The implementation of new processes and training for staff to ensure that the initial risk assessment of missing children is timely and appropriate during the initial contact phase.
- The specialist child abuse vulnerable adult abuse (CAVAA) team is effective at joint working and carrying out thorough and timely investigations into offences against children.
- The force is conducting work at a strategic level to understand the scale of child sexual exploitation (CSE) threats, and actively targeting those perpetrators who present the highest risk.
- To safeguard children, the force is making effective use of the 'relay function': an initiative in which schools are informed when one of their pupils has been present at, or affected by, an incident of domestic abuse.

In addition to these positive findings, HMICFRS also acknowledges the effective joint work undertaken at all levels of the force, from chief officer to practitioner, with external safeguarding agencies. This has led to the development of a culture of continuous improvement within the force, and early signs of tangible changes to practice that are improving outcomes for children.

However, in contrast to such improvements, HMICFRS also discovered weaknesses in the force's approach to child protection, some of which are significant:

- The force's approach to missing children requires improvement. Despite the force now having effective initial assessments of risk, HMICFRS' assessment of numerous missing children cases uncovered failures to undertake prompt and effective enquiries to locate children – many of whom are regularly reported as missing.
- The force's approach to children detained in custody, who are often vulnerable and have complex needs, requires improvement. Of the cases examined by inspectors, HMICFRS could find no evidence of referrals being made to children's social care services for an assessment of safeguarding needs. In addition, in none of the cases in which a child was charged with an

[4] For more information on this strategy, see: www.gov.uk/government/publications/counter-terrorism-strategy-contest

offence and denied bail was the child transferred to local authority alternative accommodation. This means that children are being unnecessarily detained in police custody.

- Some of the force's basic processes used to record child protection concerns are not sufficiently robust to ensure that risks are identified and safeguarding interventions are made at the earliest opportunity; there are delays and an inability to manage demand. This is exacerbated by ineffective supervision of child referral forms and the inadequate quality and content of information shared with other safeguarding agencies. The force's approach to domestic abuse and children affected by it is particularly troubling, especially in the context of cumulative risk.

- The force has an inconsistent initial approach to children vulnerable to CSE; of the cases assessed, clear warning signs were often missed, leaving some children exposed to continued risk.

During the inspection, HMICFRS examined a total of 81 cases in which children were identified as being at risk. Of these, the practice in 18 cases was rated as good, in 34 as requiring improvement and in 29 as inadequate. This demonstrates that there are still areas in which the force needs to improve if it is to ensure the quality and consistency of the service it provides to those children in need of help and protection. Many of the force's weaknesses are linked to its inability to meet demand with the current level of resources within its specialist teams.

## Conclusion

The chief constable, his senior team and the PCC have a clear commitment to protecting vulnerable children. This is widely recognised by the staff, officers and other agencies with whom HMICFRS consulted as part of this inspection.

However, while some improvements have been made, the force needs to take further action, in some cases as a matter of urgency, to strengthen its safeguarding practice to adequately protect those children most at risk.

The force is acutely aware of the areas in which it needs to improve, and it is developing a culture of continuous improvement. This report makes a series of recommendations aimed at addressing the force's weaknesses and providing support to the officers and staff who are working hard to improve outcomes for children in the Bedfordshire area.

# 1. Introduction

## The police's responsibility to keep children safe

Under the Children Act 1989, a police constable is responsible for taking into police protection any child whom he has reasonable cause to believe would otherwise be likely to suffer significant harm, and the police have a duty to inquire into that child's case.[5] The police also have a duty, under the Children Act 2004, to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children.[6]

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

In 2015, the National Crime Agency's strategic assessment of serious and organised crime established that child sexual exploitation and abuse represents one of the highest serious and organised crime risks.[7] Child sexual abuse is also listed as one of the six national threats specified in the *Strategic Policing Requirement*.[8]

[5] Children Act 1989, section 46.

[6] Children Act 2004, section 11.

[7] *National Strategic Assessment of Serious and Organised Crime*, National Crime Agency, June 2015. Available at: www.nationalcrimeagency.gov.uk

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

## Expectations set out in Working Together

The statutory guidance, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*[9], sets out the expectations of all partner agencies involved in child protection (such as the local authority, clinical commissioning groups, schools and the voluntary sector). The specific police roles set out in the guidance are:

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

These areas of practice are the focus of HMICFRS' child protection inspections.[10]

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

[10] Details of how HMICFRS conducts these inspections can be found at Annex A.

# 2. Context for the force

Bedfordshire Police has approximately 2,000 people in its workforce. This includes:

- 1,119 police officers;
- 794 police staff; and
- 46 police community support officers.[11]

The force provides policing services to a population of around 640,000 people over an area of 477 square miles. The area is a mix of small villages and major towns, such as Luton with a population in excess of 200,000 residents.

There are three local authorities in the force area: Bedford Borough, Central Bedfordshire and Luton Borough. The force operates from four deployment stations for uniformed community teams. Specialist child protection teams are divided between the north and south of the force area; force headquarters are located at Kempston in the north and Luton in the south. There are three local safeguarding children boards (LSCBs)[12] that reflect the three borough boundaries in the force area.

Deprivation in England is determined through a number of social factors resulting in a national rank of the 326 local authorities according to levels of deprivation; the local authority ranked at number 1 is determined as the most deprived. Bedford Borough is in the mid-range for overall deprivation, ranking 148 out of 326. Overall levels of deprivation in central Bedfordshire are relatively low, ranking at 260 of 326. However, Luton is ranked 59 out of 326 local authorities[13], making it one of the more deprived areas in England.

[11] *Police workforce, England and Wales: 31 March 2017*, Home Office, July 2017. Available at: www.gov.uk/government/statistics/police-workforce-england-and-wales-31-march-2017

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

[13] www.gov.uk/government/statistics/english-indices-of-deprivation-2015

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

| Local authority | Judgment | Date published |
|---|---|---|
| Bedford | Requires improvement | April 2017 |
| Central Bedfordshire | Good | April 2012 |
| Luton | Requires improvement | March 2016 |

An assistant chief constable (ACC) is the chief officer lead for child protection in Bedfordshire, and a detective superintendent is the operational lead.

There are a number of specialist teams responsible for protecting children across the force area: the child abuse vulnerable adult abuse team (CAVAA), the CSE and missing investigation team (CMIT) and the public protection unit (PPU) support hub are managed by the PPU detective superintendent. The 'emerald team' is responsible for investigating domestic abuse and serious sexual offences, under the management of the detective superintendent responsible for crime. The violent and sexual offender management team (VSOMT) is managed by the superintendent for operations, and the internet child abuse investigation team (ICAIT) is managed by the intelligence superintendent.

There are three multi-agency safeguarding hubs (MASHs)[14] that reflect the local authority boundaries. There are four members of police staff who support the hubs; one works in Bedford, one in Central Bedfordshire and two in Luton. The MASHs do not have dedicated police resources working in them; instead, police staff are drawn from the PPU support hub. The hub operates at two sites, one in the north at the force's headquarters and one in Luton in the south. Each support hub site has distinct responsibilities: the south oversees child protection and vulnerable adult referrals while the north has responsibility for domestic abuse and multi-agency risk assessment conference (MARAC)[15] referrals.

[14] This is a hub in which public sector organisations with responsibilities for the safety of vulnerable people work together. It has staff from organisations such as the police and local authority social services, who work alongside one another, sharing information and co-ordinating activities, to help protect the most vulnerable children and adults from harm, neglect and abuse.

[15] A MARAC is a locally-held meeting of statutory and voluntary agency representatives to share information about high-risk victims of domestic abuse, to which any agency can refer an adult or child whom they believe to be at high risk of harm. The aim of the meeting is to produce a co-ordinated action plan to increase an adult or child's safety.

