National Child Protection Inspections

Devon and Cornwall Police
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Foreword

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

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

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

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

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

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

Contents

1. Introduction

This report is a summary of the findings of an inspection of child protection services in Devon and Cornwall Police which took place in May 2015. The report comprises nine chapters in three main parts. The first part provides information on the background to the inspection and to Devon and Cornwall Police. The second part focuses on the inspection findings, and the third part looks to the future and makes recommendations for improvement.

2. Background

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

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

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

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

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

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

3. Context for the force

Devon and Cornwall Police has approximately 5,050 staff. The workforce includes:

- 3,068 police officers;
- 1,466 police staff; and
- 346 police community support officers.[2]

The force provides policing services to a population of around 1.69 million people over an area of 3,968 square miles; this makes it the largest geographical police force area in England. Plymouth is the major city in the force area with a population of approximately 246,000. Other significant towns are Exeter (population c. 111,000) and Torquay (population c. 65,000).

There are four local authorities in the Devon and Cornwall police area: Cornwall and the Isles of Scilly, Devon, Plymouth and Torbay. They are responsible for child protection within their boundaries. There are four separate local safeguarding children boards (LSCBs)[3] in the force area, one in each local authority administrative area. The force has three policing divisions, known as basic command units (BCUs): Cornwall and the Isles of Scilly, Devon (which includes Torbay) and Plymouth.

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

Local authority	**Judgment**	**Date**
Cornwall and Isles of Scilly	Adequate	March 2013
Devon	Requires improvement	May 2015
Plymouth	Requires improvement	January 2015
Torbay	Adequate	April 2013

Devon and Cornwall Police has a central public protection unit (PPU) which oversees safeguarding across the force area and provides governance for 11 public protection units (PPUs) located within the 3 BCUs.

[2] *Police workforce, England and Wales, 31 March 2015*, Home Office, July 2015. Available at: www.gov.uk/government/statistics/police-workforce-england-and-wales-31-march-2015

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

Public protection services as a whole are led by an assistant chief constable. The central PPU is led by a detective superintendent, supported by three detective chief inspectors (one for each BCU) who oversee the daily management of the BCU-based PPUs.

There is a single dedicated referral unit for child protection covering all of the force area except Torbay which is piloting a single safeguarding risk assessment model and has a multi-agency safeguarding hub (MASH). At the time of the inspection in May 2015, Devon and Cornwall Police had decided to roll out this model across the force area although implementation had not yet begun.

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4. The police role in child protection

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

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

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

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

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

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[4] Section 47 of the Children Act 1989.

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

[6] *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015 (latest update), available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

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

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

During the course of the inspection, Devon and Cornwall Police assessed 33 cases in accordance with criteria provided by HMIC. The force was asked to rate each of the 33 self-assessed cases. Practice was viewed as good by the force assessors in 12 of the cases, adequate in 6 cases, requiring improvement in 13 cases and inadequate in 2 cases.[7] HMIC also assessed these cases, rating 7 as good, 2 as adequate, 17 as requiring improvement and 7 as inadequate. Inspectors selected and examined a further 39 cases where children were identified as being at risk. Seven were assessed as good, 3 as adequate, 21 as requiring improvement and 8 as inadequate.

Initial contact

Inspectors found that the force responded well to incidents when specific concerns were raised about children. Officers attended promptly, undertook a range of preliminary tasks such as ensuring the immediate safety of children, securing evidence and making an assessment about how best to proceed. When further action was necessary, such as a joint visit with children's social care services, this was often arranged quickly. Officers undertook thorough initial enquires and used their powers to arrest when necessary. For example:

- the steps taken when a mother contacted the NSPCC[8] stating her 9-year-old daughter had been sexually assaulted by her 15-year-old stepson. A strategy meeting[9] and a joint investigation with children's social care services were undertaken promptly. Officers attended with social workers and the stepbrother was arrested immediately. This protected the girl from further harm. Officers gave careful consideration to her needs, and the recovery of forensic evidence was handled sensitively. The early contact and engagement

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

[8] National Society for the Prevention of Cruelty to Children.

[9] Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm there should be a strategy discussion involving local authority children's social care services, the police, health services and other bodies such as the referring agency. This might take the form of a multi-agency meeting or phone calls and more than one discussion may be necessary. A strategy discussion can take place following a referral or at any other time, including during the assessment process. *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children,* HM Government, March 2015 (latest update), page 36 – 37.

with children's social care services ensured that longer-term safeguarding measures were initiated promptly; and

- the action taken when a man was seen punching his partner in the face in the presence of her four-year-old son. Officers attended, arrested the man immediately and checked on the welfare of the child. Protecting the child was at the forefront of the decision-making process. Officers identified that he was the subject of a child protection plan and ensured that the appropriate referrals were completed to ensure longer-term safeguarding planning was undertaken.

Inspectors found that staff in the force control room were alert to risk and vulnerability, and generally knowledgeable when dealing with calls that clearly related to a child protection concern. The force had created a risk assessment and quality assurance supervision role in the control room to improve further the management of risk. Although inspectors found some examples of effective practice such as the routine screening of decision making in cases involving children, inspectors also found that some assessments were poor. For example:

- a 14-year-old girl was reported missing from home for the fourth time in a month. The control room operator failed to gather all available information to assist the officer attending, despite there being evidence of over-sexualised behaviour and a history of difficult domestic circumstances. This hindered good decision-making at the scene; and

- in the case of a 14-year-old girl who regularly went missing from foster care and was known to be at risk of substance abuse and sexual exploitation. She had been reported missing 15 times in 6 months. The control room operator graded the incident as 'absent' despite these factors. This grading was challenged by the foster carer but remained unchanged, and no effort was made to locate the girl.

