HMICFRS

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

National Child Protection Inspection Post-Inspection Review

Humberside Police
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1. Introduction

The 2016 inspection

In November 2016, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS[1]) conducted a child protection inspection of Humberside Police.

We published the report of our findings in April 2017. This concluded:

> "Humberside Police is committed to improving services for the protection of vulnerable people, and recognises it must improve how it safeguards children. The chief constable and police and crime commissioner have prioritised the protection of vulnerable people and it is clear that there is an increased focus on this across the force. However, the force needs to do more to increase awareness and understanding of the need both to safeguard children and to look beyond the obvious risk factors, to identify any wider or underlying problems which need to be addressed."

HMICFRS found some good individual examples of the force protecting children who were most in need of help, with good multi-agency work and a child-centred way of operating that effectively combined investigative and safeguarding approaches. However, we found most cases that we examined were inadequate or required improvement, and therefore the force was not consistently protecting all children at risk. In particular, we found:

- poor responses by some officers, often missing the wider risk posed to others;
- failures to pursue appropriate lines of enquiry; and
- inadequate management and supervision arrangements and insufficient evidence of recognition of these deficiencies, which compounds the weakness.

Notwithstanding the above, the force had been receptive to the early findings of the inspection and its response was encouraging.

[1] This inspection was carried out before 19 July 2017, when HMIC also took on responsibility for fire & 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.

HMICFRS was critical of the poor standard of recording on police systems across the force. Accurate and timely recording of information is essential for good decision-making in child protection matters, and we found that important information was often missing or there were delays in recording it on police systems. This included:

- delays in recording the outcome of strategy meetings (often, minutes were not taken);
- delays in updating records on the progress of investigations; and
- the omission of details regarding contact with children and families.

In a large proportion of investigations examined, we found that relevant information and minutes of important meetings were not recorded, which meant that there was no information regarding actions allocated and decisions made.

The lack of qualitative performance data was impairing the force's ability to understand the nature and extent either of child-related offending in its area, or of the police response to it. Such information is required for the force to measure its effectiveness and establish where resources are needed to improve outcomes for children. The increase in resources for safeguarding by the force was a positive step. However, without consistent data analysis (including performance data) and the appropriate management of performance as a result, the force was limited in its ability to understand how the increased resources were affecting outcomes for children. A performance and audit framework that focuses on outcomes for vulnerable children would enable the force to monitor and improve its child protection work across the protecting vulnerable people teams, particularly in the areas highlighted during the 2016 inspection.

The force's arrangements for managing high-risk sex offenders required some improvement. The force did not have sufficient capacity to ensure it could carry out enough monitoring visits, supervise the management of offenders or carry out meaningful proactive work. While we found evidence of some good inter-agency plans to manage risk, the force needed to do more to develop the knowledge and understanding of its community-based teams, which could provide valuable information to help manage these offenders and safeguard children in their areas.

The force's approach to children who regularly go missing from home also required improvement. In particular, it needed to improve its early intervention as well as staff and officers' understanding of the link between children who go missing regularly and their vulnerability to sexual exploitation. The force also needed to use feedback from safe-and-well checks and return-home interviews to inform an effective multi-agency approach to safeguard these vulnerable children.

Humberside Police had tried to gain a better understanding of the nature and extent of child sexual exploitation across the force area; it had set up dedicated teams to tackle this. However, without an up-to-date problem profile informed by the information held by partners, as well as officers and staff who fully understood their role, the work of the teams lacked focus. This meant that the force had been missing opportunities to improve outcomes for vulnerable children.

Within its custody teams, Humberside Police needed to do more to ensure that officers and staff could recognise and were acting on children who required safeguarding. It was developing a force-wide protocol to address the lack of local authority alternative accommodation for children who may otherwise be detained in police custody. This is essential, as HMICFRS' case examination revealed that for cases where bail following charge had been denied, no child was transferred to the care of the local authority because no suitable accommodation was available.

It is not in the best interests of any child to be detained in a police cell under the Mental Health Act 1983. HMICFRS was pleased to find that children were not routinely detained in this way, and that there was no evidence of any such detention of children by the force in the 12 months preceding the inspection.