# 3. Leadership, management and governance

Bedfordshire Police has a strong commitment to improving the protection of vulnerable people, with the PCC and the chief constable having clear priorities relating to the protection of children. The demand review in September 2016 resulted in additional resources being allocated to the force's child protection services, and prompted significant organisational change that reshaped its approach to both child protection and vulnerability. The force created three new teams: CAVAA, the emerald team and the CMIT, dedicated to safeguarding those who are most in need of help and protection.

The force's governance arrangements relating to child protection and public protection are clear. The police effectiveness, efficiency and leadership (PEEL) board provides strategic oversight of all issues relating to vulnerability. Its meetings are chaired by the deputy chief constable and child protection is a standing agenda item. The ACC chairs the force-wide group meetings relating to domestic abuse and those missing or absent. In this manner, the leadership is active and visible within the force and implements the force's strategic vision, in addition to increasing the workforce's understanding in particular areas of child protection.

The majority of weaknesses encountered by inspectors relating to the force's provision of its child protection services are linked to the surplus of demand on its specialist teams. A freeze on recruitment in recent years, in anticipation of potential funding cuts, has created a gap in the number of trained officers entering specialist departments and, at the time of the inspection, many child protection teams were operating below their establishment numbers – some of them significantly. For example the CAVAA team has an establishment of 35 officers but at the time of the inspection only had 25 available for deployment.

The force's joint-working arrangements alongside other local safeguarding agencies in relation to CSE are noteworthy. The chief officer team is an active participant of the Bedfordshire CSE and missing strategic group and the CSE chief executive strategic oversight group. This cohesive approach ensures that the three local authorities and their corresponding LSCBs are working towards common objectives in tackling CSE in Bedfordshire by having a single strategy driving activity to prevent CSE, to raise awareness of it and to pursue perpetrators with the protection and safeguarding of children at the heart of their efforts. The force's detective superintendent, who is the operational lead for child protection, is also chair of the multi-agency CSE group (CSEG) meeting which representatives from other local safeguarding agencies committed to reducing CSE attend.

The force's commitment to joint working is reflected in the feedback HMICFRS received from the external agencies interviewed as part of this inspection. The directors of local children's services and the LSCB chairs were all positive in their

comments relating to Bedfordshire Police's commitment to protecting children, with all indicating that there had been a significant shift by the force over the last 18 months to a more focused approach to vulnerability and child protection in particular. Their feedback indicated that all levels within the force demonstrate a positive approach, from the chief officer team to practitioner level, with LSCB chairs commenting on strong representation and active involvement at executive, board and sub-group level.

The force is active in conducting internal and external audits with partner organisations involved in safeguarding, from which learning is used to inform training, professional development and the expansion of the force's child protection action plan. The force also actively monitors national reports linked to child protection practices and emerging threats to add to its child protection action plan, which demonstrates openness to change and a clear commitment to consider new ways of improving its services to children.

In contrast, LSCB chairs and directors of children's services with whom HMICFRS consulted commented to inspectors regarding the force's inability to service demand adequately, particularly in relation to tackling domestic abuse. They submitted that this was due, in part, to backlogs of unprocessed referrals in the PPU support hub. The risk linked to these backlogs has recently been placed on the risk register of central Bedfordshire and Bedford LSCB due to the level of concern.

# 4. Case file analysis

## Results of case file reviews

To determine how well Bedfordshire Police deals with specific cases, HMICFRS asked the force to self-assess the effectiveness of its practice in 33 child protection cases. The force used HMICFRS' criteria[16] to grade the practice in each case as 'good', 'requiring improvement' or 'inadequate'.

Of the self-assessed cases, the force rated its practice as good in 12, as requiring improvement in 13 and as inadequate in 8.[17]

HMICFRS inspectors also assessed these 33 cases and graded the force's practice. HMICFRS rated this as good in 7, as requiring improvement in 12 and as inadequate in 14. In addition, HMICFRS inspectors selected and examined a further 48 cases: the force's practice in 11 was assessed as good, in 22 as requiring improvement and in 15 as inadequate.

**Figure 1: Cases assessed by both Bedfordshire Police and HMICFRS inspectors**

| | Good | Requiring improvement | Inadequate |
|---|---|---|---|
| **Force assessment** | 12 | 13 | 8 |
| **HMICFRS assessment** | 7 | 12 | 14 |

**Figure 2: Additional cases assessed only by HMICFRS inspectors**

| | Good | Requiring improvement | Inadequate |
|---|---|---|---|
| **HMICFRS assessment** | 11 | 22 | 15 |

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

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

Below is an example that was rated as good by the force but inadequate by HMICFRS. There were numerous procedural errors and in the management of risk, which determined HMICFRS' grading.

Of the 81 cases assessed, HMICFRS referred 12 back to the force because they were considered to contain evidence of a serious problem – for example, failure of the force to follow child protection procedures and/or a child being at immediate risk of significant harm. The force responded to the referrals by providing an updated assessment or by taking action relevant to the problems identified.

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

This concerns the management of a registered sex offender (RSO) who had previously been convicted both of grooming a child for sexual abuse and of the sexual assault on a 13-year-old girl. There was a one-month delay in the force conducting its initial visit following the registration of this offender; there was then a five-week delay in making the referral to children's social care services, once it became known that the RSO was in a relationship with a female who had a 16-year-old daughter. There was a further delay in the mother being contacted to inform her of her partner's status, and it appears the child was never spoken to. There was a delay in the force updating the computer database about a holiday the couple took in another part of England; this meant that the police in that area were unaware of the risk the RSO posed. In addition, there was a potential breach of notification requirements by the RSO which was not investigated adequately by the force. Finally, the force had failed to adequately update the RSO's record to reflect the fact he was in a relationship, which was a failure of the force to manage him effectively as a risk. All the delays and procedural errors in this case meant there was a lack of control of the offender which provided him with opportunity to potentially commit further offences against children.

- A 15-year-old girl disclosed to school staff that she had been the victim of a sexual assault. There was a delay of five days before the girl was spoken to by police officers, thereby failing to address both the child's immediate safeguarding needs and the threat posed to others by the perpetrator. Six weeks after the initial report there had been no investigative activity by the force, and the child had still not been spoken to by the officer in charge of the case. There is no evidence of any strategy discussion or meeting having taken place with children's social care services to discuss the best way to support the child.

- In another case, a 15-year-old boy was befriended by a 24-year-old woman who encouraged him to truant from school and spend time with her at her home, where she lived with her male partner, and from which the woman would falsely report the child to his school as sick. The investigation was allocated to a member of the CMIT while they were on leave, resulting in a month-long delay before any action was taken. Although further information obtained from the school revealed other matters of child protection relating to the child's family, there is no information on the force's records of the outcome of a strategy meeting (although it is clear one took place). It was not until after the strategy meeting that the child was eventually seen by police officers and investigation into the woman was carried out, revealing her links to the sex industry. This lack of activity left this child exposed to risk of significant harm.

## Breakdown of case file audit results by area of child protection

**Figure 3: Cases assessed involving enquiries under section 47 of the Children Act 1989**[18]

| Case type | Good | Requiring improvement | Inadequate |
|---|---|---|---|
| **Enquiries under section 47 of the Children Act 1989** | 6 | 3 | 1 |

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

- the initial response by frontline officers to incidents involving child protection is generally positive. This is demonstrated though decisive actions to safeguard children at risk of harm;
- there is clear evidence of joint working with children's social care services to safeguard children at risk;
- investigations of children who are at risk are generally well recorded when CAVAA is involved; and
- investigative activity and safeguarding are less apparent in referrals and investigations concerning sexual offences.

