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

# National Child Protection Post-inspection Review

Gloucestershire Constabulary
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# 1. Introduction

## The 2017 inspection conducted by HMICFRS

In February 2017, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS[1]) conducted a child protection inspection of Gloucestershire Constabulary.

In June 2017, we published the report of our findings. This concluded:

> "HMICFRS recognises that Gloucestershire Constabulary is committed to protecting children. We spoke with officers and staff in Gloucestershire Constabulary who are dedicated to the protection of children, and saw examples of effective safeguarding measures being implemented.
>
> "However, overall HMICFRS found that the constabulary is not adequately protecting all children who are at risk of harm and in need of protection. We found serious deficiencies in a number of critical areas including the support, supervision and leadership provided to staff, the quality of investigations, performance management, and quality assurance."

At the time of our 2017 inspection, child protection was a stated priority for the constabulary. This was positive - but many other force priorities had also been set. In addition, officers and staff reported that they were unsure of how to translate this priority into action and decision making on the frontline. HMICFRS considered that this weakened Gloucestershire Constabulary's ability to safeguard children effectively and consistently.

We found limited strategic oversight by senior leaders and a lack of effective supervision of child protection investigations. In addition, we found that performance information to inform the constabulary's understanding of outcomes for children at risk of harm required further development. At that time, the quality of work, outcomes for children and demands for service were not sufficiently well understood by senior leaders. The focus of performance measures was on the quantity of child protection incidents and cases, not the quality. This meant that senior leaders were unable to assess the nature and quality of decision making, and the effectiveness of the constabulary's systems, and processes. This was a significant weakness, and one which we recommended the constabulary address urgently.

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

Moreover, HMICFRS found that the constabulary's approach to tackling child sexual exploitation was inconsistent and that, as a result, children were left exposed to risk. Specifically, we found delays in the attendance of officers at incidents, the timely arrest of suspects, the conduct of interviews, and the seizure of evidence.

Nevertheless, there were also some encouraging findings:

- The constabulary had established a multi-agency child sexual exploitation team, which was developing ways to work with other agencies to safeguard those at risk of child sexual exploitation.
- The constabulary was working schools, licensed premises, taxi drivers and hotels to raise awareness about child sexual exploitation.
- A child sexual exploitation screening tool was being used by the constabulary and partner agencies, such as schools and healthcare professionals. When abuse is suspected, a form is completed and sent to the multi-agency safeguarding hub (MASH[2]), where it is discussed with a lead social worker and action is taken to mitigate risk.
- The constabulary's work to manage individuals posing a risk to children was generally good. The team responsible for this worked proactively to mitigate the risks faced by children from convicted registered sex offenders. Those offenders identified as posing a significant risk were being managed effectively through multi-agency public protection arrangements.

These were positive findings, providing evidence of the constabulary's commitment to protecting children, particularly those at risk of sexual exploitation. However, there were other areas where significant improvement was required. For example:

- the constabulary's approach to missing or absent children was a serious weakness. Risk (including an increased risk of sexual exploitation) was not being identified at the earliest opportunity and/or managed appropriately and, in the cases reviewed, there was insufficient evidence of activity to locate and return many of these children; and
- training relating to child protection and vulnerability, and attendance at multi-agency learning events, was fragmented and uncoordinated; it contributed to evidence of the inconsistent approach we saw during our inspection, which needed to be addressed by senior managers.

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

The report of the 2017 inspection therefore made a series of recommendations aimed at improving child protection practice by Gloucestershire Constabulary.

## The 2018 post-inspection review by HMICFRS

In July 2017, the constabulary provided HMICFRS with an action plan setting out how it intended to respond to the recommendations in the original report. Since then, HMICFRS has continued to monitor the improvement activity undertaken by the constabulary, and in January 2018 a post-inspection review was conducted to assess its progress.

The review included: an examination of constabulary policies, strategies, and other documents; interviews with officers and staff; and an audit of 35 child protection cases (related specifically to the areas for improvement set out in the 2017 inspection report).