It is clear that the force's senior leaders were and continue to be committed to improving outcomes for vulnerable children, and that the force had made some improvements in this regard. However, the force needed to do much more to improve its safeguarding practice in order to protect more effectively those children at most risk of harm.

The report of the 2016 inspection therefore made a series of recommendations aimed at improving child protection practice by Humberside Police.

The 2017 post-inspection review

After the report of the 2016 inspection was published, the force 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 and support the improvement activity by the force, and in November 2017 a post-inspection review was conducted to assess its progress.

The review included: an examination of force policies, strategies and other documents; interviews with officers and staff; and an audit of 35 child protection cases (specifically related to the areas for improvement set out in the 2016 inspection report).

Summary of findings from the post-inspection review

Humberside Police is committed to improving services for vulnerable people. The new chief officer team has started to put in place plans to ensure officers and staff understand vulnerability and their role in dealing with it. Some of the plans and training have either yet to take place or have only recently been implemented, which means that it is difficult to assess their effects.

Progress in some areas has been slow and this is due in part to the force changing its database during summer 2017, and the problems it has encountered while officers and staff become accustomed to a different way of recording on and searching systems.

Some recommendations have been acted upon more swiftly and improvements are evident in those areas of practice. They include: the way the force approaches its management of sex offenders; its assessment of risk and the fact that it now refers children in online abuse investigations at an early stage; and its approach to the completion and recording of protection documentation. There are also clear improvements in the way that systems are searched by control room teams, which leads to better quality information being passed to officers attending incidents, in particular domestic abuse incidents where children are present.

There is some evidence of slight improvement in the results from the case files' audit. In November 2016, HMICFRS assessed 96 cases and rated the force's practice as good in 20 cases (21 percent), requiring improvement in 35 cases (36 percent), and inadequate in 41 cases (43 percent). Of the 35 cases assessed in this post-inspection review, HMICFRS found the force's practice to be good in 9 cases (26 percent), requiring improvement in 17 cases (48 percent) and inadequate in 9 cases (26 percent). While the review sample sizes are smaller, they represent a slight improvement in standards but are also indicative of the force's need to build on the progress made.

There continue to be weaknesses in the force's risk assessments by its specialist teams in relation to domestic abuse, and the processes in place to conduct them. The force recognises that its current approach is not working, and it intends to review and re-design both the triage and secondary risk assessment processes; further improvement is necessary to ensure that children involved in domestic abuse incidents are identified and referred to other agencies in a timely way for proper safeguarding. The present arrangements have resulted in significant backlogs of cases which require attention.

Overall, HMICFRS' view is that Humberside Police recognises its need to improve, and understands what is required to ensure that it provides consistently good child protection practice across the force area. The force has taken some important steps to address the recommendations from the 2016 inspection and recognises there remains more to be done to provide consistently improved outcomes for children.

2. Post-inspection review findings

Initial contact

Recommendations from the report of the 2016 inspection:

Recommendation

We recommend that within three months, Humberside Police should provide training to control room staff to ensure that they have an improved understanding of vulnerability, particularly child sexual exploitation, coercive control and domestic abuse, better to inform their identification, responses and risk assessments.

Recommendation

We recommend that within three months, Humberside Police should review its processes to ensure that staff can draw together all available information from police information systems in a timely way better to inform their responses and risk assessments.

Recommendation

We recommend that within three months, Humberside Police should ensure that officers always record their observations of a child's behaviour and demeanour in records of domestic abuse incidents so that its officers make better assessments of a child's needs.

Summary of post-inspection review findings

Humberside Police has provided additional training to its control room staff and developed new processes. As a result, it now assesses risk more effectively, which has led to improved information being passed to officers and staff attending incidents in which there may be children at risk. However, the force is not using this information in a consistent way to understand the risk posed to children. The force also needs to do more to ensure that the demeanour of children at incidents of domestic abuse is properly recorded.

Detailed post-inspection review findings

In 2016, HMICFRS found worrying evidence of numerous occasions when officers and staff had been deployed to incidents where checks of police systems had not been made, and they were not therefore equipped with relevant information to inform their risk assessments. Such information was not being retrieved from police systems and passed on by control room staff, as they had received limited training in recognising vulnerability. As a consequence, there was the risk that frontline officers attending incidents were not informed of all relevant information, which could have

adversely affected their decision-making. Moreover, we were troubled to find that officers and staff were not routinely talking to children at domestic abuse incidents to understand the effects on them.