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

| Case type | Good | Requiring improvement | Inadequate |
|---|---|---|---|
| **Cases relating to domestic abuse incidents** | 1 | 5 | 4 |

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

Common themes include the following:

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

- The voice of the child is often not captured effectively by attending officers.
- Processes are not effective at identifying all children affected by domestic abuse.
- Strategy discussions, safeguarding plans and investigative plans are not being recorded or, in some instances, not taking place.
- Cumulative risk is often not being identified effectively, resulting in inconsistent referrals to the MARAC process.

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

| Case type | Good | Requiring improvement | Inadequate |
|---|---|---|---|
| **Referrals arising from incidents other than domestic abuse** | 1 | 8 | 1 |

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

Common themes include:

- There are some good examples of officers speaking to children when it is a clearly defined child protection incident.
- Child referral forms are submitted promptly following most incidents. However there are occasions when referrals to children's social care services do not take place.
- There are a few examples in which the investigation is delayed or opportunities to prosecute offenders are missed.

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

| Case type | Good | Requiring improvement | Inadequate |
|---|---|---|---|
| **Cases involving children at risk of child sexual exploitation both online and offline** | 2 | 4 | 6 |

Further detail of some of these individual cases, relating to CSE, is given in the chapters that follow.

Common themes include the following:

- High-risk cases are dealt with promptly, with timely referrals being submitted on the same day a child is identified.
- Crimes are often not recorded when offences are clearly evident.
- Cases that are not high risk can have delays in the submission of referrals and, in some cases, referrals do not take place at all.

**Figure 7: Cases assessed involving missing and absent children**

| Case type | Good | Requiring improvement | Inadequate |
|---|---|---|---|
| **Cases involving missing and absent children** | 1 | 4 | 5 |

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

Common themes include the following:

- The force control room (FCR) assesses the levels of risk effectively.
- In most cases there is little proactive work conducted to trace the missing child.
- Children who go missing regularly are often not referred to children's social care services for further safeguarding.
- Trigger plans, which improve responses to children who go missing regularly, are used inconsistently or are often not used when required.

**Figure 8: Cases assessed involving children taken to a place of safety under section 46 of the Children Act 1989**[19]

| Case type | Good | Requiring improvement | Inadequate |
|---|---|---|---|
| **Children taken to a place of safety by police officers using section 46 of the Children Act 1989 powers** | 4 | 3 | 2 |

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

Common themes include:

- There is evidence of early identification of vulnerability and good use of police protection powers to immediately safeguard children.
- There are a few examples in which the voice of the child and their demeanour are recorded in detail.
- There is evidence to show that there are delays in some investigations following the use of this power that result in evidential opportunities being lost.

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

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

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

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

Common themes include the following:

- Visits to some RSOs are overdue.
- There are delays in making referrals to children's social care services when a child is identified as being at potential risk from an RSO.
- Offences linked to breach of notification requirements are not always identified or pursued.

**Figure 10: Cases assessed involving children detained in police custody**

| Case type | Good | Requiring improvement | Inadequate |
|---|---|---|---|
| **Cases involving children in police custody** | 1 | 3 | 6 |

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

Common themes include the following:

- Appropriate adults[20] (AAs) rarely attend custody at the required times.

[20] Under section 63B of the Police and Criminal Evidence Act 1984, an appropriate adult is a parent, guardian, social worker or any responsible person over 18 years old and not a police officer or a person employed by the police.

- Visits made to check on the welfare of children in custody are often late.
- Police and Criminal Evidence Act 1984 reviews are often not sufficiently robust.
- There is a general lack of understanding of secure and alternative accommodation requirements for children who are charged and detained.

# 5. Initial contact

It is apparent to HMICFRS that Bedfordshire Police has invested resources in training both its frontline and specialist staff about their role in safeguarding children, and that this has translated into increased awareness and a more proactive approach by the force.

Inspectors saw examples in cases reviewed where officers responded quickly to specific matters related to the urgent safeguarding of children, conducting preliminary actions such as ensuring the immediate safety of the child, securing evidence and making an assessment of how best to proceed. On many of the occasions observed, officers undertook thorough initial enquiries and used their powers to safeguard effectively, as demonstrated in the following example.

An emergency call was received in relation to a 13-year-old girl suffering from mental health problems, who was assaulting her mother and threatening to harm herself. The response of staff in the FCR was good – various police systems were checked to ascertain any relevant information that would assist the officers attending to assess and mitigate the risk. When officers attended, they found the mother unharmed but wanted to investigate further into the welfare of the child and took her to hospital for a mental health assessment. The force's investigation remained child-centred, and both child and mother were appropriately referred to external agencies for help and support. There is clear evidence of the force's supervision throughout both the initial stages of this incident and the investigations that followed.

Bedfordshire Police has a single control room comprising police officers and staff. All newly-recruited call handlers undertake a 6-week training programme, which includes all areas of vulnerability. In addition, existing staff and officers receive regular inputs from CAVAA.

The management of risk by the FCR has come under scrutiny in the past, particularly in relation to the timeliness and grading of possible risks to children who go missing. HMICFRS found that training provided to address this weakness has brought about significant improvement, with most missing children being assessed appropriately and given a grading of risk which is quickly and effectively supervised by the FCR inspector.

The force was contacted by social services in relation to two boys, aged 8 and 5 years, who had not been collected from school, that their mother could not be located and there were concerns for her welfare following a message to a family member indicating she was having difficulty coping. Control room staff researched police intelligence systems to understand the family history, which was relayed to officers dealing with the incident and assisted them in deciding that other family members were unsuitable to look after the children in the short term due to their drug use. Officers considered the options and decided to use their powers to immediately safeguard the children; through effective collaboration with children's social care services, the children were made the subject of an interim care order the following day.

THRIVE[21] assessments are consistently applied to manage risk, and sets of risk-based questions are used to support officers and staff in determining risk when responding to calls concerning missing children. The force works with local children's homes to raise awareness of how and when children should be reported missing and their duties to try and trace a looked-after child prior to a report being made to police.

Warning markers referred to as 'flags' are used on the force's systems to alert operators that a child is at risk. This information is then passed by control room operators to frontline staff to assist them in making informed decisions when attending an incident involving a child.

HMICFRS was encouraged to note that FCR supervisors conduct routine audits of decision-making by call handlers and dispatchers linked to the assessment of risk in relation to missing children to assess the effectiveness of the force's initial response. This qualitative assessment is positive and is assisting in highlighting examples of effective and ineffective risk management, which in turn helps in shaping training to show the impact of positive and negative examples of risk management.

To increase awareness of vulnerability among its frontline officers and staff, the force has conducted numerous initiatives. 'Better for Bedfordshire' was a recent event focusing on the importance of recognising and dealing effectively with CSE, and included a talk from a CSE survivor. The chief constable used this event as an opportunity to outline the force's expectations of every officer when dealing with matters of CSE. Many officers commented to HMICFRS on the value of gaining the perspective of a survivor, which assisted in changing their thinking and improving their conduct with vulnerable children. The force has also produced a written guide to vulnerability, which some officers described as positive and helpful in improving their decision-making during the initial stage of contact with a victim.

[21] THRIVE is a risk assessment tool that considers six elements to assist in identifying the appropriate response grade based on the needs of the caller and the circumstances of the incident, namely: threat, harm, risk, investigation, vulnerability and engagement.

Some 750 officers in the force have received a one-day domestic abuse training course, and student officers are also provided with an attachment to the emerald team and other specialist teams to improve their knowledge and understanding of vulnerability and child protection. This is enhancing officers' understanding of the importance of speaking to children, checking on their welfare and recording their behaviour and demeanour at domestic abuse incidents. Although this approach is positive, it is not always resulting in the appropriate information being recorded on the force's systems. The force devised and added eight further questions on the DASH[22] risk assessment to ensure the voice of the child is recorded and considered. While this is a positive step by the force, HMICFRS found that many of the completed forms lacked detail, limiting the intended value of the additional questions. Such detail is essential for accurate risk assessment and safeguarding, because a child's demeanour, especially for those cases in which a child is too young to speak with officers (or to do so with a parent present might pose a risk), provides important information about the effects of the incident on the child. Information regarding demeanour should inform both the initial assessment of the child's needs and any decision to refer the child to children's social care services.

