HMICFRS

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

National Child Protection Inspections

Hampshire Constabulary

7–18 June 2021

Foreword

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

While it is everyone's responsibility to look out for vulnerable children, police forces – working together and with other organisations – have a particular role in protecting children and meeting their needs.

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

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

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

Contents

Summary

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

We examined how effective the police's decisions were at each stage of their communications with or for children. This was from initial contact through to the investigation of offences against them. We also scrutinised how children were treated in custody. And we assessed how the force is structured, led and governed, in relation to its child protection services.

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

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

Main findings from the inspection

The chief officer group and senior leadership teams are clearly committed to child protection and getting better outcomes for children. This is evident through a prominent child-centred policing strategy, as well as the force's defined areas of focus and its broader communication with children.

Senior leaders understand how well officers and staff carry out their work. And there is a regular and thorough internal inspection programme. Ad hoc sampling of specific areas of business supports this. Findings are reported in oversight meetings and progress is tracked through improvement plans.

Hampshire Constabulary has put a lot of time and energy into improving the health and wellbeing of staff. It has carried out regular psychological screening for those working in child protection. And after traumatic incidents, trained officers assess the impact these have had on the officers and staff involved.

The force's safeguarding partners said that Hampshire Constabulary's working relationships with them, its contributions to multi-agency working, and communication and involvement at both strategic and operational level were good. This includes the force's ability to offer challenge where necessary. The force also has appropriate representation in the four new multi-agency safeguarding arrangements. This involves the force working with the other local organisations and agencies that help to safeguard children.

However, some joint working arrangements require further development. For example:

- the quality of information shared through the multi-agency safeguarding hub (MASH);
- sharing information sooner in online abuse investigations; and
- the force receiving information from return home interviews (carried out by the local authority).

We found many examples of good work by frontline officers responding to incidents involving children. The workforce was motivated and engaged. Specific areas include:

- joint investigations of child abuse, with effective supervision;
- the use of police protective powers;
- the detention of children – there was a clear focus on the welfare of children in custody; and
- the response when children at higher risk of harm are reported missing.

But we did see areas for improvement. These include:

- responding to incidents quickly when there is risk to children;
- the response when children at medium risk of harm are reported missing; and
- systems and processes for managing those who pose a risk to children.

During our inspection, we examined 85 cases where the police had identified children at risk. We assessed the force's child protection practice as good in 25 cases, requiring improvement in 30 cases, and inadequate in 30 cases. This shows that the force needs to do more to give a consistently good service for all children.

Conclusion

There is a clear commitment from the leadership that child protection and wider vulnerability is a priority for the force, and that it is committed to providing better outcomes for children.

The force's child-centred policing strategy makes this commitment clear to its officers and staff, the organisations it works with, and the community.

The force works well with its safeguarding partners from across the local authority areas. It is also an active member of the multi-agency safeguarding arrangements, and has appropriate representation on related boards and subgroups, often driving the strategic direction.

We saw several examples of frontline officers responding well to incidents of concern involving children.

Specialist child protection staff were committed and dedicated to keeping children safe, working in an increasingly complex and demanding environment.

Senior leaders are aware of some inconsistencies and areas for improvement in the service it provides for children. We were encouraged by how the force worked with us and its speed in addressing our areas of concern. And to understand how it can learn from the child protection case audits during this inspection.

The force already has the governance and scrutiny arrangements in place to monitor the impact of changes and improvements it makes.

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 they have reasonable cause to believe would otherwise be likely to suffer significant harm. The same Act also requires the police to inquire into that child's case. Under section 11 of the Children Act 2004, the police must also always keep in mind 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 for any reason must recognise the needs of any child they meet and understand what they can and should do to protect them. This is particularly important when officers are dealing with domestic abuse or other incidents that might involve violence. The duty to protect children includes those detained in police custody.

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

Expectations set out in the *Working Together* guidance

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 agencies involved in child protection. This includes local authorities, clinical commissioning groups, schools and voluntary organisations.

The specific police roles set out in the guidance are:

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

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

2. Context for the force

Hampshire Constabulary's workforce is made up of:

- 2,697 officers;
- 1,766 staff;
- 248 police and community support officers (PCSOs); and
- 366 special constables.

The force provides policing services to the county of Hampshire and the Isle of Wight. This covers 1,602 square miles, with approximately 230 miles of coastline, in the south of England.

Although there are some areas of deprivation, Hampshire has areas of affluence. Around two million people live mainly in the urban centres. These include:

- the cities of Southampton, Portsmouth and Winchester;
- the towns of Basingstoke and Farnborough; and
- the town of Cowes on the Isle of Wight.

There are many university students, plus large numbers of visitors either staying in the area or travelling through. The transport infrastructure includes railway stations, an airport and seaports.

The force worked with the county's four local authorities and local clinical commissioning groups to establish new safeguarding children partnerships, as required by the Children and Social Work Act 2017. These have replaced local safeguarding children boards.

The four local authorities in the county are:

- Hampshire County Council
- Isle of Wight Council
- Portsmouth City Council
- Southampton City Council.

The most recent Ofsted judgments of the services these local authorities offer children who need help and protection are below.

Local authority	Judgment	Date published
Hampshire County Council	Outstanding	April 2019
Isle of Wight Council	Good	November 2018
Portsmouth City Council	Good	September 2018
Southampton City Council	Requires improvement	November 2019

There are three multi-agency safeguarding hubs (MASHs), one for each local authority area in Portsmouth and Southampton, and one combined one for Hampshire County Council and Isle of Wight Council (who work together to provide children's services).

A range of organisations are represented within the MASHs. This makes sure that information is shared effectively.

3. Leadership, management and governance

There is a clear commitment to child protection among the chief officer team and senior leaders

The force shows its commitment to child protection in several ways. It has six areas of focus, which set out its priorities. Some relate directly to protecting children and other vulnerable groups. These include:

- identifying and protecting those who need help;
- working in partnership; and
- tackling crime and offending.