**Summary of findings from the 2018 post-inspection review**

In 2017, we reported on the lack of strategic oversight in many areas linked to child protection. This was caused by poor governance structures, arising from an ineffective performance framework. Although many of the post-inspection changes we observed are relatively recent, it is clear that the constabulary has worked hard to prioritise the protection of children, and has established the foundations for making further improvements. Effective governance processes intended to provide more effective oversight are beginning to allow senior leaders to assure themselves about the nature and quality of frontline decision making. While further work is required, this provides the constabulary with the opportunity to ensure that its clear, unambiguous intent to improve is translating into the development of more effective protective plans, and improved outcomes for children at risk.

HMICFRS reported in 2017 that the constabulary had multiple priorities, which had resulted in frontline officers and staff being unsure of which were the most important. In our review, we were pleased to note that this position has now changed. The constabulary has provided much-needed focus on the five highest priority areas (which include both child sexual exploitation and child abuse).

The new assistant chief constable (ACC) is responsible for child protection, and since his appointment has developed new processes to ensure officers and staff understand vulnerability and their responsibilities to safeguard children who may be at risk. However, much of this work is either at a very early stage or has yet to be implemented. It is therefore not yet resulting in improved outcomes for vulnerable children.

Some recommendations have been acted upon more swiftly, and improvements are therefore evident in these areas of practice. For example, the constabulary has improved its approach to the treatment of children in police custody. We also found

that frontline officers are better now at obtaining the views of children affected by domestic abuse, and that this supports the development of more considered protective plans.

The storage and accessibility of information within the constabulary has been greatly improved. The previously multiple IT databases have been transferred to the constabulary's main operating system. This change not only provides a clearer and more efficient way of assessing risk, it also enables better quality information to be passed to officers attending incidents, particularly domestic abuse incidents where children are present.

In contrast, there are some areas of weakness highlighted in our 2017 inspection report where little or no improvement is evident. For example, the referral process has not changed; it remains cumbersome, disjointed, and inefficient, and continues to affect the timeliness of the multi-agency working. In addition, some serious offences involving children (sexual offences, for example) are still being managed by officers and teams without the skills or experience to investigate them properly.

Many of the improvements and initiatives have been recently implemented, and therefore have not yet affected frontline practice to their intended full potential. Perhaps because of this, we found only a slight improvement in the quality of case file audits. In February 2017, HMICFRS assessed 89 cases and rated the constabulary's child protection practice as good in 14 cases (16 percent), requiring improvement in 46 cases (52 percent), and inadequate in 29 cases (33 percent). Of the 35 cases assessed in this post-inspection review, HMICFRS found the constabulary's child protection practice to be good in 7 cases (20 percent), requiring improvement in 18 cases (51 percent), and inadequate in 10 cases (29 percent). While the recent sample sizes are smaller, this represents a slight improvement in standards but is also indicative of the constabulary's need to build on the progress made.

Overall, our view is that Gloucestershire Constabulary recognises it needs to improve in certain areas, and understands what is required to ensure that it provides consistently good child protection practice. The constabulary has taken some important and positive initial steps to address the recommendations from the 2017 inspection report, and recognises there remains more to be done to improve its protective practices and outcomes for children.

# 2. Post-inspection review findings

## Leadership and governance

Recommendation from the report of the 2017 inspection:

- Within three months, Gloucestershire Constabulary should
    - put in place arrangements which ensure that it has clear governance structures in place to monitor child protection practices, across both non-specialist and specialist units. The constabulary should then provide officers and staff with a clear understanding of what good service looks like and the standards it expects, and begin to develop a performance management framework that will operate to achieve consistent standards of service.

**Summary of post-inspection review findings**

The constabulary has implemented several measures to improve its governance processes linked to child protection. However, many of these improvements are very recent. As a result, further work is required to improve the consistency and quality of frontline practice and supervision.

**Detailed post-inspection review findings**

The public protection service delivery board is now chaired by the ACC, and has been reviewed and reinvigorated as a result of better attendance by partner agencies and the inclusion of the neighbourhood policing teams. Senior leaders are committed to ensuring that all officers and staff understand their safeguarding responsibilities and how to respond when they encounter children who may be at risk.

In October 2017, Operation Guardian was launched to draw together all aspects of child protection to provide clear focus across the organisation on this critical area of policing. Operation Guardian is split into three areas of improvements, namely:

- better training for and supervision of the workforce;
- closer integration with partner agencies and child protection operations; and
- initiatives to raise awareness of child protection and reduce associated offences.