**Recommendation**

- HMICFRS recommends that within three months Bedfordshire Police ensures that it improves the quality of information recorded by officers (including their observations of a child's behaviour and demeanour) in records of domestic abuse incidents so that better assessments of a child's needs are made.

[22] DASH is a checklist for the identification of high-risk cases of domestic abuse, stalking, harassment and 'honour-based' violence.

# 6. Assessment and help

Together, the force's PPU hub and three external MASHs are the focal points for information exchange and inter-agency planning in relation to local matters of child protection and safeguarding. For the most part, the hubs act quickly and efficiently, although members of police staff intimated to HMICFRS inspectors that the current rotation system (in which they work in the MASH once every 14 weeks) was undermining their ability to carry out their safeguarding roles effectively. In addition, some officers and staff felt that the decision by the force not to have police supervisors in the MASH, who can act as decision-makers, is limiting their ability to contribute to the development of meaningful joint protective plans.

The force's CAVAA works well with external agencies to enable timely safeguarding and to conduct effective investigations into matters concerning child protection. When required to attend, the force's engagement at initial child protection conferences and strategy meetings across the force area is good. On many occasions, the decisions reached as a result of these meetings are well recorded on the force's systems, particularly when CAVAA is involved.

A report to the force was made in relation to a 15-year-old boy, who was suspected of engaging in sexual activity with his 4-year-old sister. There were other young children in the household. Detectives from CAVAA liaised with children's social care services, and a timely and effective strategy meeting took place, which resulted in all children being appropriately safeguarded and an effective investigation initiated. There is good evidence of both supervisory oversight and consideration of an appropriate outcome by the force – which in this case was a youth offending team prevention referral.

Frontline officers informed HMICFRS inspectors about their confusion as to when a 'child at risk' form (referred to as a 'form 745') should be submitted, and this lack of understanding is leading to inconsistent quality of forms and incidents where forms are not being submitted when they are required. The force is aware of this confusion, and has introduced new processes in an attempt to ensure the appropriate referrals concerning children are made to the PPU support hub. Staff in the crime recording bureau now review crime reports and crime-related incidents within 24 hours of their submission to ensure that if a child has been present at an incident and the referral has been missed, they are identified and one is submitted immediately. However, this only addresses the result of poor practice and not the underlying cause for this lack of understanding. In addition, the force has a general weakness in its ability to process the volume of crime reports and crime-related incidents in a timely manner. Once these initial checks are completed, there can be delays of up to 14 days before these reports are physically recorded onto the relevant systems. HMICFRS examined the force's process and found that despite the checking process, it is still

failing to identify all children in need of assessment and help; on one day of the inspection, there were 487 crimes in the backlog waiting to be fully loaded onto the force's systems that had been checked for the appropriate referral submissions. Inspectors examined 40 cases and discovered that in 6 referrals had been missed, meaning no safeguarding activity had taken place in the 2 weeks it took to process these cases. This failure of the force is leaving vulnerable children exposed to unmanaged risk, as demonstrated below.

A 14-year-old boy made a report to the force of being sexually assaulted by a man in his mid-twenties in a local park. The force conducted some investigative work; the perpetrator was arrested and an interview arranged with the child. However, there is little activity recorded on the force's systems in relation to the investigation, and no evidence of any referral to children's social care services or any subsequent strategy discussion in relation to safeguarding for the child taking place.

In a separate incident, the parents of an 11-year-old boy made a report to the force that their son had been contacted via social media by an adult posing as a young boy. The perpetrator had engaged in sexual communication with the child and had asked him to send indecent images of himself; this was discovered by the child's parents. Although a crime was recorded, there is no evidence of the force making a referral, or of any joint safeguarding planning taking place. Further, there was a delay of three weeks before a decision was made as to which police team should investigate the matter, during which time the child and family were not updated.

Furthermore, although the PPU support hub provides feedback to individual officers regarding deficiencies or errors in submitted 745 forms, this practice does not appear to be resulting in an adequate improvement to the quality of referrals being made by officers in relation to at-risk children. Inspectors found many 745 forms were of poor quality with examples of critical information (such as location, time of incident and the child's full details) not being recorded, and little evidence of effective supervision.

In many of the domestic abuse cases reviewed by inspectors, there is a clear focus on the criminal investigation. However, there is less evidence relating to the safeguarding of the victim and children. Inspectors also found an inconsistent approach to how and when cases are referred for a MARAC. In numerous cases examined, officers had failed to recognise the escalating or cumulative risk faced by a victim and their children, meaning that the appropriate intervention and support were not considered at the earliest opportunity.

Two emergency calls were made to the force regarding a domestic abuse incident in which the male perpetrator had hit his female partner. The couple had a 2-year-old child who was present in the house at the time of the incident. The force's initial response was positive: the perpetrator was arrested for assault, a statement was taken from the victim and child referrals were submitted. Prior to this incident, there had been numerous previous domestic abuse incidents in relation to the couple, and incidents in relation to the safety of the child (including an occasion in which the child had been found in the sole 'care' of a toddler in the street). Since October 2016 there had been five reported incidents in relation to the family, none of which had resulted in a referral by the force to a MARAC.

For cases referred by the force to a MARAC, inspectors found the multi-agency working to be good; minutes of meetings are well recorded with a wide range of in-depth information shared between the agencies. Although the actions agreed upon to mitigate risk are detailed and appropriate to the safeguarding needs of the victim and children, these are recorded on a computer system which is only accessible by a limited number of officers and staff. The investigating officer is only sent actions that are relevant to the police; the broader multi-agency actions are not made available, meaning officers are not aware of all safeguarding activity taking place. A further weakness of this process is that any further incidents that are referred to a MARAC, for which there are no specific police actions required, will not always be communicated to the investigating officer, so their awareness relating to the vulnerability of the child or children will be limited.

'Relay', the process for providing information to schools about children affected by domestic abuse, was reported to HMICFRS by the force and external agencies as being a positive initiative for the safeguarding of local children. However, HMICFRS is unclear on the extent of its effectiveness, because this is dependent on children at risk being identified effectively. However, with the flawed referral processes described above, it is possible that this function is not being optimised, and that information on children affected by domestic abuse is not shared on every occasion.

Bedfordshire Police has worked hard to improve the way in which the risk to children who are reported missing is assessed. In May 2017, only 3 percent of children reported as missing from home were classified as absent whereas previously this figure was as high as 75 percent. This shift in categorisation at the initial point of assessment has been as a result of findings from previous HMIC inspections and of the force having a better understanding of the risks children face when they are missing from home. Because children cannot be classed as low risk, most are categorised as medium risk which requires an active investigation. Therefore, the significant increase in the categorisation of children as missing rather than absent has resulted in a corresponding significant increase in demand because of the additional work required to locate them. However, inspectors noted that despite a

more accurate assessment of risk, in most of the cases reviewed there was little evidence that this had resulted in any further proactive work actually conducted to locate such children.

A mother reported to the force that her 15-year-old daughter was missing after she failed to return home one evening, and on account of suspicions her daughter was associating with older men. The force's initial checks were limited to the child protection system; a more thorough investigation of intelligence on the missing person database would have revealed that there had been recent missing incidents and that the child's behaviour was deteriorating. There was no evidence of supervision of the matter or of the level of risk at which the child was assessed. In addition, there was a delay of six hours before an officer was sent to respond. The mother re-contacted the force to confirm with them that she had spoken to her daughter on the phone and to provide details of her whereabouts; the dispatcher commented that this was a 'parenting issue' as opposed to a police matter and that consequently an officer would not be deployed. There was no record of a 745 form being submitted or of children's social care services being informed.

