HMICFRS

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

National Child Protection Inspections

Lancashire Constabulary
9–19 October 2017

March 2018

ISBN: 978-1-78655-620-2

www.justiceinspectorates.gov.uk/hmicfrs

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 agencies - have a particular role in protecting children and making sure that, in relation to their safety, their needs are met.

Protecting children is one of the most important tasks the police undertake. Police officers investigate suspected crimes and arrest perpetrators, and they have a significant role in monitoring registered sex offenders. They have the powers to take a child in danger to a place of safety, and to seek restrictions on offenders' contact with children. The police service also has a significant role, working with other agencies, 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 agencies 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 children are protected and their needs are met, and to secure improvements for the future.

Contents

Summary

This report is a summary of the findings of an inspection of child protection services in Lancashire Constabulary, which took place in October 2017.[1]

HMICFRS's inspection examined the effectiveness of police action at each stage of their interactions with or for children, from initial contact through to the investigation of offences against them. It also scrutinised the treatment of children in custody, and assessed how the constabulary is structured, led and governed in relation to its child protection services.[2]

Main findings from the inspection

The chief constable, his command team and the police and crime commissioner (PCC) have a clear commitment to child protection, which is reflected in the police and crime plan and in the constabulary's priorities.

In 2016, a review of the constabulary's operating model led to a change in the structure of its specialist resources, including those teams responsible for investigating child abuse. Functions that were previously managed centrally and provided locally were devolved to the three basic command units; thereafter, individual detective superintendents acquired responsibility for the local management of these resources and the provision of protective services. As well as changes in management, the responsibilities of many of the specialist teams changed; the public protection team was renamed the child protection team, and responsibility for the investigation of high-risk domestic abuse moved to the vulnerability hubs that were formally known as the criminal investigation department (CID).

HMICFRS found that both the constabulary's recent efforts and its focus on vulnerability are translating into better child protection work and thereby improving outcomes for some vulnerable children. In particular:

[1] 'Child' in the report refers to a person under the age of 18. See the Definitions and Interpretations section for this and other definitions.

[2] For more information on HMICFRS' rolling programme of child protection inspections, see: www.justiceinspectorates.gov.uk/hmic/our-work/child-abuse-and-child-protection-issues/national-child-protection-inspection/

- Work to streamline processes in each of the multi-agency safeguarding hubs (MASHs)[3] is leading to improved information-sharing, which is enabling more effective joint decision-making and leading to the timely creation of protective plans to safeguard children.

- The multi-agency child sexual exploitation (CSE) teams are improving outcomes for children through early intervention and prevention activity. The Pan-Lancashire CSE Strategy 2015-18 sets out the strategic aims of the multi-agency collaboration to deal with CSE, which is helping to draw together all local safeguarding agencies and police areas, and is increasing the consistency of approach towards children in need of protection.

- The constabulary demonstrates a clear focus on reducing the vulnerability of children and young people through its Early Action initiative. This multi-agency approach identifies the initial trigger points for vulnerability, and works with a range of safeguarding agencies to provide support to children and their families, to address their needs and reduce their vulnerability and subsequent risk of harm.

However, in contrast to such improvements, HMICFRS also discovered weaknesses in the constabulary's approach to child protection, some of which are significant, resulting in children being left at unnecessary risk:

- Governance of child protection is under-developed: the level of oversight needed to ensure the constabulary's strategic vision is translating to better frontline practice has not yet fully evolved to reflect the new operating model. Moreover, there is an absence of any meaningful performance management framework, which is needed to ensure that senior leaders are able to reassure themselves about the nature and quality of frontline services.

- Frontline officers do not always recognise children in need of safeguarding at the earliest opportunity; this leaves some children exposed needlessly to the risk of harm.

- Many frontline officers see their responsibility for safeguarding children limited to the submission of a PVP[4] form; this can result in missed opportunities to put in place vital protective measures at the earliest opportunity.

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

[4] PVP (protecting vulnerable people) is a common term used by the police and other safeguarding agencies in relation to concerns for the welfare of a child or other vulnerable person; information on whom is recorded on police systems and shared with partner organisations.

- Some of the constabulary's basic processes for recording child protection incidents are weak: they often fail to ensure that risks are assessed and safeguarding interventions are implemented at the earliest opportunity; the supervision of PVP and DASH[5] forms is also weak, leading to poorer quality referrals and an inconsistent approach to their submission.

- Many of the departments responsible for child protection experience high levels of demand, which are not always being managed effectively; supervisors struggle to manage these demand levels because of workload pressures, and this results in the drifting of investigations and which are of a poorer quality.

During the inspection, HMICFRS examined a total of 79 cases in which there were children identified as being at risk. Of these, the constabulary's practice in 14 cases was rated as good, in 35 as requiring improvement, and in 30 as inadequate. This demonstrates that there is still work to be done by some areas of the constabulary, if it is to ensure that the quality and consistency of the service it provides to those children in need of help and protection matches its clear strategic intent to improve. Many of the constabulary's weaknesses are based on its continuing difficulties in matching resources to demand.

Conclusion

The chief officer, his senior team and the PCC have a clear commitment to protecting vulnerable children. This is widely recognised by the staff, officers and other agencies with whom HMICFRS consulted as part of this inspection.

However, while some improvements have been made, the constabulary needs to take further action, in some areas as a matter of urgency, to strengthen its safeguarding practice to provide better protection for those children most at risk.

Overall, HMICFRS found that the constabulary is not yet providing a service which is capable of safeguarding all children who are at risk of harm and in need of protection. We found deficiencies in a number of critical areas, and this report makes a series of recommendations aimed at addressing these failings and providing support to the officers and staff who are working hard to improve outcomes for children. However, we were encouraged to note that following our inspection the force has taken immediate steps to address the issues identified which is demonstrative of the commitment of its senior leaders to providing the best possible service for vulnerable children.

[5] DASH is a checklist for the identification of high-risk cases of domestic abuse, stalking, harassment and 'honour-based' violence.

1. Introduction

The police's responsibility to keep children safe

Under the Children Act 1989, a police constable is responsible for taking into police protection any child whom he has reasonable cause to believe would otherwise be likely to suffer significant harm, and the police have a duty to inquire into that child's case.[6] The police also have a duty, under the Children Act 2004, to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children.[7]

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

In 2015, the National Crime Agency's strategic assessment of serious and organised crime established that child sexual exploitation and abuse represents one of the highest serious and organised crime risks.[8] Child sexual exploitation (CSE) is also listed as one of the six national threats specified in the *Strategic Policing Requirement*.[9]

[6] Children Act 1989, section 46.

[7] Children Act 2004, section 11.

[8] *National Strategic Assessment of Serious and Organised Crime*, National Crime Agency, June 2015. Available from: www.nationalcrimeagency.gov.uk

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

Expectations set out in Working Together

The statutory guidance, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*,[10] sets out the expectations of all partner agencies involved in child protection (such as the local authority, clinical commissioning groups, schools and the voluntary sector). The specific police roles set out in the guidance are:

- 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 use of emergency powers to protect children.

These areas of practice are the focus of HMICFRS' child protection inspections.[11]

[10] *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, February 2017 (latest update). Available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

[11] Details of how HMICFRS conducts these inspections can be found at Annex A.

2. Context for the force

Lancashire Constabulary has approximately 4,800 people in its workforce. This includes:

- 2,850 police officers;
- 1,686 police staff; and
- 266 police community support officers.[12]

The constabulary provides policing services to a population of around 1.5 million people over an area of approximately 2,000 square miles. The area is a mix of cities such as Lancaster and Preston, major towns such as Blackburn and Blackpool, and small villages.

