HMICFRS

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

National Child Protection Inspections

Dorset Police

12 April–23 April 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 abused or neglected by those responsible for their care; or need to be protected from other adults. Some of them occasionally go missing, or end up spending time in places, or with people, that are 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 major 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, arrest perpetrators, and have responsibilities to monitor sex offenders. A police officer can take a child in danger to a place of safety and can seek restrictions on offenders' contact with children. The police service also has a significant role, working with other organisations, in ensuring children's protection and wellbeing in the longer term.

As they go about their daily tasks, police officers must be alert to, and identify, children who may be at risk. To protect children effectively, officers must talk to children, listen to them, and understand their fears and concerns. The police must also work effectively 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, police and crime commissioner (PCC) and the public on how well the police protect children and secure improvements for the future.

Contents

Summary

This report is a summary of the findings of our inspection of police child protection services in Dorset, which took place during April 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 force is structured, led and governed, in relation to its child protection services.

The methodology for this inspection was adapted because of the COVID-19 pandemic. We agreed arrangements with the force to conduct the inspection both safely and effectively while working within national guidelines.

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

We found that the chief constable, his senior team and the PCC are committed to protecting vulnerable people, including children. This shows in both the PCC's police and crime plan, and in the force priorities.

We saw the force was effective in its professional relationships and in its contributions to multi-agency work. It engages effectively with partner organisations at both strategic and practitioner level. The force also has appropriate representation in the safeguarding partnership arrangements.

We found examples of good work by frontline officers responding to incidents involving children. We spoke to officers and staff who manage child protection investigations, often working in difficult and demanding situations. We found them committed and dedicated.

Dorset Police works hard to safeguard the health and wellbeing of its workforce. All staff in the public protection unit (PPU) have twice-yearly health checks. More support is available through confidential counselling services if it is needed. Managers have given extra support to staff during the COVID-19 pandemic.

The force has recently trained 1,200 frontline staff in vulnerability and evaluated how this has improved its approach to protecting vulnerable people. This training covers adverse childhood experiences (ACEs) and the national referral mechanism (NRM). This is positive and there are plans to roll the training out more widely across the force later in 2021.

But the force needs to improve some of its responses to children who need help and protection. It has made protecting children a priority and senior leaders are clearly committed to this. But decisions about children at risk aren't yet consistently better as a result. Further work is needed to make sure that senior leaders can test what is working well on the front line. And leaders need to make sure that there is appropriate and effective supervision.

We saw examples of good work. Specific areas include:

- the force's comprehensive child-centred policing strategy;
- the availability of 24/7 real-time intelligence researchers in the control room;
- swift information exchange processes with children's social care services and other partner organisations in the multi-agency safeguarding hub (MASH);
- good quality investigations from specialist child protection teams; and
- a good understanding of those children most at risk from child exploitation.

Specific areas for improvement include:

- response to reports of children missing from home or care, including the quality and impetus of enquiries, and longer-term problem solving;
- investigation of online sexual exploitation, including the use of risk assessments to prioritise cases;
- management of registered sex offenders, including how and when they are visited, the recording of information, and effective use of reactive management; and
- treatment of children detained in police custody, including the timely request for appropriate adults and the use of alternative accommodation when children have been detained after charge.

The force reviews quantitative information on the number of child protection incidents and cases it has. But it has limited information about the quality of outcomes. So it is hard for the force to know if officers and staff are consistently making the best decisions for vulnerable children.

During our inspection, we examined 83 cases where the police had identified children at risk. We assessed the force's child protection practice as good in 20 cases, requiring improvement in 35 cases and inadequate in 28 cases. So the force needs to do more to make sure that it gives a consistently good service to all children.

Conclusion

There is a clear commitment from the force's leadership that child protection and wider vulnerability is a priority. And it is committed to improving its services for children who need help and support.

We also found that, while some improvements are needed, senior leaders have strong and effective partnership working arrangements.

Throughout the inspection, we found dedicated officers and staff, often working in difficult and demanding circumstances. The force has invested a significant amount of time and focus on the welfare of its officers and staff.

But, in too many cases, we found inconsistent practices and decision making. The force needs to do more to make sure senior officers' commitment to improving the service leads to better results.

We are optimistic that the force can turn its commitment into tangible improvements for children. We were pleased that the force acted quickly to address areas of concern and arrest suspects identified through our child protection audits. The force recognised the need for both individual and organisational learning because of this inspection. This is welcomed.

We have made several recommendations that, if acted on, will lead to better results for children. We will revisit the force no later than six months after the publication of this report to assess its response.

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 whom they have reasonable cause to believe would otherwise be likely to suffer significant harm. The same Act also requires the police to enquire into that child's case. Under section 11 of the Children Act 2004, the police must also make sure 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 day-to-day duty to protect children. Officers going into people's homes on 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 includes any children who are detained in police custody.

The National Crime Agency's (NCA) strategic assessment of serious and organised crime (2021) reported that the risk of child sexual abuse continues to grow and be one of the gravest serious and organised crime risks. Child sexual abuse is also one of the six national threats specified in *The Strategic Policing Requirement*.[1]

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 organisations involved in child protection (such as the local authority, clinical commissioning groups, schools and the voluntary sector).

The specific police roles set out in the guidance are:

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

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

These areas of practice are the focus of our child protection inspections.

2. Context for the force

At the time of our inspection, according to government figures, Dorset Police had a workforce of approximately:

- 1,283 police officers;
- 1,257 police staff;
- 128 police and community support officers (PCSOs);
- 122 members of the special constabulary; and
- 129 police support volunteers.

Dorset Police provides policing services to the county of Dorset. The area covers 1,024 square miles with approximately 140 miles of coastline in the south west of England.

Although there are some areas of deprivation, Dorset is generally affluent. The population of Dorset is around 0.8m people living in a predominantly rural setting. The force also covers several distinct urban areas, including the towns of Bournemouth, Poole, Weymouth and Dorchester.

The two local authorities in the county, Dorset Council and Bournemouth, Christchurch and Poole (BCP) Council, together with the police and the local clinical commissioning group (CCG), have established a new pan-Dorset safeguarding children partnership (PDSCP) as required by the Children and Social Work Act 2017. The local authority arrangements in Dorset are relatively new, following a reorganisation in April 2019.

An assistant chief constable (ACC) is responsible for child protection throughout the force area. She is supported by a chief superintendent who is the head of the crime and criminal justice command (CCJ), and a detective superintendent who is the director of public protection. Together they oversee the PPU. This consists of specialist teams responsible for protecting children and vulnerable adults.

There is one MASH for Dorset. This is hosted in police premises. Under normal circumstances, police officers and staff work together in the MASH with BCP Council children's social care services and representatives from education and the CCG. Dorset Council are not based in the MASH but contribute fully through online meetings. During the COVID-19 pandemic, most of the people based in the MASH have been working from home.

During our inspection, the force changed its policing model. It formed two local policing areas to mirror the local authority areas in Dorset. It is not yet possible to test the effectiveness of this. But the intention of working closely with local partner organisations to deliver a more effective service makes sense. An ongoing review of

the model for public protection should also give a richer picture of how services could be delivered locally. It is planned that specialist child protection teams will continue to work centrally across the force.

3. Leadership, management and governance

There is a strong commitment to child protection by senior leaders

At the time of the inspection, child protection was a priority for the PCC. The crime and policing plan had four themes and protecting people at risk of harm was prominent. The plan was last reviewed in September 2019 and reflected emerging priorities such as the criminal exploitation of children through county lines. Since our inspection, a new PCC has been elected and is making plans to implement a new police and crime plan.

Alongside this, the chief constable has set his vison for the force to give an outstanding service to the people of Dorset. This focuses on the most vulnerable members of society, where the risk is highest. Children and young people are at the centre of this.