The force's access to trigger plans (plans that assist in locating missing children by providing detail on such things as where they were located on the previous missing episode) is limited. Although the force has a process in place to enable the FCR to inform response officers of the existence and detail of trigger plans, it is inefficient in its current form and needlessly delays the implementation of an effective response, especially at times of high demand. In addition, opportunities for early intervention and longer-term inter-agency planning to protect such children are often missed or not considered. In some children's cases, most notably those at risk of CSE, they were reported missing over 30 times without any safeguarding action being taken by, or on behalf of, the force to protect them.

Inspectors found that independent return interviews for children missing from home are available across all local authority areas, although the details of whether they have been conducted and what the interviews revealed are not always recorded on the force's systems. Interviews with children following their return can provide a wealth of information regarding the reasons they run away, particularly where such behaviour is frequent; they support more effective risk management and should inform the force's planning and decision-making of future safeguarding action. Despite senior leaders of the force emphasising to frontline officers the importance of an effective response to children who go missing, particularly those who do so regularly, HMICFRS encountered some views which demonstrate that further improvements are required; in one interview, inspectors were told that the force responds well when dealing with 'proper mispers' (a police term referring to missing persons), such as very elderly people or those likely to self-harm. This is indicative of

a culture that does not fully recognise the increased risks faced by children who go missing, in particular the risk from CSE.

**Recommendations**

- HMICFRS recommends that Bedfordshire Police immediately undertakes a review to ensure that the force is fulfilling its statutory responsibilities as set out in *Working Together to Safeguard Children*. As a minimum, this should include a review of referral processes to ensure that risk is being identified effectively and shared in a timely manner with external agencies.
- HMICFRS recommends that, within three months, Bedfordshire Police improves its practice in cases of children who go missing from home. As a minimum, this should include:
    - improving officers' and staff awareness of their responsibilities for protecting children who are reported missing from home, particularly for those children for whom it is a regular occurrence;
    - improving officers' and staff awareness of the links between children going missing from home and the risk of sexual exploitation; and
    - enabling the information on children's trigger plans to be accessible or made available to all officers and staff to make tracing missing children more effective.

# 7. Investigation

HMICFRS found some good individual examples of such work; investigating officers demonstrate an appropriate mix of investigative and protective approaches. This combined approach is necessary in ensuring that the safeguarding of children remains central to the force's efforts while the criminal investigative opportunities are pursued.

A 12-year-old girl disclosed to her friend's parents that she was scared to go home because she had been hit with a broom by her mother. A report was made to the force and officers attended, spoke with the child and, on their body-worn cameras, recorded her injuries. The force initiated a liaison with social services at an early stage, and a strategy discussion was arranged. A joint s.47 investigation was agreed, following which the force conducted a visit to the child's address to check on the welfare of her younger brother. A medical examination of the victim revealed injuries consistent with her initial disclosure. Officers demonstrated an appropriately sensitive approach in speaking with the child to understand her views, including her wish for her mother not to be prosecuted. The child's mother was interviewed by officers and admitted the assault, and ultimately she was issued with a caution. During the investigation, all appropriate lines of enquiry were followed, there was good evidence of supervision, jointly-agreed safeguarding measures were conducted and the child was listened to throughout.

All officers within CAVAA are given the appropriate level of training to conduct their role, and it was clear from the officers spoken to that they are enthusiastic and committed to protecting children from harm. They carry high but manageable workloads, allowing for timely investigations and required safeguarding measures.

Bedfordshire Police uses the crime management system (CMS) to record crimes and investigative activity as cases progress. To complement this, a further system, CATS, manages the safeguarding aspects of cases and is used extensively by CAVAA to good effect. HMICFRS inspectors witnessed good inter-agency working by the force, with clear evidence of jointly-agreed safeguarding activity recorded on the CATS system. The force's effective supervision of investigations ensures on the whole they remain timely and effective.

The force's emerald team has a remit for dealing with domestic abuse and serious sexual offences. The wide-reaching remit and sheer volume of crime reports are creating workloads that are unmanageable. Inspectors noted that these high workloads were leading to delays and drift in investigations. During HMICFRS' inspection, there were 314 suspects awaiting arrest across the force area, and many of these investigations were the responsibility of officers in the emerald team. Inspectors found problems in relation to the timeliness with which crimes were

allocated to officers for investigation: 86 were awaiting allocation in the south of the force area, the oldest of which had been delayed for 22 days. During such extended delays, there is no safety planning taking place to appropriately protect the victim or their children, which will be conducted by the officer investigating the case. Further, even for those cases allocated, inspectors found the quality of safeguarding planning for children to be inconsistent; in the cases assessed, recording was often poor with little, if any, evidence of joint working and few details of strategy discussions taking place. The force has recognised this weakness and is in the process of employing five extra staff to manage safeguarding requirements more effectively. It is too early for HMICFRS to determine whether this will adequately improve the emerald team's investigative performance and its outcomes for vulnerable children.

Following the end of her abusive relationship, a woman contacted the force to report that her ex-partner was refusing to return her mobile phone and was stealing money from her. The couple have two sons, aged one and two years respectively, and had been referred to a MARAC previously. The attending officer recorded details for the DASH form and assessed the risk as 'medium'. However, there is no evidence of a 745 form being completed. The investigation was only reviewed by a supervisor in the force 88 days following the initial crime report, which noted the suspect had not been arrested and that efforts to locate him were required. A second review was completed by a senior officer, who again noted the suspect had not been arrested and directed that efforts be made to locate and arrest him. For six months following the initial report, there is an absence of any recorded meaningful investigative activity to trace the suspect, thereby exposing the children to potential harm through the possibility of further incidents of domestic abuse.

As the above example illustrates, HMICFRS is concerned by the inadequate supervision of the force's child protection investigations. Force guidelines require investigations to be reviewed by a supervisor on a regular basis. However, such targets are not being met in the majority of cases. Guidelines require that the seniority of the supervisor for a case rises in relation to the duration of the investigation.[23] On 26 July 2017, across the force's public protection remit, there were 1,002 active investigations of which 611 (or 61 percent) were overdue for review. Almost half of these sit with the emerald team, meaning high-risk cases many of which affect children are not being supervised effectively.

Bedfordshire Police has recognised the need to improve its approach to children at risk of CSE, and has invested in the creation of the CMIT (CSE and missing investigations team). Thus far, the CMIT has worked with external organisations to identify and disrupt numerous organised exploitative networks. However, inspectors

[23] A detective sergeant review must take place within 7 days, a detective inspector must review crimes after 45 days and a detective chief inspector after 100 days.

found the team's approach to other types of CSE was often of a poorer quality: signs of risk were missed, lines of enquiry were either not followed up or took too long, and there were failures to respond to information and intelligence and to pursue offenders. In most of the cases assessed, the immediate safeguarding measures were adequate. However, there was often a failure to identify wider risks.

A 13-year-old girl was introduced innocently by a friend to a 20-year-old man. The man obtained the child's mobile phone number and contacted her via text and social media over the next four days, trying to persuade her to meet up with him. The child informed her parents of the man's behaviour, who immediately reported it to the force. Officers attended promptly, recorded details and seized the child's mobile phone. However, they failed to identify that the suspect was an RSO until a month later, in which time no action had been taken against him. Internal disagreements within the force regarding which team should investigate the matter created further delays and a poor service to the child. The risk to the child was wrongly assessed by the force as 'low', and was not reviewed when the suspect was identified as being an RSO, despite recorded prohibitions in relation to his contact with children. The suspect was eventually arrested, almost two months following the initial report. No referral has ever been made for the child to children's social care services, and there is no record on the CMS of the details of the child's account, or whether a visually-recorded interview or statement was ever made. Contact with the child has been poor throughout.

