HMICFRS

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

National Child Protection Inspections

Derbyshire Constabulary
10–21 May 2021

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

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

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

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

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Summary

This report is a summary of the findings of our inspection of police child protection services in Derbyshire, which took place in May 2021.

We examined the effectiveness of the decisions made by the police at each stage of their interactions with or for children, from initial contact through to the investigation of offences against them. We also scrutinised the treatment of children in custody and assessed how the constabulary is structured, led and governed, in relation to its child protection services.

We adapted this inspection because of the COVID-19 pandemic. Working within national guidelines, we arranged with the force to carry out our inspection both safely and effectively.

We worked remotely, using video calls for discussions with police officers and staff, their managers and leaders. And we reviewed incidents and investigations online.

Main findings from the inspection

Derbyshire Constabulary has recently changed its senior leadership team. It appointed a new chief constable and a deputy chief constable within the nine months leading up to our inspection. And during this inspection a new police and crime commissioner was elected for Derbyshire.

The constabulary's child protection arrangements aren't consistently providing either the quality of service or a good enough response to effectively safeguard children in Derbyshire. In the months before this inspection, senior leaders recognised that changes were needed. They are now reviewing their safeguarding arrangements, policies and operational practices, and intend to improve the way they work with safeguarding partners.

We saw that risk analysis in the current force management statement identified the need to prioritise child abuse investigation, online crime against children and child exploitation. In February 2021 the constabulary re-established specialist child investigation teams to investigate child abuse and neglect – moving away from a generic investigation team for crimes with vulnerable victims.

This approach will allow the constabulary to make best use of its staff and managers who are highly committed to doing their best to protect children and promote the welfare of those who they find in high-risk situations. Some of these officers told us they felt their managers supported them and they were empowered to find local solutions to help vulnerable children.

Chief officers and senior leaders participate in multi-agency safeguarding partnership arrangements. They attend and contribute to multi-agency meetings and activities. But there is little evidence of effective multi-agency operational activity to safeguard children. We found examples of poor assessments of risk and therefore inconsistent information sharing with other organisations involved in safeguarding children.

Vulnerable children in Derbyshire (as in other parts of the country) are at risk from county lines gangs and others who exploit them. But there is a disjointed approach within the force to reducing child vulnerability. Responsibility for these investigations falls to various teams, depending on the child's location and level of risk. But the assessment process used for exploitation risk isn't always effective. Some children who are clearly at high risk are not getting the right level of response from the police or the organisations the police work with.

The response to missing children is also confused because cases are allocated to different teams across the constabulary. So high-risk missing children aren't always responded to with enough resources or as a priority. In fact, in some cases where highly vulnerable children were missing from children's homes, constabulary practice meant that they weren't recorded as missing. So officers didn't look for them. We explained to senior leaders why this approach to missing children needs to improve and were reassured they would act without delay.

Safeguarding and child protection are not prioritised highly enough in operational activity. The inconsistent approach to the risk from those suspected of distributing indecent images of children online illustrates that officers don't always understand their primary role – which should be to protect children.

Investigations into sexting offences – where children make indecent images of other children and distribute these among themselves – can be confused. Officers know that children shouldn't be unnecessarily criminalised for minor offences. But this approach often means that little, if any, investigation takes place for some victims. The devices and phones containing images are not always seized for evidence, to help identify other victims, or to permanently delete indecent images. And there are also missed opportunities for a multi-agency assessment of the offender's own risk and vulnerability.

We found a lack of understanding of safeguarding responsibility within some specialist units. Police online investigation team (POLIT) officers see their primary role as focusing on offenders, rather than protecting children. Staff in the custody suites often determine vulnerability during their own observations of children in police detention. But they think that investigating officers should be responsible for making referrals to children's social care (CSC) services – despite some children's vulnerability only becoming apparent when they are in police detention.

There is also a lack of supervisory capacity for the staff managing sexual and violent offenders. So, most risk management plans for registered sex offenders are unsupervised.

During our inspection, we examined 79 cases where children had been at risk. We assessed child protection practice as good in 20 cases, as requiring improvement

in 31 cases, and as inadequate in 28 cases. This shows that the force needs to do more to give a consistently good service for all children.

Specific areas for improvement include:

- ensuring all staff understand their main responsibilities towards vulnerable children;
- speaking to children, particularly very young ones, recording their behaviour and demeanour, and making sure their concerns and views are heard and inform decisions for their welfare;
- considering the wider risks to children when they are missing or living in homes where domestic abuse features, to enhance protective planning;
- making appropriate referrals to CSC and early help practitioners;
- ensuring that consideration is given to cumulative and repeat low-level risk;
- recognising that children missing from care homes are particularly vulnerable;
- supervising investigations more consistently, to make sure opportunities are pursued and cases aren't unnecessarily delayed;
- ensuring that investigations where children are perpetrators and victims are properly conducted before making disposal decisions;
- ensuring children aren't inappropriately kept in police detention, and that they aren't kept in police stations as a place of safety for prolonged periods; and
- supervising the management of registered sex offenders so that risk is correctly identified and mitigated by effective referrals and enforcement.

Conclusion

There is an urgent need for the constabulary to implement changes to improve its child protection arrangements and practices. This should be supported with a clear structure for oversight and scrutiny for all aspects of child protection activity that can also monitor the impact of the changes it makes.

We found that the officers and staff who manage demanding child abuse investigations are committed and dedicated. However, we are concerned about the variability of both frontline and specialist officers' knowledge and understanding of what makes child protection practice effective.

We have therefore made a series of recommendations. These will help improve outcomes for children if the constabulary acts on them.

1. Introduction

The police's responsibility to keep children safe

Under section 46 of the Children Act 1989, a constable is responsible for taking into police protection any child who they have reasonable cause to believe would otherwise be likely to suffer significant harm. The police have an additional duty to enquire into that child's case. They also have a duty, under section 11 of the Children Act 2004, to ensure that, when carrying out their functions, they have regard to the need to safeguard and promote the welfare of children.

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

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

Expectations set out in *Working Together*

The statutory guidance published in 2018, *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*, sets out what is expected of all partner agencies involved in child protection (such as the local authority, clinical commissioning groups, police, schools and the voluntary sector).

The specific police roles set out in the guidance are:

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

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

2. Context of the force

Derbyshire Constabulary has a workforce of approximately:

- 1,770 police officers;
- 1,625 police staff;
- 160 police and community support officers; and
- 215 special constables.

The constabulary serves a population of approximately one million people across a county area of 1,013 square miles. Derbyshire is situated in the East Midlands of England. Urban areas include the city of Derby and the towns of Chesterfield and Matlock, but many people live in rural settings. University students and the very large numbers who visit the Peak District National Park increase the population.

The constabulary, together with NHS Derby and Derbyshire Clinical Commissioning Group, NHS Tameside and Glossop Clinical Commissioning Group, and the local authorities of Derby City Council and Derbyshire County Council, form the Derby and Derbyshire Safeguarding Children Partnership.

Recent inspections

In March 2019 there was a joint targeted area inspection of the multi-agency response to abuse and neglect in Derby City Council area. The inspectors sent a post-inspection letter to the safeguarding children partners. It details multi-agency practice strengths and areas for improvement.

The most recent Ofsted inspection (August 2019) of children's social care services provided by Derbyshire County Council reported as follows:

Judgment	Grade
The impact of leaders on social work practice with children and families	Good
The experiences and progress of children who need help and protection	Requires improvement
The experiences and progress of children in care and care leavers	Requires improvement
Overall effectiveness	Requires improvement

Organisation

Most response and operational activity is split between two divisional areas. Divisional headquarters are in Chesterfield for North division and Derby for South division. Divisions are responsible for neighbourhood safeguarding teams and missing persons teams. Because of variations in volumes and types of workload, the terms of reference and staffing arrangements for each division's teams are similar but not exact matches.

The constabulary has centralised specialist teams such as the control room, known as the call management and resolution centre. The risk and referral unit, the digital forensic unit, and police online investigation team are also centrally managed.

The constabulary's public protection department is responsible for:

- managing child investigation teams;
- managing domestic abuse investigation within public protection hubs;
- management of sexual and violent offenders;
- managing children at risk of exploitation; and
- investigating crimes of neglect and abuse committed against vulnerable children and adults.

The constabulary collaborates with four other police forces in the East Midlands Special Operations Unit (EMSOU). These are Leicestershire, Lincolnshire, Nottinghamshire and Northamptonshire. This arrangement provides Derbyshire Constabulary with six services, including forensic services, major crime investigation and the services it uses to proactively investigate organised crime.

3. Leadership, management and governance

The new leadership team is working to improve the service the constabulary provides to children in Derbyshire

Derbyshire Constabulary has recently experienced significant changes in its senior leadership. During the inspection a new police and crime commissioner (PCC) was elected for Derbyshire. The current Police and Crime Plan 2016–2021 (set by the previous PCC) has seven priorities. One of these is to safeguard vulnerable people – including children. The recently elected PCC is in the process of devising a police and crime plan.

Leaders recognise that the current structures and performance aren't providing the level of response and quality of service they require for children in Derbyshire. They have begun reviewing child protection arrangements and practice. And they are reviewing how the constabulary responds to those who present risk to children.

The deputy chief constable is strategically responsible for the response to vulnerability. The strategic vulnerability board, which commenced during our inspection, oversees the constabulary's vulnerability action plan. Child protection is one strand of this. This approach has been designed with reference to the national vulnerability action plan. So, Derbyshire Constabulary's arrangements will be closely aligned to arrangements and good practice across the country.

The constabulary has a clear intention to refresh and improve the way it provides child protection services. The risk analysis within its force management statement identifies the need to quickly invest in and improve:

- child protection investigations;
- responses to online crime against children; and
- the ways it tackles child exploitation.

The constabulary recently identified that taking specialist staff off for other work undermined the quality of child abuse investigation. So it re-established dedicated child investigation teams with clear terms of reference. This is a positive step and staff in the new teams are highly motivated, trained and focused on providing better outcomes for abused and neglected children.

But in most of the units and teams dealing with vulnerable children and those who harm them, we found confused terms of reference and inconsistent and outdated practice. We saw some untrained staff and supervisors. They were operating in isolation without a clear vision of how their work contributed to the force's vulnerability priority. Differences between the operational practice and capability in the constabulary's North and South divisions have worsened the lack of central direction for vulnerability. An example of this is the inconsistency and ineffective practice in the arrangements to find missing children, which has not been addressed by senior officers. The inappropriate use of 'no apparent risk' for missing children was only stopped during this inspection.