The force has a vulnerability strategy. It is now part of a wider continuous improvement strategy under a newly-formed continuous improvement board. The first phase of work included improvements to the force's approach to domestic abuse. It also included vulnerability training for frontline staff.

To improve its response to vulnerability and child protection, the force has sought independent oversight and advice from not-for-profit organisations and academia. Examples include a SafeLives peer review of domestic abuse and improvements to specialist child interviews with Portsmouth University.

It was clear that officers and staff we spoke to understand the importance placed on protecting vulnerable people, including children.

The force contributes to partnership working arrangements

Working across two local authorities can present challenges. Different systems and processes can lead to an inconsistent service to children. This is made more difficult because the local authorities in Dorset are relatively new. They were formed in 2019 by a local government reorganisation. The force is trying hard to improve joint working and to provide consistently better practices across the county.

Senior leaders from the statutory safeguarding partners described their relationship with the police as very positive at both a strategic and operational level. The force has representation at chief officer level on the PDSCP, the regional child safeguarding board, and is involved in various committees and subgroups. There is an openness

to professional challenge, and access to senior police officers when things need to be escalated.

There is structured oversight at senior and operational levels

The head of the CCJ holds monthly senior management team meetings. While not dealing with vulnerability issues exclusively, these meetings do allow senior leaders to monitor capability, demand, and capacity for child protection. The director of public protection holds monthly and weekly management meetings to focus more on the performance of the PPU. PPU managers attend daily and weekly force meetings to oversee risk, significant incidents, or crimes to direct resources where necessary.

Performance information and quality assurance processes to understand outcomes for children are underdeveloped

The way the force measures performance is limited to quantitative data reporting including, for example, the number of open crimes and length of investigations. The force is investing in new software which we were told would give a more interactive approach to performance management and mapping functionality. But this is unlikely to be introduced before the end of 2021. So the force can't fully understand the outcomes it provides for children.

The current auditing framework is also limited. We saw that the force conducts comprehensive reviews across the PPU teams. But it does limited qualitative analysis to understand whether staff are consistently making the best decisions for vulnerable children.

The force needs to do more to check that decisions about children meet expectations.

The force recognises the many aspects of abuse and exploitation, and works in partnership to protect children

A new multi-agency operation in the BCP local authority area addresses children subject to criminal exploitation. This involved the development of a multi-agency arrest strategy. When the force is going to make a planned arrest related to child exploitation, it involves partner organisations beforehand. Children's social care services may be present when the arrest is made. This means the force and its safeguarding partners can promptly make protective plans for the children involved with a greater understanding of their experiences.

Officers and staff involved in protecting children are dedicated and enthusiastic

Throughout the inspection, we encountered highly-motivated officers and staff who talked with enthusiasm about their work.

Those who manage child-related investigations are committed and dedicated, and often working in difficult and demanding circumstances. But some specialist officers expressed concern about the volume of work they were expected to deal with.

The force has invested a lot of time and energy in the health and wellbeing of its staff

PPU staff have health checks twice a year. And the force intranet includes signposting to many other resources for staff to use to improve their mental and physical health. This includes a free, confidential psychological support service (Frontline19).

During COVID-19, managers have been innovative in keeping in touch with and supporting their teams. We heard about COVID cafés and a buddy system.

4. Case file analysis

Results of case file reviews

For our inspection, Dorset Police selected a random sample of cases and self-assessed how it had dealt with 33 child protection cases (details of case types and methodology can be found in Annex A). Force assessors graded force practice as good in 29 of the 33 cases, as requiring improvement in 4 cases, and none as inadequate. We assessed the same cases and graded the force's practice as good in 4 cases, as requiring improvement in 17, and as inadequate in 12.

Cases assessed by both the force and HMICFRS

Force assessment:

- 29 good
- 4 requires improvement
- 0 inadequate

HMICFRS assessment:

- 4 good
- 17 requires improvement
- 12 inadequate

50 additional cases assessed only by HMICFRS

HMICFRS assessment:

- 16 good
- 18 requires improvement
- 16 inadequate

We found that the force reviewers didn't always consider the totality of the child's circumstances, or wider safeguarding considerations about other children, or wider risk from perpetrators. They also concentrated on the initial response and the immediate matter at hand, rather than considering the overall service across the lifetime of the incident.

Our inspectors focus on the outcomes children receive due to police involvement. We consider the experience from the child's perspective and whether vulnerability and risk are sufficiently recognised and addressed through effective safeguarding measures.

Of the 83 cases assessed, we referred 9 back to the force because our analysis of the records found that there were still serious concerns. For example, failures to make sure that police or partner organisation activity was protecting children, or where it appeared that a child may still be at risk of significant harm from an offender because there had not been a meaningful intervention. The force responded to all our concerns. Senior managers reviewed the cases, updated risk assessments, and resolved the outstanding issues.

Breakdown of case file audit results by area of child protection

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

Enquiries under section 47 of the Children Act 1989:

- 6 good
- 3 requires improvement
- 5 inadequate

Common themes, shown in the files, include:

- good evidence of the recording of the views, thoughts and feelings of the children in most cases;
- staff in the specialist teams are well trained;
- good use of investigation plans and strong supervision in the specialist teams;
- a reliance on children's social care to request strategy meetings leading to some delays; and
- a lack of professional challenge to inappropriate decisions at strategy meetings.

Cases assessed involving referrals relating to domestic abuse incidents or crimes

Referrals relating to domestic abuse incidents or crimes:

- 4 good
- 3 requires improvement
- 4 inadequate

Common themes:

- The initial response to incidents is generally good. The control room staff identify risk and pass the information to the responding officers to aid decision making.
- Completion of the domestic abuse stalking, harassment and honour-based violence (DASH) risk assessment is good. It includes comments for further contextual information.
- Police protection notices (PPNs) are routinely submitted for children in the household whether they are present at incidents or not.
- Recording of the views, thoughts and feelings of children is inconsistent. While there were some good examples, this was not so in every case and in some cases the children weren't spoken to at all.

- The supervision of investigations is generally poor. Supervisor entries in police systems are limited and do not drive enquiries. This can lead to drift and delay.

Cases assessed involving referrals arising from incidents other than domestic abuse

Referrals arising from incidents other than domestic abuse:

- 3 good
- 2 requires improvement
- 5 inadequate

Common themes:

- when children are clearly at risk, officers often attend quickly to make sure children are safe;
- delays in responding to some incidents where risk is less clear but a swift response is still needed; and
- wider safeguarding concerns aren't routinely considered. The force focuses on the immediate incident and not the broader circumstances in which children are living.

Cases assessed involving children at risk from child sexual exploitation

Cases involving children at risk of child sexual exploitation both online and offline:

- 1 good
- 5 requires improvement
- 8 inadequate

Common themes:

- high quality investigations, joint working and safety planning in relation to children most at risk of criminal exploitation;
- children appropriately diverted from criminal justice processes when they had committed offences through exploitation;
- inconsistent use of flags on police systems for children at risk of exploitation;
- delays in progressing online exploitation cases;
- errors in risk assessments used to prioritise cases of online exploitation; and
- children's social care not being told about children at risk in online exploitation cases until after the police had taken action.

Cases assessed involving missing children

Children missing:

- 1 good
- 3 requires improvement
- 3 inadequate

Common themes:

- delays in the control room when completing risk assessments and allocating incidents to officers;
- some risk assessments didn't reflect known risks to children who were missing;
- poor investigations that didn't reflect risk and had limited activity to trace missing children – particularly overnight;
- inconsistent quality of information recorded in missing person reports;
- outcome of referrals to children's social care services unclear with no evidence of strategy meetings; and
- inconsistent longer-term problem solving to reduce the number of missing episodes.