A regular training programme was in place to keep control room staff up-to-date with force and national developments, including child safeguarding. However, the force did not have the ability to 'flag' children at risk of sexual exploitation on police systems, meaning that early opportunities to intervene could be missed. Although the force intended to rectify this problem, at the time of our inspection, it lacked the ability easily to identify children at risk of exploitation.

Devon and Cornwall Police had invested time and resources in training frontline officers on their role in safeguarding children and was delivering force-wide child sexual exploitation training at the time of the inspection. This had translated into better awareness among staff and a sense of responsibility for child protection matters. Inspectors found some examples where officers worked well with other agencies to protect children and ensured their needs were met. Inspectors also found some cases where public protection notification forms (for a child protection

concern) had not been completed when a child was at risk. As a result, opportunities to intervene and safeguard children at an earlier stage were missed. The force did not have regular supervisory oversight to ensure public protection notification forms were of a good standard and routinely submitted.

Police usually attended incidents of domestic abuse promptly, and most staff spoken to were clear about their responsibility to record whether they had checked that children present were safe and well and whether they had ensured their immediate safety. However, in all of the cases assessed by inspectors, frontline staff attending domestic abuse incidents had failed to record their observations about the demeanour or behaviour of children. A child's demeanour, especially in those cases where a child is too young to speak to officers, or where to do so with a parent present might present a risk, provides important information about the impact of the incident on the child. It should inform both the initial assessment of the child's needs and whether there should be a referral to children's social care services.

Recommendation

> We recommend that, within three months, Devon and Cornwall Police takes steps to improve staff awareness of the significance of drawing together all available information from police systems to better inform their responses and risk assessments.
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> We recommend that, within three months, Devon and Cornwall Police ensures that officers always record their observations of a child's behaviour and demeanour in domestic abuse incident records so that better assessments of a child's needs are made.

Assessment and help

The central referral unit, the MASH in Devon, the Multi Agency Referral Unit (MARU) in Cornwall, and the Safeguarding Unit in Plymouth are the focal points for information exchange and inter-agency planning. The force had also recently developed a MASH in the Torbay local policing area, the pilot site for the single safeguarding risk assessment model that will be introduced across the force area. The units and the MASH manage large volumes of information. For the most part they do so quickly and efficiently, although staff told inspectors that some delays in assessments could occur because of the bureaucratic nature of the referral process and the capacity of staff.

There were some examples of agencies working well together – identifying risks, making plans to reduce these risks and supporting children and families. While some initial enquiries were timely and thorough with specific investigation and safeguarding plans agreed, inspectors were concerned that recording on police systems was frequently poor.

The details of action taken to protect the child, such as strategy discussions and longer-term safeguarding plans to inform future decision making were often absent. For example:

- police were contacted by neighbours who were concerned that three children aged four, six and seven had been left home alone for over an hour by their parents. Police attended and ensured the immediate safety of the children, and correctly determined that there was no need to remove the children to a place of safety. The officers completed a public protection notification form. However, there was no record of a strategy discussion taking place or joint working with children's social care services to determine the appropriate safeguarding response; and

- the father of a 15-year-old girl contacted police after his daughter disclosed she had been sexually touched by her friend's father. The case was investigated; however, there was no record of a strategy discussion taking place or of any ongoing safeguarding support for the girl. Nor was there evidence that consideration had been given to the safety of the suspect's teenage daughter.

In part, a lack of effective supervisory oversight contributed to the failings identified in these cases. Inspectors were concerned to see the supervision of cases referred into the central referral unit and the MASH by trained and experienced child protection supervisors was also inconsistent. While in most cases child abuse concerns were quickly identified, records of the early investigative and safeguarding response were sometimes poor, with little evidence of effective oversight.

The PPUs did not have specialist child protection staff whose role it was to attend initial child protection case conferences; this responsibility rested with PPU staff. Inspectors were concerned at the low police attendance levels at the case conferences across the force area. We were informed that attendance was often poor because of the workload pressures of supervisors in particular, who were required to balance meeting attendance with the management of ongoing and emerging safeguarding investigations.

In the Plymouth BCU, attendance at case conferences between January and March 2015 was approximately 50 percent (although this was an improvement from September 2014 when attendance was 34 percent). The presence of a police officer at these meetings, particularly a supervisor, demonstrates an important commitment to information sharing and collective decision making about children who are in most need of help and protection.

Inspectors concluded that Devon and Cornwall Police did not always fulfil its responsibilities to attend initial case conferences when required to do so in accordance with the statutory guidance Working Together to Safeguard Children.[10]

The force had identified this as an area for improvement and was taking steps to assess workloads and review staffing levels across the force area in order to improve attendance.

The force provided training to all officers and staff on child sexual exploitation. However, inspectors found that officers did not display a thorough awareness of the risks associated with the identification of children at risk of sexual exploitation when considering a safeguarding response. For example:

- a 13-year-old girl had sent explicit images of herself to an older man over the internet. While the victim's phone was seized and a public protection form completed, there was no record of any referral being made to children's social care services. Nor was there any recognition that the girl was at risk of exploitation despite sending images of herself on at least 30 separate occasions. The investigation was closed without completing all enquiries to identify the suspect; and

- in the case of a 15-year-old girl identified as being at risk of sexual exploitation in August 2014. Officers noted concerns on police records that she had met an older man for sex in return for drugs and money. While 'risk strategy meetings' were mentioned as having taken place, inspectors found no evidence of a longer-term safeguarding plan to protect the girl from further exploitation. There was little supervisory oversight and, at the time of the inspection, the girl had not been spoken to by police.