Leaders need to improve how the constabulary assesses risk to children and shares this information with other organisations

A vital safeguarding element is how effectively police assess and share information about risk with the other organisations they work with. In Derbyshire the system isn't good enough. This is a partnership issue. Officials from the Derby and Derbyshire Safeguarding Children Partnership told us they had documented concerns about the way police shared information on their risk register. A multi-agency working group including the police has not yet resolved the problem. This means that children may continue to be exposed to risk.

Officers use public protection notices (PPNs) to record concerns about children. The risk and referral unit sends the vast majority of these to the local authorities without triaging and researching police systems for relevant information. So for children where the reported concern in an individual PPN is considered low risk, no checks of police records are made to assess the impact of the latest incident on what is known about the child's existing vulnerability. This means interventions to safeguard some children will be delayed until abuse or neglect is escalated in future incidents.

We saw little evidence of collaborative and integrated working with other organisations to provide better outcomes for vulnerable children. Some organisations told us about the benefits of co-locating some staff in a multi-agency safeguarding hub. But the constabulary and the organisations it works with do not have arrangements such as multi-agency early intervention hubs or joint teams. We have seen these operating effectively in other forces to tackle the causes of child exploitation by looking at the problem as a whole.

The pandemic has severely disrupted training. The constabulary has tried to train and inform staff about vulnerability and child protection using emails, bulletins and online material on its intranet. But most staff we spoke to said they had not received any recent vulnerability training. Some are only vaguely aware of material prompting them to seek the voice of the child. Some divisional teams have training days programmed every ten weeks. Others, such as custody staff, told us they had no training days. There are also gaps in the numbers of trained detectives.

There are significant gaps in the workforce's understanding of their personal responsibility to promote the welfare of children and of how to make good quality referrals. This includes officers in specialist units such as the police online investigation team (POLIT) and custody, where regular contact with vulnerable children should be expected.

On a positive note, the constabulary and the organisations it works with recognise the vulnerability of babies and younger children. Some detectives are specially trained in responding to child death and bereavement. This indicates an understanding and commitment to the benefits of multi-agency investigation.

The constabulary isn't using information and intelligence to best effect. Officers in various roles told us they received little support from strategic analysis. And they did not get up-to-date problem profiles to help them understand and tackle, for example, criminal exploitation. Such data and analysis are vital for strategic decisions. The performance data we saw was mostly quantitative and comparative between divisions and teams.

The constabulary should improve the quality of the data it collects so leaders understand where change is needed to improve end results for children

When we asked for details of how the constabulary records and refers cases of children within domestic abuse households, analysts couldn't give a reliable assessment from the available data. So leaders don't know the quality of their officers' responses to many vulnerable children.

This also applies to the question sets within the various audits. The constabulary would benefit from developing a more qualitative approach to data. For example, looking at the end result of cases and the quality of supervision, rather than just noting its presence. And there should be a focus on the numbers of repeat victims – including missing children. The constabulary could also ask whether appropriate escalation and intervention was in place.

Senior leaders are reviewing arrangements and responses to vulnerability. This is an opportunity to ensure that the workforce focuses on improving outcomes for vulnerable people and children.

In many of the cases we audited, we didn't see evidence that officers and supervisors understood that improving end results for children was the priority. The voice of the child is inconsistently sought and recorded. And activities in incidents and investigations aren't consistently based upon improving the situation for the child. Instead, we saw evidence of staff working in silos:

- custody staff told us that it was always the responsibility of the investigating officer to submit a PPN for a child in detention – even though custody staff may observe vulnerability or risk;
- control room staff didn't see it as part of their role to prompt officers to use body-worn video to record children's demeanour and voices or to submit PPNs before incidents are closed; and
- POLIT officers don't fully understand that the primary focus of their role is to safeguard children.

Because of this culture, safeguarding action is delayed in too many cases.

The constabulary's culture towards safeguarding is not yet fully developed. This needs to improve.

Recommendation

We recommend that Derbyshire Constabulary immediately improves how its leaders and managers promote the responsibility of safeguarding children to all sections of the workforce.

4. Case file analysis

Results of case file reviews

For our inspection, Derbyshire Constabulary selected and self-assessed the effectiveness of its practice in 33 child protection cases. In accordance with our criteria, the cases selected were a random sample from across the county.

We also assessed the same 33 cases.

Cases assessed by both Derbyshire Constabulary and HMICFRS

Constabulary assessment:

- 7 good
- 21 requires improvement
- 5 inadequate.

HMICFRS assessment:

- 7 good
- 13 requires improvement
- 13 inadequate.

HMICFRS inspectors selected and assessed 46 additional cases during the inspection.

Additional 46 cases assessed only by HMICFRS

HMICFRS assessment:

- 13 good
- 18 requires improvement
- 15 inadequate.

Total 79 cases assessed by HMICFRS

HMICFRS assessment:

- 20 good
- 31 requires improvement
- 28 inadequate.

There was a significant difference in the gradings given by the constabulary in its self-audits and the same audits completed by our inspectors. Our audits identified many more cases where investigations were inadequate.

Our analysis of this difference in grading considers evidence from all the case subject areas. The constabulary auditors focused on initial response, presence of supervisory entries and process.

We also considered:

- the recording of children's demeanour and wishes;
- safeguarding activity beyond the immediate risks or incident;
- timeliness of engaging with other organisations;
- the effectiveness of continuing supervision; and
- the outcomes for children.

Of the 79 cases assessed, we referred 10 back to the constabulary where our analysis of the evidence in case records was that there remained serious problems. For example, failures to ensure children were being protected by police or partner agency activity, or where it appeared that a child might still be at risk of significant harm from an offender because there had not been a meaningful intervention.

We also referred back to our concern about the POLIT risk assessment process and delays in acting quickly to safeguard children who were at risk from known suspects.

The constabulary responded diligently to all our referrals. Senior managers reviewed the cases, updated risk assessments and, where needed, acted on the concerns we brought to their attention.

Breakdown of case file audit results by area of child protection

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

- 2 good
- 4 requires improvement
- 4 inadequate.

Common themes include:

- evidence of good initial action by responding officers;
- lack of joint home visits and joint investigation;
- poor recognition of the voice of the child;
- inconsistent records of working with other organisations once a case is past its initial stage; and
- missing wider safeguarding concerns for other children.

Cases assessed involving referrals relating to domestic abuse incidents or crimes

- 4 good
- 7 requires improvement
- 1 inadequate.

Common themes include:

- good recognition and initial direction from the control room;
- consistent use of body-worn video at scenes – although the voice of the child is not consistently sought or recorded within investigations;
- referrals for children affected by domestic abuse aren't made; and
- supervision beyond initial investigation stages is inconsistent and doesn't set clear plans to expedite crime investigation or progress safeguarding activity.

Cases assessed involving referrals arising from incidents other than domestic abuse

- 6 good
- 2 requires improvement
- 2 inadequate.

Common themes include:

- a good initial response when contact is through the control room;
- the voice of children and wider safeguarding issues are not always considered; and
- there is sometimes limited and ineffective supervisory oversight.

Cases assessed involving children at risk from child sexual exploitation

- 2 good
- 2 requires improvement
- 12 inadequate.

Common themes include:

- the control room's initial response is usually good, but it doesn't always identify wider risks and safeguarding activities;
- in many cases, referrals are delayed and don't support joint planning for proactivity;
- strategy meetings aren't always held;
- actions and plans aren't always recorded on police records;
- risks to other children aren't always considered;
- the child's voice is not clear enough within records;
- effective supervision is lacking, leading to drift and delay; and

- enquiries to identify and locate potential perpetrators are sometimes overlooked, and the consequences of delays are not considered.

Cases assessed involving missing and absent children

- 3 good
- 3 requires improvement
- 4 inadequate.

Common themes include:

- the control room uses THRIVE risk assessments to help assess and grade the risk to a child;
- trigger plans aren't consistently used to locate children quickly;
- information from police records isn't available to initial responders to help them locate missing children;
- the voice of the child is inconsistently sought and recorded by responding officers;
- supervision of activity and records is inconsistent; and
- control room staff, frontline officers and supervisors don't fully understand that being missing increases child vulnerability. They don't gather intelligence to assist in reducing it.

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

- 2 good
- 4 requires improvement
- 0 inadequate.

Common themes include:

- responding officers consider the circumstances of vulnerable children and make effective decisions to remove children with appropriate use of the power, and liaise well with children's social care services;
- officers don't always hold strategy discussions, or record end results and joint plans;
- officers inappropriately use police stations as places of safety; and
- inspectors don't consistently supervise cases or record when the police protection powers end.

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

- 1 good
- 4 requires improvement
- 1 inadequate.

Common themes include

- supervision is superficial and doesn't direct investigations enough;
- risk to children and vulnerable adults isn't consistently identified; and
- offenders' risks aren't assessed appropriately or in a timely enough way.

Cases assessed involving children detained in police custody

- 0 good
- 5 requires improvement
- 4 inadequate.

Common themes include:

- the attendance of appropriate adults at the custody office is generally good;
- children are seen by health care professionals;
- custody staff don't fully understand their responsibility to seek appropriate alternative accommodation for detained children;
- requests for alternative accommodation are often delayed unnecessarily;
- liaison and diversion staff aren't always available to consider alternative case disposals; and
- there is confusion and inconsistency concerning who is responsible for submitting referrals about children's vulnerability when they are in custody.

5. Initial contact

The constabulary has improved systems in its control room to identify risk and prioritise responses to the most vulnerable people.

A joint targeted area inspection[1] in March 2019 reported that the control room was poor at identifying risk to children and deploying resources accordingly.

Derbyshire Constabulary has trained its control room staff to recognise vulnerability and complete THRIVE risk assessments. This improves the way risk is assessed and means that police can deploy more quickly to vulnerable callers.

Case study: call handler responds to a child with unspoken vulnerability

During the night shift an operator took a 999 call from a young female who asked to order a pizza.

It would have been very easy for the operator to dismiss the call as a mistake or a misuse of the 999 system. But the operator used her vulnerability awareness training and applied the THRIVE risk assessment. This meant thinking about the context of the call beyond the basic contact. The operator sensed the female was vulnerable and obtained additional information from her while quickly deploying police officers to the address.

When officers arrived, the girl told them that she had been raped by a male relative who was still present in the house. The officers protected the victim and began the criminal investigation.

But the actual safeguarding began when the operator used her training and responded to the caller’s unspoken vulnerability.

The incident recording system indicates when a caller has previously contacted the police. It also links with other systems and shows if a caller was previously a victim of domestic abuse or hate crime.