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

Children taken to a place of safety by police officers using powers under section 46 of the Children Act 1989:

- 4 good
- 2 requires improvement
- 0 inadequate

Common themes:

- frontline officers usually consider the circumstances of vulnerable children and make good decisions to remove children using police protection powers;
- designated officers are often not intrusive enough when reviewing the case to make sure the powers are still appropriate. They should, but don't usually, speak to the children involved (or their families) to gain their views to aid decisions;
- record keeping is often poor. The period of police protection is often allowed to lapse with no clear update about what has happened to the child;
- strategy meetings are held with children's social care services and other partner organisations to develop longer-term protective plans for children; but
- the police don't always investigate the circumstances in which children have been found.

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

Sex offender management where children have been assessed as at risk from the person being managed:

- 1 good
- 7 requires improvement
- 1 inadequate

Common themes:

- the frequency of home visits to registered sex offenders is not in accordance with national guidance;
- home visits for most registered sex offenders are not taking place in person;
- the use of reactive management is inconsistent and not always in accordance with national guidance;
- the Violent and Sex Offender Register (ViSOR) database isn't always being used according to national standards; and
- breaches of sex offender notification requirements are not always investigated properly.

Cases assessed involving children detained in police custody

Children in police custody:

- 0 good
- 10 requires improvement
- 2 inadequate

Common themes:

- attendance of appropriate adults at the custody office is timed to coincide with other events, such as interviews, rather than to promote the welfare of the detained child;
- children are not being transferred to alternative accommodation when they have been charged and denied bail; and
- children in custody are not always referred to children's social care services.

5. Initial contact

Frontline officers and staff are generally well trained

The force has trained 1,200 frontline officers using a programme called Vulnerability 2. This was developed with the Children's Society, a national charity that works with children facing abuse, exploitation and neglect. Vulnerability 2 focuses on how officers and staff record their concerns about vulnerable people. The force evaluated the programme and found trained staff felt better equipped to deal with vulnerable children.

Force control room staff are less well trained

Force control room staff have not received vulnerability training for some time. We were told that, before the COVID-19 pandemic, the force held 'power hour' continuing professional development events. But these have not taken place during the pandemic. We are aware that the force plans to roll out the Vulnerability 2 training to those staff from August 2021, and Domestic Abuse Matters training in October 2021.

When members of the public contact the force, it usually assesses risk well

Force control room staff receive all calls for service made to the force. Call takers get as much information as they can about the incident and the people involved.

We saw consistent use of the risk assessment of calls using the THRIVE model (except for most missing children cases). Call takers use specific question sets to gather information. The force also has separate domestic abuse, stalking and harassment, and missing person risk assessments. So, initial and more in-depth risk assessments help decide the most appropriate response to incidents.

The force uses vulnerability flags within the Niche system. So users know when they need to look further into the system to understand the ongoing risk. This was evident for children on a child protection plan or for registered sex offenders. But it was less consistent for children at risk of exploitation or for those regularly missing. On a positive note, unaccompanied migrant children are flagged.

A 24/7 intelligence function in the control room gives real-time intelligence support. This further aids risk assessment processes and decision making about how to respond to calls for service. During our inspection, it was clear that call takers passed this information to attending officers. So officers were aware of the history of the

address or family before they got to an incident. This helps them make better decisions.

Positive practice

Police received a 999 call about a 16-year-old boy involved in a domestic abuse incident with his mother. They had an argument at their home, in the presence of two younger children aged four and five. Arguing and crying could be heard on the call. The female listed at the address had a high-risk domestic abuse flag on the police system.

Police officers were informed of the risk and attended promptly. They spoke to the 16-year-old away from his mother. The officer recorded the boy's thoughts and feelings and noted the demeanour and presentation of the younger children and their home environment.

The officers submitted a PPN and shared it with the family's social worker.

We found that there were some delays in deploying officers to incidents involving vulnerable people

During the inspection we found that there were many calls that had not yet been responded to. We conducted a snapshot of live incidents and found 121 such calls. Of these, 45 included an element of vulnerability involving, or potentially involving, children. Four of these calls were over four days old; four were over five days; one was over six days; and two were over eight days old.

While there was no evidence of immediate risk, these delays are concerning. They mean that vulnerable children can be left without an appropriate police response for extended periods.

There are some processes in place to review and reconsider risk in this backlog. But we didn't see any evidence of challenge, or decisions about an appropriate resource to deploy. When the police response was subject to considerable delay, informants were not consistently re-contacted or updated. This means that emerging or escalating risk may not be identified.

The force control room completes some quality assurance processes, but we saw examples where risk was not properly understood

The force has a quality assurance process where supervisors audit one call per month per call taker. Supervisors use the information to assure themselves that vulnerable people get an appropriate response and are safeguarded. But, through our case audits, we saw that the assessment of risk wasn't always consistent.

Case study

The mother of a 15-year-old boy reported him missing from home. The child had been missing regularly on other occasions. A report the previous day outlined that the boy had attempted suicide in the past.

The initial call taker gained a good level of detail about the mental health issues and continuing suicidal thoughts. But the case was only graded as a medium risk. There was no rationale stated as to why it wasn't high risk.

There was a very limited investigation to try and find the child. Officers did not visit the area where the boy had attempted suicide and had been found previously. The child's mother gave an address where he might be, but this was not visited for four hours.

In total, the child was missing for more than 17 hours overnight. He was found by a police officer by chance. During that period, there was no reassessment of risk and no concerted effort to find him.

We saw some good examples of officers responding quickly to clear and specific concerns about children

When the concern is clear and specific, officers often attend quickly. They carry out initial tasks well, such as making sure the immediate safety of children and assessing how best to proceed. We also found officers can be good at making initial enquiries and using their powers to arrest or protect when necessary.

Positive practice

Police received an anonymous call reporting that two children aged five and seven were being neglected and living in squalor. The caller reported 50 cats living at the address, where the father also had a cannabis farm.

The initial response from the control room was good. The call taker obtained full details and – through other enquiries – got the details of the family involved. They added full details to the incident log so that officers had the extra information.

Officers attended the scene promptly. The details about the living conditions of the children appeared to be malicious. But the officers checked the whole house and spoke to both the children alone to ask about their welfare. The father was dealt with appropriately for possession of cannabis.

A detailed PPN was submitted by the attending officers. It was clear that safeguarding and the children's welfare was at the forefront of the officer's mind. The PPN was discussed at the MASH, before being shared with Dorset Council's Early Help scheme.

Officers don’t always speak to children to understand how they are feeling, or record their behaviour and demeanour

Body-worn video can be a useful tool in progressing victimless prosecution. It can give insight into the lived experiences of children. Officers told us that body-worn video cameras are always used for domestic abuse calls. This means all interactions and observations are recorded. Officers may also use their video cameras for child protection incidents. For example, to record the living conditions of neglected children.

How a child behaves or what they say gives important information about how an incident has affected them. This is especially true when the child is too young to speak to officers or when there might be a risk if a child spoke with a parent present. The police should watch how the child behaves and listen to what they say. This will inform both the initial assessment of need and the decision as to whether to refer a child to social care services.

In the cases we looked at, the recording of the voice of the child was not always as good as it could be. The force did not always take opportunities to understand the lived experiences of the children involved.

Recommendations

- We recommend that Dorset Police immediately reviews the force control room response to incidents where children are involved. It should make sure that the response reflects the identified level of risk, including ongoing or escalating risk.
- We recommend that, within three months, Dorset Police acts to make sure that children’s concerns and views are obtained and recorded (including noting their behaviour and demeanour).

6. Assessment and help

The police team within the MASH shares information with children's social care services and other partner organisations.

The submission of PPNs and their quality is inconsistent

When an officer has a concern for a child, they are expected to submit a PPN via the Niche system. We found that, in most cases, officers submit PPNs. But this was less evident for children arrested and detained in custody. This is mitigated to a certain degree by a daily search conducted in the MASH of all children arrested. The results of this are shared with children's social care services. But the failure to submit a PPN for these children means the force does not share a richer picture of contextual information with partner organisations. So the risk assessment can be incomplete.