Importantly, it is intended that child protection is recognised as the responsibility of every member of the workforce within the constabulary, and not just those working in specialist teams.

The awareness-raising element of Operation Guardian is being achieved in a variety of ways, including video messages from chief officers, and posters and banners around constabulary buildings. Additionally, there is an informative Operation Guardian page on the force intranet. This contains clear links which officers and staff can follow quickly to access advice on safeguarding when dealing with incidents involving children.

The constabulary has produced a comprehensive training plan for 2018. The plan breaks down the areas of public protection, including areas relating to children, with a clear message that safeguarding is central to all training objectives. Moreover, it provides clarity on the training that each officer and staff member will be expected to undertake, tailored to their respective roles and responsibilities.

It is evident that considerable thought has been put into the development of better child protection and safeguarding training, which is positive. The new training is a departure from traditional classroom or computer-based training, and focuses instead on more interactive learning (namely, scenarios based on real incidents that attendees have to work through). However, so far only a limited number of officers have completed the training, and therefore its intended benefits will take some time to be realised – although HMICFRS acknowledges that a plan is in development to ensure that more staff participate.

The performance dashboard used by the constabulary to manage acquisitive crime (such as burglary and robbery) has been expanded to incorporate child protection data. However, the development and use of this tool is relatively recent, and at present its effectiveness cannot be accurately judged. The constabulary's aim is that this performance dashboard will develop from an information tool into something that can be used to enhance the supervision of child protection (for example, through the inclusion of data relating to strategy meetings and child protection conferences[3]).

The constabulary is piloting a quality assurance framework. As part of this, internal audits will be routinely conducted on a selection of child protection cases. The requirements of the framework are clear: the audits will be carried out every month and will consist of three missing children cases; two child sexual exploitation investigations; ten VIST[4] submissions; two section 47[5] VIST submissions; and one

[3] A child protection conference brings together family members, the child (where appropriate), and those professionals most involved with the child and family, to make decisions about the child's future safety, health and development. *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, February 2017 (latest update). Available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

[4] The Vulnerability Identification Screening Tool (VIST) is an app that is available to all officers on their handheld electronic devices. The completion of the form creates a referral to the central referral unit.

[5] Under section 47 of the Children Act 1989, the police service, working with partner agencies such as local authority children's social care services, health services and education services, is responsible

incident involving the police use and management of section 46[6] powers. This is positive, and provides senior leaders with an opportunity to ensure that the clear strategic intent to improve is translating into better decisions by frontline officers and staff.

## Initial contact

Recommendation from the report of the 2017 inspection:

- Within three months, Gloucestershire Constabulary should:
    - review its processes to ensure that its staff can draw together all available information from police systems in order better to inform their responses and risk assessments; and
    - review its processes for the supervision of the decisions made when police attend incidents where children are at risk or vulnerable.

### Summary of post-inspection review findings

Gloucestershire Constabulary has provided additional training to its control room staff which has increased the effectiveness of the initial assessments of risk. The presence of multiple systems that previously impeded effective decision making has now been addressed; all relevant data is now located on one system that is accessible to all officers.

The initial assessment of risk was appropriate in most of the incidents reviewed by HMICFRS. However, there continue to be examples where risk is not recognised at this early stage. Nevertheless, it is encouraging that second assessments are conducted, in some cases, both by teams and the control room inspector - particularly in relation to risks to missing children.

### Detailed post-inspection review findings

HMICFRS found that the staff responsible for managing incoming calls for assistance are now consistently using the THRIVE model7 to assess and prioritise the response to risk, and we found the initial risk assessment to be appropriate in

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for making enquiries to safeguard and secure the welfare of any child within their area who is suffering (or is likely to suffer) significant harm.

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

[7] The threat, harm, risk, investigation, vulnerability and engagement (THRIVE) model is used to assess the appropriate initial police response to a call for service. It allows a judgment to be made of the relative risk posed by the call and places the individual needs of the victim at the centre of that decision.

most of the incidents we reviewed. However, we also encountered instances where risks to children had been missed completely. In one case example, a decision had been made in the control room not to send officers to an incident relating to an at-risk 7-week-old baby in poor health; on the incident log it was described as a "custody issue", rather than demonstrating recognition of the immediate and potential risks to the child.