Inspectors had concerns about the protection of some children who regularly go missing from home. Inspectors assessed ten such cases and judged three as inadequate, and six as requiring improvement. Only one was found to be good. Although the initial response to locate the child was often prioritised, opportunities for early intervention and longer-term inter-agency planning to protect children had not been considered. Nor did the force have 'trigger plans' (a plan to locate a child quickly when he or she goes missing frequently), which would help to locate the child sooner by using information held by police from previous 'missing' episodes.

In some cases, children, *most notably those in the care of the local authority,* were reported missing over ten times without any action being taken to protect them. In the majority of cases examined, officers conducted 'safe and well' checks promptly (to check their immediate safety) after a missing child was located, although some records contained scant information. Inspectors found that independent return

[10] See footnote 6 above.

interviews[11] for children missing from home were available across all local authority areas, although the details of whether they were conducted and what was said were not always recorded on police systems. Interviews with children at this stage can provide a wealth of information about the reasons why they are running away, particularly where this is becoming more frequent and the child is reluctant to speak to police or other agencies. A better understanding of why a child has run away can provide vital information to partners and support more effective risk management and it should inform planning and decision making about future safeguarding action.

Inspectors also found that officers did not always recognise that children who regularly go missing from home may be at risk of being groomed for sexual abuse. In nine of the ten missing from home cases examined by inspectors, there were signs that the children involved could be at risk of sexual exploitation. Inspectors found that the police response often focused on the most recent episode rather than taking account of information held by police about previous occurrences. For example:

- a 15-year-old girl had been reported missing on numerous occasions from a children's home. She had previously returned stating she had engaged in sexual activity with older men. While some multi-agency work took place, the girl was not 'flagged' as being at risk of sexual exploitation, and there was little evidence of a plan to deal with long-term problems; and

- a 15-year-old boy had been reported missing more than 30 times. Police records indicated a risk of sexual exploitation as a result of the boy struggling with his sexuality, but this did not feature as part of the risk assessment or the response in the most recent episode. When the child was located a public protection form was not submitted, a strategy discussion did not take place, nor was any assessment undertaken of the wider risks to the boy and what longer-term safeguarding measures were required.

Devon and Cornwall Police refers domestic abuse cases that are assessed as 'high risk' to a multi-agency risk assessment conference (MARAC) for longer-term safeguarding plans to be put in place. Inspectors examined minutes of MARACs and assessed 11 cases involving children. MARACs were well attended by representatives from the force and a wide range of agencies. Information was routinely shared to protect both victims and any children affected by domestic abuse. However, inspectors found the recording of immediate safeguarding measures put in place for children who were living in families at high risk of domestic abuse to be

[11] When a child is found, they must be offered an independent return interview. Independent return interviews provide an opportunity to uncover information that can help protect children from the risk of going missing again, from risks they may have been exposed to while missing or from risk factors in their home. Further information can be found in *Statutory guidance on children who run away or go missing from home or care*, Department for Education, January 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf

inconsistent. In some of the cases examined, there was no record of strategy discussions taking place prior to the MARAC meeting. This could leave children at risk because information was not shared and possible joint action was delayed as a result. In some parts of the force area, protective measures relied solely on children's social care services rather than all relevant agencies making a contribution, such as police officers undertaking home visits jointly with children's social care services to check on the welfare and safety of children.

Recommendation

We recommend that Devon and Cornwall Police immediately takes steps to improve practice in cases of children who go missing from home. As a minimum, this should include:

- improving staff awareness of their responsibilities for protecting children who are reported missing from home and, in particular, those cases where it is a regular occurrence;
- improving staff awareness of the links between children going missing from home and the risk of sexual exploitation;
- improving staff awareness of the significance of drawing together all available information from police systems, including information about those who pose a risk to children, to better inform risk assessments;
- ensuring that staff are aware of the need to pass this information on to other agencies; and
- identifying the range of responses and actions that the police can contribute to multi-agency plans for protecting children in these cases.

We recommend that, within three months, Devon and Cornwall Police undertakes a review, together with children's social care services and other relevant agencies, to ensure that the force is fulfilling its statutory responsibilities as set out in Working Together to Safeguard Children. As a minimum, this should include:

- attendance at, and contribution to, initial child protection conferences; and
- recording decisions reached at meetings, on police systems to ensure that staff are aware and of all relevant developments.

Investigation

Inspectors found some good examples of police child protection work with child abuse investigators displaying a good mix of investigative and protective approaches. This ensured that the safeguarding of children remained central to their efforts while criminal investigative opportunities were pursued. For example, police carried out a joint visit with social workers to see an 11-year-old boy with learning difficulties, following concerns of possible physical abuse raised by teachers. The boy was spoken to sensitively by officers and there was good supervisory oversight while the matter was investigated. When it became clear that there had been no abuse (the boy was diagnosed with a health problem) there was effective joint working and long-term plans developed with other agencies to support both the boy and his parents.

Inspectors were told that in some BCUs the work of child protection officers in the PPUs was difficult to manage because of high workloads. While inspectors did find some examples of good supervisory oversight, this was inconsistent because of the heavy workloads of supervisors. Inspectors found that lack of supervision in a number of the cases examined had contributed to delays in the investigation. Staff reported difficulties in managing the expectations of victims; their capacity to provide families and children with information and guidance on what would happen next was constrained. Officers told inspectors that delays adversely affected the confidence of children and families in the police.

We also found that some serious cases – for example sexual offences – were investigated by non-specialist officers. These cases were not handled well. For example:

- a case concerning the alleged sexual assault of a 15-year-old girl by a friend's father. The initial response was good and the girl was interviewed two weeks after the initial report (December 2014). However, the suspect had not been arrested at the time of the inspection, six months later, and no consideration had been given to the wider risk he might pose; and

- the case of a 16-year-old girl who alleged that she was sexually assaulted by a co-worker at a bakery. The initial response to protect her from further harm was good. However, there was no evidence of joint working (a public protection notification form was not submitted until four weeks after the initial investigation). The suspect was not considered as a possible serial offender despite a previous allegation of sexual assault and this information was not taken into account when the decision was made to take no further action.