In some cases, the forms are updated with details of the thoughts, views and feelings of children. But this is not so in every case. The PPN does not always record wider safeguarding concerns. There is often a focus on the immediate incident and not the broader circumstances in which children are living.

We were told, though, that the Vulnerability 2 training has made officers and staff more professionally curious. This has started to improve the quality of PPN submissions.

If an officer doesn't submit a PPN, the force can't consistently identify this because incidents logs may be closed without further supervisory oversight. We have seen instances where research done about a child and family before a strategy meeting identified previous incidents which should have generated a PPN. But this had not happened. This could leave children at risk, as they won't receive the help they need, at the point they need it.

Information about children at risk is shared swiftly with children's social care services and other partner organisations

Police staff in the MASH review all child-at-risk PPNs and apply a RAG (red, amber, green) rating. This tells children's social care services the order in which the PPNs should be considered.

In July 2020, the system was improved by a joint twice-daily triage of PPNs graded amber and green with children's social care services for Dorset, but not with Bournemouth, Christchurch and Poole. This lets police share information about known risks early on. Social workers can then signpost the child to the most appropriate service. This system has led to an increase in cases assigned to early help provision, and to a 60 percent drop in contacts created for social workers. This should help

prevent problems escalating to the threshold for statutory intervention, with the appropriate level of support being provided to children and families. More recently, the force has started sending all green-graded PPNs directly to early help services. So information gets shared even more quickly.

As this system is not in place across Dorset, we found cases where the lack of research hadn't identified broader risk to other children, or from perpetrators.

Case study

A nine-year-old girl contacted her father, as she was present when her mother and new partner were involved in a domestic incident. The father, in turn, contacted the police.

The police found the child's mother and her partner extremely intoxicated. The child's father took the child to stay with him for the night.

Officers took full details of the parties involved and submitted a PPN.

Another incident was reported the following night, as the father of the child wouldn't allow her back to live with the mother. A further PPN was submitted but this didn't generate a strategy discussion.

During the inspection, we found that the partner of the child's mother had been wanted by the police since 2019 for a sexual offence committed against a 15-year-old child in 2018. The male was still in a relationship with the nine-year-old child's mother.

We sent this case back to the force as we were concerned that the child was at risk from this male. The force response was swift, and the male was arrested. The child's social worker was contacted and a plan was put in place to make sure the child was safeguarded.

Domestic abuse cases assessed as high risk are referred to multi-agency risk assessment conferences to make longer-term safeguarding plans

In the Dorset local authority area, there are four high-risk domestic abuse (HRDA) meetings a week. We observed a HRDA meeting and saw quick assessment and management of the risks through effective information sharing with a broad range of partner organisations. But we also saw that sometimes there are delays in hearing the cases.

We saw a backlog of domestic abuse PPNs waiting to be assessed

All PPNs relating to domestic abuse incidents are subject to further assessment and research. This identifies repeat MARAC cases and cumulative and escalating risk. But we identified a backlog of 154 medium- and standard-risk cases. This was subsequently reduced to 78 during the inspection.

We were told that the force identifies high-risk domestic abuse incidents and those involving children through a triage process. They are shared straight away with safeguarding partners. But we identified a gap in this process: previous incidents are not checked at this triage stage to see if children have previously been involved. We were told about a case that was processed seven days after it had occurred. Research indicated that previous incidents involving this family or address had involved children. This delay could leave children at risk.

The force shares information about children involved in domestic abuse incidents with their schools

The force has recently introduced Operation Encompass to improve how it supports children affected by domestic abuse. But, at the time of the inspection, seven schools in Dorset had not signed up to the scheme. If details of the school(s) attended by the children involved are not in the PPN, police staff in the MASH can check local authority systems for that information and update the PPN. But this is only the case for children in BCP, and not the Dorset local authority area. So, for these children, there could be a gap. Schools cannot get vital information to offer appropriate support.

Strategy meetings are usually requested by children's social care services

Police contributors to strategy meetings are constables in the MASH. Although they have received some multi-agency safeguarding training, none of them is a child protection specialist.

We are concerned that these officers may not have enough seniority, skills and knowledge to contribute effectively to decision making. We saw little evidence of challenge or escalation where the police felt that a strategy meeting should have been held, or if an inappropriate decision had been made.

Case study

A strategy meeting was requested by children's social care services due to a mother attending hospital late at night with her two-month-old baby. The baby had bruising which neither the mother nor the assessing doctor could explain.

The mother advised that she had left the baby, along with his six-year-old and nine-year-old siblings, in the care of their father the previous day. She noticed the bruise when getting the baby changed after returning home.

A strategy meeting was held the same day. Information was shared from the health representative that the father had previously suffered mental health issues and, until quite recently, had been taking medication for anxiety.

The decision from the strategy meeting was that children's social care services should lead an investigation.

There was no further police involvement. This decision was not challenged, there was no update provided and the police should have been involved in the investigation in this case.

Detective sergeants in the MASH close all incident logs relating to strategy discussions. But the force should reassure itself that this process is robust enough to identify inappropriate decision making and escalate these concerns to children's social care managers.

The force is good at contributing to child protection conferences to make longer-term safeguarding plans

Dorset Police employs four dedicated members of staff to undertake research for and attend child protection conferences. Force data shows 100 percent attendance at initial conferences and 94 percent at review conferences. During these meetings the force contributes to longer-term safeguarding plans.

If children are placed on a child protection plan, the case is flagged in the Niche system. This means that officers attending incidents will be aware of the vulnerabilities of the children involved.

The force makes good use of controls placed on domestic abuse perpetrators

A Domestic Violence Protection Notice or Order (DVPN/DVPO) protects a vulnerable victim, allowing an officer and the courts to prevent a suspected perpetrator from returning to a victim's home and/or contacting the victim. The force issues a DVPN as an emergency measure and then applies to magistrates for a DVPO. Between April 2020 and March 2021, Dorset Police issued 153 DVPNs, with the courts subsequently authorising 151 DVPOs.

The force has a team of lawyers to help with this process and professionalise the approach.

There is a good understanding of children at risk of exploitation

The force intelligence bureau (FIB) has a dedicated children's desk. It does scanning, research and analysis about children at risk of exploitation. Where required, analytical reports identify children most at risk, hotspot areas and people presenting a risk to children through exploitation.

The force gets information from partners such as social workers and other professionals working with children, using a partnership information sharing form. It can directly submit information to the FIB for this to be converted into intelligence.

Referrals about children at risk of exploitation are assessed in the MASH using a risk assessment tool. This determines the level of risk and allocates the case to the most appropriate lead agency.

To manage the police response, higher risk cases are allocated to the integrated missing person and child exploitation team (IMPACT). Lower risk cases are allocated to the neighbourhood policing team (NPT). Staff from these teams keep in touch with children and their families, supporting them and building their trust.

Officers from these teams attend multi-agency meetings held in each local authority area. They contribute to joint planning about these children and those who pose a risk to them. Multi-agency safety plans are created and flags added to the relevant Niche records.

We also saw good evidence of the force working with other organisations to reduce the risk to children and, where possible, target perpetrators.

The standard of missing children investigations is poor

Force policy states that missing children can't be assessed as being at no apparent risk or low risk. Consequently, we found that children are routinely graded as medium risk. But, in some cases, we saw significant concerns such as self-harm, mental ill health and exploitation. In these cases, a high-risk grading may have been more appropriate. There was a lack of rationale as to why such cases had been graded as a medium risk.

Case study

A 16-year-old boy in local authority care was reported missing late in the evening by his supported accommodation. He was a regular missing person and at high risk of criminal exploitation. He was involved in gangs, was a drug user and had been known to carry knives.