In another incident involving a child, the initial risk had been assessed as low (and therefore suitable to be dealt with by the initial investigation unit), despite the presence of clear risk indicators. However, we were reassured to some extent by the reassessment of the incident; the error in the risk grading was discovered and, as a result, it was referred back to dispatchers for appropriate resource allocation. We were pleased to see other such examples where control room inspectors highlighted previously-unidentified risk, and the grading of and response to some incidents involving children was changed as a result.

All control room operatives we spoke to reported that they had received training on recognising child sexual exploitation, and felt confident they could identify relevant risk indicators. Moreover, we found evidence of both the consistent use of a '19-point question set' relating to children reported as missing, and of the timely creation of records on the computer system used for managing missing episodes. Further, for children identified as high-risk or 'repeat missing', we found evidence of early intervention by the missing team, as well as an enhanced response from frontline officers and staff.

HMICFRS was told that to improve the assessment of risks to missing children, officers and staff can refer to a 'top 20 missing children' list. However, at the time of our review this list had not been updated for two months. Moreover, the list is updated a month in arrears, which could limit its potential benefits.

There is evidence that when officers attend newly-reported incidents, control room staff search systems to establish whether there is any information relating to perpetrators associated with the addresses. This practice is particularly common in incidents involving domestic abuse, and increases officers' ability to assess risk accurately. However, HMICFRS found no evidence that information relating to at-risk children at specific addresses is passed on to officers attending. Any such information would further enhance the ability of officers to make effective decisions where children may be at risk of harm.

## Assessment and help

Recommendation from the report of the 2017 inspection:

- Within three months Gloucestershire Constabulary should undertake a review, together with children's social care services and other relevant agencies, to ensure that the constabulary is fulfilling its statutory responsibilities as set out in Working Together to Safeguard Children. As a minimum, this should include:
    - the assessment of risk, how information is shared and the development of joint protective plans;
    - attendance at, and contribution to, initial child protection conferences; and
    - recording decisions reached at meetings, on police systems to ensure that staff are aware and of all relevant developments.

**Summary of post-inspection review findings**

Gloucestershire Constabulary has conducted a review with children's social care services, and a plan is in place to establish (in September 2018) more efficient referral and MASH processes. However, this plan has been slow to evolve, and resourcing in these areas has not changed. As a result, the constabulary is not yet managing demand levels in the most efficient and effective way. That said, HMICFRS acknowledges that plans are in place to bring about improvements to these processes in the near future.

The constabulary conducts a daily assessment of standard- and medium-risk domestic abuse incidents, including those where children are present. This is positive. However, the limited capacity of some decision-makers means the research processes that underpin assessments are insufficiently robust.

The constabulary has increased significantly its attendance at initial child protection conferences. The director of children's social care services told us that this is much improved, and that the representatives were of the appropriate level to enable decisions to be made. However, recording on police systems of joint working to enable more effective risk management for children is still poor, with little change from our findings of the 2017 inspection.

**Detailed post-inspection review findings**

In our 2017 inspection report, HMICFRS highlighted significant weaknesses in parts of the referral and assessment processes within the central referral unit (CRU), and concluded that these were adversely affecting the development of appropriate protective plans for children. In particular, we found delays in holding strategy discussions because increasing demand had not been met with corresponding

increases in staff numbers. Following our inspection, the constabulary commissioned a consultancy firm to assess its processes and demand; the findings largely mirrored those of HMICFRS.

It was therefore disappointing to find in our revisit to the constabulary that this position has not improved. Although there have been some changes to the mechanisms for referral, the referral process itself remains cumbersome, disjointed and inefficient. There are insufficient police decision-makers to meet the demand, which is a vital resource in the referral process, and this results in delays in joint working.

The constabulary recognises the need to improve this process, and plans are well-developed to move the CRU to the MASH by September 2018. It is hoped that this relocation will provide more resilience, resulting in efficient and timely responses to referrals and involvement in subsequent joint working.

When strategy meetings are held, we found poor recording of outcomes and set actions for each agency – including that of the constabulary. We also reviewed incidents for which there was no record of a strategy meeting taking place, even though one clearly had.