Specific strategies reinforce these priority areas. For example, the child-centred policing strategy sets out that the force expects its staff to:

- treat children as children first;
- listen to them; and
- treat communication as opportunities to improve outcomes for them.

The force has appointed an assistant chief constable (ACC) as the lead for child protection. This role makes sure that there is clear leadership at chief officer level. There is strong communication at a senior level through a joint portfolios group. An ACC chairs this group. They meet every two months and all chief superintendents attend. It provides an opportunity to discuss issues that affect different areas of policing and to act on them.

The force's safeguarding partners said that its working relationships with them, its contributions to multi-agency working, and communication and involvement at both a strategic and operational level were good. This includes an ability to offer challenge where necessary. The force has appropriate representation on the local safeguarding children partnership (LSCP) board and various sub-groups.

The force trains officers and staff to help them support people who have had adverse childhood experiences or faced trauma.

There is structured oversight at strategic and operational levels

Management and governance of child protection matters are arranged through daily management meetings in each area. We saw that specialist child protections teams contributed well to these meetings. Those who chair these meetings focus on issues relating to children. These include high-risk missing children, sex offenders who pose a risk to children, and domestic abuse incidents.

This is managed longer term through fortnightly tactical planning meetings and monthly force tasking and co-ordination meetings. These also have a child protection and broader vulnerability focus.

Good practice: performance information to understand the outcomes for children

The force has an internal inspection programme. The inspection staff regularly visit different areas to carry out in-depth analysis of the standards of practice. This includes analysing cases and interviewing officers and staff. We were told there is flexibility in the approach, so senior leaders can influence the theme or content of these inspections. For example, in 2019 the force inspected serval aspects of policing in the Isle of Wight. This included the response to domestic abuse. It found not enough perpetrators of abuse were arrested and children were often missed from referral forms. Senior leaders agreed an improvement plan, which included extra training for staff.

The inspection team audited cases again in 2021 and found performance had improved.

Senior leaders can also commission specific internal inspection and scrutiny work. At the time of our visit there was an analysis of the response to domestic abuse throughout the force.

The findings of internal inspections, external inspections (such as those we carry out) and multi-agency reviews are reported to both the force performance board and the risk and review oversight panel. This means improvement plans can be agreed.

Each area of business has a strategic lead who is responsible for the improvement plan and promoting activity.

Most managers of teams dealing with child protection also receive regular data analysis. This helps them understand the workloads and performance of their officers and staff. During our inspection, the force was developing a dashboard using business intelligence software. This was to enable managers to gather this information themselves in real time.

The force shares information with other safeguarding partners

The force and its safeguarding partners work together to share information. This helps them better understand child protection issues. For example, in Southampton information-sharing is being used to allocate resources to tackle youth violence.

The force also encourages other organisations to share information about people at risk of harm through its online community partnership information form. These include schools and social care services. This makes it easy for organisations to let the force know about places that might be a risk to children, or emerging problems, such as adults trying to exploit them or supply them with drugs.

The force understands the current risks to children from exploitation

The force regularly reviews its own intelligence and data. It uses this information to produce an annual child strategic profile relating to children at risk of exploitation. This includes some data from its safeguarding partners. To create this, senior leaders use information that includes:

- in-depth analysis of the risks;
- year-on-year trends; and
- recommendations about activity to reduce those risks.

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

The force has a wellbeing strategy for its entire workforce. This recognises the extra demands on those working in child protection roles. Officers and staff in these roles have an annual psychological assessment, with access to further support if needed. Their roles rotate after three to five years, to reduce the impact of exposure to trauma.

The force has trained some staff to be ‘wellbeing bronze co-ordinators’. After significant incidents, these co-ordinators assess whether staff and officers need psychological and wellbeing support. If it is needed, they arrange this.

Officers and staff dealing with childhood deaths are also assessed on how they have been affected.

Those we spoke to during this inspection were positive about this wellbeing support.

Officers and staff in Hampshire have a good understanding of risks to children and how to respond

In 2019, the force invested in training its officers and staff about adverse childhood experiences. This included those working within the custody suite and the contact management centre. The information is also now part of the training programme for new employees.

Those we spoke to talked confidently about:

- dealing with domestic abuse;
- the links between children reported missing and the risk of exploitation; and
- using their protective powers.

They told us that they have access to extra guidance on the force's intranet. They also described good relationships with specialist officers who were available to give advice.

There aren't enough qualified investigators

The force is clear about the training required for roles that have responsibility for child protection investigation. Those officers and staff should be accredited to level 2 of the professionalising investigation programme (PIP). Once accredited, they can enter the specialist child abuse investigation development programme (SCAIDP).

The force is aware that around 30 percent of those in these roles do not yet have PIP2 accreditation. These roles are currently filled by PIP level 1 investigators.

The force is working hard to resolve this. It is using many options, such as:

- directly recruiting investigators;
- training PIP1 officers and staff for PIP2 accreditation;
- allowing PIP1 investigators to attend the initial SCAIDP course and work towards accreditation;
- using direct entry investigators; and
- transfers from other forces.

Where necessary, the force has also employed short-term contractors (retired investigators) and temporarily filled roles with investigators from other departments.

Recruiting and retaining investigators is a national problem. We have made a recommendation to the Home Office in our joint thematic inspection of the police and Crown Prosecution Service's response to rape.

Hampshire Constabulary officers and staff are dedicated and enthusiastic

All the officers and staff we spoke to supported the inspection process. Without exception, they were friendly, polite and keen to talk about their work.

The officers and staff we spoke to who manage child-related investigations are committed and dedicated. Their work is often difficult and demanding. Some specialist officers were worried about high workloads, with not enough staff to deal with the number of cases.