There are three local authorities within the constabulary area: Lancashire County Council, Blackpool Borough Council, and Blackburn and Darwen Council. The constabulary is divided into three basic command units (BCUs): East, South and West, which overlap council boundaries. There are three local safeguarding children boards (LSCBs)[13] within the constabulary's area.

The constabulary has a centralised quality, development and compliance department responsible for ensuring that policies and procedures are regularly updated and implemented in line with national and regional recommendations, to maintain the quality of service. Child protection resources are based in each BCU; they are managed at a local level in each area by a detective superintendent who has the authority to deploy resources where they believe it is appropriate to address risk.

Deprivation in England is determined through various social factors, resulting in a national rank for each of the 326 local authorities;[14] the local authority ranked at number 1 is determined as being the most deprived. Lancaster is in the mid-range for overall deprivation, ranking 125 out of 326. However, Blackburn and Darwen and Blackpool out of 326 are ranked 24 and 4 respectively, making them two of the most deprived areas in England.

[12] *Police workforce, England and Wales*, *30 September 2017*, Home Office, January 2018. Available from: www.gov.uk/government/statistics/police-workforce-england-and-wales-30-september-2017

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

[14] For more information, see: www.gov.uk/government/statistics/english-indices-of-deprivation-2015

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

Local authority	Judgment	Date published
Blackburn and Darwen Council	Good	March 2012
Blackpool Borough Council	Requires improvement	September 2014
Lancashire County Council	Inadequate	November 2015

An assistant chief constable is the overall lead for child protection, and is supported by a detective superintendent who is head of public protection. The strategic lead for child protection specifically is a detective superintendent based at constabulary headquarters.

There are a number of specialist teams responsible for protecting children across the constabulary area, these include: the dedicated child protection teams; the multi-agency CSE teams (which have recently been joined by the missing from home co-ordinators); and the vulnerability hubs (that many in the constabulary still refer to as the CID), which are multi-functional with responsibility for rape and high-risk domestic abuse investigations. There are also dedicated safeguarding teams that work with high-risk domestic abuse victims to mitigate risk. Each BCU has a dedicated sex offender management unit (SOMU), and these are managed by the respective area detective superintendent. The online child abuse investigation team (OCAIT) and high-tech crime units are centrally-based and are managed as such.

In 2013, three MASHs were established for public (including child) protection services, which collectively reflect the local authority boundaries. There is a strong commitment from a wide range of statutory and non-statutory partners and the constabulary towards each of the hubs.

Multi-agency risk assessment conferences (MARACs)[15], used to mitigate risk in cases of domestic abuse, are chaired by a dedicated member of the constabulary who oversees approximately 13 conferences per month across the constabulary area.

[15] A MARAC is a locally-held meeting of statutory and voluntary agency representatives to share information about high-risk victims of domestic abuse, at which any agency can refer an adult or child whom they believe to be at high risk of harm. The aim of the meeting is to produce a co-ordinated action plan to increase an adult or child's safety.

3. Leadership, management and governance

Together, the PCC police and crime plan and the Lancashire Constabulary ambition, mission and values statement demonstrate a strong commitment to improving the protection of children in the county.

In 2016, child protection functions across the constabulary were being managed centrally but provided locally. A review has led to the constabulary's operating model becoming location-based. This means that senior leaders in each of the three BCUs are now responsible for the management and provision of local child protection functions. Child abuse investigations are now the responsibility of dedicated child protection teams within each BCU. This model was implemented in stages, with the East BCU changing in June 2017 and the two remaining BCUs of South and West implementing this model on 1 September 2017. This restructure also involved merging the dedicated domestic abuse and vulnerable adult teams into broader multi-functional vulnerability teams that have the remit of rape, high-risk domestic abuse, serious violent crime and fraud. During the inspection, some officers expressed the view that there had been a lack of clarity provided by senior leaders in relation to the changes to the operating model, and the roles and responsibilities of specific teams within the new structure.

The ACC chairs the monthly tactical management board which focuses on a broad range of strategic matters linked to tackling vulnerability, workforce performance and crime outcomes. This is attended by a large number of representatives from across the constabulary, however its size means that it provides limited oversight of matters relating to child protection. The newly-established monthly PVP meeting, chaired by the detective chief superintendent, is attended by all the area detective superintendents and the respective public protection unit (PPU) thematic leads, as well as representatives from the headquarters' quality and compliance team. There is some oversight achieved through this forum, but the absence of any qualitative performance data or analysis to support this meeting means that the constabulary's efforts to bring about improvements to its service through such means are under-developed at present.

There are daily threat, harm and risk meetings in each BCU that are heavily influenced by matters of vulnerability, and the protection of children in particular, which is positive. It is apparent that informal conversations take place between BCU senior leaders and the chief officer team, which are based on risk and need. However, the daily meetings do not contribute to the formal risk management processes at a constabulary level, to inform the chief officer team about emerging and critical child protection risks.

The new operating model has enabled the constabulary to be more agile in taking action to mitigate risk; it provides leaders in each BCU the autonomy to allocate resources where they are required. However, in the short period of time that this has been in place, it is clear that different approaches are evolving across the constabulary which, in some areas, is creating a fragmented and inconsistent approach to the protection of children. Moreover, the absence of an effective governance structure (needed to set standards for good practice and maintain the frontline provision of local child protection) has led to limited influence and effectiveness by the policy and compliance team.

The governance processes that help shape the constabulary's approach to child protection have not kept pace with the changes to its operating model. However, it is positive that the constabulary has recognised this weakness in its governance and intends to bring about clearer oversight arrangements; these will enable the ACC to gain a greater understanding of performance and the effectiveness of frontline services. The constabulary intends to implement monthly performance meetings in each BCU that will inform a truncated version of the current tactical meeting. The ACC is clear that this meeting will focus upon those most vulnerable in Lancashire, and will be heavily influenced by child protection.

The constabulary was successful in its bid for innovation funding to create the Early Action initiative in 2015; this has led to the formation of multi-agency teams, including the police, to provide targeted early interventions for vulnerable children, adults and families. The aims of this initiative are to: reduce vulnerability and crime; improve the wellbeing of communities; and improve the life chances of those involved, or at risk of engaging, in organised criminality and those at risk of causing problems for wider society.

Professional relationships and engagement with partners involved in safeguarding across all levels of the constabulary were described to HMICFRS as very positive, with the ability to challenge where appropriate. The directors of children's services (DCS) and the LSCB chairs were all positive about Lancashire Constabulary's commitment to protecting children, particularly in relation to the significant amount of collaborative work in developing MASH processes.

There was acceptance by the DCSs that there were too many referrals coming through the MASH; in one area we were informed that as many as 60 percent did not meet the threshold for statutory assessment. This indicates that the application of appropriate thresholds is not properly understood, which is a significant weakness. It was also acknowledged that while the constabulary sends dedicated conference

attendees to initial child protection case conferences (ICPCCs),[16] they were not always fully aware of all the relevant circumstances; the meetings would on occasions have benefitted from the contribution of officers with first-hand knowledge of the investigations and children involved. LSCB chairs commented to us that although there is effective engagement throughout the organisation (from the chief officer team to practitioner level), in addition to strong representation and active involvement at board level, the turnover of officers and staff involved in sub-groups renders it difficult to make progress in a timely way.