Control room staff use information from police systems such as warning flags and vulnerability markers to determine the level of response to incidents. They also obtain information from intelligence research of the police system. Technology called i24 helps operators and responding officers to better understand risk and vulnerability.

[1] Joint targeted area inspections are inspections of local authority areas where Ofsted, HM Inspectorate of Constabulary and Fire & Rescue Services, HM Inspectorate of Probation, and the Care Quality Commission jointly inspect the effectiveness of safeguarding arrangements and practice, and how well the different organisations work together.

We saw data that indicated practices had improved in recording crimes and staff now generate crime records on initial contact with callers. This meant an increase in the number of investigations. When possible, operators will seek to resolve investigations by telephone. But there is guidance about the types of crime that aren't suitable for telephone resolution. These include any incidents where the operator considers a person to be vulnerable. Child protection cases fall into this category.

Supervisors must dip-sample incident logs to make sure that the police responses are appropriate. A quality assurance process helps to maintain standards and feedback learning to staff.

The control room isn't routinely meeting its service level agreement for answering non-emergency 101 calls. In March 2021, about 30 percent of calls to Derbyshire's 101 were abandoned after 60 seconds. Many 101 calls are abandoned before being answered. It is likely that vulnerable people or children, or others who want to report incidents on behalf of them, aren't speaking to the police when they need to.

Despite staff training, better systems and more effective supervision, which are improving responses to incidents such as domestic abuse, we found more work is needed. For example, we were told that control room staff didn't think it was within their role to prompt officers to use body-worn video to record children's demeanour and voices at incidents, or to submit public protection notices (PPNs) before incidents are closed.

The initial response to missing children is inconsistent and leaves some children at high risk

When control room staff are told a person is missing, they determine the risk grading and the response. Unless the missing incident is graded as high risk the record is closed and responsibility for further responses is passed to divisional officers. In high-risk cases the record may stay open to help manage deployments. In some of these incidents we saw good use of information from the i24 intelligence research that helped officers to prioritise enquiries.

Most police forces use trigger plans, which contain useful information about vulnerable children who are frequently reported missing. But in Derbyshire, trigger plans are inconsistently created, updated and used. This severely undermines the effectiveness of the response to the most vulnerable missing children. There were only three trigger plans available to the control room operators when we visited. And in one of the cases we saw, there was a trigger plan, but it wasn't used to inform activity while the child was missing.

The specialist missing persons system – COMPACT – is opened after the responding officer completes a new record and enters a formal risk assessment. But we saw that divisional officers weren't routinely using COMPACT and had developed local practice. So important information about vulnerable children isn't immediately available to all staff. We were told that divisional supervisors are routinely made aware of missing children. But we saw cases where divisional supervisory direction and activity was superficial.

The two divisions have different arrangements for missing children investigations. The South division neighbourhood safeguarding team (NST) has a missing persons team. Dedicated missing persons officers develop knowledge and contacts, and have more time and resources to focus on finding missing children. These officers will also work to reduce risks to children who are repeatedly reported as missing from home.

The North division has a less structured approach. It assigns enquiries more generally across its NST. But just before our inspection, the constabulary had formed a dedicated missing persons team for North division.

Case study: child at risk from criminal exploitation goes missing from care home

Staff at a children's care home reported a 16-year-old boy missing because he hadn't returned home that evening. This was his 26th missing incident.

He was assessed as at medium risk of criminal exploitation but there was a warning marker on the police system. There was also intelligence that he had previously been threatened by a male with a gun.

Control room staff identified these risks. But the constabulary took no action that night. The incident log notes: "This will be for the AM [morning] shift to conduct a safe and well check should he turn up as he usually does."

A divisional officer subsequently completed a prevention interview with the boy. But there was no COMPACT record made and a PPN wasn't submitted.

We saw no evidence of assessment of the missing episode in relation to the child's vulnerability to exploitation. We saw no evidence of work to prevent further missing episodes.

There is an inappropriate response to some vulnerable missing children

We found inappropriate practice within the control room when care home staff reported looked-after children as missing. Control room staff routinely refuse to consider these children as missing persons and pass the responsibility to locate them back to the care home staff. None of the 11 children who were reported as missing from care homes on 30 April 2021 were looked for by police.

We saw that the rationale for this generalised practice was inappropriately based on the College of Policing authorised professional practice guidance, which is intended to improve police responses to missing persons incidents. Unfortunately, some officers are misinterpreting this guidance and the practice means that control room staff refuse to deploy officers to locate some looked-after children.

The week before our inspection, the constabulary decided to stop using the grading 'no apparent risk' (NAR) for missing children. In the 12 months before this change, 366 missing children were classified as NAR – 300 by divisional staff and 66 by the control room. To support this change, staff need to understand that risks for each child will vary and that risks can increase quickly for some children. This means police responses should be tailored to the vulnerability assessment every time a child is reported as missing.

Supervision of missing children incidents is inconsistent

Both divisions hold daily missing persons briefings. This allows some oversight and lets supervisors review the risk assessments. However, we found most records didn't contain supervisory entries that drove enquiries.

We saw little evidence of supervisors endorsing risk assessments on COMPACT. So activity to find children may not be progressed according to their true level of vulnerability.

We also saw that PPNs weren't routinely submitted for missing children. In some of the cases with PPNs, the voice of the child was absent or insufficiently recorded.

Case study: child missing from care home

A 15-year-old boy on a full care order – previously missing 155 times – was reported missing by staff in his care home. He was at high risk of criminal exploitation.

Control room staff graded the incident as high risk but there was no trigger plan to assist responding officers. The care home provided an address where the boy might be, but officers didn't check this overnight. No other meaningful activity to locate the child followed and the incident was assigned to divisional officers.

A divisional supervisor reduced the risk grading to medium. They commented, "Care home staff have not raised any pressing issues… and have not suggested that he is a risk to either himself or the public." There was no consideration of the exploitation risk.

When the boy returned, an inspector recorded: "Officers are not required to visit for a 'safe and well' check as he lives in a care home and this can be conducted by the staff. He is a regular missing person – staff have to report him missing when he fails to return on time."

The incident was closed as 'no apparent risk'. No PPN was submitted.

Officers inform schools about children present at domestic abuse incidents

Stopping Domestic Abuse Together (SDAT) is a police-led initiative that includes social and health services, schools and other safeguarding organisations. SDAT automatically notifies schools and colleges that a pupil has recently been present at, witnessed or been involved in a domestic abuse incident. This scheme involves officers obtaining details of children's schools while they are dealing with the incident. If the child attends a school in Derbyshire the details of the incident will be sent directly to the school.

This helps school staff to support the child and monitor their welfare and safety. SDAT is widely supported but the constabulary and the other organisations it works with are yet to evaluate the project.

There is a timely response to domestic abuse incidents, but officers don't always receive enough background information

The constabulary prioritises its response to domestic abuse. In the incidents we saw, officers usually attended in a timely way. Officers provide protective measures based upon the information they have and their own dynamic assessments. Responding officers seek to progress criminal investigations and offenders are arrested when they should be. Body-worn video is also used to record some of these incidents.

But control room operators don't always research domestic abuse incidents in detail – often relying on flags such as 'child on a plan' or a 'critical risk' marker. But flags and markers aren't always correctly or consistently attached. For example, we saw cases with multi-agency risk assessment conference (MARAC) flags placed for the victim but not the perpetrator or 'vulnerability' markers for their children. So responding officers aren't always fully aware of the risks.

We were told the control room didn't THRIVE-assess incidents already graded as 'immediate'. Where THRIVE is used it tends to be basic. Records of previous incidents on police systems aren't routinely accessed or reviewed. And patterns of abuse, which are important in assessing risk, aren't provided to responding officers.

The workforce has been told to record the voice of the child but there is inconsistency in how they deal with children affected by domestic abuse

A child's behaviour gives important information about how an incident has affected them. This is especially true when they are too young to speak to officers, or where having a parent there might present a risk. Officers should carefully observe a child's behaviour and demeanour to inform the initial assessment of the child's needs. Briefings to reinforce the importance of capturing the voice of the child at incidents, especially those where domestic abuse is a concern, are provided on the intranet.

We saw evidence of officers speaking to victims and checking children are safe. But the quality of recording the voice of the child is inconsistent. There is often a lack of detail on how they are affected.

Officers are told to submit DASH risk assessments for domestic abuse incidents and record the details of children within these records.

The current DASH process doesn't assess risk to children but focuses solely on the adult risk. It means that children, whose vulnerability is different to that of parents, aren't being considered in their own right.

It also means that many repeat incidents of domestic abuse are assessed in isolation, without the full context of previous assessments of risk and vulnerability.

The constabulary practice is not to complete PPNs for children in domestic abuse incidents unless officers have additional concerns about them. For example, the house is in a poor condition or it looks likely that the children are being neglected.

The constabulary has introduced an additional voice of the child form on its system. But this form isn't routinely used. Frontline staff told us they didn't understand the need for the form, and they considered it bureaucratic duplication. We didn't see this form used in any of the cases we reviewed. As a result, many incidents where domestic abuse is affecting children are not being fully risk assessed or recorded.

Where PPNs aren't submitted or the voice of the child isn't recorded, the information about children affected by domestic abuse isn't referred to children's social care. The constabulary doesn't quality assure this issue.

Recommendations

- We recommend that Derbyshire Constabulary immediately reviews its missing persons arrangements and practices to ensure that, throughout the missing incident, there is always an effective response to vulnerable children.
- We recommend that Derbyshire Constabulary immediately reviews its arrangements and practices to ensure that officers responding to domestic abuse incidents benefit from good quality information from police systems. And that all children affected are seen and spoken with so that their vulnerability is recorded, fully assessed and acted upon.

6. Assessment and help

The constabulary's assessment and referral process doesn't reflect the needs of safeguarding partners

The statutory guidance *Working together to safeguard children* (2018) states:

> Everyone who works with children has a responsibility for keeping them safe. No single practitioner can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.

Derby and Derbyshire Safeguarding Children Partnership has published a threshold document that describes four levels of children's need and the help they require. Practitioners are expected to use professional judgement when assessing children's vulnerability.

The constabulary supports the two multi-agency safeguarding hubs (MASHs) in its area: Derby City MASH and Derbyshire County Council's Starting Point. The risk and referral unit (RaRU) at the constabulary's headquarters manages safeguarding referrals, strategy meetings and child protection conferences, but we were told that the unit's workload had increased significantly since it was established in 2019. So staff and supervisors can't risk assess every public protection notice (PPN) that they receive.

Some RaRU staff told us they hadn't received formal training for their roles and must "learn on the job". The detective inspector in charge of the RaRU has created an online file with useful reference documents to support them.