At the time of our 2017 inspection, the constabulary was in the process of transferring all child protection databases to a single computer system. This was intended to replace the multiple systems in use, which made it extremely difficult to draw together all the available information to assist in the assessment of risk when dealing with new incidents. This move has now been completed, with child protection data going back five years converted and uploaded. This new system has clearly assisted in improving the timeliness of some assessments of initial risks to children.

The submission of VISTs remains inconsistent, in terms of the breadth and quality of content and their timeliness. Delays in the submission of VIST forms to supervisors (and then onwards to the MASH) are too often affecting the daily domestic abuse multi-agency triage meeting, which can hinder the support and safeguarding provided by the constabulary and partner agencies.

During this post-inspection review, our observation of the daily triage meeting revealed incidents being discussed in isolation, with no detailed consideration of any previous incidents. There clearly were relevant histories to some of the families discussed in these meetings (evidenced by information provided by the independent domestic violence advisors on previous interactions with them). The process appears to be reliant on the memories of individuals present rather than searches of basic information relating to family history, which would enable all attending representatives to approach the risk-management process with more complete information and a fuller context. This weakness may mean that the cumulative risk for standard-risk domestic abuse victims and their children is missed, and that appropriate intervention is not provided. Nevertheless, the review of standard- and

medium-risk VISTs for domestic abuse cases conducted during these multi-agency meetings has many positive aspects; support and safeguarding can be offered to victims and their children, and problems can be resolved.

During our 2017 inspection, we found the constabulary often did not attend case conferences, and that there was a lack of clear, risk-based rationale regarding police attendance. The constabulary has since made significant improvements in its attendance at initial case conferences: figures obtained during our review indicate a 70 percent attendance rate. Decisions to refrain from attending are based on risk assessment, and a comprehensive report is supplied in lieu. Further, there are now three dedicated case conference attendees. As a result, the constabulary now contributes to safeguarding decision making in a multi-agency setting to a much greater extent. Moreover, Gloucestershire Constabulary informed us that it is keen to explore whether investment in new technology would support further improvement in its attendance at meetings, through the use of video and telephone conferencing, which is encouraging.

## Investigation

Recommendations from the report of the 2017 inspection:

- Immediately Gloucestershire Constabulary should take action to improve child protection investigations by ensuring that:
    - it provides guidance to staff that identifies the range of responses and actions that the police can contribute to multi-agency plans for protecting children;
    - every referral the police receives is allocated to those with the skills, capacity and competence to undertake the investigation;
    - investigations are supervised and monitored, with supervisor reviews recording clearly any further work that may need to be done; and
    - it conducts regular audits of practice that include assessing the quality, timeliness and supervision of investigations.
- Take steps to improve practice in cases of children who go missing from home. As a minimum, this should include:
    - improving staff awareness of their responsibilities for protecting children who are reported missing from home and, in particular, those cases where it is a regular occurrence;
    - improving staff awareness of the links between children going missing from home and the risk of sexual exploitation;

- improving staff awareness of the significance of drawing together all available information from police systems, including information about those who pose a risk to children, to better inform risk assessments;
- ensuring that staff are aware of the need to pass this information on to other agencies; and
- identifying the range of responses and actions that the police can contribute to multi-agency plans for protecting children in these cases.

**Summary of post-inspection review findings**

The constabulary has produced an informative booklet entitled *Management of Investigations by Detectives*, which provides guidance and sets out the expectations of officers conducting investigations (including those involving children). Despite this, we found that investigations involving children continue to be conducted by untrained officers. Many investigations lack the appropriate supervision needed to guide activity, and quality assurance audits are in the pilot stage and therefore have yet to affect frontline practice. Our most recent case audits showed that joint working is not always instigated in relation to children who would benefit from it.

The creation of the missing team has helped improve understanding within the constabulary of the risks children face while missing, and the associated links to child sexual exploitation. Moreover, information relevant to child protection is now easily accessible on a single computer system, making the process of risk management more efficient and effective. The introduction of the missing/child sexual exploitation multi-agency risk assessment conferences (MARACs) is a positive step in bringing together partner agencies to mitigate risks faced by children vulnerable to these areas. However, the process for creating and managing trigger plans remains under-developed.