Lancashire Constabulary is working in collaboration with Cumbria Constabulary to provide training to its officers and staff. However, we were informed by training leads that out of 68 officers in child protection roles, only 22 (i.e., 29 percent) had been trained and accredited in the specialist child abuse investigation development programme (SCAIDP). This does not adhere to constabulary policy, which states that every officer dedicated to child protection work should have this accreditation.

The constabulary's training of frontline officers and staff in areas linked to child protection is inconsistent. Continuous professional development (CPD) events are held five times a year by the constabulary; previously they have covered:

- domestic abuse;
- CSE;
- stalking and harassment;
- so-called 'honour-based' violence; and
- coercive control.

These training events are not mandatory but rather on a first-come-first-served basis and, as a result, some officers have not attended such events in years. Moreover, the constabulary does not have any arrangements in place for recording the training courses and dates undertaken by individual officers and staff. This is leading to inconsistent levels of knowledge in frontline officers and staff, which is reflected both in their disparate approaches to safeguarding and the varying outcomes for children.

In addition, the constabulary has incorporated training days (which take place once every ten weeks) into the shift patterns of frontline teams. However, we found these training days are not being used to best effect; some officers we spoke with indicated

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

that they were inconsistent, and that on many occasions they were encouraged to catch up with administrative work instead. This is a missed opportunity by the constabulary to improve the practical knowledge of its frontline officers and staff.

Recommendation

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

4. Case file analysis

Results of case file reviews

To determine how well Lancashire Constabulary deals with specific cases, HMICFRS asked the constabulary to self-assess the effectiveness of its practice in 33 child protection cases. The constabulary used HMICFRS criteria[17] to grade the practice in each case as 'good', 'requiring improvement' or 'inadequate'.

Of the 33 it self-assessed: the constabulary rated its practice as good in 13 cases; as requiring improvement in 18 cases; and as inadequate in 2 cases.[18]

HMICFRS inspectors also assessed these 33 cases and graded the constabulary's practice in each. HMICFRS graded the practice in 8 cases as good; as requiring improvement in 15 cases; and as inadequate in 10 cases. In addition, HMICFRS inspectors selected and examined a further 46 child protection cases: in 6 the practice was assessed as good; in 20 cases as requiring improvement; and in 20 cases as inadequate.

Figure 1: Cases assessed by both Lancashire Constabulary and HMICFRS inspectors

	Good	Requiring improvement	Inadequate
Constabulary assessment	13	18	2
HMICFRS assessment	8	15	10

Figure 2: Additional cases assessed only by HMICFRS inspectors

	Good	Requiring improvement	Inadequate
HMICFRS assessment	6	20	20

[17] The assessment criteria for and indicators of effective practice used in this report are taken from *National Child Protection Inspection: Criteria Assessment*, HMIC, London, 2014. Available at: www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/ncpi-assessment-criteria.pdf

[18] The case types and inspection methodology are set out in annex A.

There are numerous examples of cases in which the force had self-assessed its practice as good, but HMICFRS had rated the force's practice as inadequate.

A 10-year-old girl told her biological father that she had been physically assaulted by her step-father, whom she said had held her by the neck against a wall. The child was spoken to by an untrained response officer, and said that her mother had told her about this incident, but that she herself could not recall it. There is no evidence either of further investigation or of the child's mother being spoken to, and no recorded details of her step-father, including whether he was spoken to. Although the child was safeguarded through placement with her biological father, the constabulary appeared to have conducted no investigation to establish whether the alleged assault took place, or whether the step-father had contact with any other children who may have required safeguarding. Children's social care was made aware of this incident only 13 days after the initial report to the constabulary.

Of the 79 cases assessed, HMICFRS referred back 10 to the constabulary because they were considered to contain evidence of a serious problem – for example, failure to follow child protection procedures and/or a child at immediate risk of significant harm. The constabulary responded to the referrals by conducting an updated assessment or by taking action relevant to the problems highlighted.

A report was made to the constabulary of a disturbance involving a man and a woman at a caravan park in the early hours of the morning. The woman had two children aged 12 and 8 years, who were present at the time of the incident. Witnesses report seeing the male suspect assault the woman, damage the caravan and then physically assault one of the children. Officers attended and arrested the suspect for a breach of the peace. They noted a reddening to the eye of the 12-year-old. In the presence of her mother, officers asked the child how she had hurt her eye, to which she stated it was caused by her walking into a lamp post, which her mother corroborated. There is no record that officers spoke with, or took a statement from, the independent witness, and the records wrongly indicate that there were in fact no witnesses. Although the suspect was detained in custody for over 24 hours, he was never arrested nor interviewed for assault on either the child or the mother.

In a separate case, a 15-year-old girl with learning difficulties (she has been assessed as having the mental capacity of a 10-year-old) was living in a care home in Lancashire, from which she had been reported as missing numerous times. Staff at the care home checked her computer and found a large number of messages from a 25-year-old male suspect living in her home county. He had asked the child to send him pictures of her, and there was clear evidence that he was making plans to meet the child. The records show a request for a strategy meeting, but it is unclear whether this ever took place. Further, nothing is recorded on police systems to indicate whether an investigation had been conducted, no warning markers made in respect of the child's address, and no mention of her computer having been examined. There are also no records demonstrating whether the child had ever been spoken to regarding the suspect, nor of any efforts to trace him.

Breakdown of case file audit results by area of child protection

Figure 3: Cases assessed involving enquiries under section 47 of the Children Act 1989[19]

Case type	Good	Requires improvement	Inadequate
Enquiries under section 47 of the Children Act 1989	1	6	4

These are cases in which a child has been identified as in need of protection, i.e., is suffering or likely to suffer significant harm. HMICFRS found that:

- the constabulary's initial approach to such incidents is mixed, with some good early action taken and other cases in which there are children in the wider family/household in need of safeguarding who are overlooked;
- although there is evidence of joint working with children's social care services, the outcomes of that work, particularly strategy meetings, are not recorded in any detail; and
- the voice of the child is absent from the recorded assessment of most such incidents.

[19] Local authorities, with the help of other organisations as appropriate, have a duty to make enquiries under section 47 of the Children Act 1989 if they have reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm.

Figure 4: Cases assessed involving referrals relating to domestic abuse incidents or crimes

Case type	Good	Requires improvement	Inadequate
Cases relating to domestic abuse incidents	4	3	3

Further detail of some of these individual cases, relating to domestic abuse incidents, is given in the chapters that follow.

Common themes include:

- The inconsistency of processes used by frontline officers to record details for the DASH assessment result in many assessments not being completed when required.
- Processes are not effective at identifying all children affected by domestic abuse.
- Crimes are often not recorded when they should be.
- There is little evidence of the voice of the child being considered by officers attending domestic incidents.

Figure 5: Cases assessed involving referrals arising from incidents other than domestic abuse

Case type	Good	Requires improvement	Inadequate
Referrals arising from incidents other than domestic abuse	4	2	4

Further detail of some of these individual cases, relating to non-domestic abuse incidents, is given in the chapters that follow.

Common themes include:

- Officers respond to incidents quickly in which there are children at immediate risk.
- There are some good examples of safeguarding and investigations for cases in which specialist child protection teams are involved from the outset.
- There are examples of cases in which immediate investigative opportunities are not pursued by frontline officers.

- Officers do not consistently document investigative activity, and therefore the progress and quality of investigations often cannot be monitored.