4. Case file analysis

Results of case file reviews

For our inspection, Hampshire Constabulary selected and self-assessed the effectiveness of its work in 33 child protection cases. Under HMICFRS criteria, the cases selected were a random sample from across the county.

Our inspectors also assessed the same 33 cases.

Cases assessed by both Hampshire Constabulary and us

Constabulary assessment:

- 22 good
- 7 require improvement
- 4 inadequate.

Our assessment:

- 11 good
- 11 require improvement
- 11 inadequate.

Our inspectors selected and assessed 52 more cases during the inspection.

Extra 52 cases we assessed

- 14 good
- 19 require improvement
- 19 inadequate.

Total 85 cases we assessed

- 25 good
- 30 require improvement
- 30 inadequate.

Breakdown of case file audit results by area of child protection

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

- 6 good
- 4 require improvement
- 2 inadequate.

Common themes include:

- evidence of good initial action by responding officers;
- prompt joint strategy discussions with safeguarding partners;
- good supervision levels; but
- missing some wider safeguarding concerns for other children.

Cases assessed involving referrals relating to domestic abuse incidents or crimes

- 3 good
- 3 require improvement
- 4 inadequate.

Common themes include:

- attending officers took prompt action to safeguard victims and children;
- investigations were usually good;
- body-worn video (BWV) was consistently used at scenes; but
- attending officers didn't consistently seek or record the voice of the child.

Cases assessed involving referrals arising from incidents other than domestic abuse

- 0 good
- 2 require improvement
- 3 inadequate.

Common themes include:

- information was usually shared quickly with children's social care services; but
- the quality of information shared was inconsistent and often incomplete; and
- the voice of children and wider safeguarding issues were not always considered.

Cases assessed involving children at risk from child sexual exploitation

- 2 good
- 11 require improvement
- 9 inadequate.

Common themes include:

- a good multi-agency response to support children at most risk;
- clear plans to mitigate the risk to the most vulnerable children;
- risks to other children are not always considered;
- when investigations relate to offenders sharing indecent images of children online, information often isn't shared with children's social care services as soon as the risk to children is identified;
- when children generate indecent images of themselves, opportunities to investigate are missed and children often aren't seen or spoken to.

Cases assessed involving missing and absent children

- 3 good
- 1 requires improvement
- 5 inadequate.

Common themes include:

- the control room makes good use of risk assessment tools and information held on Niche (a single police information management system) to assess and grade the risk to a child;
- the planning and response are good when those at most risk are reported missing;
- when children return, officers are usually professionally curious about the risk they were exposed to; but
- the response when children at medium risk are reported missing is often delayed and enquiries to find them are limited; and
- supervision of activity and records is inconsistent.

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

- 6 good
- 0 require improvement
- 0 inadequate.

Common themes include:

- responding officers consider the circumstances of vulnerable children and make effective decisions to remove children, using their power appropriately;
- there are prompt discussions with children's social care services;
- children are taken to appropriate places of safety;
- the use of power, and when it ended, is recorded; and
- investigations after the police powers are used are good, with effective supervision.

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

- 2 good
- 4 require improvement
- 7 inadequate.

Common themes include:

- visits to offenders are usually unannounced;
- there is a good level of investigative focus during offenders visits;
- recording of activity is poor, which makes effective supervision difficult; and
- risk-management plans are inconsistent.

Cases assessed involving children detained in police custody

- 3 good
- 5 require improvement
- 0 inadequate.

Common themes include:

- there is a child-focused culture within the custody suites;
- children are only arrested when absolutely necessary;
- the attendance of appropriate adults at the custody office is generally good and children are seen by health care professionals;
- custody staff understand their responsibility to seek appropriate alternative accommodation for detained children; but
- safeguarding concerns aren't always reported to children's social care services.

5. Initial contact

When members of the public contact the force, it usually assesses risk well and grades the response appropriately

All calls to the force are handled by the contact management centre staff. Staff taking these calls get as much information as they can about the incident and the people involved.

During our inspection, it was clear that call handlers used the THOR model to assess risk. THOR is a risk assessment model which considers the threat, harm, opportunity to investigate and risk associated to the incident reported. Call handlers use supplementary risk assessment questions for some types of incidents, and research information held on the police database to better understand the risks. This information is used to grade the response to calls.

The staff get information from Niche. This includes flags and warning markers showing the addresses of registered sex offenders (RSOs) or children on child protection plans. In more complex cases, staff trained to research intelligence are available 24 hours a day to carry out more in-depth research.

During our inspection, it was clear that dispatchers passed this information to attending officers. This meant that officers were aware of the issues relating to the address or family before they got to an incident. This helps them make better decisions.

But we found that the call handlers often don't use the supplementary risk assessment questions when a third party reports domestic abuse, such as a neighbour. In these circumstances, we found that call handlers rarely ask if children are present. As a result, some risk goes unnoticed.

It takes too long for the force to respond to some incidents

The aim of these risk assessment questions is to determine whether a police officer needs to attend an incident, either immediately or as a priority. In these cases, the force control room manages the call. Officers should attend these priority calls within two hours. This often doesn't happen because of competing priorities.

We were told that force incident managers monitor this queue and discuss outstanding incidents at their shift handover. But there isn't a structured review of the risk and whether the delay means the call should be re-graded.

A mother reported that her husband had assaulted her and her 15-year-old son. Her other children, aged eight and 13, were also present.

The call was graded as a priority response. But, because of a lack of available resources, officers weren't sent to the address until 12 hours later.

The offender had remained at the address overnight. By the time the police attended, the younger children had gone to school. So, the police didn't see or speak to them.

Less urgent cases are usually handled well, but some children aren't seen or spoken to

When incidents are less urgent, a triage team reviews them to decide who should deal with the incident. They refer some cases to the resolution centre if they can be dealt with over the phone. And they refer some to community-based neighbourhood policing teams (NPTs).