It is good approach for the constabulary to ask its staff to complete PPNs for every child they have concerns about.

The police need to pass information to other professionals, but before doing so they should check whether there is relevant information in police records. This assessment is a triage to decide if a referral is necessary. The assessment also helps ensure the sharing of the information is proportionate and relevant to the welfare of a child.

However, the RaRU doesn't have an effective triage process to review all PPNs against the partnership's threshold criteria. There is no research and all the PPNs are forwarded directly to children's social care (CSC). This approach overloads the CSC assessment teams with low-level information about single incidents that will not be progressed.

It also means that the RaRU isn't researching police systems to understand the context of each PPN. Sometimes a new concern, coupled with previous information, might raise the child to a higher risk level that justifies a referral for early intervention or a statutory CSC assessment or child protection investigation. Senior children's safeguarding partners told us they were concerned with the way the constabulary sent them PPNs. They said it had a negative impact on their work.

The constabulary's referrals processes don't identify all risks to children

When referrals are received from other organisations, the RaRU will research police systems to determine the seriousness of the matter. It uses this research to decide the most appropriate team to progress the intervention or investigation, such as the child investigation team (CIT).

Staff use PPNs in the crime recording system to make referrals to CSC and other organisations. Staff in the RaRU receive all the constabulary's PPNs – on average 258 per week. If high-risk child protection concerns or high-risk domestic abuse are identified, RaRU supervisors hold strategy meetings with safeguarding partners promptly. CIT supervisors also hold strategy meetings for their investigations.

There are several types of PPN, but only the domestic abuse (DASH) PPN contains a risk assessment, which is for adult victims, rather than any children linked to the incident. RaRU staff only review high-risk DASH PPNs. This means that police do not risk assess the majority of PPNs with concerns about children before sending them to CSC.

The constabulary has improved its contribution to multi-agency child protection arrangements

At the time of our inspection there were approximately 1,400 children across Derbyshire who were subject to child protection plans. This meant about 18 child protection conferences were held each week. A team of six dedicated conference attenders have responsibility to attend and provide reports for initial and review conferences. In a few complex cases, investigating officers from the CIT will attend these meetings. This is a good use of a blended workforce. It allows the detectives to focus on investigation and increases the quality of police contributions to cases where children are in continuing need of protection.

Derbyshire County Council CSC recently commented favourably on this commitment.

Working practices have changed during the pandemic. Most multi-agency case discussions and strategy meetings are online. Staff record initial notes of decisions and actions from strategy discussions promptly. But we were told of delays. About 300 documents of detailed strategy meeting and case conference minutes are waiting to be attached to case records.

There needs to be clearer understanding of the police role in responding to domestic abuse crime

Senior officers are aware of some problems with the quality of service for families who are victims of domestic abuse. We were told that the constabulary was about to review its response to domestic abuse.

The constabulary monitors the impact of the COVID-19 pandemic on domestic abuse through a monthly report from the Safer Derbyshire Research and Information Team. This information helps it to understand vulnerability and risk within the community.

We saw that officers protect victims and progress investigations – often despite victims failing to answer officers' calls or withdrawing their complaints. Offenders are arrested when they should be, and in many cases officers check that children are 'safe and well'. But for too many children living with domestic abuse, there was inconsistent evidence of strategy meetings, joint visits, assessments and multi-agency planning.

The constabulary currently relies on front-line officers to decide the DASH risk level for domestic abuse victims and whether to complete PPNs for children. We saw that supervisors tended to confirm officers' assessments without reference to any other information. It means that many cases are assessed without the benefit of existing information. So a significant number of cases aren't risk assessed appropriately.

The police assessment of domestic abuse risk is vital to the timeliness and the level of service victims and their children receive from the safeguarding partnership. Inaccurate assessments reduce the opportunities for appropriate early interventions and are likely to lead to escalation of risk and harm.

Multi-agency risk management isn't fully effective

Some high-risk domestic abuse cases are referred to a multi-agency risk assessment conference (MARAC). But MARAC in Derbyshire isn't following the national SafeLives guidance by including all repeat victims of domestic abuse.[2] Because of this local policy, in January 2021 MARAC considered only 76 cases. If the constabulary followed the guidance, it would have considered 276 cases. There has been no analysis of the implications of this practice.

MARACs are held weekly, alternating between North and South divisions.

MARAC helps provide additional oversight and communication to a single agency's response to domestic abuse. This is an important function, but we saw less focus in the conference minutes and actions on developing co-ordinated multi-agency plans to understand risk and reduce harm.

The introduction of domestic abuse intervention management (DAIM) indicates support for victims, but this can be a long-term process. DAIM staff work with victims, social care, and independent domestic abuse advocates, including other family members and children, in their plans. The intention is to improve victim confidence and resilience to the effects of domestic abuse. A management review should confirm

[2] The SafeLives guidance definition is: "any instance of abuse between the same victim and perpetrator(s), within 12 months of the last referral to MARAC".

that DAIM terms of reference are appropriate to policing responsibilities. It may be more appropriate for other organisations to take on this work.

The children at risk of exploitation (CRE) units deal with cases of children at high risk of exploitation. Officers work with other organisations in both divisional areas to protect children and disrupt offenders who exploit children. The areas of responsibility include:

- safeguarding aspects of child criminal exploitation (CCE);
- children at risk from county lines criminality;
- unaccompanied asylum-seeking children;
- child victims of human trafficking and modern-day slavery; and
- high-risk victims of child sexual exploitation (CSE).

The teams and the organisations they work with attempt to understand the extent of the threat to children. There are well-established arrangements for referring and recording CSE. Recorded CSE crimes have increased in the past five years and analysis in Derbyshire predicts this will continue.

But understanding CCE levels is more difficult. Cases are more complex and can involve any crime type involving a child offender or victim where exploitation is identified. Officers told us that other organisations they worked with would refer children to them who were connected to criminality but without identifying the link to exploitation.

Awareness of CCE has increased significantly within law enforcement and partner organisations. The constabulary uses a risk-assessment toolkit to help officers and the organisations they work with to identify CCE. But we were told that this assessment tool wasn’t always consistent with the actual level of risk impacting on the child.

Case study: child vulnerable to sexual exploitation goes missing from local authority care

A 17-year-old girl living in supported accommodation was looked after by the local authority. She had a long history of CSE vulnerability and had been reported missing. A comprehensive trigger plan was in place.

She was located in another county in the company of a 33-year-old man. He had previously been served with a child abduction warning notice because he was seen as a threat to the girl.

Flags on the police system identified her vulnerability and the investigators contacted police in the other area to arrest the man. A social worker obtained an account of the incident from the girl. But the investigation record didn't show if a strategy meeting had been held or if there was a joint plan to engage and protect the girl. No PPN was completed.

It was noted that the case was discussed in a multi-agency meeting but no actions to address the risk resulted. The investigation stalled and was closed. The officer did not explain this decision to the victim.

Two weeks later the girl was reported missing again. This missing episode was graded as medium risk. The same offender took the girl to another force's area where he drugged and sexually assaulted her.

Risk assessment for missing children is inconsistent

Officers should hold prevention interviews with missing children when the children return home. But we saw the quality of these interviews was inconsistent because officers didn't always find ways to engage with a child, observe their demeanour or record their voice. Officers are missing opportunities to get intelligence and give children the environment and support to disclose abuse or crime. The local authority should do return to home interviews (RHIs) within 72 hours of a child's return.

There are significant delays in the RHIs being sent to the police. And these reports are sent in batches of 80 to 90 at a time – some, months after the missing incident. Police and safeguarding partners agreed a review of the process, and to evaluate the quality of the information within the RHIs. We were told that they only found three pieces of useful intelligence in a sample of 100 RHIs.

The timeliness of the RHI process has improved. But the records we saw had missed opportunities to gain useful information. This affects the constabulary's ability to understand the information about a child's vulnerability and use it to intervene and reduce risks.

The information should also inform trigger plans. Trigger plans help risk assessments for future missing levels. And they prompt swift action based on the child's previous history. But the constabulary isn't consistently using the information available to create and update trigger plans. It means that the response to a report of a missing child is

likely to be inefficient and ineffective, because staff aren't using existing information to accurately assess risk and then act accordingly.

The College of Policing publishes guidance on policing practice known as authorised professional practice (APP). We saw that for missing children incidents the constabulary wasn't always following APP. For example, trigger plans weren't always created, and high-risk missing incidents weren't always reviewed and directed by detective supervisors.

Case study: boy vulnerable to CSE goes missing from foster care

The foster parents of a 15-year-old boy who was vulnerable to CSE reported him missing. He had gone missing 48 times before.

The information about his vulnerability on police systems contradicted the assessed risk level. There was also a request for the South division safeguarding unit to be informed if he was reported missing. But there was no trigger plan to direct activity to find him.

The constabulary completed a risk assessment, but it wasn't endorsed by a supervisor. It took two and a half hours before an officer was assigned to locate the boy, who had returned home before he was found by police.

The report was closed without a prevention interview. So the constabulary missed an opportunity to obtain information and assess the child's vulnerability. A PPN was completed and sent to CSC, but the records weren't clear about whether any safeguarding plan was in place.

There are suitable facilities to assess and help child victims of sexual abuse

Derbyshire doesn't have its own sexual assault referral centre (SARC). But the constabulary has arrangements with other forces and providers. It mainly uses a SARC provided by the Queen's Medical Centre in Nottingham. This means a lengthy journey for some children, but the service provision is good.

The SARC doesn't provide a 24/7 service, but frontline officers and supervisors told us about how they assessed victims. Where appropriate they would use early evidence kits to obtain and preserve forensic evidence.

Victims can self-refer to the SARC. They can access a range of support services from the centres. Frontline officers and specialist investigators have a good understanding of how to contact and deploy intermediaries to help communication with vulnerable victims and witnesses.

Recommendations

- We recommend that Derbyshire Constabulary immediately reviews its arrangements and practices for incidents of missing children to align with the national standards within the College of Policing APP.
- We recommend that within three months Derbyshire Constabulary engages with its safeguarding partners and reviews its assessment and information-sharing practices to ensure that vulnerable children are identified at the earliest possible stage and referred without delay to the most appropriate level of support.
- We recommend that within six months Derbyshire Constabulary engages with its safeguarding partners and reviews the terms of reference and practices of all its multi-agency risk management meetings – including those for children at risk of exploitation or domestic abuse, and children missing from home.

7. Investigation

Dedicated child investigation teams are now in place

We saw a good initial response to child protection incidents, with frontline officers acting confidently to safeguard children and, in most cases, record concerns about child abuse or neglect. This meant police and children's social care (CSC) could discuss plans promptly and start multi-agency investigations without delay.