Figure 6: Cases assessed involving children at risk from child sexual exploitation

Case type	Good	Requires improvement	Inadequate
Cases involving children at risk of child sexual exploitation both online and offline	3	5	8

Further detail of some of these individual cases, relating to CSE, is given in the chapters that follow.

Common themes include:

- The constabulary's recognition of CSE and its initial response in such cases is generally good.
- There is evidence of the constabulary's involvement in a multi-agency approach in the early detection and disruption of CSE incidents.
- Child abduction warning notices (CAWNs)[20] are being used effectively for many incidents.
- The constabulary's pursuit of perpetrators and its investigations are not always as robust as they should be, and often lack effective supervisory oversight.

Figure 7: Cases assessed involving missing and absent children

Case type	Good	Requires improvement	Inadequate
Cases involving missing and absent children	2	5	4

Further detail of some of these individual cases, relating to missing and absent children, is given in the chapters that follow.

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

Common themes include:

- Generally, the processes in place in the force control room identify and assess risk effectively from the outset.
- Cases which are assessed as being high-risk receive a rapid and appropriate response.
- There is a lack of structure in the activity undertaken to trace missing children and, as a result, basic enquiries are sometimes not made.
- The actions of frontline officers to trace missing children are not sufficiently governed by supervisory oversight.
- Frontline officers often fail to submit the required PVP referrals.

Figure 8: Cases assessed involving children taken to a place of safety under section 46 of the Children Act 1989[21]

Case type	Good	Requires improvement	Inadequate
Children taken to a place of safety by police officers using powers under section 46 of the Children Act 1989	0	3	2

Further detail of some of these individual cases, relating to section 46 of the Children Act 1989, is given in the chapters that follow.

Common themes include:

- There is evidence of the constabulary's early identification of vulnerability and good use of police protection powers to safeguard children immediately.
- The constabulary's approach to subsequent investigative activity in these cases can be slow with little or, in some such cases, no evidence of supervisory oversight. This leads to delays which are unexplained and may adversely affect outcomes for children.

[21] Under section 46 of the Children Act 1989, a police constable who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm may (a) remove the child to suitable accommodation and keep the child there, or (b) take such steps as are reasonable to ensure that the child's removal from any hospital, or other place in which the child is then being accommodated, is prevented. A child in these circumstances is referred to as 'having been taken into police protection'.

- There are examples of cases in which officers do not consider effectively the safeguarding of children in the wider family context.
- Paper records are not loaded onto systems; this renders them inaccessible and the resulting gaps in available information adversely affect the constabulary's ability to make informed, risk-based decisions.
- In all of the cases assessed, the maximum 72-hour period for use of these powers was allowed to elapse without justification.

Figure 9: Cases assessed involving sex offender management in which children have been assessed as at risk from the person being managed

Case type	Good	Requires improvement	Inadequate
Sex offender management for which children have been assessed as at risk from the person being managed	1	7	0

Further detail of some of these individual cases, relating to sex offender management, is given in the chapters that follow.

Common themes include:

- The constabulary's approach is generally good in relation to incidents in which there are immediate safeguarding needs for children potentially at risk from registered sex offenders (RSOs).
- The constabulary's slow introduction of ARMS assessments[22] has impeded the speed of risk-identification in some cases.
- Some children have been left at risk through poor record-keeping and occasional failures to reassess risks in response to changes in offenders' circumstances.

[22] ARMS is a structured assessment process to assess dynamic risk factors known to be associated with sexual re-offending, and protective factors known to be associated with reduced offending. It is intended to provide police and probation services with information to plan management of convicted sex offenders in the community.

Figure 10: Cases assessed involving children detained in police custody

Case type	Good	Requires improvement	Inadequate
Cases involving children in police custody	0	4	4

Further detail of some of these individual cases, relating to children detained in police custody, is given in the chapters that follow.

Common themes include:

- The constabulary generally has a good understanding and consistent application of the requirements for alternative and secure accommodation after a child is charged and detained in custody.
- Appropriate adults[23] rarely attend custody at the required times.
- In many cases reviewed, health care professionals were not requested to conduct an examination of a child in custody when this was clearly required.
- There is inconsistency in the referrals made to children's social care services in relation to children in custody: some are submitted but in other cases they are not; consequently, there often is no longer-term safeguarding implemented for such detained children.

[23] Under section 63B of the Police and Criminal Evidence Act 1984, an appropriate adult is a parent, guardian, social worker or any responsible person over 18 years old and not a police officer nor a person employed within the police.

5. Initial contact

HMICFRS observed instances in which officers responded quickly to clear and specific matters related to the urgent safeguarding of children; conducting preliminary actions, such as ensuring the immediate safety of the child, securing evidence and making an assessment of how best to proceed. On many of the occasions observed, officers undertook thorough initial enquiries and used their powers to safeguard children effectively.

The constabulary was made aware of a male suspect in his twenties who had groomed an 11-year-old boy with whom he had come into contact through his work. The suspect had befriended the child's family and stayed at their house overnight a number of times, sleeping downstairs. The child also began sleeping downstairs with the suspect. After some weeks, the family spent a night at a hotel, accompanied by the suspect, who stayed in a room alone with the 11-year-old and his 14-year-old brother. The younger child and suspect slept in the same bed "cuddling" and also bathed together. When the constabulary was made aware of the behaviour, an incident log was created, and the matter appropriately recorded as a crime. The constabulary took immediate steps to safeguard the children and arrest the suspect, against whom a detailed investigation was commenced by specialist officers. Evidence was quickly secured and many items seized for examination. There is clear evidence of multi-agency work to promote the longer-term safeguarding of the affected children. The suspect admitted a number of offences and was later charged.

Lancashire Constabulary has a single force control room (FCR). Initial contact is managed by police staff who are responsible for call-handling and officer dispatch. The success of the call-handling process relies upon the ability of FCR staff to make correct decisions based on the national decision-making model,[24] and through the effective use of question sets (relating to, for example, children missing from home). Located in the control centre is the demand management unit (DMU), made up of police supervisors, and the initial investigation unit (IIU) comprising police constables. These units assist in the secondary assessment of risk, and provide a means of diverting incident logs for which the deployment of officers is not needed; such incidents are instead dealt with and closed through telephone resolution. The FCR does not have any qualitative assurance processes, for example dip-sampling calls, to assess the overall quality of its risk-management.

[24] For more information, see: www.app.college.police.uk/app-content/national-decision-model/the-national-decision-model/

In April 2017, a decision was taken within the constabulary that, to reduce the numbers of incomplete incident logs, some processes would need to be streamlined; specifically that it would no longer be a requirement to endorse a log with a crime number or a PVP form prior to it being closed. However, the result is that there are now no effective checks in place to ensure PVP forms are submitted. The effect of this is that not all vulnerable children are benefitting from referral to children's social care services. HMICFRS observed an example of this in practice: children's social care services approached the police within the MASH to request submission of a PVP for an at-risk child following an incident attended by police the previous night. The deficiency of this process is evidenced in a large number of cases audited, and as a result some children are being left exposed to risk unnecessarily.