We found the triage team usually made good decisions. These were recorded clearly and typically resulted in the most appropriate response. But we saw several cases, when children had sent indecent images of themselves, sent to the resolution centre.

In these circumstances, we found children often weren't spoken to. Speaking to the child would help understand the circumstances. And it would be an opportunity to make sure they weren't coerced into sharing images. Also, the children's devices weren't examined to check whether they contained indecent images. In some cases, lines of inquiry to identify offenders weren't followed.

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 that officers are good at making initial inquiries and using their powers to arrest or protect when necessary.

A neighbour reported that she was concerned about a three-year-old child wandering in the street. She was also concerned about the condition of the child's home.

Officers were dispatched quickly and made enquiries at the address. They found the living conditions to be very poor. They spent time speaking to the four children present to find out what it was like for them to live there. Officers recorded evidence on their body-worn video.

They arrested the children's mother. They then quickly spoke to children's social care services and made enquiries to find somewhere safe for the children to stay. They arranged for the children to stay with a responsible family member.

Officers worked with children's social care services. Their enquiries were recorded clearly and actions were completed. This resulted in longer-term protective planning for the children, and the mother receiving a formal caution.

Officers don't speak to children or record their behaviour and demeanour often enough

In the cases we reviewed, we often found that the police hadn't always spoken to children, or recorded their concerns, behaviour and demeanour. How a child behaves gives important information about how an incident has affected them. This is especially true where the child is too young to speak to officers, or doesn't feel they can talk openly while a parent or carer is present. The police should watch how the child behaves. This will help them assess the child's needs. It will also help them decide whether to refer the child to social care services.

Officers we spoke to understand the benefits of body-worn video cameras when capturing evidence, especially specifically in domestic abuse incidents. We saw evidence that body-worn video is used regularly and gives the force an opportunity to better capture children's voices.

Recommendations

- We recommend that Hampshire Constabulary immediately reviews its processes within the contact management centre, control room and resolution team. This is so that it can make sure that:
    - risk is regularly assessed when attending incidents is delayed; and
    - only appropriate cases are dealt with over the phone.
- We recommend that within three months Hampshire Constabulary acts to make sure that children's concerns and views are gathered and recorded. This includes noting their behaviour and demeanour.

6. Assessment and help

The process for sharing information with the force's safeguarding partners has some weaknesses

Statutory guidance within *Working together to safeguard children* (2018) states:

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

When an officer is concerned about a child, they must submit a police protection notice (PPN1) form. If an officer fails to submit a PPN1, the force is not able to consistently establish whether a referral is needed. This is because incident logs are closed without further supervision.

We found that the quality of PPN reports is inconsistent. Some have good levels of detail, with a focus on the children. But some simply outline the circumstances of the case.

Once submitted, the PPN1 forms are reviewed by the force's MASH co-ordinators. The co-ordinators decide which cases should result in the police asking for a strategy discussion. They alert the MASH sergeants to these cases using a flagging system. The co-ordinators are also responsible for reviewing the risk grading of domestic abuse reports.

As mentioned above, the force is clear about the training required for roles that have responsibility for child protection investigation. This isn't the case for its MASH co-ordinators. We were told that the co-ordinators haven't had specific training for their role or, in particular, relating to risk assessment or thresholds for services. Although some have attended multi-agency training, all have learned their role from their peers.

We were also told that their managers don't regularly oversee or test co-ordinators' decision-making. In a sample of ten domestic abuse cases, we found that co-ordinators incorrectly re-graded two high-risk cases to medium risk. As a result, those cases weren't discussed at the multi-agency meetings described below.

This means the force can't be sure that the decisions co-ordinators make are in line with its expectations, or those of other safeguarding partners.

In cases when the force doesn't ask for a strategy meeting, PPN1s are shared without further research or information. Therefore the context of the child's family or others who pose a risk to them isn't shared. This information could include relevant previous convictions or domestic abuse history of adults in the child's life. The voice of children is also often absent.

As a result, children's social care services potentially decide about the needs of the family based on incomplete information. This further information could mean the threshold for services has been met. Incomplete information could also lead to social care assessments being carried when they are not needed.

Strategy discussions are prompt

When the force or other safeguarding partners decide that a strategy discussion is needed, we saw that these usually take place quickly. We saw evidence of contributions from relevant agencies, which result in decisions about whether a joint investigation was needed. Those decisions were recorded clearly, and the case quickly allocated to the appropriate team to carry out the agreed inquiries.

We saw prompt multi-agency planning and support for victims and children exposed to domestic abuse

We saw the force's domestic abuse safeguarding team (DAST) provide good support to investigations when the victim might be reluctant to co-operate with a prosecution. This team contacts victims to understand why they are reluctant, and to offer advice about keeping safe. In these situations, the DAST looks for opportunities to progress investigations when it is in the best interest of victims. It does this by finding other evidence, such as from neighbours or CCTV.

The force contributes to a daily high-risk domestic abuse (HRDA) meeting in the three MASHs. These meetings allow safeguarding partners to quickly discuss the most high-risk cases. They provide an early opportunity to make joint protective plans for victims and their children. This is a positive activity which means those at most risk receive support when it is most needed. It also supports the longer-term planning discussed at multi-agency risk assessment conferences (MARACs). And it means that support is in place much sooner.

The force has recruited and trained over 600 domestic abuse champions to promote good ways of working among their colleagues. They also assess sample cases regularly. This sampling is reported through the command structure to make sure learning is shared and the improvement plan updated.

The force also instigated Operation Encompass, which means children can get extra support from their school if they are exposed to domestic abuse. But we saw several PPNs when the school wasn't recorded so it wasn't informed.

There is a good response when children at most risk are reported missing

In September 2020, the force began a pilot scheme called Operation Salvus. This was designed to improve the response when the most vulnerable children are reported missing.