**Detailed post-inspection review findings**

There is a clear understanding across the constabulary, that cases involving children must be classified as missing (and not absent), regardless of the circumstances – this is to ensure that all cases where a child is reported 'missing' should provoke an appropriate response to trace the child. However, in many of the cases examined during our post-inspection review, there was little evidence of activity to trace missing children, and in a small number of incident logs there were unhelpful entries. For example, in one case a 15-year-old boy was reported missing by his mother; it was discovered he was abusing drugs, self-harming and was in the company of an adult male. Despite this, the log was updated with the comment "[this] is a parenting issue". Moreover, in some incidents there appears to be a reliance on children returning home of their own accord, rather than evidence of appropriate activity to trace them.

Although the constabulary's use of trigger plans[8] has increased, they are still not used on all occasions; some require updating, and their quality (and therefore value) varies significantly. Plans are created by children's social care services, and many of those reviewed would benefit from greater clarity about the police activity needed to provide the best chance of tracing and safeguarding the missing child. Moreover, the long-term management of plans is inefficient; much of the relevant information is in the possession of the police, yet it is the named social worker's responsibility to update the plan, which creates unnecessary delays. The current process of creating, completing and managing trigger plans would benefit from a review, to ensure it is effective in guiding police activity and mitigating risks to children.

The most recent completion rate for return-home interviews of 70 percent is a significant improvement on the 36 percent completion rate found at the time of the 2017 inspection. Our feedback to the constabulary on the outcomes and intelligence obtained from these interviews is an improving picture, although the constabulary is aware of opportunities for further improvements.

The multi-agency child sexual exploitation team engages well with the partner agencies, and this enables the constabulary to draw together information for the earlier assessment of risk in identifying vulnerable children. A children's social care services' team leader is the child sexual exploitation co-ordinator for the local authority, and part of the multi-agency team. In addition, there are social workers throughout Gloucestershire who are responsible for assessing children identified as being at-risk of child sexual exploitation, as well as child sexual exploitation youth workers and family support workers. Nevertheless, the limited resilience and capacity of the child sexual exploitation team is affecting its effectiveness: three of the five members are part-time workers, and presently resources do not match demand. At the time of its creation, the team represented an innovative approach to supporting those at risk of child sexual exploitation. However, we were told during our review that there are further opportunities to develop this team to achieve its full potential.

In June 2017, the constabulary and partner agencies introduced a child sexual exploitation/missing children MARAC meeting. The purpose of this multi-agency meeting is to direct short-, medium-, and long-term actions to safeguard children, and to disrupt and reduce the opportunities by which they may be harmed through sexual exploitation and missing episodes. This process is still evolving; it currently deals with an average of 9 children's cases every month, with the intention to expand this shortly to 20 children's cases per fortnight. Although this ambition is positive, our review of minutes of previous meetings found few details of attendees and, on a few occasions, actions set that appeared to be of limited value.

[8] A trigger plan is a plan to locate a child quickly when they go missing.

HMICFRS attended one of the meetings and found missed opportunities to implement protective interventions and agree actions; for those which were set, none was given a deadline for completion. Moreover, although there was good representation both from a broad range of partner agencies and different police teams, there were no officers from the child sexual exploitation team (specifically, the allocated officer relating to a high-risk child whose matter was discussed at the meeting). In addition, the social workers handling the respective children were also absent, which inhibited the exchange of information and subsequent safeguarding activity.

From the decisions reached, it was clear to HMICFRS that this meeting was not used to guide the constabulary's daily activity. For example, discussions were held in relation to a vulnerable 14-year-old girl who was missing at the time of the meeting. Following the exchange of information, it was decided that the child's risk grading should be raised from medium- to high-risk. Despite this decision being relayed to the inspector in charge of activity to trace her, the risk grading had not been changed on the system some five hours after the decision was made (instead, a comment was recorded that there were insufficient resources to deal with the matter if the risk was reclassified as high). Although there was evidence of some limited activity to trace the child, she therefore remained graded as medium-risk.

Although a large amount of information is exchanged and discussed at these multi-agency meetings, it is not recorded in any detail. The constabulary should review this process to ensure there is clear guidance on who must attend, the purpose of any activity, and the requirements for recording information. When we relayed our findings to the constabulary, we were pleased that there was a quick response to review this process to make it more robust and effective.