HMICFRS inspected a number of domestic abuse incidents resolved by IIU; we found that call-handlers sometimes failed to enquire as to whether there were children on the premises and that, when they did pose this fundamental question, they occasionally omitted the children's details from the incident log. One of the roles of the IIU is to ensure DASH forms are submitted for reported incidents. HMICFRS encountered some examples of cases in which officers in the IIU had contacted a victim of domestic abuse who declined to answer DASH-related questions, however, the completed DASH form showed wrongly that the victim had responded 'no' to each of the questions; this creates an inaccurate record of such incidents and could lead to a poor assessment of risk and inappropriate decisions being made. Further, we examined cases in which children at risk from domestic abuse should have benefitted from referrals to children's social care services and interventions, however these measures were missing from incident logs. Moreover, the constabulary does not record the number of domestic abuse incidents being dealt with and finalised by the IIU.

There appears to be little in the way of guidance, oversight or training of the officers who perform these valuable roles. Those who joined the DMU and IIU four years ago were given three weeks training initially (which included handling of domestic abuse), however there has been no subsequent training. New recruits to these units are mentored but no longer receive the initial training; the constabulary appears to rely on the assumption that because they are police officers they should be experienced enough to manage the requirements of the role. It has been acknowledged by the constabulary that the skills within these units, specifically the deficit of officers with specialist safeguarding knowledge, is an area of weakness in which it needs to improve.

Control room staff have been given extensive training linked to vulnerability including child protection, the latest series of which commenced in October 2017. However, this crucial training is not given to the police officers in the DMU or IIU.

The constabulary's use of flagging is inconsistent on the command and control system. HMICFRS did find some evidence of flagging used in relation to addresses at which there were children on child protection plans; officers spoken to confirmed that, when available, such information would be provided to them by dispatchers whilst en-route to incidents. However, these flags are not being used on all relevant occasions; some are out-of-date and require archiving. Furthermore, the constabulary does not flag as a matter of routine the addresses of known sex offenders on the command and control system. The effect is that, unless officers request specific checks, they could be attending addresses of RSOs unknowingly, and this will adversely affect their ability to make effective decisions regarding risks to children.

The constabulary's lack of audit processes in the FCR means the true levels of demand are unclear. Additionally, the lack of oversight and scrutiny limits the constabulary's ability to be satisfied in its effectiveness at managing all risk.

We found evidence to demonstrate that the constabulary's activity is highly-focused upon either the child making or being the subject of a report. However, frontline officers attending incidents often fail to consider the need for the wider safeguarding of other children within the household. Furthermore, there is no routine practice of recording the views of children in terms of their wishes and demeanour, and there are no prompts within systems to reinforce this requirement. A child's demeanour, especially in those cases where a child is too young to speak to officers, or where to do so with a parent present might present a risk, provides important information about the effects of the incident upon the child. Information about their demeanour should inform both the initial assessment of the child's needs and the decision as to whether there a referral made to children's social care services is required. In many cases examined, there was a failure to record a crime in line with the national standards. The effect of such weaknesses is the lack of available or evident information pertinent to matters of crime and at-risk children; this impairs the constabulary's ability to conduct informed risk assessments, allocate resources appropriately, and support victims effectively.

The constabulary was made aware of an incident at a house in which there resided a mother and her four children aged 16-, 15- and twin 5-year-olds, respectively. An argument had occurred between the 16-year-old and mother, during which he reportedly caused damage to the house and assaulted both the mother and his 15-year-old brother. The police attended promptly, however the 16-year-old had left the scene. The crime record detailed the assault on the mother, but there is no crime record for the alleged assault on the 15-year-old, or any information to negate that he was assaulted. Although the mother was given safeguarding advice, no safeguarding measures were implemented at the scene of the incident for the other children. There is also no record of the pursuit of the 16-year-old. Although the PVP form stated the 15-year-old did not witness the incident, this is undermined by his call to the police and his allegation of assault. Finally, the form also failed to mention the whereabouts of the 5-year-old twins at the time of the incident, or whether any checks had been made in relation to their wellbeing.

In the course of this inspection, the view expressed by many of the officers and staff to whom we spoke was that some frontline officers regard their safeguarding role as being limited to the submission of the PVP, and that any further activity to promote the welfare of children and victims' safety is regarded as the responsibility of others. We were informed that this view and the culture it represents is widespread and deeply embedded. HMICFRS examined multiple cases in which frontline officers had submitted PVPs when they were not required, in addition to numerous examples in which PVPs were required but had not been submitted. The constabulary's current approach lacks effective quality assurance or performance management mechanisms to ensure officers and staff are discharging their safeguarding responsibilities when they first come into contact with children in need of help. The effect is that children are being left exposed to risk unnecessarily.

Recommendations

- Within three months, Lancashire Constabulary should:
    - review its processes to ensure that its staff can draw together all available information from police systems in order better to inform their responses and risk assessments.
    - reviews its processes for the supervision of the decisions made when police attend incidents where children are at risk or vulnerable.
- Within three months, Lancashire constabulary should ensure that officers always check on the welfare of children and record their observations of a child's behaviour and demeanour, so that a better assessment of a child's needs can be made

6. Assessment and help

There are three MASHs within the constabulary boundaries, each based in and covering one of the three local authority areas; these are the focal points for information-exchange and inter-agency planning. In addition to the constabulary, there is representation from agencies including children's social care services, adult services, health, education, fire and rescue services, and probation. The constabulary and its safeguarding partners have invested significant time and resources in developing MASH processes, and there is a clear commitment to improving joint-working. HMICFRS found examples of agencies working well together, assessing risks, making plans for mitigation of these risks, and supporting children and families.

The constabulary was made aware of a 15-year-old girl who had been groomed for abuse by a 24-year-old male via social media, which resulted in numerous meetings involving sexual intercourse between the two. When the activity was reported, the constabulary provided a good initial response; the officers attending spoke to the child, recorded details of her account, and put into place swift safeguarding interventions. Moreover, the constabulary made a timely referral to the MASH to ensure that an appropriate multi-agency protective plan was developed. Effective information-sharing within the MASH revealed other potential victims and linked other offenders. This effective multi-agency intervention resulted in this child and others being safeguarded from potential further abuse.

Collectively, the county's MASHs deal with approximately 50,000 referrals per year. Since 2016, a continual review of the systems has been conducted, specifically focusing on the journey of a referral; this led to new processes being implemented in September 2017. The new processes have been received positively by the MASH staff and partners. Agency representatives are now located together in 'pods'; this arrangement promotes better quality professional discussion and information-exchange. This assists in expediting decision-making, the timely recording of decisions and an increased focus on cases, which results in quicker and more effective interventions for vulnerable children and families.

Together, the constabulary and other safeguarding partners acknowledge that the number of PVP submissions is unmanageable, and that the referrals process needs to change. The constabulary is aware that it needs actively to bring about improvements to practices regarding effective safeguarding by frontline officers and staff, in particular the need for the consistent and timely submission of PVP referral forms. Through 'risk sensible training', the constabulary intends to increase the

confidence of officers in making direct referrals for early help, or to take action early in the appropriate circumstances. Work on the new IT Connect system will enable more effective information-sharing in the future between the constabulary and other agencies.

Some processes linked to joint-working require review to ensure they are operating in the best interests of children and their families. For example, when child protection officers and staff require the urgent support of children's social care services to carry out joint visits, at present they would need to send the PVP referral for assessment by the MASH. Such processes can cause significant delays and too often result in a single agency police response when multi-agency input would be far more beneficial. HMICFRS was informed of one recent case in which a social worker was not allocated for six hours, by which time essential independent police activity had begun.