The call taker took relevant details to inform the missing person risk assessment. Further intelligence checks were also completed. The case was graded as medium risk. A control room supervisor did not review the case until 70 minutes after the call was received. There was no explanation as to why the case was graded in this way, given the recognised risks for this child.

The child was missing for just over three days and returned of his own accord. While he was missing there were very few enquiries conducted to find him.

In most cases we looked at, there were delays and limited enquiries to trace the child. We were told that there was often a lack of resources for regular missing children cases.

We found the initial actions were often templated and generic. They were not specific to the child and their circumstances. This means that opportunities to quickly find missing children may be easily overlooked. Despite regular and, in some cases, detailed supervisory reviews, we only saw one case where the lack of urgency was challenged. The force's daily tasking meeting covers children who have been reported missing. But there was no evidence that this improved the response.

We found a lack of professional curiosity at the point of reporting and when the child was found. This means that the force may not get all relevant information to safeguard the child. The force consistently completes prevention interviews but sometimes only limited detail is recorded. Also, the voice of the child can be lacking. So the force may lose out on valuable intelligence to prevent future episodes and safeguard the child.

We were told that local authorities complete return home interviews. But we found no evidence of them on police systems. So any intelligence gained is not available in the event of future missing episodes.

PPNs are inconsistently completed for missing children, and, together with missing person reports, do not always contain an appropriate level of detail. The outcome of police referrals to children's social care services and any ongoing multi-agency safeguarding is also often not clear. Sometimes a strategy meeting is warranted after a missing episode. But we saw no evidence that the force considers such meetings.

Case study

A 17-year-old girl in the care of the local authority failed to return to her supported accommodation. This was reported to police at about 2am.

The force completed a missing person risk assessment and found that the girl had 25 previous missing episodes and was believed to be meeting an unknown male. She was known to police, children's social care services and other organisations. This was because of concerns about her risk of sexual exploitation. Further intelligence checks identified two associates.

The initial risk grading was medium. Despite the concerns, there was no explanation given for the risk level.

There was no substantive action to find this child and she returned of her own accord. She was missing for 18 hours.

During this period there were several supervisory reviews of the case, but this did not lead to any meaningful response.

The child said that she had stayed at the address of one of the associates identified in the early intelligence research. So, with basic enquiries she could have been found and removed from the risky situation.

The next day, the police conducted a prevention interview with the child, but she would not engage.

There were no follow-up enquiries to find out what the relationship with the male was. And there was nothing done to stop the girl from meeting the male again. There was also no consideration of the wider safeguarding risk that he may pose to others.

A PPN was submitted to children's social care services, but there was no evidence of a strategy meeting. There was also no record in police systems of the local authority return home interview.

The management of cases involving regularly missing children is inconsistent

We were told that the responsibilities of the IMPACT team have changed. They no longer manage, monitor and problem solve for regular missing children cases unless there is an element of exploitation in the case. This change is not widely understood across the force.

Some staff we spoke to during the inspection told us about a missing person "top 10" while others referred to a "top 3", Other staff spoke about a missing person team. There are plans to create one, but it is not yet in existence.

Each of the NPTs in Dorset is expected to adopt the top 3 missing children together with the top 3 missing from and found at locations in their areas. This is to provide

a proactive multi-agency approach to problem solve and reduce the number of missing episodes.

But there is inconsistency in how NPT officers understand their responsibilities in managing the process. We were told by one supervisor that this should involve clear rapport building, problem solving and partnership working to prevent future episodes. Others indicated there was no engagement with partner organisations other than through care homes. They saw their primary purpose as ensuring care providers were complying with the Philomena Protocol.

Supervisors on each of the NPTs have flexibility about how to select children to be in the top 3 list. This means that in some areas the children may be selected according to the number of missing episodes, while in others it is based on the level of vulnerability of the children.

This inconsistency undermines the purpose of the process. It means that the force cannot understand the work being done. And the force cannot be assured that it is taking appropriate steps to reduce the risk to children.

The recording of information about regularly missing children is also inconsistent

For each of the children identified through the top 3 process, the force should create a repeat missing management log and flag the individual's record. But this did not happen in some of the cases we looked at. Even where logs had been created, we saw limited information recorded. So should these children be seen by the police, officers and staff would not be aware of their risk. And they wouldn't know about work being done to mitigate that risk.

There is also a pan-Dorset log in Niche that should be updated by the NPTs indicating who their top 3 are. This log wasn't being used consistently, and the NPT was retaining information and knowledge about individual children. This means that the force cannot have a clear understanding of what is being done to manage the risk posed to and by regularly missing children.

Recommendation

- We recommend that Dorset Police immediately reviews its missing persons arrangements and practices to ensure that throughout the missing episode there is always an effective response to missing children.
- We recommend that, within three months, Dorset Police carries out a review including (where relevant) with statutory safeguarding partners. This should consider how the force is meeting its responsibilities as set out in *Working Together* when it comes to assessing risk, sharing information, participating in strategy meetings and developing joint investigative and protective plans.

7. Investigation

Officers in specialist teams are well trained

Officers in the child abuse investigation team (CAIT) and IMPACT are well trained. Most staff are detectives or are on a pathway to becoming one. This is a similar position with the specialist child abuse investigation development programme (SCAIDP). There is also a process to provide continual professional development for ongoing SCAIDP accreditation. The learning and development department hold a skills matrix which is used to identify future training requirements.

There are some opportunities for multi-agency training. But this is not co-ordinated through the learning and development department. There may be an opportunity for the force to better use this training through central co-ordination.

We found some examples of investigating officers using a good mix of investigative and protective approaches

Through cases we looked at, we saw evidence of good joint investigations. These investigations have appropriate investigation plans and supervisory oversight.

Positive practice: IMPACT investigation

A 14-year-old girl was groomed and raped by a 23-year-old man.

Safeguarding measures were promptly put in place for the victim and her sibling.

The male was quickly arrested and later bailed with conditions to protect the victim and other children. This was a well-recorded investigation, with all relevant documents added to the record. There was also meaningful supervisory oversight of the investigation.

There were no unnecessary delays in the case and relevant flags were placed in police systems highlighting vulnerabilities and risk.

At the time of our inspection, the force had completed the case file and was waiting for a CPS decision.

Positive practice: CAIT investigation

A 7-year-old girl reported to her mother that she had been sexually touched by her grandfather. This was reported to the police.

The case was reviewed by a CAIT supervisor. The suspect was arrested, his house searched, and a computer and media devices seized.

A strategy meeting was quickly arranged. This considered the victim, her siblings, and another child who the suspect had access to. A full safeguarding plan was listed, and a joint investigation agreed.

The suspect was interviewed and bailed with appropriate restrictive conditions.

There was good evidence throughout the investigation that it was child-centred. The family got regular updates and the victim was interviewed with the support of an intermediary.

There was good evidence of working with children's social care services. Other potential victims were considered and visited jointly.

This was a well-supervised case. The case file was submitted to the CPS for a charging decision.

Investigations by non-specialist officers are not as strong

Cases involving children managed by non-specialists were found to have weaker supervision. There was a lack of investigation planning in these cases and they didn't always consider the wider risk to victims and children.

Case study: Volume crime team investigation

The police were called to a domestic abuse incident involving an 18-year-old female and her 19-year-old partner with whom she has a 5-month-old baby. They were classed as a high-risk MARAC couple. The baby and another child were present during the incident.

The control room response was good, the THRIVE risk assessment identified the risks and further research identified the MARAC history.

The police attended promptly. Although the male was originally arrested, he was soon released and taken to a friend's house. The attending officers also didn't check on the welfare of the children.

Officers reviewed the incident upon return to the station and the suspect was arrested again six hours later.

The investigation was desk-based while the suspect was in custody. The victim and other witnesses were contacted by phone, but no statements were taken from them.