Since the 2016 inspection, Humberside Police has provided additional training to its control room staff to help them identify vulnerability, and processes are now in place to enable them to search systems and provide comprehensive background information on families and children. HMICFRS was pleased to see that in the majority of control room logs sampled for domestic abuse incidents where children were present, the necessary initial checks were both made and recorded. Although we found some of the checks were delayed, they had been completed and recorded in all the records we examined. This is an improved picture since our 2016 inspection; some relevant previous offending has been identified which could be used by the force to inform future risk assessments. However, the approach of attending officers has not yet been developed to use this information consistently in informing their activity, and to make better assessments of the risks posed to children.

In October 2017, the force conducted an internal audit of domestic abuse, stalking and harassment (DASH) risk assessment forms; it found there are still inconsistencies in the standard of recorded detail regarding the demeanour of children at domestic abuse incidents. Although we found that frontline officers and staff understand the need to record the demeanour of children, this does not always happen. The force has continued to emphasise to its workforce the importance of recording this information; it recently issued a video in which a detective chief inspector explains the significance of such information, and requests the inclusion of this detail by officers and staff attending such incidents. This video has been viewed by HMICFRS and while it is very informative, the force has no way of knowing how many officers and staff have seen it. Moreover, due to its very recent introduction it is not possible to assess its effect on the practices of frontline officers and staff.

HMICFRS would echo the force's own findings that the recording of the demeanour of the child and the consequential assessment of a child's needs is still inconsistent. All staff have recently been issued with a 'Your Guide to Vulnerability' booklet, outlining aspects of vulnerability and how they should be dealt with. It is too early at present for us to determine whether these measures have changed practice.

Assessment and help

Recommendations from the report of the 2016 inspection:

Recommendation

We recommend that Humberside Police should immediately take steps to reduce the domestic abuse cases waiting for further research and information sharing, ensuring that those involving children are dealt with as a priority.

Recommendation

We recommend that within three months, Humberside Police should review its policy about attendance at case conferences; both initial and review, to ensure appropriate risk based representation at these meetings to properly contribute to safeguarding children.

Recommendation

We recommend that within three months, Humberside Police should review its new shift system for its protecting vulnerable people unit to ensure the system enables close joint working with partner organisations.

Recommendation

We recommend that within three months, Humberside Police should improve its 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; and
- improving staff awareness of the significance of drawing together all available information from police systems, including information about people who pose a risk to children, better to inform risk assessments.

Summary of post-inspection review findings

Humberside Police continues to have high levels of domestic abuse cases awaiting secondary risk assessment. However, the force recognises the current system is not working; it intends to completely review and change the process with a view to reducing backlogs and improving its ability to identify and safeguard affected children. The force's attendance at case conferences has improved significantly; it has filled all posts within the team responsible for attending. Moreover, decisions regarding which conferences to attend are now priority-based, and any decision not to attend is properly risk-assessed. Officers demonstrate better awareness about children who are missing from home, including how to locate them, and there is better recognition of the links between those children who go missing frequently and child sexual exploitation. However, the force continues to demonstrate poor recording on police systems of cases involving children who frequently go missing from home, and therefore much of the good work being done to address this issue is not available to help inform future risk assessments.

Detailed post-inspection review findings

In 2016, HMICFRS was critical of the number of domestic abuse risk assessments awaiting further research and victim contact, particularly those where children were connected to the victim or perpetrator. At the time of the 2016 inspection, there were 1,247 standard-risk and 1,188 medium-risk cases awaiting further work. In 2017, Humberside Police still had high numbers of cases awaiting further or 'secondary' research and victim contact: 225 high-risk; 1,007 medium-risk; and 8 standard-risk cases. The oldest high-risk case awaiting research at this time was five months old. The force now uses an initial triage process to reduce the need to conduct research for standard-risk cases; it prioritises secondary research for those that are medium- or high-risk where there are identified children. At the time of our review, the oldest cases in the queue awaiting secondary assessment were five months for medium-risk and four weeks for high-risk, respectively. However, any children involved in these cases should have been referred to children's social care (CSC) at the initial triage stage. HMICFRS continues to be troubled by the possibility that cases within the main backlog may contain children connected with victims and perpetrators who were not identified by attending officers and, consequently, have not yet been safeguarded; as a result, the escalation of risk in such cases may not be detected at an early enough stage.