There has been limited use of child abduction warning notices (CAWNS)[24] in the last 12 months, with only 4 having been issued. HMICFRS reviewed numerous cases in which these notices would have been appropriate but had not been considered. Therefore, safeguarding opportunities had been missed by the force.

The force routinely searches for children being abused or exploited online and the internet child abuse investigation team (ICAIT) is the dedicated unit for overseeing these investigations. HMICFRS inspectors found that the team's processes for the development of safeguarding plans were inadequate, with the criminal investigation often prioritised over and above the development of a protective plan for affected children.

When an ICAIT case is categorised as high or very high risk, referrals to children's social care services are immediate. However, in medium-risk cases where the suspect has access to children, a referral is not made as soon as children are identified: it is made on the day that warrants are executed at the suspect's address,

[24] A non-statutory notice issued when the police become aware of a child spending time with an adult whom they believe could be harmful to them. A notice is used to disrupt the adult's association with the child, as well as warning the adult that the association could result in arrest and prosecution.

which could be days or even weeks after the initial identification of risk. This is leaving children unnecessarily exposed to risk in the intervening period between identification and overt police action.

The force's response officers generally respond well to children who go missing who have been assessed as high risk. The CMIT is responsible for tracing all medium-risk missing children (aside from the immediate enquiries conducted following receipt of the initial report). Members of the CMIT indicated to inspectors that they are unable to deal with current demand, and this inhibits their abilities to carry out any meaningful proactive work to address the underlying causes for which children go missing on a regular basis. It is not uncommon for there to be 30–40 people missing at any one time but only 2 or 3 staff on duty.

The creation of the CMIT is a clear indication that the force is committed to improving its services to children who go missing and/or are vulnerable to CSE. However, its current processes and demand pressures are compromising the effectiveness of the team's work. During the inspection, HMICFRS examined 10 cases involving CSE; 6 were graded as inadequate and 4 requiring improvement; 5 of these cases were investigated by specialist CMIT officers.

**Recommendations**

- HMICFRS recommends that, within three months, Bedfordshire Police improves its child sexual exploitation investigations, paying particular attention to:
    - improving staff awareness, knowledge and skills in this area of work;
    - ensuring a prompt response to any relevant concern raised;
    - improving the oversight and management of cases to ensure that standards are being met; and
    - ensuring that referrals and investigations conducted by ICAIT are prompt and effective.
- HMICFRS recommends that within six months Bedfordshire Police improves its investigations into domestic abuse and children affected by it. As a minimum this should include;
    - improving processes to ensure that investigations are timely and that all opportunities to mitigate risk are exploited (e.g., domestic violence prevention notices/orders); and
    - ensuring that specialist staff and officers are appropriately trained to apply safeguarding measures effectively for children affected by domestic abuse.

# 8. Decision-making

We are pleased to note from our observations of Bedfordshire Police that when an incident is clearly defined as a child protection matter from the outset, the force's response is generally appropriate, and it has seen examples of effective decision-making to protect children. For matters relating to the safety of children, officers handle incidents well, using their powers appropriately to remove children from harm's way. It is a very serious step to remove a child from their family by way of police protection; in the cases examined, decisions made by the force to take a child to a place of safety were well considered and in the best interests of the child.

A 10-year-old boy contacted police to report having been assaulted by family members with whom he lived; he said that he had been hit with a stick and had his hair shaved off because of his behaviour. Officers attended his address and found the child in the bathroom. After listening to him they decided to take the child in to police protection. The relevant family members were arrested and interviewed. A medical examination of the child corroborated his report. The child was safeguarded in the medium term by being placed with foster carers. Throughout the investigation that followed, there is clear oversight by the officers' supervisor and the wellbeing of the child remained central to the force's activity throughout.

Although HMICFRS notes the practical examples of officers taking appropriate protective action, inspectors also saw a weakness in the force, through its general poor standard of recording on police systems. Accurate and timely recording of information is essential for good decision-making in child protection matters. Important information was often found to be missing and there were delays in recording essential information on the force's system: delays in recording the outcomes of strategy meetings, updating records about the progress of an investigation, and details relating to the force's contact with relevant children and families.

In contrast, some of the cases audited showed that officers had taken clear and decisive action to provide long-term safeguarding for the children affected; there was evidence of body-worn video being used to support some decisions to use police protection powers and to support subsequent safeguarding activity. Such action is positive, but unfortunately undermined by poor information recording. In many, though not all, of the police protection powers cases examined, there was evidence of multi-agency safeguarding activity taking place. Where strategy meetings had taken place and were recorded, outcomes were generally clear and well structured with agreed actions for each agency. Subsequent investigative activity following the

use of police protection powers was generally good, but there were cases in which opportunities were missed and incidents were not appropriately investigated, as demonstrated below.

A 12-year-old girl reported to the force that she had been assaulted by her sister while her mother watched but failed to intervene. A decision was made to take the child into police protection, and in the early stages of the matter there is good evidence of joint working recorded on the force's systems. The child's sister was interviewed at the police station and she admitted assaulting the child following an argument. However, as the result of the absence of the investigating officer, there was a delay of seven weeks before a decision was made to take no further action, and there is no evidence of whether the child was spoken to before this decision was reached.

# 9. Trusted adult

From HMICFRS' inspection it is evident that in some, though not all, child protection cases officers consider carefully how best to approach the child or parents and that they explore the most effective ways to communicate with the child; such sensitivity creates demonstrably stronger relationships between the child and police. Further, inspectors were pleased to note that for matters in which immediate safeguarding was needed, the force worked well with external organisations, family members and other individuals to better protect children, and that their carefully considered and sensitive approach enabled effective safeguarding outcomes for the relevant children.

A member of the public reported to the force that she had witnessed a young child being beaten with a stick by his mother. Officers attended and arrested the mother, who was with her 2 children: a 5-year-old boy and a baby girl of a few months. The children were taken into police protection by officers. Subsequent and considerable joint work was conducted by the force and social services to understand the situation from the child's perspective. The force maintained detailed records of its interactions with the child, which revealed that he generally led a happy life and wanted to return to his mother. Further work with the child's mother revealed that she had been raped previously and was in need of help and support; an appropriate referral for help and support services for her needs was quickly made.

Areas within Bedfordshire, in particular Luton, face significant risks in relation to the radicalisation of young people. The PREVENT/CONTEST work conducted by the force has led to the identification of 500 individuals affiliated to groups connected to extremism, of whom 122 are children, and of those 96 are of school age. Child referral forms have been submitted by the force for all the relevant children, enabling the local authority and Ofsted to implement appropriate safeguarding activity. This course of action involving the force has effectively diverted and protected, or assisted in the diversion and protection of, a significant number of children from harmful environments. This is positive and continuing work, and comprises part of the monthly force CONTEST board meeting, in which the heads of public protection are updated.

# 10. Managing those posing a risk to children

Bedfordshire Police has a dedicated unit, the VSOMT, to manage RSOs and higher-risk violent offenders. At the time of HMICFRS' inspection, the team was managing a caseload that inspectors considered to be reasonable, with most officers managing approximately 50 offenders each. Of the RSOs in Bedfordshire, there are currently 530 residing within the community and 162 in custody. Officers are trained in the use of the active risk management system (ARMS)[25] and inspectors were pleased to note that, at the time of inspection, almost all offenders had been the subject of an ARMS assessment, and further that these were being used proactively to monitor and reduce risk to local children. Officers and staff in the VSOMT have received the appropriate training to conduct their role, and force resources are made available to support their work in monitoring the highest-risk offenders. RSOs are 'flagged' on the police national computer and their addresses are flagged on the force command and control system; if an offender comes to notice, the offender's manager will be informed.