Inspectors were also told by staff that delays of up to four months were common in cases sent to the Crown Prosecution Service (CPS) for review and charging decisions. We saw evidence that the force was working constructively with the CPS in an attempt to improve the timeliness of decision making.

There were also delays in the examination and analysis of computers and other media undertaken by the high-tech crime unit (HTCU). For example:

- the tablet computers[12] of two 10-year-old girls who were sent explicit images by a man in January 2015 awaited examination at the time of the inspection in May 2015;
- in relation to an allegation in December 2014 that a 13-year-old girl was being groomed online by an older man. The examination of the girl's phone had not been completed in May 2015 necessitating the suspect's continued release on bail; and
- it took three months to examine the phone of a girl who had been contacted by a man inciting her to engage in sexual activity.

The force had allocated additional funding to clear the backlog by sending it to an external service provider but inspectors saw no evidence that this had improved the timeliness of examinations.

Delays are not in the best interests of children who are unable to put the incident behind them, nor do they serve the suspect who may be on bail or in custody. When delays occur in evidence gathering, media analysis and receipt of charging decisions from CPS as was seen in cases in this inspection, the length of time between the first call to police or children's social care services and a criminal justice outcome can be considerable.

Devon and Cornwall Police had recognised the need to improve its response to tackling child sexual exploitation, but at the time of the inspection the force's response remained largely reactive and lacked coordination. The force routinely searches for children being abused or exploited online and has a dedicated unit for overseeing these investigations. However, other types of child sexual exploitation were not investigated by a dedicated team but by child abuse detectives in the PPUs or non-specialist teams (such as neighbourhood and response teams[13]*).* Inspectors examined eight cases involving child sexual exploitation and found six to be inadequate. Signs of risk were missed, lines of enquiry were either not followed up or took too long, and there were failures to respond to information and intelligence and to pursue offenders. Poor practice was more evident in Devon and Torbay which together accounted for five of the cases graded as inadequate. In most of the cases

[12] A tablet computer is a mobile computer with a touch screen display, circuitry and battery in a single unit.

[13] A neighbourhood team is a team of police officers and police community support officers who predominantly patrol and are assigned to police a particular local community. Teams often comprise specialist officers and staff with expertise in crime prevention, community safety, licensing, restorative justice and schools liaison. Response teams are assigned to deal with emergency and priority calls.

assessed, the immediate safeguarding measures were adequate but there was often a failure to identify wider risks. For example:

- in a case concerning a 13-year-old girl who had been enticed to send inappropriate sexual images of herself to an older man on social media and engaged in sexualised conversations. The case was investigated by a neighbourhood officer who was not trained in child protection. A referral was not made to children's social care services and the investigation was not passed to a specialist officer when further victims were identified (increasing the complexity and the risk to other children); and

- in relation to a 13-year-old girl who was found sleeping rough with an 18-year-old man in Torquay. She was using 'legal high' intoxicants supplied by the man and her behaviour was increasingly erratic. Although consideration was given to serving the man with a child abduction warning notice[14] should he be found with the girl again, there was no record that this had taken place. No consideration was given to charging the man with criminal offences because the victim did not want to make a complaint. A strategy meeting was held where the risk of the girl being sexually exploited was acknowledged but was described in the minutes of the meeting as a 'choice'. Although this comment was not made by the police representative, it is a concern that her behaviour was considered in this context. Force records showed no evidence of a safeguarding plan to address her ongoing risky behaviour and no further support was provided.

Recommendation

We recommend that Devon and Cornwall Police immediately takes action to improve child sexual exploitation investigations paying particular attention to:

- improving staff awareness, knowledge and skills in this area of work;
- ensuring a prompt response to any concern raised;
- undertaking risk assessments that consider the totality of a child's circumstances and risks to other children; and
- improving the oversight and management of cases (to include auditing of child abuse and exploitation investigations to ensure that standards are being met).

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

We recommend that, within three months, Devon and Cornwall Police takes action to improve child protection investigations. By ensuring that, as a minimum:

- every referral received by the police is allocated to a team with the skills, capacity and competence to undertake the investigation;
- investigations are supervised and monitored and, at each check, the supervisor reviews the evidence and any further enquiries/ evidence gathering that may need to be done;
- until such time as these changes are embedded, the force should conduct regular reviews of practice that include the quality and timeliness of investigations; and
- further steps are taken with the Crown Prosecution Service to monitor and improve the timeliness of case reviews and charging decisions.

We recommend that, within three months, Devon and Cornwall Police takes steps to reduce delays in the high-tech crime unit.

Decision making

The police response was generally adequate when the case was clearly defined as a child protection matter from the outset. For the most part, referrals from other agencies were assessed effectively, although as previously noted, some delays in assessment were apparent. There were examples of effective decision making to protect children. Officers handled incidents well when there were significant concerns about the safety of children, such as parents leaving children home alone or being drunk while looking after them. It is a very serious step to remove a child from their family by way of police protection.[15] In the cases examined, decisions to take a child to a place of safety were well considered and in the best interests of the child.

With the exception of cases involving children at risk of sexual exploitation and missing from home, there was evidence that frontline staff made effective decisions in the early stages of child protection matters. Inspectors found a good level of understanding among frontline staff of the need to record and report information that had come to their attention when attending an incident involving concern for a child. Many staff spoken to by inspectors described the increasing emphasis being placed

[15] Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to (a) remove the child to suitable accommodation and keep him/her there, or (b) take such steps as are reasonable to ensure that the child's removal from any hospital, or other place, in which he/she is then being accommodated is prevented.

by the force on safeguarding children as ‘everyone’s business’. However, inspectors also found that this understanding had not yet resulted in improvements in recording practice.