During the inspection, some frontline officers indicated that processes used for the assessment of domestic abuse incidents lacked structure. We were informed that despite the automated DASH and PVP forms being available on hand-held electronic devices, these functions rarely worked effectively. Frontline officers explained to us their varying approaches used in the completion of DASH assessments: one officer used an aide memoire to ask all the relevant questions; one officer reported that for verbal arguments they would not submit a DASH form (even if their children were present); and one suggested they relied on memory in relation to the questions and victims' answers given at an incident scene, and that they would complete the form upon their return to the police station.

Such inconsistency of approaches is adversely affecting the quality and consistency of DASH submissions; it also increases the risk of numerous incidents occurring at an address in which children are present, who may never be subject of any form of referral to prompt intervention. When this weakness is viewed in conjunction with the IIU processes of finalising incident logs for which DASH forms are missing, in addition to the generally inconsistent practices in crime-recording, together they indicate that not only is the constabulary unable to assess demand effectively but, more importantly, it is unable to assure itself of the quality of protection provided to victims and children affected by domestic abuse.

A 17-year-old female who was the subject of domestic abuse reported being raped by her 17-year-old boyfriend. The constabulary's initial response and investigation was good; there is evidence of effective safeguarding and the prompt arrest of the suspect. However, no PVP form was submitted, no DASH risk assessment was completed, and no flags were placed on police systems to highlight the risk of domestic abuse and factors of child vulnerability. Although there is a clear focus upon the criminal investigation, there is no evidence to indicate any multi-agency intervention was implemented.

During the inspection, HMICFRS conducted interviews in relation to, and reviewed minutes from, MARAC meetings. We are pleased to note that engagement in all reviewed MARAC meetings was good from all representatives, including the constabulary and third sector organisations, in addition to active collaboration with independent domestic violence advisor (IDVA)[25] and independent sexual violence advisor (ISVA)[26] services.

The constabulary employs a dedicated MARAC co-ordinator who is responsible for chairing meetings across the county. This encourages a consistent approach and supports effective information-sharing between agencies to protect both the victims of domestic abuse and those children affected by it. We found the minutes of these meetings to be comprehensive and well-recorded, with appropriate actions set out for each agency. The use of domestic violence protection notices and domestic violence protection orders[27] in Lancashire is good, and is assisting in reducing the risks faced by victims of domestic abuse and their children.

HMICFRS was told that although the referral criteria for use by the MARAC in Lancashire reflects established best practice guidance (based upon the occurrence of high-risk incidents, employing professional judgment, and/or three or more police call-outs within a 12-month period), the constabulary criteria is slightly different; there must be three criminal incidents reported within a 12-month period. We found that those responsible in the constabulary for the management of MARAC were unaware of this difference. As a result, the constabulary is potentially restricting access to those who may benefit from multi-agency intervention, in particular for families in which multiple lower-level incidents occur and the cumulative effect is impairing the welfare and development of children within the household. Moreover, officers investigating incidents of domestic abuse may not know of the actions set at MARAC meetings, therefore they could be unaware of all relevant safeguarding activity.

Although the constabulary and local authority partners have processes in place to inform schools when a child has been affected by domestic abuse, this is seen as a social care responsibility, and the constabulary has little input in the process. We were told this process functions better in some areas of Lancashire than in others.

[25] The main purpose of independent domestic violence advisors (IDVAs) is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members; to secure their safety and that of their children.

[26] For more information, see: www.gov.uk/government/uploads/system/uploads/attachment_data/file/647112/The_Role_of_the_Independent_Sexual_Violence_Adviser_-_Essential_Elements_September_2017_Final.pdf

[27] For more information, see: www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/arrest-and-other-positive-approaches/domestic-violence-protection-notices-and-domestic-violence-protection-orders/

Call-handlers are responsible for the initial grading of calls relating to children reported as missing[28]; in doing so they use the question set and application of criteria as set out by the national decision-making model; this enables them to arrive at a grading of risk and a classification of either 'absent' or 'missing'. There are then secondary assessment processes conducted by the DMU; there is evidence that these are effective in most cases - identifying and reclassifying risk-levels of missing children when appropriate. For children who are missing, incidents which have been graded as being as high-risk receive a rapid response by the constabulary, and the effective completion of basic enquires.

HMICFRS found some good (but isolated) examples of the constabulary dealing with reports of children who had gone missing. We found evidence of a coherent end-to-end approach, from the investigative activity to trace the child to the subsequent joint-working and resultant safeguarding. However, examples such as these were in the minority of the cases reviewed.

A 15-year-old boy was reported as missing on his way to school (his 14-year-old girlfriend was also absent from school, so it was thought he may have been with her). His mother indicated that although he had not previously gone missing, he was vulnerable and prone to self-harming. Within ten minutes of receiving the incident log, a DMU search of systems was conducted. This revealed the existence of recent high-risk PVP submissions, detailing an escalation in incidents of self-harm; although his assessed level of risk was raised, there were no units available to attend. Moreover, there was a delay of three hours before attempts were made to contact the child. A sergeant's review completed six hours following the initial call resulted in several actions being added to the report, however the continuing assessment of risk was limited; it did not consider the full circumstances of the child nor give any rationale as to why he was not classified as high risk. Although the child and his girlfriend independently returned home, no subsequent PVPs were submitted for the child, despite his clear vulnerability, nor for his girlfriend. There is no recorded evidence of whether his social worker was spoken to in relation to the incident. The safe-and-well check conducted was minimal, and there is no evidence of conduct of a return-home-interview.

Investigation and activity to trace missing children is often not planned methodically. The Sleuth system, used for the management of investigations into missing children, is not effective at promoting mandatory actions; as a result basic enquiries may be missed or are often delayed. In some cases, basic checks (such as of home

[28] Anyone whose whereabouts cannot be established will be considered as missing until located, and their well-being established or otherwise confirmed. All reports of missing people sit within a continuum of risk from 'no apparent risk (absent)' through to high-risk cases that require immediate, intensive action. For more information, see: www.app.college.police.uk/app-content/major-investigation-and-public-protection/missing-persons/missing-person-investigations/?s=absent.

addresses) did not take place until 24 hours after the initial report, and in others named social workers of children were not contacted (in one particular case, not until the child had been missing for six days). Such failures represent missed opportunities to gather first-hand knowledge of the child, the risks they face, and their probable whereabouts.

For cases in which a child is missing from another force area and is suspected to be in the Lancashire Constabulary area, their details are not recorded or managed on the Sleuth intelligence system, but rather on the constabulary's command and control system. In one case, a child who was missing from a care home in Manchester was suspected of having returned to his home area in Lancashire; limited enquiries were undertaken, with few details recorded on the command and control log. As a result of this approach, the search for the child was delayed by five days, moreover it lacked any structured enquiries and was denied of the benefits of regular reviews (which are available through the use of Sleuth). This approach is also used for children missing locally who are found, and for children missing from within the county: if they are found quickly the matter will not always be transferred to the Sleuth system, therefore the record of such missing episodes may exist only on the command and control system. The consequence of this is that when risk assessments are completed for those children who routinely go missing, they are based only on the information held on Sleuth. If a child is located and returned quickly then none of the information about the episode is likely to be placed on Sleuth, meaning that assessments will not be based on all the information known to police, who therefore may not be able to effectively assess escalating or cumulative risk.