When a child that has been identified as particularly vulnerable goes missing, the missing, exploited, trafficked team (METT) use multi-agency information to develop a safety plan. This identifies the risks to the child and includes guidance and advice on how to respond. For example, who the child is likely to be with, where they are likely to be and where they have been found before. These plans are regularly updated when new information comes to light. The plan is kept on a separate occurrence log within the child's Niche record. This is so contact centre staff can quickly find it. The children are graded as high risk when they are reported missing.

We found that when these children go missing, the force response is consistently good. There are prompt inquiries to trace the children and supervision is effective. The METT visit each child when they return to make sure they are safe and to understand the risks they were exposed to.

A foster carer reported their 15-year-old foster child missing when she failed to return home. Contact centre staff carried out good research and quickly identified that she was a part of the Operation Salvus scheme.

They took a lot of information from the foster carer, graded the child as at high risk and quickly deployed a police officer.

The officer used the information available on the child's Niche record to draw up an investigation plan and began to make inquiries. The supervision of the case was good, with clear directions recorded throughout the time the child was missing.

The child was located at a hotel. Officers believed she would run away if they approached her so called the foster carer. The foster carer arrived and took the child back into their care.

The response when other children are reported missing is much poorer

When children are reported missing who aren't part of Operation Salvus, we found that the force contact centre usually carry out a risk assessment and use information from Niche to grade the risk.

But in these circumstances, we found that the response was poorer. We saw that there are often delays in dealing with the situation. There are limited inquiries to trace these children. The inquiries lack supervision so the force can't be sure all is being done.

A social worker reported that a 16-year-old girl who was looked after by the local authority had gone missing. She had previously been the victim of serious sexual assaults and was at risk of further sexual harm.

It was believed she was going to try to travel to London for an illegal rave.

Other than trying her mobile phone, no immediate enquiries were carried out to find her. It was 15 hours before an officer went to where she lived. Examination of her belongings revealed a diary which raised concerns about her intention to take class A drugs.

Another three hours later, her details were circulated on the Police National Computer, showing her as missing.

She eventually returned home of her own accord. But there was no record that she was seen by officers, or any information recorded to show that a local authority return home interview had been done.

Some opportunities to understand why children go missing are being lost

When children return home after being missing, we saw that the force carries out a personal visit and prevention interview. This is to make sure that the returning person is safe and well. Its purpose is to identify any continuing risk or factors that might contribute to the person going missing again. We found that when children talk to an officer, that conversation is child-focused with a good level of professional curiosity. Risks to the child are established. And this updated information is shared with safeguarding partners through a PPN1 form.

Return home interviews (RHIs) uncover information that can help avoid children going missing again. This includes risks they might have been exposed to while they were missing and risk factors in their home. An RHI is a conversation between a child and a trained professional when they return from a missing episode. The Department for Education states that local authorities must offer this service, and that an independent person must carry out the interview.

In the cases that METT manage, we saw that plans contained shared information and were better informed as a result. But for children who are at less risk of harm, we didn’t see any evidence in our case audits that information from those interviews was shared with the force.

This means important information known to the local authority, and which may help to prevent risk escalating or help the force respond better, isn’t provided to the force.

Recommendations

- We recommend that within six months Hampshire Constabulary engages with its safeguarding partners to review its assessment and information-sharing practices. It needs to make sure that those responsible for making decisions have the skills they need, and that all relevant information is shared at the earliest opportunity when vulnerable children are involved.
- We recommend that within three months Hampshire Constabulary improves its practices in relation to missing children. It needs to make sure that its response is consistently effective and appropriate to the risks identified to missing children.

7. Investigation

Investigations are usually allocated to those teams with the necessary skills and experience to carry them out

The child abuse investigation team (CAIT) investigates all cases of child abuse when it takes place in a family setting or is committed by someone in a position of trust. They also deal with those cases involving children who are already on a child protection plan; or when a joint investigation is necessary; or if a child is the victim of a serious sexual offence and is under 13 years old.

The Amberstone team investigates rape and serious sexual offences. The team deals with child abuse cases when the victim is between 13 and 17 years old, and outside the criteria described above.

The METT work with safeguarding partners to support and reduce risk to those children most vulnerable to exploitation. The team also investigates when children have been exploited.

The force's MASH grading policy and guidance is clear about which investigations should go to which teams. We found that the MASH sergeants, responsible for allocating the cases, understand the process well. So do the teams who carry out those investigations.

We saw a good standard of investigation when cases are allocated to specialists

When there is clear risk to children from the start, there is a swift response and good decision-making by attending officers.

As mentioned in the previous section, strategy discussions are prompt and result in decisions about whether a joint investigation is needed. These decisions are clearly recorded, but there is some inconsistency in the amount of detail about the specific investigative actions agreed.

CAIT and Amberstone staff and supervisors usually create good investigation plans. Initial investigations are usually of a high standard. But we saw delays in completing some inquiries because of officers' workloads and other commitments.

The father of ten-year-old twin boys reported to the police that the boys told him that their mother's boyfriend assaulted them and that their living conditions were poor.

The force arranged a prompt strategy discussion and agreed to carry out a joint investigation with children's social care services. A detective sergeant recorded a clear investigation plan, including agreed joint actions.

Officers visited the twins and their older sister the next day. Officers observed and recorded the children's demeanour, views and concerns. They also checked the living conditions. There was clear communication between the police and social care services throughout the investigation.

The suspect was interviewed under caution. The investigation revealed no criminal offences had been committed. But longer-term protective planning was agreed and co-ordinated by social care services.

Some investigations were poorer when allocated to non-specialists

When children are involved, some investigations are allocated to CID teams. Some were of a good standard with meaningful oversight from supervisors. But when those cases are more complex, we found that some risks weren't recognised, or lines of inquiry not followed. For example, the risk an offender posed to other children, or the risk posed by extended family members in suspected honour-based abuse.