In February 2021 the constabulary reintroduced child investigation teams (CITs). Previously, vulnerability investigations were assigned to a pool of investigators within public protection unit (PPU) hubs, which have a wider area of investigative responsibility. But the constabulary recognised that this did not improve end results for children. This was partly because specialist child protection investigators were routinely diverted to other work such as dealing with domestic abuse offenders.

CITs are staffed with experienced and specialist trained staff, who have appropriate caseloads and receive good levels of welfare support. Staff confidence and morale is high, and we saw some good quality child abuse investigations.

Investigations are inconsistently supervised, leading to delays and poor end results for children

We saw cases where police officers inappropriately relied on CSC staff to progress investigations. For example, following allegations of assault, a strategy discussion decided that social workers should visit the family and child alone. Police investigators would only go out if additional information arose. But assaults are criminal offences, so the police should usually lead these investigations while CSC coordinates related enquiries.

Within the child abuse investigations, investigating officers often rely on voluntary attendance interviews rather than arresting the suspects. We also saw that officers would release suspects under investigation and ask CSC staff to obtain written agreements with suspects about their future contact with children. In some cases, police bail with conditions can provide extra protection for children. Better direction from supervisors would improve how investigators manage the risk posed by some perpetrators.

Supervisory reviews and investigation plans on some investigations are inconsistent. Some merely note previous entries, which doesn't drive investigations or safeguarding interventions. This, in turn, causes delays that can affect children's wellbeing.

Case study: assault investigation

A six-year-old boy alleged that he had been assaulted by his father. A strategy discussion took place and started a joint child protection investigation. After this timely initial investigative activity there was a delay of a month before the child was interviewed.

There was further investigative drift for three weeks, until the suspect was interviewed as a voluntary attender at a police station. There was no meaningful supervisory oversight for a further month.

At this point a new investigating officer took charge of the case. They then progressed appropriate lines of enquiry and the case file was sent to the Crown Prosecution Service.

There are inefficient arrangements for domestic abuse investigation

Derbyshire Constabulary has seen an increase in reported domestic abuse crime.

Officers from the PPUs investigate high-risk domestic abuse cases. Officers from the North and South divisions investigate medium and standard-risk cases. The neighbourhood safeguarding teams support some domestic abuse victims.

Despite the increasing demand from reported cases, the constabulary believes it has enough staff within its PPU to deal with the high-risk cases. At the time of our inspection we were told there were 16 vacancies within the PPU, out of 103 officers. This equates to 15.5 percent of the team.

Like many other forces, the constabulary has a general shortage of trained detectives. This skills and knowledge gap reduces the effectiveness of the investigative response for the more complex domestic abuse cases. If investigations are not progressed with understanding and skill, children's needs are more likely to be overlooked. This leaves children vulnerable.

But we were told of some good developing practice in the South division, where officers formulate a safety plan related to the home that benefits children too. The North division is considering this practice.

Officers who investigate medium and standard-risk domestic abuse crimes are less specialist and deal with a wider range of incident types. Any further increase in domestic abuse crime will create greater pressure on these officers. It is likely to adversely affect the quality of their investigations. The pressure of caseloads and inexperienced officers and supervisors mean that the constabulary will not always recognise escalating risk in repeat incidents assessed at lower levels of risk.

Case study: child with history of neglect calls 999

Several dropped 999 calls were made to the police. The operator called back. A female said, “It doesn’t matter,” before hanging up.

Immediate research indicated that a 16-year-old girl subject to a child protection plan for neglect lived at the address. The record said that CSC should be contacted because of concerns for domestic abuse and her mother’s misuse of alcohol.

Response officers attended promptly and completed a public protection notice (PPN). However, the only information gathered about the child was, “She was clear she didn’t want to stay at the address.” Police agreed with CSC that the girl could be taken to stay with her grandmother.

There were numerous police records of incidents between the mother and child, including two domestic abuse incidents in the previous three months.

In the first of these, the drunk mother assaulted the child after an argument, causing a scratched and reddened cheek. The child responded by slapping her mother. Police and CSC jointly started an investigation but closed it as further action was not in the public interest.

The second was an allegation that the girl, at that time subject to a child protection plan, had been hit in the face by her mother, who was drunk. This allegation was also dealt with without a comprehensive police investigation. The records showed the multi-agency assessment as, “The problem is mum’s generic parenting rather than a specific incident.”

Officers and supervisors treated the 999 calls’ incident in isolation. They didn’t understand that they needed to investigate further to understand why the child was vulnerable and why she had repeatedly called the police, or the possibility of escalating risks to the child’s safety.

Leaders are working to improve the quality of domestic abuse investigations

To focus on domestic abuse, senior leaders instigated an Achieving Excellence in Investigations board. The constabulary audits domestic abuse case records. It uses the findings in feedback to improve knowledge and practice for all investigators involved in domestic abuse and stalking and harassment cases. This is positive but the audits would be improved by including questions about safeguarding interventions, the quality of PPNs and how well officers seek and record the voice of the child.

The programme is aimed at developing officers’ skills and promoting opportunities in the evidence-led investigative approach. The benefit of this approach for both vulnerable adults and children is they are less likely to be asked to give evidence at court in person.

A Domestic Abuse Best Practices Group links police with partners from the Crown Prosecution Service and courts. They work together to identify improvement opportunities to support victims and achieve better end results within the criminal justice system.

The constabulary's capability and capacity to investigate domestic abuse crime is at its limit. And, nationally, reported cases of domestic abuse are increasing. Officers are committed and working hard in their various teams. We were told that senior managers were reviewing their arrangements. This is timely. Some of the processes, such as MARAC and PPN referral thresholds, are currently reducing the number of cases being fully assessed by the constabulary.

The constabulary's arrangements and practices to investigate child exploitation are disparate

The children at risk of exploitation (CRE) unit investigates offences and implements safeguarding measures for high-risk child sexual abuse (CSE) and child exploitation (CE) cases. For CSE there are well-established referral and partnership arrangements. This is in part because CSE has a clear group of defined offences and therefore can be more easily identified and understood. Records of CSE offences are increasing and this trend is expected to continue.

Understanding criminal exploitation demand is more difficult. It can be any crime involving a child offender or victim where exploitation is identified. The team often relies on responding officers recognising exploitation and making referrals. Some risks to children will not always be initially recognised. The CRE unit is now managing more children at high risk of exploitation than children at high risk of sexual exploitation.

The CRE unit doesn't have enough staff for the level of workload. This is because of staff vacancies and increases in demand. The constabulary is aware that the unit lacks qualified detectives. It plans to recruit and train additional officers.

Medium levels of CSE risk and crime are dealt with by various investigation officers dependant on the type of crime. But the safeguarding activity for these children is the responsibility of divisional safeguarding hubs. So several officers from different teams will be involved with a vulnerable child. There will also be different approaches for children depending upon where they live and the type of crime affecting them. This situation will be further complicated if the child's risk assessment grading changes. Vulnerable children are unlikely to benefit from this inconsistent approach.

We were told about proactive investigative successes in identifying and disrupting county lines in Derbyshire. The county lines teams use intervention tactics to divert and interrupt criminality involving children. The detective inspectors share practice locally to help ensure a consistent response and service. But we were told the two county lines teams had different operating practices, and this was further complicated by different partnership arrangements. This is confusing and is likely to lead to an inconsistent service.

Case study: girl at risk of CSE goes missing

A 15-year-old girl at risk from CSE was frequently reported as missing and often found in the company of adult males who were suspected of sexually exploiting her. She was also known to have shared indecent images online. Her mother was concerned her daughter was being sexually exploited.

Despite this, the girl was assessed to be at medium risk of CSE.

There were flags and vulnerability markers on the police system, and a trigger plan, but this was not visible to all frontline officers. The police records were unclear, lacking details of any work with other organisations or action to safeguard the child and disrupt the perpetrators.

Officers found the missing girl partially clothed in bed with an adult male. He was arrested and she was taken into police protection.

CSC were contacted. Even though the child was in police protection there were delays in holding a strategy meeting.

The officers didn't initially secure the room as a crime scene or seize clothing and bedding as forensic exhibits. Items were later seized but remained unexamined for several months.

The child's risk level for CSE was subsequently raised to high.

There is little evidence of working effectively with other organisations

In other parts of the country, children's safeguarding partnerships respond to vulnerable children and disrupt offenders using multi-agency operational teams. We saw little of this type of working in Derbyshire.

We saw little evidence of joint investigations with CSC or other safeguarding practitioners. There were few records of joint visits to children and families in the cases we reviewed. Safeguarding activity isn't always evident or well recorded. So important information, such as strategy meeting decisions that should be central to protective planning, isn't readily available to all staff.

When officers identified serious offences early on, we saw that investigations were mostly started without delay. And in some cases, officers went online and obtained useful information about potential suspects. But in other investigations this information wasn't accessed in a timely way, even though the constabulary knew about a child's vulnerability or the risks from perpetrators.

Poor supervision of CSE investigations means children are left at risk

In some CSE investigations, there are records of regular and meaningful supervisory direction. But in other cases, the supervision isn't good enough and investigations can drift. So risks are not assessed and dealt with.

In some investigations, supervisors don't direct or escalate activity needed to protect children. For example, in one case the suspects weren't arrested in a timely way. And they weren't circulated as 'wanted' on the constabulary's systems or the police national computer (PNC) for several months. So even though they came into contact with the police, they remained at large and a risk to the victim and other children.

We saw that there weren't processes to ensure that staff consistently flagged CSE/CE vulnerability and risk on police systems. Incomplete and inaccurate information can lead to inappropriate levels of response. And it impedes the initial investigations in exploitation crimes against children.

We also saw that supervisors of CSE cases weren't checking that officers recorded the circumstances and demeanour of children using voice of the child forms. Three of the forms we saw attached to investigations represented a moment in time, rather than assessing the whole case including the child's views. So subsequent intervention planning wasn't focused enough on providing the best end results, taking account of the child's wishes.

The online investigative team have unsustainable workloads

The constabulary has recognised the threat of online crime to children. It has a case backlog in this area and investigative demand is rising. To deal with this it is planning very soon to increase the numbers of officers on the police online investigation team (POLIT). This will include an additional supervisor.

The constabulary has written a new operating procedure for the POLIT. It sets out its terms of reference, but neither the terms of reference nor the strategic intent specify that the team's main objective is the identification of risk and safeguarding of children.