In 8 of the 11 missing children cases assessed by HMICFRS, the officer dealing with the initial incident failed to submit a PVP form in relation to those for whom there were additional and apparent aspects of vulnerability. For cases in which a PVP form has not been submitted, the missing from home (MFH) co-ordinator may detect the omission and complete the PVP on the officer's behalf. However, the MFH co-ordinator will not be as familiar with the case; they are unlikely to have met the child, have been involved in the frontline search, or have spoken to individuals involved, etc.; the only details an MFH co-ordinator can provide are those gathered from the incident log and Sleuth. Moreover, we were informed that the MFH co-ordinator would not necessarily check all command and control incidents of missing children to ensure the consistent submission of PVPs. HMICFRS examined multiple cases in which PVP referrals had not been picked up at all; this suggests that the constabulary's ability is being limited with respect to conducting joint work with children's social care services, and in implementing protective plans to mitigate risks to missing children.

In addition to the above, officers are not routinely recording whether they have spoken to the child upon locating them, or details of the child's account given during safe-and-well checks.

A 14-year-old girl had been reported missing from home on four separate occasions, however only one of these had been recorded on Sleuth. Although the child was usually found fairly quickly at friends' or family's addresses, there were clear signs of risk in all of these incidents, namely that she was self-harming, suffering from suicidal thoughts and was receiving treatment for a mental health condition. She was incorrectly assessed as being of medium-risk. The supervisor's reviews of the child's case were superficial; checks were made as to whether previous actions were completed, but enquiries had not been added to, nor was there evidence of the reviews being used to prompt further activity. Furthermore, in the latest case examined in which the child was found, the record on Sleuth does not contain details how or where. Although a safe-and-well check was completed, the details are brief ("a friend taking her home to sleep at hers"). Although the friend's first name and her approximate address is recorded, there are no details of further enquiries made with the child's parents or her school to identify the friend. Examination of the case file shows a return-home-interview was not conducted. Furthermore, a PVP form was not submitted on the rationale that the child was already in receipt of support from a mental health support worker. As a result of these omissions, partner agencies may not have been updated about the latest missing episode, and the opportunity to co-ordinate plans to safeguard this vulnerable child would have been missed.

HMICFRS found that independent return interviews[29] for children missing from home are available across all local authority areas, although their use and the quality of information fed back to the constabulary is inconsistent; some areas are better than others in disseminating information for police intelligence systems to inform trigger plans (that assist in locating missing children). Interviews with children following their return can provide a wealth of information regarding the reasons they run away, particularly where such behaviour is frequent; they support more effective risk-management and should be used to inform the constabulary's planning and decision-making for future safeguarding action.

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

We found that the constabulary did have trigger plans in place for children routinely reported as missing; the effectiveness of which would have been improved through using information held by the constabulary from previous missing episodes. Although frontline officers with whom we spoke were unaware of their existence, supervisors did demonstrate knowledge and use of trigger plans to expedite efforts in finding children reported as missing.

Recommendations

- Within three months, Lancashire constabulary should improve its practice in cases of children who go missing from home. As a minimum, this should include:
    - improving officers' and staff awareness of their responsibilities for protecting children who are reported missing from home, in particular, those cases where it is a regular occurrence;
    - improving supervisory oversight required to drive activity to trace children who are reported missing from home;
    - a review of recording processes linked to children missing from home, in particular how children missing from other police areas are managed when information suggests they are in the Lancashire police area;
    - Ensuring there is consistency in the how information obtained from return home interviews conducted with children is being relayed to the constabulary to assist in the formulation of plans to reduce risk and frequency of future episodes.
- HMICFRS recommends that, within three months, Lancashire constabulary should review its approach to children exposed to domestic abuse as a minimum this should include
    - the referral criteria to MARAC to ensure that cumulative risk is being identified appropriate and that families and children affected by it are benefitting from multi agency intervention when appropriate.
- Within six months, Lancashire constabulary should undertake a review to ensure that the force is fulfilling its statutory responsibilities as set out in Working Together to Safeguard Children. As a minimum,
    - this should include a review of referral processes to ensure that risk is being identified effectively and shared in a timely manner with external agencies when appropriate.

- providing guidance to frontline staff that identifies the range of responses and actions that the police can take to ensure immediate safeguarding concerns are addressed which contribute to multi-agency plans for protecting children in these cases.

7. Investigation

HMICFRS found some good examples of police child protection work, with child abuse investigators displaying a good mix of investigative and protective approaches. This ensured that the safeguarding of children remained central to their efforts while the criminal investigative opportunities were pursued.

A 15-year-old girl was employed by an RSO to clean his house; this was a breach of his sexual offences prevention order (SOPO). He then went on to show the child pictures of underwear he wanted her to wear, asked to engage in sexual activity with her, and requested that she stay overnight at his house. There was swift action taken by officers: the child took part in a visually-recorded interview; other statements were obtained to corroborate the criminal behaviour; the crime was recorded; the appropriate PVP referral was made; and the RSO was arrested. In addition, the constabulary considered matters of wider safeguarding, and referrals were made to safeguard other children to whom the RSO had access.

The review of the constabulary's operating model has resulted in responsibility for high-risk domestic abuse investigations being moved from the child protection teams (formerly the PPU) to the vulnerability teams (formally the CID). However, most officers in these teams have received no training in relation to safeguarding. Therefore, this responsibility sits mainly with recently-created dedicated safeguarding teams, which put measures in place to safeguard domestic abuse victims and their children. Although this arrangement is positive and enables the implementation of appropriate measures, HMICFRS found little in the way of safeguarding activity for incidents that do not meet the high-risk threshold; most of these become the responsibility of frontline officers who lack the skills or experience to develop the appropriate safeguarding responses.

Multi-agency CSE teams in each BCU work jointly with the constabulary's child protection teams, and officers in the teams are appropriately trained to undertake their role. The teams take a child-centred approach, and there is clear evidence of them taking children's wishes into consideration. Safeguarding is paramount to these teams, and the majority of their work focuses upon prevention and intervention for children; an approach is used of placing flags within the intelligence system to indicate a child that is at risk of CSE. The missing person co-ordinators work within the child protection teams and operate under a single line of supervision; this is both positive and indicative of the constabulary's recognition of the close links between missing children and their vulnerability to CSE.

A report was made in relation to a 15-year-old girl having been sent indecent images by a 15-year-old boy from school. The girl's younger sister saw the photos and informed her parents. The constabulary's approach was one of education rather than prosecution: both children were spoken to and given advice regarding the dangers of partaking in such activity. A crime was appropriately submitted and filed. A PVP form was completed, the details of which were subsequently provided to the children's school, in order to maintain longer-term wider safeguarding and monitoring.

CSE is a standing agenda item both in the daily threat and risk meetings and monthly BCU tasking meetings. There is also a dedicated monthly MACSE (multi-agency CSE) meeting in each BCU, in which an average of 20 cases are discussed. Although these meetings are well-attended, representatives from education providers (one of the most important agencies in the process to mitigate risk), are often absent.

The branding and approach to CSE taken across the constabulary area varies for each BCU; a search of intelligence systems would only return the details of relevant individuals within the boundaries of that operational area, and not across the entire county. As a result, offenders and children affected by CSE could go undetected through the most basic of intelligence checks. Additionally, each area has initiatives that are limited to that specific area and are not co-ordinated county-wide, for example, engagement with taxi firms and hotels.

The high level of demand being managed by the multi-agency CSE teams results in their only being able to undertake preventative work, with little or no capacity to conduct any meaningful pro-active work against suspects. When suspects are identified, investigations can be inconsistent; in many cases they are voluntarily interviewed in circumstances in which an arrest maybe more appropriate, and for cases in which the victim does not actively support prosecution, often no interview is conducted. Moreover, there is evidence to show that demand is impeding supervisors from maintaining effective oversight of investigations, which is resulting in unnecessary delays (these can be anything up to nine months or even a year). Officers in these teams also expressed their frustration at the delays encountered in obtaining digital evidence from electronic devices, which are adversely affecting their investigations and abilities to keep victims engaged.