While there were examples of officers taking appropriate protective action, inspectors were concerned about the poor standard of recording on police systems across the force. Accurate and timely recording of information is essential for good decision making in child protection matters. Important information was missing and there were delays in recording it on the system. This included delays in recording the outcome of strategy meetings (minutes were often not taken), updating records about the progress of an investigation, and details about contact with children and families. Devon and Cornwall Police has several IT systems on which information relating to child protection is recorded. This is inefficient. It results in duplication and confusion for officers about how to locate the most recent details of an investigation. As a result, it was not always clear what decisions had been made to protect a child or what actions were within the criminal investigation. Accurate, timely and consistent recording of information on a single system would better support decision making.

Inspectors found consistently good practice across the force in relation to the management of risk on a daily basis for immediate and urgent child protection matters, including for those children being detained in custody suites. The daily management meeting in particular was considered to be effective and supported good decision making.

Recommendation

We recommend that, within three months, Devon and Cornwall Police takes steps to ensure that all relevant information is properly recorded and is readily accessible in all cases where there are concerns about the welfare of children. Guidance to staff should include:

- what information should be recorded (and in what form) on systems to enable good quality decisions;
- the importance of sending the information to the correct police department and/or relevant partner agency; and
- the importance of ensuring that records are made promptly and kept up to date.

Trusted adult

In some cases, though not all, it was clear that when the concern was serious and immediately recognised as a child protection matter, the approach to the child or parents was carefully considered, and the best ways to engage with the child were explored. This sensitive approach resulted in stronger relationships between the child and police. Examples of this involved:

- a referral from a school that a 12-year-old girl had been sexually assaulted by another pupil at the school. A joint visit was made to the girl by police and children's social care services. The girl was spoken to and safeguarding actions were agreed. Throughout the case there was continued support from children's social care services and the girl's school which arranged ongoing support; and

- an emergency call to an incident involving the mother of a nine-year-old girl who was drunk and causing a disturbance in the street. Officers attended promptly and found her daughter had been left alone at home. Officers were concerned for the child's immediate safety and she was taken to a nearby relative. Her mother was arrested and a joint safeguarding investigation commenced. Throughout the investigation, the views of the child were recorded and considered in decisions taken. The mother received a caution and the girl and her older brother continued to receive multi-agency support.

Inspectors found a number of cases where the decisions reached clearly took account of the needs of children, but there was very little information in the majority of case files on the views of the child, the impact of the issues in the case on the child or the outcomes of police intervention for the child.

We also found that insufficient consideration was given to children at risk of sexual exploitation and those who went missing from home. The examples referred to in previous sections of this report are indicative of an underdeveloped response to these cases.

Recommendation

We recommend that, within three months, Devon and Cornwall Police ensures that:

- staff record the views and concerns of children;

- staff record the outcome for the child at the end of police involvement in a case;

- staff inform children, as appropriate, of any decisions that have been made about them; and

- information about children's needs and views is made available, on a regular basis, for consideration by the police and crime commissioner and to service managers to inform future practice.

Managing those posing a risk to children

Multi-agency public protection meetings for registered sex offenders were generally good and well attended by agencies, although police representation at some meetings was not always by officers of the appropriate seniority. Risks to children were identified and plans were put in place. Inspectors examined minutes from the most recent meetings and assessed four cases of this nature as good, three as adequate and three as requiring improvement.

Devon and Cornwall Police has dedicated units – dangerous offender units – to manage registered sex offenders. Inspectors found that plans to manage risks were proportionate and in place, monitoring visits to check that registered sex offenders were keeping to their registration requirements were not always undertaken in a timely manner. Across the force the units were dealing with caseloads in excess of the sex offender managers' ratio recommended by national guidance[16] with approximately 80 to 90 offenders being managed by some officers. The only exception was Plymouth BCU, where additional staff had been deployed to the unit. However, inspectors found that there insufficient capacity in the dangerous offenders units for proactive surveillance work because of the large number of sex offenders requiring supervision.

Despite the challenges outlined above, staff working in the teams were clear about their responsibilities, undertook detailed enquires, assessed risk well and took action to reduce it. They used their powers to arrest those who failed to keep to their registration conditions or other requirements, such as prohibitions on contact with children. For example, police received information that a registered sex offender was in the company of children. Officers conducted prompt enquiries and identified the children. A thorough investigation was conducted. Appropriate safeguarding measures were put in place by supervisors, and joint visits to each child and their families were undertaken with children's social care services. The offender was arrested, charged and imprisoned.

We found links between the dangerous offender units and neighbourhood policing teams varied across the force area. Officers were made aware of registered sex offenders living in their area through regular intelligence updates on the force intranet[17] that provided information about those who posed a risk to children.

[16] *MAPPA Guidance 2012 version 4*, Ministry of Justice National Offender Management Service, February 2015 (latest update), available at: www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2.

[17] A website internal to the force and accessible only by authorised users of force systems.

However, inspectors found that awareness of these 'bulletins' was inconsistent and limited information was being fed back from frontline officers to the units.

Recognising the need for better arrangements to deal with child sexual exploitation, the force had taken steps to review its processes and resourcing aligned to public protection. Nevertheless, at the time of the inspection, we found that there were too few staff with specialist knowledge and good understanding of disruption tactics to identify and deter perpetrators. The force had made some progress, such as the delivery of force-wide training, and inspectors found some good, but isolated cases of missing person safeguarding officers working to prevent the risk posed by perpetrators. However, the lack of a co-ordinated force-wide response, the absence of 'flagging' on force systems for victims and perpetrators, the inability to categorise an incident as 'child sexual exploitation' and effective trigger plans, mean the force still has much to do to understand and tackle child sexual exploitation effectively within its communities.