In January 2017, the National Police Chiefs' Council (NPCC) agreed that the management of RSOs would move towards active or reactive management approaches. Where have had an ARMS assessment indicating low levels of risk, and where the offender manager is satisfied they have committed no offences or presented any risk for a three-year period, the force may move from active management (where visits are prescribed), to reactive management (which means visits do not occur). This is kept under regular review and would change if there was a significant shift in circumstances. Although this style of management is still in its early stages in the force, it is expected that its effective use will allow more focus on those RSOs posing the highest risk and will, to an extent, ease demand through the reactive management of those who fit the criteria.

In the cases assessed by HMICFRS, inspectors encountered numerous instances in which visits to RSOs were considerably overdue, and where opportunities to prosecute offenders, such as for breaching sexual harm prevention orders or notification requirements, were not being pursued by the force. Failure to hold RSOs to account for offences such as these leaves children exposed to risk of harm.

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

A high-risk RSO, previously convicted of possessing indecent images of children and grooming a child for sexual activity, was prosecuted on two further offences, namely breach of notification requirements in 2014 and 2016, respectively. Two further incidents occurred involving the alleged breach of a sexual harm prevention order and a further breach of notification requirements. However, no action was taken in relation to these later allegations because they were deemed as not being in the public interest (although a warning letter was issued). No rationale has been recorded to support the decision to determine that further action against the RSO was not in the public interest despite the fact that he had been prosecuted in the past.

An RSO shared a flat with another man who had a 6-year-old grandson who visited regularly. The RSO's flatmate was unaware of his past and that there was a sexual offences prevention order in place (which stipulated he may not have contact with a child under the age of 16 unless they are in the presence of the child's parent, guardian or other responsible adult). A decision was made by the force to inform the flatmate of the RSO's status, and the RSO was subsequently asked to leave the flat. Following this decision, officers discovered that the child had been given a phone by the RSO. However, there is no evidence that the phone was examined by the officers to identify evidence of potential offences. The child subsequently informed a teacher that he had stayed with his grandfather one night and had woken to find that his grandfather was not present, so he got into bed with the RSO until his grandfather returned. Although the force was eventually made aware of this fact, there was no evidence of any investigation taking place until the matter was referred back to the force by HMICFRS.

HMICFRS inspectors found that links between the VSOMT and community policing teams are limited across the Bedfordshire area; local frontline officers are not routinely informed about the RSOs living in their areas, other than when they are due to be released from prison or if they are high risk. Consequently, opportunities to use the community teams to gather information about those posing a risk to children may be lost. However, HMICFRS can report that during the inspection an IT system was implemented which will enable local community teams to access this information. This is a positive step by the force, and could improve its ability to safeguard children more effectively by routinely gathering information on offenders to better inform assessments of the risk they pose.

Finally, multi-agency public protection meetings to develop and oversee risk reduction plans for RSOs are generally well conducted and well attended by agencies, including Bedfordshire Police. The minutes show good information exchange between partner organisations present, and actions are clear and updated when complete.

# 11. Police detention

In matters concerning offences committed by children, and for which a child is to be denied bail and detained, the local authority is responsible for providing appropriate alternative accommodation. Only in exceptional circumstances (such as during extreme weather) would the transfer of the child to alternative accommodation not be in the child's best interests. In rare cases – for example, if a child presented a high risk of serious harm to others – secure accommodation might be needed.

HMICFRS found that in the Bedfordshire area children are detained unnecessarily in police custody. Inspectors examined ten cases in which local authority accommodation was required following a child being charged with an offence and denied bail; HMICFRS assessed the force's practice in one case as good, in three as requiring improvement and in six as inadequate. In none of these cases was the child transferred to alternative local authority accommodation. This led to some children spending significant periods in custody.

A 16-year-old boy was arrested for the theft of motor vehicle. While in custody he was given his rights without the presence of an AA. The following day, there were numerous conversations held by the police with the child's care home and social services emergency duty team relating to an AA. But police failed to mention any contact with the youth offending team (who should provide this function during office hours). Once a potentially suitable AA was found, the child was interviewed, charged and detained in police custody. The child's detention certificate indicated that secure accommodation was not required but alternative accommodation was not available – this contradicted the entry within the detention log that stated secure accommodation was required and not available. The child was detained for the duration of the weekend, during which his welfare checks were carried out late. In total, the child was detained for just under 63 hours in custody, approximately 40 of which were post-charge.

In April 2017, the force's chief constable wrote to each local authority chief executive to highlight the critical gap in the provision of alternative accommodation for children who have been charged with offences and denied bail. Despite this, there has been little improvement in the transfer of children from custody after charge. However, partner organisations expressed the view that there is still some confusion in the force relating to the different types of accommodation that are available to detained children, and the circumstances in which these should be requested.

In the cases assessed by inspectors, HMICFRS found that there were long delays in AAs attending to support children in custody, and that this contributed to the time they spent in detention. Once an AA is identified, they should be asked to attend the

custody office where the child is detained as soon as practicable.[26] Officers spoken to expressed the view that there had been a clear message from the force that children should only be brought in to custody when absolutely necessary with alternative arrangements and appointments for voluntary attendance where appropriate. Force performance documents reflect this, indicating that in April 2016 there were 113 juveniles arrested; this reduced to an average of 64 a month between January and April 2017. The number of children detained after charge remained static at five per month.

HMICFRS is troubled by further aspects of the force's approach to the detention of children. Many children entering custody have complex needs, and are likely to be vulnerable and in need of safeguarding support. In many of the cases assessed, a referral to social care was warranted but there was no evidence of any such referrals being made.

Additionally, from their assessment of cases, inspectors found that some reviews of the detention of a child were conducted when the child was asleep, and that there was no record on the detention log that the child or AA were advised that a review had taken place. Where the AA had not attended by the time of the inspector's review, there were no efforts recorded where the inspector had intervened to expedite their attendance.

HMICFRS also encountered a number of cases in which risks identified through the force's initial assessment of a detained child failed to be referred to a healthcare professional. For example, inspectors assessed a case regarding a 13-year-old complaining of nausea as well as pain in his jaw and abdomen following an assault, which was not referred by the force for medical attention.

Detention certificates, which outline to a court the reason for a custodial remand, are essential for police accountability and enable forces to monitor how well they are discharging their responsibilities under the Police and Criminal Evidence Act 1984. In all the cases seen by HMICFRS inspectors, detention certificates were completed but consistently they did not reflect the information on the custody record in relation to the type of accommodation requested. In all the cases inspected, the certificates indicated that secure accommodation was not requested by the force when in fact it was, despite none of the cases being evidenced as sufficiently high risk to warrant secure accommodation; this suggests that custody officers and staff do not fully understand the different types of accommodation and the circumstances under which they should be requested.

[26] Police and Criminal Evidence Act 1984, Code C (Detention, treatment and questioning of persons by police officers): www.gov.uk/government/publications/pace-code-c-2017

To ensure that children in police custody are being routinely reviewed, a daily report is sent to the head of custody for their review. However, other than the reduction in the number of children arrested, this has so far failed to demonstrate any improvements in the treatment or detention of children. The children and young persons' board considers information regarding children detained after charge, which is positive. However, the board deals with numbers of children, and the process could be improved by introducing an element of qualitative auditing to assess the validity of decision-making linked to such detentions.

**Recommendation**

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

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

Bedfordshire Police has demonstrated a strong commitment to improving its services for the protection of vulnerable children, and this is visible at all levels of the force – from the chief constable to frontline staff. The chief constable and PCC have prioritised child protection, and it is clear there is a force-wide focus on safeguarding and working to improve outcomes for children. Inspectors observed the progress made to improve the force's awareness in relation to vulnerability and the wider aspects of safeguarding.

Throughout the inspection, HMICFRS encountered specialist staff responsible for managing child abuse investigations who are knowledgeable, committed and motivated. Inspectors also found examples of good work by individual frontline officers responding to incidents involving children. The s.47 cases conducted within CAVAA demonstrate that where specialists undertake investigations with appropriate supervision, the outcomes for children are more positive; if this approach is replicated across all areas of child protection, it will ensure a consistency of service.