A 17-year-old girl reported to her CAMHS (child and adolescent mental health services) worker that she had been sexually assaulted at college. She didn't want to speak to the police but acknowledged the CAMHS worker needed to.

Officers tried to speak to the girl via her CAMHS worker. When the girl didn't respond, the matter was closed. We saw no evidence that she had been given advice about the support available to her.

There was no attempt to identify the offender, establish whether he posed a risk to other children, or whether similar allegations had been made about him.

There is a good multi-agency response when children are at high risk of exploitation

METT manage situations where children are assessed as being at high risk of exploitation. METT are responsible for developing a rapport with children and working with safeguarding partners. Together, they aim to reduce the risk to those children through diversionary activity. The multi-agency team reviews that activity each month at their METT operational meeting. We reviewed some minutes of those meetings and found a strong partnership approach, with meaningful activity agreed.

The response is poorer when the risk is graded as medium or low

Children assessed as being at medium or low risk of sexual exploitation are referred to neighbourhood policing teams (NPTs). Although the METT provide a detailed plan of expectations to guide the NPT officer, we found the approach was inconsistent. Although there were cases in which NPT officers communicated well with children and their carers, some children hadn't been seen for several months. So, it wasn't understood what the current risk to them was. We saw little meaningful supervision of these cases.

We acknowledge that the force acted quickly to review all these cases when we brought them to its attention.

There is usually prompt action to trace those sharing child abuse images, but not all cases are followed up on

The force internet child abuse team (ICAT) investigates the sharing (peer-to-peer) and distribution of child abuse images online. It also deals with referrals from the National Crime Agency's child exploitation and online protection command.

The force has worked hard to manage the volume of offences committed in its area. It regularly reviews its systems to identify potential offenders. But in our analysis we saw some cases that warranted further investigation that the force had not followed up on.

Once an investigation is instigated, ICAT carries out more checks to locate suspects and understand their circumstances. Once these checks are done, they complete a risk assessment. This affects how quickly they act.

When risk is graded as high or medium, the ICAT is responsible for the investigation. To manage the increasing demand of these investigations, the force allocates some low risk cases to investigative staff from other departments.

We found cases are usually dealt with within the force's timescales.

But the standard risk assessment tool doesn't fit some cases. For example, when a child is the suspect, or when more than one person in the household could be responsible. In these circumstances, we found that risk wasn't assessed as well and activity to trace suspects took longer.

The force doesn't share information with its safeguarding partners early enough

Senior leaders told us that they expect the ICAT team to share information with children's social care as soon as they are aware of the risk to children. We found that they usually do not share that information until activity, such as a search warrant, takes place. Although risk is reduced by the fact that activity usually takes place within set timescales, this does not take account of peaks in demand. Nor does it take account of known risk to children during intelligence-gathering.

More importantly, it is a missed opportunity to share information with other organisations. This would help to better understand the risks to children and put protective plans in place ahead of proposed activity.

We were encouraged that senior leaders are already working to understand how the force can improve on how and when it shares information.

Recommendations

We recommend that within three months Hampshire Constabulary improves its approach to investigations related to the exploitation and abuse of children via the internet. It is important to pay particular attention to:

- understanding the circumstances in which children share images of themselves;
- making better use of the intelligence system available to locate offenders;
- its risk assessment processes; and
- sharing information with safeguarding partners sooner when risk to children is known.

8. Decision making

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

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

In the cases we examined, decisions to take a child to a place of safety were well-considered and made in the best interests of the child.

Recording the use of the power is good

Designated officers are responsible for inquiring into cases where police take children into their protection. They must be of the rank of inspector or above. We found that they had a good understanding of their responsibilities. They recorded their decisions and regularly reviewed the use of the power.

We saw that they recorded when another officer took over responsibility, such as at shift changeovers. Designated officers also recorded when the power ended and in what circumstances. This means that those dealing with future incidents have the information they need to make better decisions.

Prompt discussion with the local authority leads to children being taken to appropriate places of safety

When the police use this power, they must quickly speak to children's social care services and decide on what should happen. In the cases we audited, the force did this and children were usually quickly taken to an appropriate place of safety.

Discussion about joint investigations into the circumstances and agreed activity was also recorded well.

Offences were promptly investigated with evidence of good supervision

This power is often used when there has been a criminal offence. We saw that when this is the case, officers carry out good, child-focused investigations. We saw that inquiries were usually made quickly, with evidence of effective supervision.

We also saw that once investigations were complete, officers carefully consider what the best outcome for the child would be, and decisions are made in the child's best interest.

A neighbour reported a noisy party in breach of COVID-19 restrictions. When officers attended, they found more than 50 people in a small flat.

Those present were trying to hide a six-year-old girl from view. Officers quickly identified her mother and discovered she was drunk. They arrested her and decided to use their protective powers to safeguard the child.

Officers quickly spoke to children's social care services and the child was taken to a foster carer while enquiries continued.

The child and her mother were from the London area. There was evidence of good communication between the force, local children's social care services and those from the child's area.

Following investigation, the mother was cautioned. This was on condition she receive education about adverse childhood experiences and that she worked with her local children's social care services on a 16-week parenting programme.

All activity and decisions, including the end of the use of the power and returning the child to her mother, were recorded clearly.

9. Trusted adult

It is important that children feel they can trust the police. We saw that, in some child protection cases, officers consider the impact of their actions and explore the most effective ways to communicate with them. For example:

> An adult son reported that his mother had been assaulted by her partner. His 11-year-old brother was also at the premises.
>
> Officers quickly attended and arrested the suspect.
>
> They took the time to speak at length to the 11-year-old boy, exploring his thoughts and feelings. The boy felt able to tell the officers that he too had been assaulted and said that he hoped he "could be happy again" because of the police attending.
>
> The force quickly arranged a strategy discussion and agreed there would be a joint investigation. More support was arranged for the family through the daily high-risk domestic abuse (HRDA) meeting. A longer-term joint protective plan was put in place, with children's social care services giving the family further support.