HMICFRS is also still concerned about the backlog within the initial triage process, for which no specialist risk assessments or safeguarding referrals have been made. Of the 63 cases in the queue, at the time of our review the oldest case involving children was eight days old. In these queued cases there had been no referral to other agencies to undertake necessary safeguarding, and no notification to the children's school through Operation Encompass (a system of sharing information with schools about children exposed to domestic abuse). The consequence of this is that action to develop a protective plan is delayed and schools and other agencies may be without important safeguarding information which they could use to inform better decision making. . HMICFRS is pleased that the force intends to review its triage and risk assessment processes and recognises that in its current form it may leave children unidentified and at risk.

A 24-year-old male, who was living with his female partner and her young daughter, reported to the force that his partner had assaulted him in an encounter (during which he had told her that he was terminating the relationship) and where the child was present at the time. However, the male did not want to press charges and the investigation was ceased. The control room checks revealed the male had five years previously been investigated for grooming an 11-year-old girl. However, his potential risk to the child of his most recent partner was not mentioned in the force's investigation of this matter. Moreover, the risk was not identified during the initial triage, and the matter was still awaiting further risk assessment some months after the incident.

During HMICFRS' 2016 inspection, we found inconsistent attendance by the force at case conferences; there was a lack of clear, risk-based decision-making relating to whether representatives of the force would attend. In 2017, we were pleased to see that the force has made significant improvements in its attendance at initial case conferences. Vacancies within the team charged with attending these meetings have been filled, and there are now four case conference co-ordinators. When there is more than one conference scheduled for a particular day, a decision regarding force attendance is made based on risk. The force reported that this improved approach has attracted positive feedback from external safeguarding agencies, as the force now contributes to safeguarding decision-making to a greater extent. Moreover, Humberside Police informed us that it is keen to explore whether technology can improve further its attendance at meetings, through the use of video and telephone conferencing.

Since our 2016 inspection, the force has reviewed the working hours of its specialist teams. This has led to a change in shift patterns within the child sexual exploitation (CSE) and the domestic abuse (DA) teams, to enable the force and fellow safeguarding agencies to work together better and at similar times of the day. The protecting vulnerable people (PVP) core teams remain on shifts similar to the rest of the force, providing cover between 8.00 am and 10.00 pm each day. The force believes this approach meets the needs of the external agencies with whom it collaborates, as well as its internal demands for dealing with those in custody and the provision of specialist advice. The 'half-night' shift (which saw officers working until 2.00 am) has been removed from the rosters and members of the teams reported that while they remain busy, they feel they have been listened to and their views addressed. It is worthy of note that while the teams still reported high workloads, morale has improved significantly in the relevant PVP teams.

The force has introduced an additional detective sergeant to improve its work with partners regarding referrals for children at risk; the previous shift pattern sometimes prevented the availability of an appropriate supervisor to contribute to these meetings and assist with decision-making.

The PVP teams reported that the quality of training days has improved: they are now tailored to their needs and helpful, covering the areas where they feel they need greater information and knowledge.

In 2016, HMICFRS established weaknesses in the standard of practice by officers and staff for children missing from home. There has been a general improvement in the way that long-term complex cases are investigated and managed by the force, although this is let down by poor recording on police systems which undermines the accuracy of risk assessments owing to incomplete information, particularly when a child goes missing again. In a number of the cases of missing children sampled by HMICFRS, it was unclear whether important strategy meetings had taken place and what action had been taken to safeguard children.

Initial action by officers when taking the report of a missing child shows that they are aware of their responsibilities for protecting children (for example, rapidly searching the grounds of a hospital for a child who had gone missing during a mental health assessment). Although this level of awareness was also demonstrated by officers regarding children who repeatedly go missing, this appeared typically based on their view of the child's character, as opposed to arising from the assessment of risk. Moreover, for cases where missing children are suspected to be involved in criminal activity, we found the force's search to be more focused on arresting the child than the need to safeguard.