The suspect was released under investigation. This meant that restrictive bail conditions could not be applied.

After 25 days, a statement was taken from a neighbour who provided mobile phone footage of the incident. This showed the suspect smashing something against the door, shouting, swearing and kicking it open to gain entry.

This further evidence was obtained on the same day as the initial child protection conference, but it wasn't shared. That meeting decided that the threshold for a child protection plan had not been met.

The file was reviewed by a supervisor 16 days later. He advised that the suspect be summonsed for a public order offence. No further investigation or other offences were considered.

The force did not apply for a DVPN or DVPO.

We are concerned about the force's response to online child exploitation

The police online investigation team (POLIT) is responsible for most of the force's investigations into child exploitation online. The force has recognised that there are capacity issues in this team through the use of the management of risk in law enforcement (MoRILE) model. So it has allocated more resources to this team. But not all are in place yet and some will not be permanent.

At the same time, the force has seen more referrals from the NCA. At the time of the inspection this had led to a backlog of NCA cases (25 awaiting allocation and 20 in development).

We found errors in risk assessment processes to identify children at risk

To prioritise these cases the force completes a risk assessment.[2] The MASH and FIB conduct research (including with safeguarding partners) to identify if there are any children at risk. Details of the research are added to the Niche record. This is good practice, as information from partner organisations will help to identify if there are children at risk.

But delays and errors in the completion of the risk assessment means that cases involving children are not always prioritised. In some cases, we saw the risk assessment done just before a search warrant was executed or an arrest made. This could be some weeks after the information about children at the address was known. This leaves children at risk.

Case study

The force received two NCA referrals in February and March 2021 about a subject downloading indecent images of children. Enquiries indicated that the subject may be a teacher and that there was a one-year-old child living at the address. The risk assessment wasn't completed until after the second referral. This assessed the case as low risk. It said – wrongly – that the subject had no unsupervised access to children and was not working in a trusted position.

The arrest took place seven weeks after the initial referral. This left the child at risk during this period. It was established that the subject was a teacher at a primary school. The local authority designated officer was informed and a PPN submitted for the child.

Law enforcement tools to identify peer-to-peer file sharing of indecent images of children are not being used consistently enough

The force has a policy relating to indecent image file sharing. This states that where only one indecent image is downloaded the case will not be investigated. Cases with less than five images downloaded will be monitored to see if the subject comes to notice again. This policy means that children at risk may not be identified if these cases are not investigated.

The force has access to two systems to support investigations into file sharing of indecent images of children. One system is only accessed once a month, and then only FIIP high-risk cases are extracted from the system and investigations commenced. In total, only eight investigations have been commenced in this way in the last year. The force does not use the other system.

[2] The force uses a tool to assess the level of risk posed by a suspect who possesses and views indecent images of children on the internet, and likelihood of that person becoming a contact offender – someone who commits sexual offences against children.

The failure to use these systems more effectively to identify online perpetrators is potentially leaving children at risk.

Information about children at risk isn't shared soon enough with children's social care services

In the cases we examined where it was believed that children may be at risk, we did not see any meaningful engagement with children's social care services before execution of search warrants or the arrest of suspects. This is even though they may be aware of a latent risk, due to earlier research.

We found that PPNs were only submitted after a search warrant had been executed or an arrest made. We also found that there was little evidence of officers engaging with children. This would help the force understand how the children felt about the police actions and how this may have impacted upon them.

We have also seen some frustration from children's social care services in trying to contact the POLIT team for information.

Case study

In October 2020, the force received a referral about the downloading of 13 indecent images of children. The MASH asked other safeguarding partners for information about the address and its occupants. An immediate response from health services indicated that the subject had applied to be a foster carer.

A social worker tried to find out more, as they were matching a child to the family. But the police declined to give further details at that time.

A supervisor reviewed the case. They indicated that – until the images had been assessed and categorised by Dorset Police – no action was to be taken. This was even though this information was readily available in the initial referral.

The social worker tried to engage with the officer in the case on several occasions to find out more. The POLIT team did not have any direct contact with children's social care services. Any communications appeared to take place via email, the MASH or control room.

The images were reviewed and confirmed as indecent images of children. The subject was arrested two days later. But this was five weeks after the force was informed of the offender's application to be a foster parent. After arrest, it was established the subject was employed as a bus driver transporting children to school.

There have been improvements in digital forensics examinations but there are still some delays

The demand for examination of devices has increased. This is because of more referrals from the NCA and because of wider reporting and identification of offences. The complexity and amount of data on devices has increased, too. So there are delays in digital forensics.

The force uses digital forensic triage software so that only relevant items likely to contain illegal material are submitted for examination. This includes the capability to triage devices at addresses. The POLIT and digital forensics unit (DFU) have two shared digital media investigators. They support searches, attending when a warrant is executed to triage the devices. But this process is for POLIT investigations only. Other teams need to submit all items for examination to the DFU. This contributes to delays.

The Dorset DFU has recently received additional funding to increase resourcing and equipment. Since summer 2020, the additional staff have helped to reduce the backlog of cases. Devices are now being examined more quickly, although there are still delays.

At the time of our inspection there were 39 cases involving computers waiting to be examined and 63 cases involving mobile phones. We were told that it can take up to 50 weeks to have a computer examined.

The force is not using the child abuse image database effectively

The child abuse image database (CAID) helps identify and protect victims of child abuse and provides evidence to support investigations and prosecute suspects.

The force has not had proper access to the system for about two years. We were told that this is caused by IT infrastructure issues. It recorded the problem on the CCJ command risk register several months ago. But it has not done enough to resolve the issue.

In the cases we examined, we saw that a lack of a CAID connection has delayed some investigations by several weeks. Images could only be viewed on discs sent to the force following the referral from the NCA, as they couldn't be remotely accessed on CAID.

When the DFU identifies indecent images of children, it creates a pack of these images. An officer grades and categorises them. We found that there were more than 200 packs that had been graded but not uploaded to the system. We were told, though, that arrangements had recently been made to have these packs uploaded by another police force.

This delay affects the efficiency of the national database. New and previously uncategorised images discovered by Dorset police will not be searchable by other forces. They may also be missed when using triage equipment to scan an offender's device as the image's 'hash' (digital fingerprint of an image) identifier will not be registered on CAID. This reduces the ability of police forces to identify

and safeguard children. And there is a wider impact of these backlogs on the online industry. It uses the unique 'hash' identifier from CAID to scan their platforms for abuse imagery. This allows them to identify and remove images and alert police forces.

This delay may also affect the wellbeing of staff, by failing to reduce the times an image must be viewed and verified nationally by grading officers in other forces.

These are significant problems that affect, not only the force, but the wider police service and other industries. This needs urgent remedial action by the force.

There is usually a child-centred approach to dealing with youth-produced sexual imagery cases

The safer schools and communities team deal with youth-produced sexual imagery (YPSI) cases where there are no aggravating factors, such as exploitation, coercion, or a significant age gap between the parties. The school officers are motivated and well trained. They have a supportive educational approach to children, rather than criminalising them, which would not usually be in their best interests. But we found some frontline officers do not recognise aggravating factors. So investigations are not always conducted appropriately.

Investigating officers are not always seizing devices for examination

School officers do not view or delete YPSI images on mobile devices. They rely on schools and parents to delete them. The force does not always examine seized devices. So there is a risk that devices still contain indecent images when they are returned to children.

The force has invested in equipment to download evidence from mobile phones and other devices. But it can't be used for indecent image of children cases

The force has three 'kiosks' – IT equipment that uses forensic software to extract evidence from mobile devices. To meet increased demand, the force will shortly place a fourth terminal in Poole.

But the kiosks can't be used to triage cases involving indecent images of children and YPSI. So devices from these cases need to be submitted to the DFU for examination. This causes delays.