We saw excessive caseloads within the POLIT, which meant the supervisor and the intelligence development officer had unsustainable workloads. There were 44 cases in intelligence development and 93 cases awaiting allocation for investigation. Urgent change to the system is required so that the constabulary can act in a timely way to reduce harm to children.

The POLIT responds to high and very-high-risk cases in a timely fashion, ensuring safeguarding of identified children. This is not the case for medium and low-risk cases.

POLIT officers are unclear about their primary role

POLIT staff don't see themselves as child protection officers. They see their primary role as the identification of offenders that are a risk to children, rather than identifying children who are at risk and acting effectively to safeguard them.

Most POLIT staff are detectives but they aren't specifically child protection trained. They told us they didn't receive continuing professional development to improve knowledge and practice. These officers would benefit from training that focuses on recognition of vulnerability and multi-agency safeguarding practices. We saw that in many online investigations officers didn't record or consider the voice of the child. So the investigative focus was not on the best end results for children.

There are too many delays before officers act to safeguard children

The constabulary isn't consistently using and expediting the intelligence from law enforcement organisations and systems such as the National Crime Agency (NCA), Child Protection Systems (CPSys) and Child Online Protective Services (COPS) to identify children needing safeguarding.

The POLIT doesn't engage early enough with other organisations to share information and agree an approach to safeguarding children identified in its investigations. PPNs are not submitted until after offenders are arrested.

The KIRAT risk assessment is only completed at the end of the intelligence development process. But in many cases, risks to children are known at an earlier stage. The current process is too rigid and the risk to children should be continually assessed.

Even in these cases, we saw that medium and low-risk cases were not acted on within risk assessment timeframes. So numerous children are not safeguarded as soon as they could be. These cases are not effectively prioritised or escalated.

In an effort to clear POLIT backlogs, the constabulary initiated Operation Lombard. This brought in additional resources to move cases forward. It reduced some of the immediate pressure on the POLIT. But it emphasised the high numbers of children whose safeguarding was significantly delayed.

When the constabulary reviewed Operation Lombard, it found safeguarding delays for 111 children. We saw that some of these children still had not been safeguarded.

Case study: children living with a suspected sex offender

The POLIT received intelligence that an internet user had downloaded and was offering to send out images of child sexual abuse to other internet users.

Intelligence checks quickly identified that three children aged between 10 and 16 lived at the suspect's address. The case was risk assessed as medium risk. The constabulary knew about the three children at a very early stage in this investigation. But 14 weeks later – at the time of our inspection – it had not safeguarded them.

It had not submitted a PPN or made a referral to CSC. There was no recognition on the case record that these children needed safeguarding. The case was being progressed under Operation Lombard. It was not a child-centred investigation and children were left at risk of significant harm.

We referred this case, along with other Operation Lombard cases, back to the constabulary so it could reassure itself that appropriate action had been taken to safeguard the children.

Case study: intelligence about a suspected sex offender includes details of children potentially at risk

In February 2020 the POLIT received intelligence about an address where indecent images of a young male child being sexually abused were accessed. Officers quickly identified a suspect. They found that children lived at the premises. The risk was graded as medium.

The constabulary took no safeguarding action. A supervisory review several weeks later noted, "It [the investigation] will not be enforced for a few months due to the backlog and the fact that we have a large amount of medium risk enforcements ahead of this in priority." There was no recognition that children might be at risk of significant harm and needed safeguarding.

The case was assigned to Operation Lombard. In February 2021 officers abandoned their first attempt to progress the investigation. At the point we saw the case, 15 months had passed without safeguarding action or a referral to CSC.

An additional concern was that the initial intelligence also contained details of a named 15-year-old child located in mainland Europe. The intelligence included her date of birth, Facebook details and IP address. The constabulary did not recognise the risk to this child. And they did not share the intelligence with international law enforcement partners so they could safeguard her.

The constabulary supports investigations by investing in specialist digital forensic systems

The constabulary collaborates with its partners in the East Midlands Special Operations Unit to examine digital devices in-house, reducing delays and outsourcing costs.

The digital forensic unit (DFU) and POLIT have a desktop link to view images from the national child abuse image database (CAID). This can improve efficiency when investigating NCA referrals to identify victims at an earlier stage.

POLIT investigators use forensic triage equipment to ensure relevant devices are submitted for examination. This helps to identify any new indecent images and children who are at risk.

But we saw inconsistency in the use of CAID. For example, the constabulary did not use victim identification tools such as facial and crime scene identification to assist future investigations. And only the specialist departments were adding the details of victims identified in the seized images to CAID. This practice should include victims identified in all investigations. When images of those victims are subsequently seized in other investigations, investigators nationally and internationally will know that those children have been identified by local police and are safe.

The POLIT and DFU work together effectively, meeting regularly to assess cases and agree prioritisation. There are no significant delays within the DFU for computer examinations. But they are not examining mobile devices as quickly as they have agreed, although we were told that the DFU was flexible and prioritised urgent cases. Projected increases in demand from online sexual crime will affect DFU capacity. So its caseload needs to be monitored to maintain the current good level of service.

Specialist equipment that reduces the time taken to examine files on mobile phones is available to officers in three locations. Examination of mobile devices now takes days rather than weeks. The constabulary is also considering other innovative solutions to quickly extract evidence from victims' mobile devices. Victims are reluctant to hand over mobile phones, even for short periods of time, so these developments support better end results for children.

The constabulary is mindful of its responsibility for the wellbeing of staff in these specialist units. It is piloting an artificial intelligence grading tool. This will reduce the need for officers to repeatedly grade indecent images. All staff in these specialist units receive appropriate levels of psychological and wellbeing support.

There is an inconsistent approach to online sexual abuse between children and young people

Officers investigating cases of online child sexual abuse outside the POLIT aren't always considering the benefits of seizing devices for examination. And we saw an example of a device being seized but not examined, and then returned with the content still on it. The impact on children and their carers, who might be expected to remove the images themselves, is not understood or considered.

Where a prosecution is unlikely, the constabulary has not yet developed a clear process to examine and remove images from devices belonging to children in a timely manner. So victims and their families may retain and potentially share those images again. The constabulary needs to reinforce to all its staff that devices containing indecent images should not be returned to victims or handed to others.

When children share indecent images of themselves or others, investigators and their supervisors are often failing to recognise aggravating features or harmful sexual behaviour. So they don't differentiate child victims and offenders.

It is right that the constabulary doesn't want to unnecessarily criminalise children. But predetermined approaches are likely to result in an ineffective investigation. For example, devices might not be seized and examined; witnesses and suspects not interviewed; and the voice of the child might not be fully understood.

Case study: investigation of an indecent video made by a child

A mother received a copy of a video containing indecent images of her 13-year-old daughter from another parent. The girl had made the video herself and shared it with her 14-year-old boyfriend. They had argued and he then shared the video with his friends.

An ineffective investigation followed. There was no record of the impact on the victim or her wishes. The officer didn't seize any phones as evidence or for forensic examination or to remove the images. The details of the other parent were not obtained, nor those of any children with copies of the video.

The victim was a vulnerable child and subject to an existing child protection plan for emotional abuse. The officer submitted a PPN but there was no strategy meeting with CSC.

The supervision of this investigation was ineffective. The officer tried to close the case without making enquiries, but the victim's mother complained.

It took over two months to speak to the boy who had distributed the video. He denied sharing the video and then he was dealt with as a witness rather than a suspect. His account wasn't challenged.

Two other children were identified: a 12-year-old girl admitted sharing the video; and another named a 12-year-old boy, who was never spoken to.

The video wasn't deleted, and neither was it uploaded on to CAID to assist future investigations. A PPN was not completed for the other children involved.

Recommendations

- We recommend that Derbyshire Constabulary immediately improves child protection investigations by ensuring that:
  - investigations are effectively supervised, with reviews clearly recording any further work that is required;
  - safeguarding referrals are timely and comprehensive;
  - joint multi-agency investigations are appropriately supported;
  - investigations are assigned to officers with the skills, capacity and competence to progress them effectively; and
  - the quality of practice is regularly audited, including the effectiveness of safeguarding measures and a focus on achieving the best end results for children.
- We recommend that within three months Derbyshire Constabulary reviews its policy and practice for responding to incidents where indecent images of children are present on digital devices. This should include:
  - issuing guidance to all operational staff;
  - providing technical support to identify and remove files;
  - supporting children and families;
  - appropriate responses to child offenders; and
  - effective supervisory oversight.

8. Decision making

The use of police protection powers was appropriate in all the cases we audited but record keeping was often poor

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

In the cases we examined, decisions to take a child to a place of safety were well considered and in the best interests of the child. When we spoke with children's social care (CSC) managers and the independent scrutineer for the Safeguarding Children Partnership, they said they considered that police officers used these powers appropriately.

Although we saw cases where officers made enquiries to safeguard children promptly and effectively, there wasn't always a full record of it on police systems. There weren't always details of strategy discussions with CSC, including agreed actions to safeguard and promote the welfare of the child. The power of police protection has a maximum time limit of 72 hours and a record should be made when it ends. However, when the power was rescinded before the maximum time had elapsed (such as when a child was passed to the care of a family member) these details were rarely entered. Nor were there any details of what the longer-term protective plan was likely to be.

The records we saw of children in police protection showed that it was frequently some hours before designated officers reviewed the use of the power and the necessity for it to remain in place. This means that the constabulary is insufficiently reviewing the welfare of children against the proportionality and necessity of continued use of the power. A positive recent development is a daily morning check of police protection cases by supervisors from the child investigation team. This is intended to improve oversight and ensure consistent recording of information and decisions about children's welfare.

Some children are still being taken to police stations while in police protection

The lack of oversight can mean that the constabulary does not challenge CSC to urgently accommodate a child somewhere more appropriate than a police station. Statutory and professional guidance states that a child should only be taken to a police station as a place of safety in exceptional circumstances. Frontline officers told us that they would consider taking children to buildings with specialist interview suites as these are a more suitable place for children to wait for CSC accommodation.

Case study: child under police protection

Officers arrested a 13-year-old girl at her home after she assaulted her mother. The girl was well known to police and CSC, and the arrest was proportionate in the circumstances. But her mother and family were reluctant to support a prosecution and, after six hours in police detention, the girl was released under investigation.

However, the girl didn't want to return to her family and threatened to self-harm. She was placed under police protection and officers liaised with CSC. The girl remained at the police station for a further ten hours until a foster placement was arranged. Afterwards, police protection continued for three days and at the end of the power CSC decided to return the child to live with her family.

This child spent 16 hours at a police station. The police records were not updated with information explaining the child's situation and the delay in finding her an appropriate place of safety. The end of the use of police powers wasn't sanctioned and appeared to have ended by default after three days when the child was returned home.