Investigation

Recommendations from the report of the 2016 inspection:

Recommendation

We recommend that Humberside Police should immediately review how its internet sexual offences team (ISOT) operates to ensure that it shares information with partners at the earliest opportunity and that ISOT understands that safeguarding children is a priority.

Recommendation

We recommend that Humberside Police should immediately ensure that it complies with national crime recording standards.

Recommendation

We recommend that within three months, Humberside Police should improve its child protection investigations, by ensuring that, as a minimum:

- every referral received by the police is allocated to a team with the skills, capacity and competence to undertake the investigation;
- investigations are supervised and monitored regularly and, at each check, the supervisor reviews the evidence and any further enquiries or evidence gathering that may need to be done; and
- it develops an audit process which focuses on the outcomes for children.

Summary of post-inspection review findings

Humberside Police has taken action to improve the way that children are referred to CSC at the earliest point possible during the investigative process. There has also been an improvement in the force's timely recording of crimes. Although staffing levels within the PVP teams are similar to those found in 2016, changes to shift patterns have enabled officers and staff to align their work more closely with external safeguarding agencies' hours. Officers in the core PVP teams are awaiting receipt of

the specialist child abuse investigation development programme (SCAIDP), and the force is in the process of establishing a plan to ensure all officers and staff are properly trained to deal with child abuse investigations. Further, in some of the cases examined there are improved levels of supervision.

Detailed post-inspection review findings

During the 2016 inspection, HMICFRS was critical of the force's approach whereby officers in the internet sexual offences team (ISOT) were not referring children to CSC for safeguarding at the earliest opportunity, but rather at the point when a suspect was arrested. The force now has systems and processes in place to ensure cases involving at-risk children are referred to CSC as soon as it is apparent they are connected to a suspect, and that relevant information is shared. While referrals are made via the PVP teams, there is an expectation from the ISOT that all the strategy discussions and safeguarding will be dealt with by the dedicated decision-maker within the PVP team. Despite this arrangement, HMICFRS found nothing entered on systems which evidence that strategy discussions have taken place, or what measures (if any) have been implemented to safeguard affected children. As a result of this weakness, there are no child-related updates recorded on systems when suspects are arrested or charged, leading to an incomplete understanding of the levels of risk to children.

In 2016, we found that Humberside Police was not recording crimes at the point at which it was clear one had been committed, which contravened the national crime recording standards. Since then, the force has introduced a weekly review of investigations conducted by the ISOT, focused specifically on data quality and referrals to CSC. This is helping to ensure that crimes are appropriately recorded and the wider safeguarding of the children is considered.

HMICFRS' dip-sampling of cases showed the ISOT team ensures crimes are recorded in a timely way. It also showed that 28-day supervisory reviews, and the associated investigation and safeguarding plans, are being completed. However, the dip-sampling and case audits also included a small number of cases where the force had failed to record a crime.

In the 2016 inspection, we found that the officers and staff within Humberside Police who were responsible for managing child abuse investigations were generally committed and dedicated to providing the best outcomes for children. However, we found that the specialist teams were experiencing high workloads and sickness levels, as well as holding vacancies. Our 2017 findings indicate that staffing levels remain similar, although a current and force-wide review aiming to better align manpower with demand may result in additional posts in the PVP teams. A new SCAIDP course is planned - but it will be a significant undertaking to provide this to all 90 investigators, as only 8 can attend each session.

The PVP teams receive joint training with external safeguarding agencies, and we were told that they regard this as positive. A number of officers and staff have also attended the rapid response to child death course.

HMICFRS' 2016 audit revealed inconsistent levels of supervisory oversight and input, with some supervisory updates lacking in robust management of activity. A 28-day supervisory review process is now in place, and a recent audit conducted by the force indicates that 80 percent of cases are compliant. As previously mentioned, the recent case audit conducted by HMICFRS showed a slight improvement in the standard of investigations. However, this continues to be an area of weakness and the force needs to do more to ensure that all safeguarding and investigative activity is taking place in a timely manner and being properly recorded on police systems. This is essential to ensure the the force can understand all the actions being taken to protect children.