Recommendation

We recommend that, Dorset Police should immediately improve its child protection and exploitation investigations, paying attention to:

- improving the way cases are risk assessed and recorded;
- allocating investigations to teams with the skills, capacity and competence to carry them out well;
- improving the quality of oversight and supervision; and
- sharing information with children's social care services at the time that a risk to a child is known.

8. Decision making

The use of police protection powers was appropriate in all the cases we saw

Officers use their protective powers appropriately to remove children from harm. It is a very serious step to remove a child from a family. In the cases we examined, decisions to take a child to a safe place were well considered and made in the child's best interests.

In all cases we looked at where police protection powers were implemented, a strategy meeting with partners followed. At these meetings, longer-term protective plans were made.

Positive practice

The police received reports of a female in the street causing a disturbance. Police attended and located her, and a male involved in a domestic abuse incident.

Officers established that it had been going on for over an hour. An 18-month-old child had been left alone for this period. The mother was arrested for several offences, including child neglect.

The child was taken into police protection. Officers liaised with children's social care services and the child was taken to a foster carer.

The officer submitted a detailed PPN. There was a strategy meeting and a joint investigation followed.

We found that record keeping was often not good enough

Submitted PPNs included good detail such as the living conditions and demeanour of the children, and the full circumstances of the incident. But we saw no evidence that the designated officer sought the views of the children or parents/carers when reviewing the grounds for police protection.

As well as the PPN, a police protection log is also completed in the Niche system. This outlines the actions taken during the period of police protection. We found the quality of the information recorded was often poor. It was difficult to understand what was happening and what protective plans were safeguarding the children. In many cases, it was not clear how long the powers were in force. Sometimes the maximum period of 72 hours police protection was allowed to lapse with no meaningful update.

We found some examples where the force had carried out investigations quickly and effectively, and others where it hadn't. The force should fully investigate potential offences. This can contribute to the longer-term safeguarding of the children affected.

Case study

A 12-year-old child was found home alone in the early hours of the morning. The initial response to the case was good with officers promptly locating the child.

The parents of the child could not be found. The officers spoke to an out-of-hours social worker and an inspector. They agreed that the child should be taken into police protection. The officers took the child to a foster carer.

The officers submitted a detailed PPN which contained the child's demeanour, living conditions and captured the voice of the child. Later, there was an urgent strategy meeting. But the force did not start an investigation into any offences.

The police protection forms were not completed and the time and date the powers ended was not recorded. There was no indication that the authorising inspector made any attempt to speak to the child.

Recommendations

We recommend that, within six months, Dorset Police should improve its approach to children taken into police protection, making sure that:

- offences are properly investigated; and
- all relevant information is properly recorded and made readily accessible in all cases where there are concerns about the welfare of children.

Guidance to frontline staff and designated officers should include:

- advice on what information they should record on their systems, and in what form, to help them make good decisions; and
- an emphasis on the importance of making sure records are made quickly and kept up to date.

9. Trusted adult

It is important that children can trust the police. We saw that, in some child protection cases, officers consider carefully how best to approach a child and/or their parents or carers. They explore the most effective ways to communicate with them. Such sensitivity builds confidence and creates stronger relationships between the child and/or the parents or carers and police.

The force has developed a strong child-centred policing strategy

The force has adopted the national child-centred policing model. It has also developed an associated delivery plan. This is reviewed quarterly at the child-centred policing performance meeting, which is chaired by an ACC. This feeds into the force legitimacy board chaired by the chief constable.

We saw several positive initiatives across the force to engage with children, seek their views and identify their needs.

- The force has introduced a new policing in schools model. The safer schools and communities officers work with the 51 schools across Dorset with the most need. The staff have been well trained. They deal with incidents and non-complex crimes from the perspective of children, to achieve the most appropriate outcomes. They also train children and parents about topics including sexually harmful behaviour and digital safety. Between April 2020 and December 2020, 617 children took part in training sessions. NPT officers work with other schools across the county.
- Through the children in care protocol there are markers on the 45 children's care homes across Dorset. The protocol aims to reduce the criminalisation of children in care for low-level incidents and to seek restorative outcomes. Through the markers, all calls received from care providers are scrutinised with the strategic youth co-ordinator. This ensures the force adheres to the protocol and makes decisions in the best interests of children.
- The force introduced a new process in November 2020, to give consistency when accommodation providers register new children's homes in Dorset with Ofsted. Local organisations including the police, local authorities and other partner organisations assess whether the accommodation is suitable. The previous responses to these requests had been sporadic and unco-ordinated. Twenty of these new assessments have been completed. Two of them resulted in the provider pulling out of the purchase of the properties when police raised concerns about known risks nearby. (An example would be areas where children are at risk from exploitation.)

- The youth justice team reviews the case of every child who is arrested or voluntarily interviewed. Where possible, the force seeks out-of-court disposals to divert children away from criminal behaviour. This approach is strengthened by a weekly meeting with the youth offending team and early help, at which they discuss each child. They make sure that, as a multi-agency team, they consider all personal, educational and social circumstances to achieve the best outcome for the offender and the victim.

10. Managing those who pose a risk to children

At the time of our inspection, the Dorset Police management of sexual and violent offenders (MOSOVO) teams were managing 1,083 registered sex offenders, with 850 living in the community. They have 16 offender managers. This is an average of 53 offenders per manager and is a reasonable number.

The force policy for the frequency of visiting registered sex offenders is not in accordance with national policing practice

The police should visit all registered sex offenders at their home address to assess their current risk. According to national policing practice, the force should decide the frequency of these visits for each individual, with reference to their risk management plan.

But Dorset police visit registered sex offenders according to a rigid regime based on 1, 3, 6 and 12 months, according to their level of risk. Dates of future visits are pre-programmed until the end of the offender's notification period. We saw this in all the cases we looked at.

Bespoke risk management plans as part of the active risk management system (ARMS) assessment allow for flexibility in how often an offender should be visited. This would allow the force to focus its resource on those posing the most risk to the community.

Most registered sex offenders are not being visited at home

The force was not visiting most registered sex offenders at home. This practice developed in the initial stages of the COVID-19 pandemic. At that time, the National Police Chiefs' Council lead for MOSOVO issued advice in light of lockdown restrictions. It indicated that face-to-face visits should be considered in accordance with each offender's ARMS assessment and risk management plan. The force interpreted this guidance and stopped visiting medium- and low-risk offenders in most cases. We also saw this in some high-risk cases. The consequence is that the force now has a limited ability to check the home environment and conduct enquiries. It has limited its ability to fully understand current risk from those offenders.

Reactive management of registered sex offenders is being used inconsistently

Lower-risk registered sex offenders who have not come to the notice of the police recently may be considered, subject to specific criteria, for reactive management. This means they are not visited at home but are monitored remotely so the force can focus resources on those posing greatest risk. Any intelligence or changes to their circumstances should trigger a review of their risk assessment. If appropriate, their level of risk can be increased, or home visits reintroduced.

The force manages around 10 percent of the registered sex offenders in the Dorset community reactively. But there is inconsistency across the MOSOVO teams in how an offender is moved into reactive management.

We found that some offenders had been placed in reactive management when they weren't eligible, according to the criteria. For example, they hadn't been managed for three years with police as the lead agency. We also found some offenders in reactive management had breached sex offender notification offences. This should have generated a review of their risk, to determine if reactive management was still appropriate. This increases risk to the public, as these registered sex offenders may be being managed in an inappropriate way.

Local police officers are not routinely aware of registered sex offenders living in the communities they are responsible for

Neighbourhood police officers told us that they are not regularly informed about the registered sex offenders in their area. This lack of awareness makes it harder for the force to understand the risk from registered sex offenders. And it means that neighbourhood officers do not routinely gather intelligence about registered sex offenders. This is particularly important for those offenders under reactive management, who are only passively monitored.