Recommendation

> We recommend that, within three months, Devon and Cornwall takes action to improve the identification, disruption and prosecution of those involved in child sexual exploitation (CSE).

Police detention

Inspectors examined 12 cases of children in detention. The youngest was 15 years old and the oldest, 17. Ten of the children were boys and two were girls. They had been detained on suspicion of offences that included burglary, criminal damage and arson. Two children had been detained under Section 136 of the Mental Health Act 1983[18]. Inspectors judged two of the cases as good, and one as adequate, nine required improvement.

Devon and Cornwall Police self-assessed three of these cases, all featuring boys. They assessed one as adequate and two as requiring improvement. Inspectors assessed all three as requiring improvement.

In the ten criminal cases examined by inspectors, eight of the children were charged and refused bail by the custody sergeant. In these circumstances, the local authority is responsible for providing appropriate accommodation if a child is to be detained.[19]

[18] Further information on this power can be found in chapter 10 of *Code of Practice: Mental Health Act 1983*, Department of Health, 2008, available at: http://webarchive.nationalarchives.gov.uk/20130123193537/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597

[19] Under section 38(6) of the Police and Criminal Evidence Act 1984 a custody officer must secure the move of a child to local authority accommodation unless he certifies it is impracticable to do so or, for

It should only be in exceptional circumstances (such as during extreme weather) that the transfer of the child to alternative accommodation would not be in their best interests. In rare cases – for example, if a child presented a high risk of serious harm to others – secure accommodation might be needed.

In the cases examined by inspectors, none of the children detained overnight were transferred into the care of the local authority. In five of the cases, custody records showed that no request was made to the local authority for accommodation after a decision to refuse bail.

Detention certificates, which outline to a court the reason for a custodial remand, are essential for police accountability and enable forces to monitor how well they are doing in terms of their responsibilities under the Police and Criminal Evidence Act 1984. In all but one case detention certificates were completed.

Devon and Cornwall Police undertakes reviews of children being detained at the force-wide daily management meetings. It was clear that the force had taken steps to raise awareness amongst custody staff of the need for alternative (secure and non-secure) accommodation for children detained in police custody. However, this had not yet resulted in better outcomes for all children and there was still confusion among custody staff about the minimum thresholds for secure and non-secure accommodation.

Section 136 of the Mental Health Act 1983 allows a police officer to remove an apparently mentally disordered person from a public place to a place of safety. Although a place of safety can include a police custody suite, these should only be used in exceptional circumstances and it is preferable for the person to be taken directly to healthcare facilities such as a hospital. There were 3 cases of children detained under this power in Devon and Cornwall who were taken to police custody suites in the 12 months prior to the inspection. This represents a significant downward trend across the force area.

Inspectors were pleased to see that Devon and Cornwall Police, in conjunction with partners, had invested time and resource to create multi-agency places of safety for children (and adults) where proper support and accommodation can be offered to those suffering with mental health problems. Healthcare practitioners provided services to detainees in custody suites throughout the force area 24 hours a day, and in each of the cases of children being detained under the Mental Health Act there was clear evidence of custody staff acting in the best interests of the children. Inspectors were also pleased to see that in all three cases the time the children spent in custody was minimised, appropriate accommodation was sought promptly and issues escalated to senior officers where necessary.

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those aged 12 or over, no secure accommodation is available and local authority accommodation would not be adequate to protect the public from serious harm from him.

Inspectors were told by custody staff that they had not received training in child protection and sexual exploitation; nor was information about children, such as risks of sexual exploitation or whether a child was subject to a child protection plan, readily available to them. However, at the time of the inspection, all custody staff were on notice to take part in upcoming child sexual exploitation training.

Recommendation

We recommend that, within six months, Devon and Cornwall undertakes a review (jointly with children's social care services and other relevant agencies) of how it manages the detention of children. This review should include, as a minimum, how best to:

- ensure that all children are only detained when absolutely necessary and for the absolute minimum amount of time; and
- assess, at an early stage, the need for alternative accommodation (secure or otherwise) and work with children's social care services to achieve the best option for the child.

6. Findings: leadership, management and governance

Protecting vulnerable people is a priority for the force and the PCC and is reflected as such in the police and crime plan.[20] The chief constable, his chief officer team and the PCC all have a strong commitment to child protection.

The review of multi-agency referral and safeguarding arrangements (safeguarding vulnerable people review), underway at the time of the inspection, further demonstrates the force's commitment to improving child protection. However, inspectors found that the current structure had created some inconsistencies in practice across the force area which were exacerbated by resource and demand pressures within child abuse teams. It was not possible to assess at the time of the inspection whether the review will provide the force with a more consistent framework to meet the needs of children effectively.

There was visible leadership of child protection in the force, including in BCU command teams where child protection was recognised as a priority. This had a positive impact on operational staff. Inspectors found some good examples of officers demonstrating awareness of safeguarding. But in many cases this was undermined by poor record keeping. It was also apparent that the supervision of decision making was not always robust and there was limited oversight of whether outcomes for children were improving.

Throughout the inspection it was apparent that all the staff spoken to who were responsible for managing child abuse investigations were committed and dedicated to providing good outcomes for children identified as being at risk of harm. However, as noted above, in a number of cases competing priorities meant that child protection investigations were undermined by the absence of effective supervisory oversight. All child protection staff in PPUs were trained in, or in the process of completing, the specialist child abuse investigator development programme. However, some complex cases were being investigated by untrained staff in non-specialist units.

Arrangements for managing high-risk sex offenders were inconsistent across the force and there was insufficient capacity for proactive work. Inspectors found evidence of some good inter-agency plans to manage risk; however attendance at meetings was not always by officers of the appropriate seniority. This can limit effective decision making.