Recommendation

We recommend that within six months Derbyshire Constabulary engages with its safeguarding partners and reviews guidance to improve practices for when children are taken into police protection to:

- reduce the time before children are found appropriate accommodation;
- consistently record relevant information and decisions; and
- regularly review and endorse the use of protective powers.

9. Trusted adult

Approximately 160,000 children live in Derbyshire. The constabulary has developed a plan for engaging with children in collaboration with the Derby and Derbyshire Safeguarding Children Partnership (DDSCP). This joint plan has the following aims:

- proactively seek out the views of children and their families; and
- ensure the individual and collective voice of children in decision-making, planning and review processes across the partnership to help drive forward how the organisations work together to keep children safe from abuse and neglect.

It is important that children can trust the police. We saw that in some child protection cases, officers considered carefully how best to approach a child and the parents or carers. Officers also explore the most effective ways to communicate with them. Such sensitivity builds confidence and creates stronger relationships between the child, the parents or carers and the police. We found that the constabulary worked well with CSC to protect children when they needed immediate safeguarding.

The constabulary works closely with other organisations to engage with children

We saw examples of how the police worked with other organisations to keep children safer in Derbyshire. I-Vengers is a programme funded by the police and crime commissioner, and Derbyshire County Council that engages with children and the adults who support them to make their online and digital experiences safer.

Most of the constabulary's work to engage with children is collaborative and supports the activities of the DDSCP. This includes projects to deal with cyber-bullying and support young people's mental health.

Contact with schools is a generic responsibility within the two divisions' safer neighbourhood teams. The constabulary doesn't assign officers as dedicated schools liaison officers to serve the needs of over 400 schools in its area.

There is clearly a demand from schools for police information about children's vulnerability, as we saw in the widespread adoption of the Stopping Domestic Abuse Together (SDAT) notifications for children affected by domestic abuse. This information gives school staff a better understanding of how to support children. It also can provide context to other concerns and encourage schools to refer children at an earlier stage. There are opportunities to engage further with schools. The constabulary could quality assure the SDAT process. And it could consider including other indicators of childhood vulnerability such as missing episodes.

10. Managing those posing a risk to children

There are good multi-agency partnership arrangements, but risks from practice change may reduce safeguarding effectiveness.

Derbyshire Constabulary works with its statutory partners to support multi-agency public protection arrangements (MAPPA). It has teams of specialist staff that manage sex offenders and violent offenders (MOSOVO).

The two MOSOVO teams are divisionally based with the team that administers the Violent and Sex Offender Register (ViSOR). They are located within the constabulary headquarters. But the ViSOR administration team is burdened by antiquated practices and additional administrative layers that lead to duplication.

These teams work closely with the MAPPA manager to coordinate the agendas and ensure actions are completed. There are effective arrangements to identify risks to children and assign responsibility to the most appropriate agency.

All appropriate organisations are invited to MAPPA meetings. But we saw there were difficulties in getting all partner organisations to attend MAPPA meetings.

The strategic management board (SMB) meetings are chaired appropriately by an assistant chief constable. But we saw that MAPPA Level 3 meetings were being chaired by the MAPPA manager – rather than a senior police or national probation service (NPS) officer. The COVID-19 pandemic response means that MAPPA meetings are held online. The constabulary should ensure that its contribution remains at a senior level.

SMB performance indicators show that not all organisations are regularly attending MAPPA meetings. The restructuring of the NPS during the summer of 2021 means that its boundaries will no longer be aligned to police areas. There is also a significant backlog in NPS-led offender assessments. So the probation service is making fewer home visits to offenders. This reduces the effectiveness of joint police and NPS registered sex offender management. Leaders need to assure themselves that despite problems with the organisations working together, risk to children is still appropriately managed.

MOSOVO staff are innovating to improve risk assessment and offender management

The constabulary is developing its information systems and using the Power BI tool to convert data and intelligence into a format that is more accessible to its staff. This is being used to map MOSOVO offenders geographically and provide information about them to frontline staff. The system is new and still under development so not all offenders are included. And not all staff are trained so they don't have complete understanding of what is available to them. But those who have started using the tool are enthusiastic and believe it provides good quality information to help them deal more effectively with those who are a threat to children.

The constabulary has invested in technology called E-Safe that helps offender managers to remotely monitor registered sex offenders' electronic devices. All MOSOVO staff are trained. They are beginning to use the system proactively to deter inappropriate browsing. It also allows offender managers to review an offender's online activity during monitoring visits.

The MOSOVO unit is aware of the potential benefits and efficiencies that polygraph testing of registered sex offenders can bring to offender management. It is working with other police forces and law enforcement organisations to pilot this technology and understand whether routine use will improve the effectiveness of its offender management practices.

There are good staffing levels but not enough supervisors

The numbers of sex offenders within Derbyshire continues to rise, in line with the national increase. It is anticipated that demand for policing of sex offenders will continue to rise over the next four years. Currently the constabulary looks at demand in terms of overall numbers, rather than risk and threat. It is developing other ways of understanding demand that will be based on analysis of supervisor oversight, unallocated offenders and offender compliance.

Although case numbers are increasing, currently MOSOVO staff have manageable workloads for registered sex offenders, with officer to offender ratios aligned to national guidance. But there aren't enough fully trained supervisors to direct, check and quality assure the team's caseload. There are approximately 400 cases with unsupervised risk management plans (RMPs). This is excessive.

The supervisors are aware of the need to focus on safeguarding children. They have instructed their staff to submit public protection notices to engage children's social care (CSC). Where appropriate, offender managers are advised to disclose an offender's risk to families and carers so they can protect their children. But delays in supervision can delay safeguarding activity. So children may remain at risk for longer than necessary.

Any unallocated cases arising from increased offender registration will add further demands on supervisors. Currently, the detective sergeants don't have capacity for the routine volume of work, and cases we saw lacked supervisory oversight. There is little opportunity to quality assure the teams' outputs.

The constabulary recognises this weakness and is assigning a full-time detective inspector (DI) to enhance MOSOVO supervision. This is a positive step, but it is vital that the dedicated DI is appropriately trained for this specialist role. Previously this wasn't the case.

The constabulary has a mixed workforce of police officers and police staff for offender management services. The constabulary is recruiting more staff and a police staff supervisor so it can more effectively manage violent offenders.

To reduce supervisory demand, the constabulary has a policy to delegate the approval of all RMPs for low-risk offenders to administrative staff in the ViSOR team. So there isn't routine supervisory oversight of the risk management of this group of offenders.

Case study: managing a registered sex offender

A registered sex offender assessed as low risk, with a conviction for sexual activity with a child, was not visited for 20 months. In a phone call visit [COVID-19 policy] the registered sex offender told the officer that his new friend had a three-year-old child. The officer completed a new RMP but made no record of concern about the registered sex offender's access to the child, and the risk assessment remained at low.

The following week the registered sex offender was again contacted. He stated he hadn't disclosed to his friend. The officer contacted him again a week later and the registered sex offender claimed that he had made the disclosure.

The next day the officer visited the friend in person and was told that no disclosure had been made. The officer made an official disclosure. The friend indicated that she would still see the registered sex offender and said that he hadn't had unsupervised contact with her child. But a second family child who joined them at weekends while the registered sex offender was present was mentioned for the first time.

The officer made a referral about the offender's risk to CSC, but the case was closed. A month later the officer queried the decision and agreed they should make a joint visit to the family.

But CSC visited as a single agency and told police that the family had signed a written agreement about supervising the children when the registered sex offender was present.

In this case there was no effective supervision in place to oversee the appropriateness of the RMP. It meant action to safeguard children was delayed because the registered sex offender was wrongly trusted to complete a self-disclosure to the family and CSC was not informed early enough.

Better risk assessment processes are needed

The reactive management process adheres to national guidance. Each offender should have a personalised RMP to reduce the risk they pose to the public. This allows police to actively manage those offenders who pose the greatest risk while providing a proportionate approach to offenders who are consistently assessed to be at low risk of re-offending. We saw that all the cases were authorised by a DI using a checklist.

But there isn’t a comprehensive and reliable process for completing the reactive management reviews. MOSOVO officers rely almost completely on the constabulary’s own information systems to alert them to any new concerns about these registered sex offenders. This is unsafe as it limits alerts to information held solely by the constabulary and doesn’t identify concerns arising elsewhere. We were told that MOSOVO staff didn’t routinely check national intelligence systems such as the police national computer (PNC) and police national data base (PND).

In response to the COVID-19 pandemic, the constabulary revised its practice for registered sex offender visits. Medium and low-risk offenders are now contacted by telephone instead of being visited, unless there is a specific requirement for officers to visit the address in person (such as to check a new concern or to examine the registered sex offender’s electronic devices). Officers are continuing to visit high-risk offenders in person.

This practice remains in place. Although there is clearly justification for a balanced approach, some registered sex offenders have not been seen in person for too long. There is now a significant gap in the constabulary’s understanding of the current risk posed by some registered sex offenders. But the constabulary has not identified this as a problem or reviewed its practice.

Changes in practice caused by the pandemic also mean that notification requirements for registered sex offenders are mostly completed by telephone or email. This doesn’t comply with legislation, which states that notifications must be completed in person at a prescribed police station. This situation should be put right as soon as possible. Otherwise there may be evidential difficulties if an offender commits a breach offence.

Case study: managing a high-risk sex offender

A registered sex offender convicted of distributing indecent images was visited by officers. They found that he was breaching a sexual harm prevention order by using private browsing and not retaining his search history on his mobile phone. They seized the phone for forensic examination.

The registered sex offender's risk level was raised to high, but the offender manager failed to record the rationale determining the change in risk or any details of their visit on ViSOR. This meant there was not enough information on the system to help others to understand the registered sex offender's risk assessment.

Subsequently the registered sex offender told the offender manager that he had a new device. We saw a record of a further home visit within a new RMP. But this plan was completed outside the approved professional practice. It was confused and difficult to understand.

The registered sex offender was required to complete an annual notification by attending a prescribed police station. But he was told by the offender manager that due to COVID-19 policy he shouldn't attend in person but should send them an email instead.

This MOSOVO practice was below the national standards and the notification requirement didn't comply with the law. Therefore this high-risk registered sex offender was not under effective management.

Recommendations

- We recommend that Derbyshire Constabulary immediately reviews its MOSOVO arrangements and practices to ensure that the risk from offenders in the community is effectively managed.
- We recommend that within three months Derbyshire Constabulary engages with its safeguarding partners (local authority CSC and the National Probation Service) to develop the effectiveness of multi-agency operational activity to protect children at risk from registered sex offenders.