A 17-year-old boy was believed to be subject to sexual exploitation by a 41-year-old male registered sex offender. The force demonstrated good recognition of the risk of CSE, and timely action was taken to arrest the offender. However, there was little evidence of any investigative activity recorded on the crime file: the fact of the offender's arrest was omitted, and the most recent entry by the officer in the case was dated in early August 2017. There was also no record of any further safeguarding activity in relation to the offender, who is of high risk to children.

While the force participates in multi-agency audits, there is no formal, police-only audit programme for PVP disciplines (although we were told this may be introduced in the future). The development of the vulnerability dashboard may help the force to better understand the nature and scale of child protection problems within its area (although we found this work has stalled while the new databases are being established).

Decision-making

Recommendations from the report of the 2016 inspection:

Recommendation

We recommend that Humberside Police should immediately take steps to ensure that where police protection powers are used, all relevant documentation is recorded on a single database for auditing and practical purposes.

Recommendation

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

- what information should be recorded (and in what form) on systems to provide evidence of good quality decisions;
- the requirement that meetings where actions are allocated and decisions made are minuted to ensure a comprehensive audit trail; and
- confirmation of the importance of ensuring that records are made promptly and kept up to date.

Summary of post-inspection review findings

Humberside Police has introduced a database on which officers and staff can record all decisions made and actions taken to protect children. Although this is positive, there continue to be significant weaknesses with recording information within the force. Documents and information are often held on systems which cannot be searched or audited.

Detailed post-inspection review findings

In 2016, HMICFRS found that decisions to take children into police protection were generally well-considered. However, we were critical that the force's recording of the use of these powers was inconsistent. This meant that the force could not monitor or audit how and when children were being taken into police protection. In 2017, HMICFRS was pleased to find that these decisions are generally being effectively recorded on a new, force-wide and searchable database (Connect).

Overall, however, the poor recording of information continues to be a significant weakness for the force. In a number of the cases we audited, strategy meetings had not been recorded, and it was unclear whether or not such meetings had taken place. Moreover, the absence of minutes from these meetings (which should outline decisions made and the rationale) means that future decisions about the risk posed to a child are based on potentially incomplete information. We found that officers and staff are still unsure of where documents should be stored; HMICFRS found documents filed in different locations on police systems. In many cases, this means they cannot be accessed by all officers and staff to help inform decision-making, or to enable the force to understand what action has been taken to safeguard children.

Officers do not always submit relevant child-concern notifications (called '125s') to help others (both in the force and in partner agencies) to make good quality decisions. Some members of the force told us that they sometimes submit intelligence reports instead, because they find them easier to complete (as to do so, they can use their hand-held devices). Failures to submit 125 notifications mean that partner agencies, such as social care, are not made aware of risks to children.

The recent introduction of the Connect database for recording crime and incidents provides the force with an opportunity to clarify to officers and staff where documentation and decision-making should be recorded. The system is also easy to search and audit, although at the time of the post-inspection review the force was still getting used to how it works.

Trusted adult

Recommendations from the report of the 2016 inspection:

Recommendation

We recommend that, within three months, Humberside Police should ensure that its staff:

- record the views and concerns of children;
- record the outcome for the child at the end of police involvement in a case;
- inform children, as appropriate, of any decisions that have been made about them; and
- deal with child victims and witnesses expeditiously, to build rapport and trust.

Summary of post-inspection review findings

HMICFRS found that the force still needs to improve the consistency with which it records information. Remedial work to address this weakness has been delayed to some extent by the recent introduction of a new crime and incident recording system, Connect. The force is aware that the current systems do not contain all available information about vulnerable children, which means that risk assessments are made based on incomplete information.

Detailed post-inspection review findings

In 2016, HMICFRS found that details of decision-making, rationales and activity were often not well-recorded on the force's systems. We found in 2017 that this continues to be a problem for the force, compounded by a lack of clarity among its officers and staff about the locations of documents within its systems. The relatively recent introduction of Connect has, in part, contributed to this continuing problem, as the force needs time to become familiar with the use of the system. We also found that documents are being stored in personal files and not always uploaded to Connect, so although individual officers are aware of what is happening in relation to a child, this intelligence is not searchable or visible to the rest of the force. Connect has enormous potential to help with these problems; the force needs to exploit its potential by ensuring that all documentation is appropriately recorded and stored within it.