There is a lack of oversight and governance for the MOSOVO teams

Senior officers we spoke to were not aware of the detail of the MOSOVO teams' work. This is made worse because the force routinely collects only a limited amount of performance data. This data is not used effectively to monitor team performance and thereby manage risk. The unit detective inspectors have not received specialist MOSOVO training. We saw no evidence that they undertook qualitative sampling of records to be assured about the quality of work.

The ViSOR system is not being used effectively

ViSOR is the national multi-agency database used to record information about registered sex offenders. The effectiveness of the system depends on the quality and timeliness of information and intelligence recorded in it. The College of Policing has a course that ViSOR users should complete. This makes sure users are compliant with ViSOR national standards. But in Dorset, the MOSOVO teams have not all received this training, with new team members being trained by others in the team.

This lack of training is evident from some of the records we looked at. Use of the system was inconsistent and not always effective. We found that there was a lack of detail on ViSOR records leading to an incomplete picture of the offender's current circumstances. We also found a lack of consensus among offender managers about what should be recorded on the system, if, for example, it was on other police systems. This does not consider that the case may be transferred out of the Dorset police area and the information would not then be accessible. This means that valuable information could be lost or not always visible. And other police or probation officers encountering the offender may not be fully informed about the offender's current situation or risk.

Each registered sex offender should have a risk management plan. Where the lead agency is the police, the MOSOVO officer should create it in response to their assessment of the offender. They should record it in the ViSOR system. These plans should indicate how an offender should be managed to reduce risk of harm and the likelihood of reoffending. Actions should be created from risk management plans and recorded in the action tab on the ViSOR system for completion by the appropriate person. The supervisors in the MOSOVO team should check that all actions have been completed in the timescale specified.

In all the records we examined, we found that the action tab on ViSOR was not used. The offender managers we spoke to were not aware of this function. So supervisors cannot be assured that actions have been completed to mitigate identified risk from registered sex offenders.

Responsibility for the management of registered sex offenders is not reallocated when there are vacancies in the team

We found that there were two vacancies for offender managers in the MOSOVO teams. But the offenders had not been reallocated on ViSOR to other members of the team. They were being overseen by a supervisor. This is of concern, as information may be added to the record, for example by another force, without the supervisor being notified. This could affect the level of risk posed by those offenders. There are more than 100 offenders managed in this way across the force.

Breaches of notification requirements or court orders are not always dealt with appropriately

We found several cases where registered sex offenders breached their notification requirements or court orders, and sometimes both. But the offender manager took no action and did not give a rationale for this decision. Crime reports were not always created. So, the force did not take opportunities to manage offenders and mitigate risk through criminal justice processes. It also provides an incomplete picture of compliance by the offender. This could have an adverse impact upon future risk management processes.

Case study

A registered sex offender with convictions for sexual offending against children was found using an alias name on a social media account. This name hadn't been registered, which was a breach of notification requirements.

Further enquiries revealed that he was in a friendship with a woman who had two children. The woman had visited the offender at his home address. This was a breach of his Sexual Harm Prevention Order. The offender subsequently failed to complete his periodic notification on time. This was a further breach of notification requirements.

Officers did not submit crime reports for these offences and the offender was not arrested or asked to account for them.

Recommendations

We recommend that Dorset Police immediately acts to improve its management of registered sex offenders, paying particular attention to:

- how it monitors offenders through home visits;
- how it uses reactive management processes;
- how it deals with those offenders who don't comply with notification requirements; and
- how it records information.

11. Police detention

The arrest and subsequent detention of children in the cases we looked at was appropriate and necessary in the circumstances.

In most of the cases we looked at, the force held children in youth cells. We were told that the custody suites in the force had separate, discreet booking-in areas for children.

We found long delays in the attendance of an appropriate adult

Appropriate adults should support the child's overall welfare needs, rights and entitlements from the start of the process. But, in some cases we examined, rather than arriving early on in the process, they came at the start of the interview. In some cases, the delay was more than 20 hours.

Children are not being transferred to alternative accommodation when they have been charged and denied bail

The local authority must provide children charged with offences, denied bail, and detained with somewhere suitable to stay. This is known as alternative accommodation. Only in exceptional circumstances (such as during extreme weather) would it not be in the child's best interests to transfer them to such accommodation. In rare cases – for example, if a child presented a high risk of serious harm to others – secure accommodation might be necessary.

Custody officers and staff clearly understand the conditions under which they can deny bail. But when they contact children's social care services to request alternative accommodation, it is not always clearly recorded whether the request is for secure or non-secure accommodation. In the cases we looked at, we didn't see any children being transferred to local authority alternative accommodation. This means children are kept in the police station overnight, which is not in their best interests.

In February 2020, Dorset Police and the two local authorities signed up to a multi-agency protocol – *Reducing the Use of Police Custody for Children in Dorset*. This outlines what should happen to a child detained in these circumstances. We were told that there is always a bed available for children requiring non-secure alternative accommodation. Although there is an escalation process for the police to challenge children's social care services where alternative accommodation is not provided, we didn't see any evidence of this being followed.

Case study

A 15-year-old boy was arrested for being in possession of a knife and causing criminal damage following a disturbance at his home. His mother was involved in the incident and could not act as his appropriate adult.

After 20 hours, an alternative appropriate adult was contacted, just before the police interview.

The boy was charged and remanded in custody. Children's social care services were contacted but did not have suitable accommodation. It was unclear whether alternative or secure accommodation was requested. The child was detained overnight to appear at court the following morning.

A PPN was not submitted about the arrest of this child.

Recommendation

We recommend that, within six months, Dorset Police should carry out a review of how it manages the detention of children. This should be done jointly with statutory safeguarding partners. The review should include, as a minimum, how best to:

- make sure that appropriate adults promptly attend the police station;
- make sure officers consider the needs of the child and refer them to children's social care services, when necessary;
- make sure custody officers are clear about when secure accommodation is or is not needed;
- 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; and
- when alternative accommodation can't be found, escalate the problem to find a solution.

Conclusion

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

Child protection and wider vulnerability is a priority for Dorset Police. The leadership's clear commitment to improving its services for children is demonstrated in many ways in this report. The force works well with partners across both local authority areas. It is an active member in the multi-agency safeguarding arrangements, with appropriate representation at senior officer level.

It is important that senior leaders can test the nature and quality of decision making and its effects on children. Processes for assessing performance don't emphasise this enough. A framework that focuses on the outcomes for children who need protection would help the force improve in this area. It would also make sure that the service offered meets leaders' expectations.

Senior leaders know that there are some inconsistencies and areas for improvement in the service to children. We welcome the response of the force, its engagement with us and its expressed commitment to act quickly to address the areas of concern identified through the child protection case audits we carried out.

Individual frontline officers are doing good work in responding to incidents of concern involving children. We also found that specialist child protection staff are committed and dedicated to keeping children safe.

But we found that outcomes are not yet consistently good. The force does not always recognise broader risks to children. There are some poor responses and investigations, and the management of those who pose a risk to children must be improved. These inconsistencies affect safeguarding and potentially leave children at risk. They need to be addressed to make sure that the force safeguards all children appropriately.

When investigations are well supervised, employ joint working and use effective safeguarding plans, a positive outcome can be achieved for the child. If this model is replicated across all areas, outcomes for all children will be improved. Our recommendations aim to help the force improve in these areas.

Next steps

Within six weeks of the publication of this report, HMICFRS requires an update of the action the force has taken to respond to the recommendations that we have asked it to act on immediately.

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

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

Annex A – Child protection inspection methodology

Objectives

The objectives of the inspection are:

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

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

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

These areas of practice are the focus of the inspection.

Inspection approach

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

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

Methods

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

The purpose of the self-assessment is to:

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

Self-assessment and case inspection

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

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

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