The submission of intelligence reports by officers on matters of child sexual exploitation is low. There is also a significant amount of information exchanged at the child sexual exploitation/missing MARAC which is not recorded on the intelligence system. This represents a missed opportunity, although we acknowledge that the constabulary recognises this, and that work is underway to ensure this intelligence is gathered and recorded appropriately in future meetings.

Although the missing team was established in June 2017, it was only integrated into the constabulary's current structure in the two weeks preceding the our post-inspection review. Nevertheless, in our case audit we found very early signs of the positive difference the team is making when it is involved in the management of missing children.

A 16-year-old girl was reported missing. She was vulnerable, with mental health problems and had history of self-harm. There was clear intervention, both from the missing team and the missing person co-ordinator. In addition, there was evidence of regular strategy meetings in relation to the child, with representation from the missing team; a trigger plan containing clear instructions to direct activity; and markers on the main computer system highlighting the risks she faced (including that of child sexual exploitation). Moreover, there was evidence of good multi-agency work over an extended period of time.

Despite the missing team's clear motivation to improve outcomes for children, it is too early at present for HMICFRS to assess its overall effectiveness.

Workload demands and staffing levels are adversely affecting the ability of the child abuse investigation team (CAIT) to undertake its role effectively. The constabulary has recognised this, and is undertaking a review of demand and resourcing in its specialist crime teams. Nevertheless, officers from the CAIT remain positive and dedicated to their role, and they expressed to us that awareness of child protection has increased across the constabulary. Further, they reported feeling that, because of this increased awareness, both frontline officer responses to child protection and the recognition of risk has improved; this was particularly evident in the confidence displayed by frontline officers when using their section 46 powers (i.e., taking children who are at risk of significant harm to a place of safety).

In the 2017 inspection report, we highlighted that many child protection investigations were being handled by officers who did not have the skills or experience to carry them out effectively. We were troubled to find during our post-inspection review that this is still the case. Approximately half of those officers in the CAIT have not received any specialist training to conduct complex investigations with child victims. In addition, we also continued to find examples of officers from non-specialist teams investigating serious offences (sexual offences, for example) involving children. The constabulary is aware of this, and further training courses are planned to take place over the next few months. However, during our review we were told that the frequent movement of officers between teams because of the continuing demand review means it is unlikely this situation will improve quickly.

From the cases audited, HMICFRS found little documented evidence of joint working once a child has been identified as at risk of significant harm. It is unclear whether this is due to poor recording practice, or an actual absence of joint working. This omission also applies to the supervision of investigations; in many of the cases examined detective inspector reviews were absent, detective sergeant reviews were inconsistent, and many simply noted enquires conducted to date. Moreover, the use

of investigation plans and their quality also varies significantly. We identified some good examples of plans where supervisors had added to them extensively, but these

were in the minority. Many investigations we inspected included no plan at all, or for those that did, they were often superficial and insufficiently robust to guide investigative activity.

## Trusted adult

Recommendation from the report of the 2017 inspection:

- Within three months Gloucestershire Constabulary should take action to improve child protection investigations by ensuring that officers always record their observations of a child's behaviour and demeanour in domestic abuse incident records so that better assessments of a child's needs are made.

### Summary of post-inspection review findings

Clear improvements have been made in gaining the views of children affected by domestic abuse, as well as of those involved in other incidents where they are potentially at risk. However, this is not the case on every occasion where it would be appropriate.

### Detailed post-inspection review findings

In the 2017 inspection report, we highlighted Gloucestershire Constabulary's need to improve officers' focus on children affected by domestic abuse. In our review, we found this to be an improving picture; there were some good examples of interaction with children – gaining and recording their voices and views - and these extend beyond incidents of domestic abuse. However, this practice is not being applied on all occasions when it would be appropriate.

The constabulary has continued to provide training on 'the voice of the child', and has reinforced the importance of this information through video messages from senior leaders. In our view, the time and effort the constabulary has put into this area has benefited practice and is helping to improve outcomes for children. The quality assurance framework now includes routine sampling of cases to ensure the voice of the child has been considered and recorded, and this should further enhance the constabulary's understanding of its effectiveness in this area of practice.