[20] The Devon and Cornwall police and crime plan for 2014-17 is available at: www.devonandcornwall-pcc.gov.uk/about-us/police-and-crime-plan/

Performance information to inform the force's understanding of outcomes for children at risk of harm was underdeveloped and inconsistent across the force. Consequently, the quality of work, outcomes for children and demands for service were not well understood by senior leaders. The focus of performance measures was on the quantity of child protection incidents and cases, not the quality. Although the force was contributing to the development of a more qualitative performance framework across the four LSCBs, it needs to do more to understand and record outcomes in order to improve and further develop services. Inspectors found BCU command teams and senior leaders were committed to improving management information and developing a performance framework, but more work is required to develop this across the force.

The central PPU detective superintendent represents the force on the executive board of each of the four LSCBs. LSCB chairs and local authority directors of children's services praised the commitment of the force, and the consistency of representation at board level. At executive and sub-group level, they reported some difficulties in making progress with the work of the board due to competing demands on officers. Some LSCB chairs and local command teams considered that better direct engagement with BCU commanders could improve the work of the boards. While LSCB chairs and directors of children's services felt that thresholds were generally understood by the force, some concerns were expressed about the quality and timeliness of assessment and screening processes.

Devon and Cornwall Police has developed a child sexual exploitation problem profile. However, inspectors considered that the force's response to child sexual exploitation was under-developed and lacked focus and co-ordination. Although the force has prioritised child sexual exploitation, it has much to do to understand the extent of offending across the force area and to develop an effective response to protect children. At the time of the inspection, there was limited evidence that frontline staff were aware of how to respond effectively to sexual exploitation and safeguard those children identified as being vulnerable. The force was in the process of rolling out training to all staff, but it was too soon to assess the impact of this training on the quality of frontline practice.

There were too few staff with specialist knowledge and a good understanding of child sexual exploitation including disruption tactics. The force has made some progress, such as the introduction of a weekly/monthly multi-agency meeting to manage identified CSE risk, but inspectors found a number of cases where children at risk were not identified and, as a result, proper safeguarding processes were not considered. There was no provision for flagging victims or perpetrators on force systems and no ability to classify an incident as CSE limited meaningful data collation and analysis.

Inspectors were concerned about the protection of some children who regularly go missing from home. Intervention and long-term inter-agency planning was often ineffective. That said, BCUs had good daily oversight of children who go missing and absent, and there were individual examples of good work by the missing from home co-ordinators. Nevertheless, we found limited evidence of early diversionary support being considered for some children who had been reported missing multiple times.

As noted earlier, the force operates a central referral unit across its three BCUs and had recently established a multi-agency safeguarding team in the Torbay local policing area. Although this was in the early stages of development, and at the time of the inspection police were not yet fully co-located with children's social care staff, this environment may enable police, social workers and health professionals to discuss cases more promptly to determine the best approach for children. As noted previously at the time of the inspection the force had decided to implement the Torbay model across the force area.

Children and young people were being unnecessarily detained in police custody post-charge when they should be transferred to the care of the local authority. Inspectors were informed that there was a lack of secure and unsecure accommodation available, but were pleased to find senior officers had taken steps to resolve the issue with partners and the number of children being detained by the force had reduced. Those who were detained were reviewed each day through the daily management meeting process. Inspectors found that a small number of children were also being detained in police cells under the Mental Health Act 1983, which is not in the best interests of the child. However, this number had decreased significantly and inspectors commend force leaders for their work with partners to establish dedicated places of safety for children suffering with mental health problems and in need of care.

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

Devon and Cornwall Police demonstrated a strong commitment to improving services for the protection of vulnerable people. The chief constable and the PCC have prioritised child protection and it is clear that there is a force-wide focus on reducing risk and harm to vulnerable children. However, while there were a number of examples of good work to protect children, this commitment has not yet resulted in consistently improved outcomes for children.

Inspectors found some good examples of the force protecting children who were most in need of help with good multi-agency work and a child-centred approach. However, in a significant number of cases poor supervision and record keeping had undermined decision making and safeguarding measures. If the force is to be confident that it is adequately protecting vulnerable children, safeguarding arrangements require improvement. The safeguarding vulnerable people review provides an opportunity for services to be re-configured to match resources with demand, and ensure that consistently good standards of practice are applied across the force area to improve outcomes for children. Alongside this, a performance framework that focuses more on outcomes for children who need protection (rather than the number of cases processed) should be developed and introduced to enable the force continuously to monitor and improve its child protection work.

The response to children who regularly go missing from home also requires improvement, with a particular focus on early intervention and ensuring that officers and staff understand the link between children who regularly go missing and sexual exploitation.

Work to address child sexual exploitation is under-developed and lacks co-ordination. While the force is taking some steps to address this, it still has much more to do to demonstrate that it is effectively able to identify and safeguard children at risk from sexual exploitation.

Devon and Cornwall Police has good working relationships with the four local authorities and other services that operate across the force area. It is to be commended for its partnership working to create multi-agency places of safety for children (and adults) with mental health problems who might otherwise be detained in police custody. However, more needs to be done through joint working to deliver better services, particularly for children in police detention in need of alternative accommodation.

8. Recommendations

Immediately

We recommend that Devon and Cornwall Police immediately

- takes steps to improve practice in cases of children who go missing from home. As a minimum, this should include:

  improving staff awareness of their responsibilities for protecting children who are reported missing from home and, in particular, those cases where it is a regular occurrence;

  improving staff awareness of the links between children going missing from home and the risk of sexual exploitation;

  improving staff awareness of the significance of drawing together all available information from police systems, including information about those who pose a risk to children, better to inform risk assessments;

  ensuring that staff are aware of the need to pass this information on to other agencies; and

  identifying the range of responses and actions that the police can contribute to multi-agency plans for protecting children in these cases.