11. Police detention

Custody suite staff don't fully understand their role in safeguarding vulnerable children

Many children suspected of committing criminal offences have complex needs. They are likely to be vulnerable and in need of safeguarding support. The constabulary has acted to reduce the numbers of children arrested and brought into police detention.

But it has yet to achieve a comprehensive approach that prioritises safeguarding and a child's welfare throughout the detention process.

Custody staff told us that they didn't have training days within their shift patterns. They hadn't received training about responding to vulnerability or specifically on the voice of the child. The only formal training in place was yearly authorised professional practice re-accreditation for the custody role. This didn't contain any child protection training. They had seen some information on the intranet about safeguarding and vulnerability, but they didn't see this as important training.

Health care professionals (HCPs) are continually present when custody centres are open. They usually see children without delay and enter information about the child's health and wellbeing directly on to custody records to inform risk management.

Custody staff don't take responsibility for submitting public protection notices (PPNs). If any safeguarding concerns are raised while a child is in custody, they rely on the investigating officers to make a referral to children's social care (CSC) on a PPN.

This was evident in cases we saw where a child's vulnerability while they were in custody was seen by staff, but no referrals were made. For example, a child was detained for over 36 hours and the HCP recorded concerns about self-harm and mental health on the child's custody record. But no one then referred the child to CSC.

Inspectors speak with detained children and complete reviews of the need for continued detention in person. But these reviews don't always fully balance the requirements of the investigative activity against the effects on the child's welfare.

There is inconsistency in the support available for children in police detention

Staff from liaison and diversion (L&D) teams work within both the constabulary's custody suites. But their operational practices are different, and these staff are less available in the North suite than the South suite.

L&D staff include mental health practitioners. They will liaise directly with CSC, other services, and the youth offending service (YOS) to provide mental health support for children. But L&D teams don't see every child, particularly at weekends or at night. This means there isn't always liaison between an L&D team and investigating officers to consider alternative disposals for children before decisions are taken to charge or deny bail.

Appropriate adults who support and advocate for children while they are in police detention respond quickly and achieve their target attendance time of 1-hour for 92 percent of calls. But we saw delays in the custody staff contacting this service. This means that in 45 percent of cases, they are missing the 2-hour target time from the detention of a child to providing appropriate adult support. These delays mean some children are being detained for several hours without the appropriate level of support.

The constabulary gathers data on children in police detention and it monitors any children held in custody overnight in its daily audits. But we found a lack of oversight or performance information about how children were treated while in custody. Or about how those children who were arrested progressed through the criminal justice system.

Custody staff have a peer audit process. Apart from a question about the timeliness of the arrival of appropriate adults, we noted that the audit templates didn't ask about the quality of service provision for children. This is a missed opportunity.

The constabulary hasn't developed a clear plan with criminal justice partners to routinely consider alternative case disposals and agree a framework to divert children from the criminal justice system. We were told that the constabulary had reviewed its youth offending services referral process and was planning to improve its effectiveness and levels of staff awareness.

There is a lack of understanding of the thresholds and requirement to seek alternative accommodation

Neither of the local authorities in Derbyshire has secure accommodation for children, so they commission it from specialist providers. We were told that sometimes this meant children were sent as far away as Scotland.

Not all children charged with serious offences need secure accommodation. In most cases, other alternative accommodation is more appropriate for the child's vulnerability and risk. If a child is charged with an offence, the police must decide whether to release them on bail or to detain them until their first court appearance. This decision should be based on the risk a child poses to themselves or others. It should not be based on the seriousness of the offence they are charged with.

Officers don't understand the high threshold for refusing bail to children after charge. We saw cases where the threshold for remand in custody wasn't met, and conditional bail would have been more appropriate. These children were bailed (to their home address) at the first court appearance.

The children in the cases we saw were justifiably under arrest and in police detention while police investigated allegations of serious crime. In most of these cases it should have been obvious at the start of the child's detention that the case should have been referred to the local authority. This referral would ensure the local authority knew about the situation and could start discussing how the child would be looked after and kept safe at the end of the investigation.

But generally, despite children being in detention for many hours, the constabulary do not contact the local authority until decisions to charge the child are made. So it is difficult for the local authority to provide either secure or other appropriate accommodation for children charged with serious offences. We saw several cases where children who had remained in police detention were granted conditional bail at their first court appearance, with local authorities agreeing suitable accommodation.

Case study: child detained by police

A 14-year-old boy was arrested and charged with robbery over a weekend.

The arrest was necessary and proportionate. An appropriate adult supported the child through all the procedures. The boy was seen by a nurse and a youth engagement officer. Both made detailed notes of their observations and plans on the detention log. The welfare of the child was supported and he was given clean clothes and refreshments, and detention was regularly reviewed.

In this case, the investigating officer and custody officer did consider the likelihood of the child requiring local authority accommodation at an early stage. But a lack of mutual understanding about the thresholds and the purpose of secure accommodation between the organisations meant the local authority didn't provide an alternative to continued police detention.

The child was kept in police detention for over 68 hours. The court remanded the child into local authority secure accommodation, which the youth offending service provided without delay.

The constabulary and its partners meet regularly to discuss how to improve and develop working together on criminal justice matters. But officers told us that although the custody concordat was included in discussions, there wasn't a clear understanding between police and local authority staff of their responsibilities towards children in police detention. The problem hasn't been escalated well enough for senior leaders to resolve and it isn't recorded within the safeguarding partnership's risk register.

Recommendation

We recommend that Derbyshire Constabulary engages with its safeguarding partners and reviews the effectiveness of arrangements for children in police detention.

Conclusion

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

During the inspection we held daily meetings with senior officers and provided feedback from our initial findings. This provides opportunities for the constabulary to act to rectify any immediate unaddressed risks and to start considering changes to practice. An example in this inspection was that the control room stopped using 'no apparent risk' as a category for missing children.

Derbyshire Constabulary should continue to review its child protection arrangements and practices to ensure that they are all effectively focused on improving outcomes for vulnerable children. There should be a clear structure in place for oversight and responsibility for all aspects of the constabulary's child protection activity.

Leaders would benefit from regularly updated intelligence profiles of risk and vulnerability, and qualitative data that shows the results of their interventions and the end results for children.

Our inspection found that the officers and staff who manage demanding child abuse investigations are committed and dedicated. But we have concerns about some aspects of their knowledge and understanding of what makes child protection practice effective:

- the assessment of children's vulnerability;
- communicating with children and understanding their concerns;
- the consistency of decision-making in responding to children at risk;
- the importance of working together effectively to secure safe outcomes for children;
- the quality of planning and recording safeguarding activity;
- the current processes for referring child protection concerns to the local authority;
- the quality of investigations and appreciation of escalating risk;
- the prevention of further harm by removal of indecent images from devices;
- meaningful supervision that drives best practice; and
- learning from case audits of recent practice.

We were encouraged to note that the constabulary was planning to increase the numbers of detectives and specially trained officers so that more technical and complex investigations are serviced appropriately.

Although the constabulary contributes to multi-agency child protection arrangements, more can be done to develop closer operational multi-agency work. We saw too many examples of missed opportunities for the constabulary to work with other organisations to secure safe outcomes for children.

We have therefore made recommendations that will help improve outcomes for children if the constabulary acts on them.

Next steps

Within six weeks of the publication of this report, the force should provide an action plan. The plan should set out how it intends to respond to our other recommendations.

Subject to the update and action plan received, we will revisit Derbyshire Constabulary no later than six months after the publication of this report. We will assess how it is managing the implementation of all the recommendations.

Recommendations

Immediately

We recommend that Derbyshire Constabulary immediately improves how its leaders and managers promote the responsibility of safeguarding children to all sections of its workforce.

We recommend that Derbyshire Constabulary immediately reviews its missing persons arrangements and practices to ensure that throughout the missing incident there is always an effective response to vulnerable children.

We recommend that Derbyshire Constabulary immediately reviews its arrangements and practices for incidents of missing children to align with the national standards within the College of Policing authorised professional practice.

We recommend that Derbyshire Constabulary immediately reviews its arrangements and practices to ensure that officers responding to domestic abuse incidents benefit from good quality information from police systems. And, that all children affected are seen and spoken with so that their vulnerability is recorded, fully assessed and acted upon.

We recommend that Derbyshire Constabulary immediately improves child protection investigations by ensuring that:

- investigations are effectively supervised, with reviews clearly recording any further work that is required;
- safeguarding referrals are timely and comprehensive;
- joint multi-agency investigations are appropriately supported;
- investigations are assigned to officers with the skills, capacity and competence to progress them effectively; and
- the quality of practice is regularly audited, including the effectiveness of safeguarding measures and a focus on achieving the best end results for children.

We recommend that Derbyshire Constabulary immediately reviews its MOSOVO arrangements and practices to ensure that the risk from offenders in the community is effectively managed.

Within three months

We recommend that within three months Derbyshire Constabulary engages with its safeguarding partners and reviews its assessment and information sharing practices to ensure that vulnerable children are identified at the earliest possible stage and referred without delay to the most appropriate level of support.

We recommend that within three months Derbyshire Constabulary reviews its policy and practice for responding to incidents where indecent images of children are present on digital devices. This should include:

- issuing guidance to all operational staff;
- providing technical support to identify and remove files;
- supporting children and families;
- appropriate responses to child offenders; and
- effective supervisory oversight.

We recommend that within three months Derbyshire Constabulary engages with its safeguarding partners (local authority CSC and the National Probation Service) to develop the effectiveness of multi-agency operational activity to protect children at risk from registered sex offenders.

Within six months

We recommend that within six months Derbyshire Constabulary engages with its safeguarding partners and reviews the terms of reference and practices of all its multi-agency risk management meetings – including those for children at risk of exploitation or domestic abuse, and children missing from home.

We recommend that within six months Derbyshire Constabulary engages with its safeguarding partners and reviews guidance to improve practices for when children are taken into police protection to:

- reduce the time before children are found appropriate accommodation;
- consistently record relevant information and decisions; and
- regularly review and endorse the use of protective powers.

We recommend that within six months Derbyshire Constabulary engages with its safeguarding partners and reviews the effectiveness of arrangements for children in police detention.

Annex A – Child protection inspection methodology

Objectives

The objectives of the inspection are:

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

The expectations of organisations are set out in the statutory guidance *Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children*. The specific police roles set out in the guidance are:

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

These areas of practice are the focus of the inspection.

Inspection approach

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

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

Methods

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

The purpose of the self-assessment is to:

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

Self-assessment and case inspection

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

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

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