# Police detention

**Recommendations from report of the 2017 inspection:**

- Within three months Gloucestershire Constabulary should undertake a review (jointly with children's social care services and other relevant agencies) of how it manages the detention of children. This review should include, as a minimum, how best to:
    - ensure that all children are only detained when absolutely necessary and for the absolute minimum amount of time;
    - 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;
    - ensure that custody staff comply with their statutory duties to complete detention certificates if a child is detained for any reason in police custody following charge;
    - ensure that custody staff make a record of all actions taken and decisions made on the relevant documentation; and
    - improve awareness among custody staff of child protection (including the risk of sexual exploitation), the standard of risk assessment required to reflect children's needs, and the support required at the time of detention and on release.

**Summary of post-inspection review findings**

Gloucestershire Constabulary has made it clear that it will detain children only when absolutely necessary. This is extremely positive, and we were pleased to find that this approach is reflected in the small numbers of children entering custody. The constabulary has made some improvements in the understanding of officers and staff in relation to their duty to request alternative and secure accommodation; the differences between the two types of accommodation; and the circumstances in which they are required. We were also pleased to find evidence of effective partnership working to improve the availability of alternative accommodation for those children who are charged and denied bail.

Although improvements are evident in the completion rates of detention certificates[9], the quality of information within them still requires improvement. Current training provided to custody officers has improved their ability to identify and respond to

[9] A detention certificate outlines to a court the reason for a custodial remand.

children at risk of child sexual exploitation. However, requests for appropriate adults are often made to coincide with interview times, resulting in delays in children receiving support at the earliest opportunity.

**Detailed post-inspection review findings**

In the 12 months to December 2017, only 16 children were detained after charge by Gloucestershire Constabulary, indicating that continued detention is used only after careful consideration.

However, we found examples of children being detained in custody pre-charge for long periods of time for relatively minor offences. In two such cases, the interviews were not conducted until 23 hours after their detentions were authorised (and both children were released pending further investigation immediately after interview). Moreover, we found minimal evidence in the reviews of detention completed by staff to demonstrate that they ensure investigations are carried out expeditiously.

It is encouraging that we found evidence of effective engagement by the constabulary with the social care service's emergency duty team, to source alternative accommodation for children who have been charged and remanded to appear at court. Continuing work by the local authority to train those who provide foster care to take in children under this provision is also positive. However, there is still some confusion evident among officers and staff about the concordat[10] relating to the detention of children, and the circumstances where a child could or should be passed to the care of the local authority. In addition, HMICFRS found no evidence that the constabulary escalates those cases where the local authority fails to provide alternative accommodation.

In four cases audited where children were remanded after charge, we found on the computer system that detention certificates had been completed. Detention certificates, which outline to a court the reason for a custodial remand, are essential for police accountability, and enable forces to monitor how well they are discharging their responsibilities under the Police and Criminal Evidence Act 1984. However, in the files we reviewed, only the child's name was recorded and no printed copy of the detention certificate could be found on the file which accompanied the child to court. This is not dissimilar to the findings of our 2017 inspection, and means that the ability of senior leaders to understand the quality and appropriateness of decisions is still limited. As a result of this persistent weakness, the constabulary is unable to reassure itself that decisions about the continued detention of children (though the number of cases is small) are consistently proportionate, necessary and lawful.

HMICFRS found that when a child is taken into custody, there are lengthy delays before an appropriate adult attends: in the six cases reviewed, the delay ranged from between 6 and 19 hours. When an appropriate adult does attend, it generally

[10] www.gov.uk/government/publications/concordat-on-children-in-custody

coincides with the time of the interview. This is not in the spirit of the codes of practice governing police detention, which require custody staff to arrange attendance as soon as is practicable to provide support and assistance to a detained child, as opposed to using them simply to facilitate the investigative process. The recording of information about when (or even if) appropriate adults have been requested is also inconsistent.

One child was subject to multiple reviews of his detention without an appropriate adult present. Additionally, we found that where reviews had been conducted in the absence of a detained child (for example, when the child was asleep), there was no record that the child had been informed that the review had taken place, and there was no reference to the appropriate adult being either present or informed. Generally, we found that the quality of information recorded on detention records was inconsistent and required improvement.

The regular training given to custody staff contains information about child protection and child sexual exploitation. This is positive. We were also pleased to find that comprehensive risk assessments had been completed in the cases we reviewed. These demonstrates an awareness of the vulnerabilities of these children, and of the responsibility of custody staff to respond to those vulnerabilities.