By contrast, there are still inconsistencies and some areas requiring improvement (in some cases as a matter of urgency) to the force's provision of its services to children. This is particularly urgent for children who are exposed to domestic abuse, those who go missing and those who are at risk of sexual exploitation. These inconsistencies need to be addressed to ensure all vulnerable children in the Bedfordshire area are appropriately safeguarded.

Some of the force's weaknesses can be attributed to ineffective and inefficient processes. However, many stem from the force's inability to service demand with the current level of resources in specialist roles; the emerald team, for example, is servicing a caseload which is demanding in both size and levels of risk. Inspectors also highlighted the force's poor standard of record keeping and supervision across many of its child protection areas. This is compounded by an inconsistency across the force's understanding of safeguarding, and the effects of cumulative and escalating risks to children particularly in domestic abuse incidents. The lack of supervision apparent in many investigations has led to signs of risk being missed, and chances for the force to intervene and safeguard a child at the earliest opportunity frequently being lost.

The force has taken some significant steps to tackle CSE through its work with external agencies to understand the main threats against children at the highest levels of such risk. However, there are still improvements needed if the force is to demonstrate that it is effectively and consistently able to identify and safeguard all children at risk of sexual exploitation.

The shift in the force's categorisation of risk in relation to missing children is an improvement to its approach at the initial point of contact; however, the audit of cases demonstrates that the competing demands placed on frontline resources is inhibiting the force's ability to proactively locate missing and vulnerable children. Additionally, improvements are still needed to ensure that staff and officers understand the risks associated with those children who are routinely missing.

The force needs to ensure it has effective oversight of the detention and treatment of children in custody. Despite the efforts of the chief constable to work with local authorities to improve the provision of alternative accommodation, custody officers and staff continue to make requests for the wrong type of accommodation. As a result of this lack of understanding, the cases reviewed demonstrate that no children have been transferred to appropriate alternative accommodation, and therefore Bedfordshire Police continues to detain children wrongfully in police custody.

The force's management of RSOs is often too focused on the offender and not on the wider safeguarding required to keep children safe from harm. Additionally, inspectors found examples of the force's failure to investigate further offences committed by RSOs, which potentially leaves children exposed to risk. The force has opportunities to strengthen the links between its specialist teams responsible for managing RSOs and local community teams which, if used effectively, can further safeguard vulnerable children from such offenders.

In conclusion, while there is an unambiguous commitment from senior leaders to improve outcomes for vulnerable children, and while some improvements have been made, this is not yet translating into consistently improved outcomes for all vulnerable children. The force needs to do more to improve its safeguarding practices to protect adequately those children at the most risk of harm.

# Recommendations

## Immediately

- HMICFRS recommends that Bedfordshire Police immediately undertakes a review to ensure that the force is fulfilling its statutory responsibilities as set out in Working Together to Safeguard Children. As a minimum, this should include a review of referral processes to ensure that risk is being identified effectively and shared in a timely manner with external agencies.

## Within three months

- HMICFRS recommends that within three months Bedfordshire Police ensures that it improves the quality of information recorded by officers (including their observations of a child's behaviour and demeanour) in records of domestic abuse incidents so that better assessments of a child's needs are made.
- HMICFRS recommends that, within three months, Bedfordshire Police improves its practice in cases of children who go missing from home. As a minimum, this should include:
    - improving officers' and staff awareness of their responsibilities for protecting children who are reported missing from home, particularly for those children for whom it is a regular occurrence;
    - improving officers' and staff awareness of the links between children going missing from home and the risk of sexual exploitation; and
    - enabling the information on children's trigger plans to be accessible or made available to all officers and staff to make tracing missing children more effective.
    - HMICFRS recommends that, within three months, Bedfordshire Police improves its child sexual exploitation investigations, paying particular attention to:
    - improving staff awareness, knowledge and skills in this area of work;
    - ensuring a prompt response to any relevant concern raised;
    - improving the oversight and management of cases to ensure that standards are being met; and
    - ensuring that referrals and investigations conducted by ICAIT are prompt and effective.

## Within six months

- HMICFRS recommends that within six months Bedfordshire Police improves its investigations into domestic abuse and children affected by it. As a minimum this should include;
    - improving processes to ensure that investigations are timely and that all opportunities to mitigate risk are exploited (e.g., domestic violence prevention notices/orders); and
    - ensuring that specialist staff and officers are appropriately trained to apply safeguarding measures effectively for children affected by domestic abuse.
- HMICFRS recommends that, within six months, Bedfordshire Police should, in conjunction with children's social care services, review how it manages the detention of children. As a minimum it should:
    - ensure that all children are only detained when absolutely necessary and for the absolute minimum amount of time;
    - ensure that officers and staff in the custody suite assess at an early stage a child's need for alternative accommodation (secure or otherwise) and work with children's social care services to achieve the most appropriate option for the child;
    - ensure that custody staff comply with their statutory duties to complete detention certificates if a child is detained for any reason in police custody following charge;
    - ensure that custody staff make a record of all actions taken and decisions made on the relevant documentation; and
    - improve the timeliness of adequate appropriate adult support for children who are arrested.

# Next steps

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

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

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

# Annex A – Child protection inspection methodology

## Objectives

The objectives of the inspection are:

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

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

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

These areas of practice are the focus of the inspection.

## Inspection approach

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

## Methods

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

The purpose of the self-assessment is to:

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

## Self-assessment and case inspection

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

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

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

| Type of case | Number of cases |
|---|---|
| At risk of sexual exploitation | 3 |
| Child in custody | 3 |
| Child protection enquiry (s. 47) | 5 |
| Domestic abuse | 5 |
| General concerns with a child where a referral to children's social care services was made | 5 |
| Missing children | 3 |
| Police protection S46. | 3 |
| Online sexual abuse | 3 |
| Sex offender enquiry | 3 |

# Annex B – Definitions and interpretations

| | |
|---|---|
| child | person under the age of 18 |
| multi-agency public protection arrangements (MAPPA) | mechanism through which local criminal justice agencies (police, prison and probation trusts) and other bodies dealing with offenders work together in partnership to protect the public from serious harm by managing sexual and violent offenders; established in each of the 42 criminal justice areas in England and Wales by sections 325 to 327B of the Criminal Justice Act 2003 |
| multi-agency safeguarding hub (MASH) | hub in which public sector organisations with responsibilities for the safety of vulnerable people work together; it has staff from organisations such as the police and local authority social services, who work alongside one another, sharing information and co-ordinating activities, to help protect the most vulnerable children and adults from harm, neglect and abuse |
| Office for Standards in Education, Children's Services and Skills (Ofsted) | a non-ministerial department, independent of government, that regulates and inspects schools, colleges, work-based learning and skills training, adult and community learning, education and training in prisons and other secure establishments, and the Children and Family Court Advisory Support Service; assesses children's services in local areas, and inspects services for looked-after children, safeguarding and child protection; reports directly to Parliament |

| | |
|---|---|
| police and crime commissioner (PCC) | elected entity for a police area, established under section 1 of the Police Reform and Social Responsibility Act 2011, responsible for securing the maintenance of the police force for that area and securing that the police force is efficient and effective; holds the relevant chief constable to account for the policing of the area; establishes the budget and police and crime plan for the police force; appoints and may, after due process, remove the chief constable from office |
| registered sex offender (RSO) | a person required to provide his details to the police because he has been convicted or cautioned for a sexual offence as set out in Schedule 3 to the Sexual Offences Act 2003, or because he has otherwise triggered the notification requirements (for example, by being made subject to a sexual offences prevention order); as well as personal details, a registered individual must provide the police with details about his movements, for example he must tell the police if he is going abroad and, if homeless, where he can be found; registered details may be accessed by the police, probation and prison service |