- takes action to improve child sexual exploitation investigations paying particular attention to:

  improving staff awareness, knowledge and skills in this area of work;

  ensuring a prompt response to any concern raised;

  undertaking risk assessments that consider the totality of a child's circumstances and risks to other children; and

  improving the oversight and management of cases (to include auditing of child abuse and exploitation investigations to ensure that standards are being met).

Within three months

We recommend that, within three months, Devon and Cornwall Police

- takes steps to improve staff awareness of the significance of drawing together all available information from police systems better to inform their responses and risk assessments.
- ensures that officers always record their observations of a child's behaviour and demeanour in domestic abuse incident records so that better assessments of a child's needs are made.
- undertakes a review, together with children's social care services and other relevant agencies, to ensure that the force is fulfilling its statutory responsibilities as set out in 'Working Together to Safeguard Children'. As a minimum, this should include:

    attendance at, and contribution to, initial child protection conferences; and

    recording decisions reached at meetings, on police systems to ensure that staff are aware and of all relevant developments.

- takes action to improve child protection investigations. By ensuring that, as a minimum:

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

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

    until such time as these changes are embedded, the force should conduct regular reviews of practice that include the quality and timeliness of investigations; and

    further steps are taken with the Crown Prosecution Service to monitor and improve the timeliness of case reviews and charging decisions.

- takes steps to reduce delays in the high-tech crime unit.
- takes steps to ensure that all relevant information is properly recorded and is readily accessible in all cases where there are concerns about the welfare of children. Guidance to staff should include:

    what information should be recorded (and in what form) on systems to enable good quality decisions;

the importance of sending the information to the correct police department and/or relevant partner agency; and

the importance of ensuring that records are made promptly and kept up to date.

- ensures that:

  staff record the views and concerns of children;

  staff record the outcome for the child at the end of police involvement in a case;

  staff inform children, as appropriate, of any decisions that have been made about them; and

  information about children's needs and views is made available, on a regular basis, for consideration by the police and crime commissioner and to service managers to inform future practice.

- takes action to improve the identification, disruption and prosecution of those involved in CSE.

Within six months

We recommend that, within six months, Devon and Cornwall:

- undertakes a review (jointly with children's social care services and other relevant agencies) of how it manages the detention of children. This review should include, as a minimum, how best to:

  ensure that all children are only detained when absolutely necessary and for the absolute minimum amount of time; and

  assess, at an early stage, the need for alternative accommodation (secure or otherwise) and work with children's social care services to achieve the best option for the child.

9. Next steps

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

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

Subject to the responses received, HMIC will revisit the force no later than six months after the publication of this report to assess how it is managing the implementation of all of the recommendations.

Annex A
Child protection inspection methodology

Objectives

The objectives of the inspection are:

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

The expectations of agencies are set out in the statutory guidance Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children[21], published in March 2013. The specific police roles set out in the guidance are:

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

These areas of practice are the focus of the inspection.

Inspection approach

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

The inspections considered how the arrangements for protecting children, and the leadership and management of the police service, contributed to and supported

[21] *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015 (latest update), available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

effective practice on the ground. The team considered how well management responsibilities for child protection, as set out in the statutory guidance, were met.

Methods

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

The purpose of the self-assessment is to:

- raise awareness within the service about the strengths and weaknesses of current practice (this formed the basis for discussions with HMIC); and
- serve as a driver and benchmark for future service improvements.

Self-assessment and case inspection

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

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

- the detention of children in police custody.

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

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

Annex B
Glossary

child	person under the age of eighteen
multi-agency risk assessment conference (MARAC)	locally-held meeting where statutory and voluntary agency representatives come together and share information about high-risk victims of domestic abuse; any agency can refer an adult or child whom they believe to be at high risk of harm; the aim of the meeting is to produce a co-ordinated action plan to increase an adult or child's safety, health and well-being; the agencies that attend will vary but are likely to include, for example: the police, probation, children's, health and housing services; there are over 250 currently in operation across England and Wales
multi-agency safeguarding hub (MASH)	entity in which public sector organisations with common or aligned responsibilities in relation to the safety of vulnerable people work; the hubs comprise staff from organisations such as the police and local authority social services; they work alongside one another, sharing information and co-ordinating activities to help protect the most vulnerable children and adults from harm, neglect and abuse

Office for Standards in Education, Children's Services and Skills (Ofsted)	a non-ministerial department, independent of government, that regulates and inspects schools, colleges, work-based learning and skills training, adult and community learning, education and training in prisons and other secure establishments, and the Children and Family Court Advisory Support Service; assesses children's services in local areas, and inspects services for looked-after children, safeguarding and child protection; reports directly to Parliament
multi-agency public protection arrangements (MAPPA)	arrangements set out in the Criminal Justice Act 2003 for assessing and managing the risk posed by certain sexual and violent offenders; require local criminal justice agencies and other bodies dealing with offenders to work together in partnership to reduce the risk of further serious violent or sexual offending by these offenders
police and crime commissioner (PCC)	elected entity for a police area, established under section 1, Police Reform and Social Responsibility Act 2011, responsible for securing the maintenance of the police force for that area and securing that the police force is efficient and effective; holds the relevant chief constable to account for the policing of the area; establishes the budget and police and crime plan for the police force; appoints and may, after due process, remove the chief constable from office

registered sex offender	a person required to provide his details to the police because he has been convicted or cautioned for a sexual offence as set out in Schedule 3 to the Sexual Offences Act 2003, or because he has otherwise triggered the notification requirements (for example, by being made subject to a sexual offences prevention order); as well as personal details, a registered individual must provide the police with details about his movements, for example he must tell the police if he is going abroad and, if homeless, where he can be found; registered details may be accessed by the police, probation and prison service