Such sensitivity builds confidence and creates stronger relationships between the police and the child, parents and/or carers.

The force communicates well with children in the community

The force works closely with the office of the police and crime commissioner (OPCC) in communicating with young people in the community. The OPCC's youth commission is a group of over 50 members aged between 14 and 25. This gives young people an opportunity to have their say on the crime and policing issues that matter to them.

To support this, the OPCC carries out an annual survey called 'The Big Conversation'. Its aim is to get the views of children and what matters to them. In 2020, there were over a thousand responses to the survey. As a result of the responses, policing priorities for children were identified as hate crime, serious violence, and exploitation.

The force has also introduced a youth independent advisory group (IAG), which covers those living or working in Southampton and on the Isle of Wight. IAGs review and constructively challenge policing practices. During our inspection, Hampshire Constabulary was working to make sure that all areas of the force were represented.

The force has a well-established cadet scheme for 13–17-year-olds. There were 261 cadets in the programme at the time of our inspection. The scheme is designed to inspire children to take part in their communities. The cadets learn about law and procedure, how the police operate and practical skills (such as first aid).

The force also runs a ‘community court’. This involves young volunteers deciding consequences for suitable, first-time young offenders who commit applicable crimes.

The community court holds peer-led hearings involving young people who have offended. It gives victims of a crime the opportunity to explain what harm has been caused and how it can be repaired. This helps to divert children from the criminal justice system.

10. Managing those posing a risk to children

Staffing levels in the team dedicated to managing those who pose a risk to children are good

The force has a management of sexual or violent offenders (MOSOVO) team. It is dedicated to multi-agency public protection arrangements (MAPPA).

At the time of our inspection, 2,202 registered sex offenders (RSOs) were being managed in the community in Hampshire. There was an average ratio of about 52 RSOs to one manager, which is only slightly higher than what is considered reasonable (approximately 50–1). Those managers also manage some other offenders. But we found that this didn't increase their workload significantly.

Most staff have had specialist training but some of the content is outdated

The force gives offender managers MOSOVO training. And it keeps track of those who have yet to have that training through a skills matrix. The training includes using the active risk management system (ARMS). ARMS is a structured process to assess risk factors known to be associated with sexual re-offending, and protective factors known to be associated with reduced offending. Its aim is to provide police and probation services with information to help manage convicted sex offenders in the community.

We found that most staff have completed the training, but they report that some of the content is out of date. Staff also told us that some aspects were not in line with current best practice. For example, using fixed intervals between visits, when a more proactive, and less prescriptive, approach is now recommended.

Also, offender managers didn't believe that the training allocated enough time to risk-management planning. This is reflected in the cases we have reviewed. Some risk-management plans just state the risk without including actions to reduce that risk.

Frontline officers are informed about registered sex offenders in the areas they patrol

As the numbers of registered offenders increase, collecting and sharing intelligence about them, and managing them, is becoming more demanding. It is positive that the force recognises this and makes information about RSOs available to frontline and neighbourhood teams.

The force flags RSOs on Niche. This means that officers going to apparently unrelated incidents at the addresses of RSOs know that they are visiting known offenders. As a result, they have the information they need to make good decisions.

There are also good links between the MOSOVO team and frontline teams. Information about registered sex offenders is also shared through briefing frontline officers.

Visits to offenders have an investigative focus

The team is determined to visit offenders without any warning, which is the best way to do it. The team operates a shift system, so offender managers work during the evening and at weekends. This allows flexibility, including unannounced visits to those offenders who work or are difficult to trace.

Each Friday, a list of outstanding high-risk visits is shared among all teams. This is so their time at the weekend can be used effectively across the force.

We saw that during visits to offenders, managers consider ARMS risk assessment headings and structure their records of those visits with this in mind. This helps to focus on the risk and make better judgments. But this is locally referred to by offender managers as ‘ARMS light’, and it is sometimes used instead of a full ARMS assessment. This means that some risk management plans are based on incomplete risk assessments.

Risk management planning needs to improve

When the police are the lead agency for managing an RSO, they should complete an ARMS risk assessment within 15 days.

Based on the risks they identify, offender managers should draw up a risk management plan. This sets out how they will manage the risk posed and what actions they will take, such as regular visits to the offender. We saw that these plans were often a repeat of the risk, without a clear plan to reduce it.

We saw that actions often aren’t entered on the system in a way they can be tracked. This makes it difficult for offender managers and their supervisors to see what has been completed. So, we saw examples of actions not completed and risk to children not addressed as quickly as it could have been.

Poor recording practices are having a negative impact on managing offenders

Visor is a national database used for:

- recording and sharing information about registered sex offenders; and
- recording activity to reduce the risk they pose.

In Hampshire, we found that the MOSOVO team also keep information on a standalone system of shared folders. We were told this came about because of a problem with the force IT system, making it difficult to load Visor.

This means that a lot of important information is not held on Visor, and so not available to anyone outside the team.

When an offender moves to another area or travels between areas, the Visor record is shared with other forces. So, when an offender travels from Hampshire, other forces will not have all the information they need.

It also means that access to this information is limited outside normal working hours. Those offender managers completing the high-risk visits at weekends therefore might not have all the information they need.

There is not enough oversight of practice

The force contributes to some multi-agency audits of work relating to offender management through MAPPA. However, at the time of our inspection it didn't carry out internal routine sampling or audits. And, because of the standalone systems, analysing data to understand performance is a problem.

We were reassured that senior leaders understand the impact this has on the force's management of those who pose a risk to children. They have already developed an improvement plan to address the issues.