We found that the force's approach to recording the views of and outcomes for children continues to be inconsistent. However, for cases where children return after being reported missing, safe-and-well checks are usually completed in a timely and thorough way. We also found that information on these checks is now recorded on systems, and so can be used by the force if the child goes missing again.

Managing those posing a risk to children

Recommendations from the report of the 2016 inspection:

Recommendation

We recommend that Humberside Police should immediately provide ARMS assessment training to MOSOVO supervisors and managers, to enable effective approval of ARMS assessments.

Recommendation

We recommend that, Humberside Police should immediately review capacity within its MOSOVO team, to include prioritisation of outstanding visits and actions.

Recommendation

We recommend that Humberside Police should immediately prioritise the development of performance information to ensure managers are aware of any backlogs and the level of risk these pose.

Recommendation

We recommend that, within three months, Humberside Police should take action to improve the knowledge of communities' officers about registered sex offenders living in their area.

Recommendation

We recommend that, within three months, Humberside Police should improve its identification, disruption and prosecution of the perpetrators of child sexual exploitation, to include the development of an up-to-date multi-agency problem profile.

Summary of post-inspection review findings

Humberside Police has amended its boundaries to make the division of work between its north and south offices more even. Although workloads remain high, chief officers are currently considering how they will address this; this may result in increasing the size of the teams for the management of sexual offenders and violent offenders (MOSOVO). Although there continue to be backlogs in visits made by the police to registered sex offenders in the area, the force now has a greater

understanding of the risk these represent. All managers and supervisors have now received training in the use of active risk management systems (ARMS), and are able better to ratify the work of their teams.

Detailed post-inspection review findings

In the 2016 inspection, HMICFRS established that the number of registered sex offenders (RSOs) allocated to each officer working in the MOSOVO teams was much higher than that recommended by national guidance, and that ARMs assessments were not being managed effectively or supervised. Moreover, the supervisors and managers within MOSOVO teams were unaware of the levels of risk posed by the RSOs to whom visits were delayed.

Since our inspection, the detective sergeant, detective inspector and detective chief inspector with responsibility for ARMs assessments have all received targeted training on how to approve and ratify the work completed by their teams. As a result, they now understand the process and can ensure the completion of ARMs to a good standard. The force believes that this will help start to address the numbers of incomplete ARMs assessments.

The force has reviewed the current and projected demand for the MOSOVO teams, but the number of RSOs allocated to each officer continues to be high (generally between 60 and 65). This number has been reduced partly by altering the boundaries for the two offices to even out the respective workloads. The force has explored further options to resolve its capacity problems, including the potential use of neighbourhood teams to manage lower-level offenders. Consideration is also being given to increasing staffing levels in the MOSOVO teams in order to better deal with the numbers of RSOs being managed. If this happens, these officers are likely to be in place by the end of March 2018, and should have a positive effect in reducing the number of outstanding visits to RSOs.

Humberside Police previously struggled to recruit staff to the MOSOVO teams, largely because the original criteria for the role required applicants to be trained detectives. The force has made changes to its recruitment processes as a result; the most recent recruitment exercise has allowed non-detectives to apply to join the team, and of the six recently successful candidates, half were non-detectives.

The force has also established that some low-risk offenders are still being actively managed when they are elderly and confined to care homes, or are otherwise incapacitated. The force is making applications in appropriate cases for a small number of individuals to be de-registered, as their risk of harm is much diminished.

The MOSOVO teams and their managers now have a much greater awareness of the backlog of visits to RSOs in Humberside, and the level of risk these individuals present. Such cases are discussed daily at the office meetings, and the teams take necessary action to address any immediate matters of significance.

While this is an improved situation for the MOSOVO teams, HMICFRS found that the standard of investigations they conduct remains inconsistent. We saw evidence of some good, thorough investigations, but also some in which investigative leads were not followed up and too much credence was given to the RSO's explanations, without further investigation. In addition, the wider problem of poor information-recording was again demonstrated by the MOSOVO teams, with their completed activities and supervisory reviews often missing from records.