Recommendation

We recommend that Hampshire Constabulary immediately reviews its MOSOVO arrangements and practices. It needs to make sure that the risk from offenders in the community is managed effectively.

11. Police detention

Custody officers and staff receive regular training and guidance

The initial training for custody sergeants and detention officers includes aspects relating to detaining children. In 2019, all custody staff also received a half-day of training relating specifically to detaining children. This included adverse childhood experiences (ACEs) and the links between arrest and exploitation.

There is more guidance on the custody section of the force's intranet. The force also issues a newsletter every two months. Called the Custody Courier, it gives up-to-date guidance and advice.

Twice a year, the central custody team carry out an internal inspection of a custody suite and the work of staff. This is reported to custody senior leaders. Immediate feedback is given to staff and lessons learned are added to the custody improvement plan.

There is a clear focus on diverting children away from custody

During our conversations with staff and officers in the custody suite, and those dealing with children, they clearly took a child-centric approach aimed at diverting children away from custody. They are aware that a child should only be arrested when absolutely necessary.

Frontline officers are expected to have a clear justification for bringing a child into custody. We saw that detaining a child was only authorised if the custody officer was satisfied that other options had been considered. Our case audits showed that custody officers explored, in detail, other options.

Custody officers focus on the welfare of children when they are detained

In most of the cases we reviewed, the welfare of children was central to the custody staff's actions.

We were told that all four custody suites in Hampshire have a discreet booking-in area for children and vulnerable people. Children are detained away from adult detainees.

We saw that custody officers researched the child's history and used the information held on the Niche system when carrying out initial risk assessments.

When it was considered necessary, children were seen by a health care professional. They were also referred to the liaison and diversion service. Available within custody

suites, this service screens and assesses (or referring for assessment) people of all ages in contact with the youth and criminal justice systems. It helps identify people with mental health problems, learning disabilities, cognitive disorders, substance mis-use problems and other vulnerabilities as soon as possible. Information from these assessments is passed to relevant justice agencies to help decision-makers make more informed decisions.

When a 16-year-old boy was arrested, an initial risk assessment revealed he had ADHD, autism and anxiety. The custody officer made sure his parents came to the police station as quickly as possible. The custody staff took time to understand the boy's health issues and discovered that routine and home comforts were important to him.

He was put in an appropriate cell. When it was clear that he would be detained for several hours, the custody officer provided an extra mattress and made the bed up for him. The officer also offered to provide him with his pillow from home, as well as distraction gadgets and puzzles.

Custody officers displayed a good understanding of the requirements for alternative and secure accommodation, and understood the difference

The local authority is responsible for providing suitable alternative accommodation for a child charged with offences and denied bail. Only in exceptional circumstances would this not be in a child's best interests. For example, if they couldn't be moved elsewhere because of bad weather. Secure accommodation is needed in rare cases, such as when a child is at high risk of causing serious harm to others.

When it was likely alternative accommodation would be needed, we saw in most cases that the force had conversations with the local authority early on. This gave the local authority the best opportunity to find somewhere.

When no accommodation was available, we saw evidence of the force and the local authority working together to find solutions. For example, a child staying with a family member, rather than be detained overnight.

We also saw that the force has early discussions with the court to make sure they were open in an afternoon to receive a child. This avoided a child being detained overnight at a police station.

Juvenile detention certificates outline to a court the reason a child should be remanded in custody. They are essential to make sure that the police are accountable. They also enable forces to check how well they are meeting their responsibilities under the Police and Criminal Evidence Act 1984 (PACE). We found that custody officers understood this, and the certificates were usually completed. This means that important information is being recorded and shared with the court. For example, justifying detaining the child in police custody overnight.

Detained children with complex needs sometimes aren't referred to children's social care services

Many children brought into police custody have complex needs. They are often vulnerable and need support to keep them safe. Often, a referral to children's social care services is needed. But when we reviewed case files, we found the number and quality of referral forms submitted for children in custody was inconsistent. Some were comprehensive, but others didn't contain important information. And, in some cases, they weren't submitted when they should have been.

Appropriate adult attendance is inconsistent

The Police and Criminal Evidence Act 1984 (PACE) states that once an appropriate adult is identified, they should be asked to come to the custody centre as soon as possible.

Although we saw prompt attendance of appropriate adults, in some cases this was arranged just for the child to be interviewed. On those occasions, they weren't there to offer early support to meet their overall welfare needs, rights and entitlements. This can lead to delays in a child seeing someone other than the police.

The force already has the quality assurance processes in place to help make sure appropriate adults consistently attend earlier.

Conclusion

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

The leadership team is clearly committed to child protection and providing better outcomes for children. Wider vulnerability is also a priority for the force.

The child-centred policing strategy makes this commitment clear to staff and officers, other safeguarding partners and the community. This has been shown in the many ways described in this report.

The force works well with safeguarding partners from across the local authority areas. It is an active member of the multi-agency safeguarding arrangements. And is represented at the appropriate level on boards and subgroups, often driving strategic direction.

As highlighted earlier, there were several examples of good work by individual frontline officers responding to incidents of concern involving children.

We also found specialist child protection staff to be committed and dedicated, operating in an increasingly complex and demanding environment to keep children safe.

Senior leaders are aware of some inconsistencies and areas for improvement in the service it provides to children. We were encouraged by how the force works with its safeguarding partners and with the speed it addresses areas of concern. And to understand how it can learn from the child protection case audits during this inspection.

The force already has the governance and scrutiny arrangements in place to monitor the impact of changes and improvements it makes.

We have made recommendations that will help improve the outcomes for children.

Next steps

Within six weeks of the publication of this report, we require an update of the action the force has taken to respond to those recommendations where we have asked for immediate action.

Hampshire Constabulary should also provide an action plan, within six weeks of the publication of this report, setting out how it intends to respond to our other recommendations.

Subject to the update and action plan received, we will revisit Hampshire Constabulary 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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