In recent months the force has made a concerted effort to upload information and photographs of RSOs onto the Connect system; these will become available for all officers and staff in the force to view. Although officers are currently unaware of this facility (as the work is not yet complete), community officers and staff told us they would know who to ask if they wanted more information about RSOs living in their areas.

The majority of medium- and high-risk RSOs' identities are now recorded within Connect and flagged within the system, so that any checks made by the force on these individuals are visible to those in the control room. The MOSOVO teams provide details of around 20 RSOs per month via 'I-brief' (the force's briefing system), which alerts officers and staff to those offenders posing the greatest risk and those who have been released recently from custody or have moved into the area. This provides frontline officers and staff with information of some of those posing high risks to the public, and we found that some (though not yet all) members of the communities-based teams are aware that this information is available to them.

Following the 2016 inspection, HMICFRS reported that Humberside Police did not have a good understanding of the nature and scale of CSE in the area, and did not have up-to-date problem profiles covering the whole force area. Since 2017, the situation is slightly improved. North Lincolnshire now has a problem profile, prepared jointly with other agencies, which is regularly refreshed and maintained. North-East Lincolnshire has a profile based on police data alone; and the remaining two local authority areas of Hull and East Riding have no profiles. Although multi-agency child exploitation (MACE) meetings are held in all four areas, an up-to-date problem profile for each would enhance activity and lead to a more complete understanding of the context and scale of this type of offending across the force area. This would allow the force and its fellow safeguarding agencies to develop strategies to focus their activities upon safeguarding children, and identifying and disrupting the criminal behaviour of perpetrators.

Police detention

Recommendations from the report of the 2016 inspection:

Recommendation

We recommend that, within three months, the force provides its custody staff with training that includes as a minimum;

- an understanding of child safeguarding, recognising when this is required and what action they should take;
- details of the referral process to children's social care or the multi-agency safeguarding hub;
- confirmation of the difference between alternative accommodation and secure accommodation, and when these are required; and
- information to provide increased knowledge and awareness of child sexual exploitation.

Summary of post-inspection review findings

Humberside Police has more to do to improve the knowledge and understanding of its custody officers and staff about their role in safeguarding children. The force has a plan in place to provide such training, but this has not yet been implemented. The force has improved the understanding of officers and staff in relation to: their duty to request alternative and secure accommodation; the differences between the two; and the circumstances in which these types of accommodation are required.

Detailed post-inspection review findings

In 2016, HMICFRS found that custody officers and staff had limited knowledge of child safeguarding, and of their role within this. There was also confusion between the appropriate circumstances in which they could request alternative and secure accommodation for children.

In 2017, we found that no additional training had been provided to custody officers and staff. The force stated that this is due to the time limitations of their shift patterns, and that it plans to provide a member of the multi-agency safeguarding hub (MASH) staff to brief the custody teams in relation to vulnerability, safeguarding children, and referrals; this will be supplemented by a presentation, which has yet to be developed. The force considers that this will enable officers and staff working in custody to have greater awareness of all areas of vulnerability, including CSE.

Despite the lack of formal additional training, we found an improved understanding in the force of the differences between alternative and secure accommodation; custody officers and staff now use flow charts to assist their decision-making in this regard. However, for cases where alternative accommodation had been found, officers and

staff reported that children may still have been kept in custody overnight due to the lack of available transport to take them to the more appropriate accommodation, which may have been out of the county. These problems have now been escalated by the chief constable, and a resolution is being sought with the local authorities.

We also found that children are still being kept in custody overnight unnecessarily due to the lack of availability of appropriate adults. In 7 of the 10 cases reviewed by HMICFRS in which children were arrested and brought into custody ‘out-of-hours’, the child was in custody for more than 12 hours before an appropriate adult arrived. For cases where alternative accommodation had been found, officers and staff reported that children may still have been kept in custody overnight due to the lack of available transport to take them to the more appropriate accommodation, which may have been out of county. These problems have now been escalated by the chief constable, and a resolution is being sought with the local authorities.