A 17-year-old girl residing in a children's home in Manchester was known to be at risk of CSE. On her return to the home following a missing episode, she disclosed that she had been assaulted in Preston by her 35-year-old ex-boyfriend. The initial safeguarding and support was conducted by the Greater Manchester Police. Although a crime was appropriately recorded and allocated for review and investigation, the investigation then drifted pending contact with her social worker. After a ten-week delay, a CAWN was served on the suspect, during which time the child had returned to live in Preston and was therefore exposed to continuing risk from him. Moreover, there was no investigation conducted of the assault, and no arrest or interview of the suspect. The only intervention made was that of the CAWN.

Strategy meetings are often conducted using video-conferencing technology which is an efficient use of time, however, a constabulary representative will still attend in person for cases that are particularly complex. ICPCC attendance by the constabulary is near to 100 percent; these meetings are attended by a dedicated member of staff so as to reduce the burden on officers.

The workloads of officers in the child protection teams are manageable; each member has conduct of 10 – 15 investigations on average. However, many of these cases lack the necessary supervisory oversight: supervisors indicated to us that they do not always have time to review all investigations according to constabulary guidelines. Owing to the high levels of demand, these review requirements are rarely being met in many departments responsible for the protection of children across the constabulary.

To further assess the levels of supervision within the constabulary, HMICFRS dip-sampled ten investigations for offences reported in June and July 2017 involving children and for which there was a named suspect. Out of these ten investigations, in only two was the arrest carried out promptly; at the time of inspection, the remaining eight cases contained an outstanding wanted person, some of whom were wanted for extremely serious offences. While the constabulary has taken steps to address the issues created by increasing demand levels (for example, by moving the responsibility of conducting domestic abuse investigations from the child protection teams to the vulnerability teams), at the time of inspection it was too early to assess the effect of these changes.

Recommendations

- Immediately Lancashire Constabulary should take action to improve child protection investigations by ensuring that:
    - investigations are supervised and monitored, with supervisor reviews recording clearly any further work that may need to be done;
    - recording on police systems decisions reached at meetings to ensure that staff are aware of all relevant developments to assist in future risk management, and
    - to conduct regular audits of practice that includes assessing the quality, timeliness and supervision of investigations.
- Within three months, Lancashire constabulary should take action to improve the investigation of child sexual exploitation, paying particular attention to:
    - improving investigation and proactive responses in dealing with perpetrators involved in CSE;
    - improving the oversight and management of cases (to include auditing of child abuse and exploitation investigations to ensure that standards are being met).

8. Decision-making

It is a very serious step to remove a child from their family by way of police protection and, in the cases examined, HMICFRS was pleased to note some good decisions to take a child to a place of safety that were well-considered and in the best interests of the child. However, we encountered a few examples which demonstrated a lack of understanding in relation to the correct use of this power. HMICFRS was troubled to find cases of children left with parents who were failing to protect them, indicating that some vulnerable children are not being safeguarded at the earliest opportunity and are being left exposed to unnecessary risk.

A member of the public contacted the police to report that there was a young girl (who it later transpired was 8 years old) walking down street with a backpack and wearing no shoes. Officers approached the child and, although she was reluctant to speak, they gleaned that she had previously been placed into care but had been returned to the care of her mother. They also learned that her mother had previously been taken away by the police. The child disclosed to officers that she had not attended school for two days as her "mummy [was] poorly and [had] no money". Asked why she had no shoes, the child explained that her shoes were broken and she had no others. The child showed the officer a one pound coin in her hand and indicated that that was all the money she and her mother had. Officers took the girl to her mother's house and spoke to her mother at the front door; records suggest that she behaved aggressively and explained that she had sent the child to the shop as she (the mother) was feuding with the shop owner. The officer recorded that the child appeared afraid of her mother, was cowering, and ran into the house. Officers' notes describe the house as untidy outside and inside, however there is nothing further to indicate officers actually went inside the house. Checks conducted by an officer indicated that this was not the only incident in which young children from the address had been found wandering the streets dressed inadequately. Although PVP referrals were submitted in relation to this incident, the appropriate police powers to immediately safeguard this child and others in the household were not used.

HMICFRS also examined examples of cases in which officers used their powers of protection in taking at-risk children to relatives' addresses, however in these cases there is no record of any checks conducted about the suitability of those relatives. Furthermore, we found no evidence that officers are using body-worn video to support the appropriate use of these powers.

The management of the use of these powers is documented on paper records and not on a system that is searchable by officers and staff. The consequence of this is that unless a separate PVP form is submitted (which as already described the

constabulary has no effective means of ensuring) this information is not used when considering the appropriate response to subsequent incidents. Similarly, the management of this power by the designated officer rarely documents when the use of the power ceased; almost all the cases audited showed that the maximum 72-hour period had been allowed to elapse without any recorded justification. Moreover, the use of section 46 powers is rarely accompanied by any record to demonstrate that multi-agency activity was implemented to support safeguarding, or where there are such records, they are of poor quality and lack detail.

During the inspection, HMICFRS found some very good examples of investigations conducted promptly and effectively; officers had listened to children and taken appropriate steps that were in their best interests. However, the details of safeguarding and joint work, such as strategy meetings, are often not recorded on systems and, for those that are, they often lack detail of the protective plans made; the outcomes have not been recorded and the planned actions for each agency are unclear. The voice of children is rarely noted in sufficient detail to understand their (appropriate) views. This weakness creates a gap in available information and, as a result, there can be a lack of evident activity in ensuring the appropriate measures are in place to protect children from harm. Consequently, the constabulary cannot always assure itself that vulnerable children are being safeguarded appropriately.

Recommendation

- Within three months, Lancashire constabulary should take steps to ensure that all information relevant to the use of powers under section 46 of the children's act 1989, 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 on systems to enable good quality decisions;
    - the importance of ensuring that records are made promptly and kept up to date and visible to all to assist in future safeguarding and risk management decisions.

9. Trusted adult

In some cases, though not all, it was clear that when the matter was serious and immediately recognised as a child protection matter, the approach to the child or parents (or social worker when the parent was a suspect) was carefully considered and that the best ways to engage with the child were explored. This sensitive approach results in strong relationships between the child and police.

A woman reported her 14-year-old daughter to the police as missing; she had failed to return home from school and her mother had found a note from her daughter explaining that she was sorry and that she loved her mum. Officers gathered basic information and checked a number of addresses, as a result of which the child was located at her 16-year-old girlfriend's house. The child was spoken to at length by an officer, who managed to gain a significant amount of information, namely that she had gone missing because her mother disapproved of her relationship. Additionally, the officer was able to glean information in relation to the child's behaviour of self-harming and using alcohol. The efforts to engage with the child were evident in the detailed PVP form submitted. The child's mother was also spoken to at length; it was discovered that she was struggling to cope during her recovery from serious illness. In addition, potential risks relating to other children in the house were recorded. A detailed return-to-home interview was completed that assessed the risks; although it was indicated that there was no appropriate role for children's social care services at the time, it provided some recommendations to the family, both to support it and mitigate relevant risks.

Since 2014, the constabulary has been instrumental in the creation of the Early Action initiative. To date, £8million of innovation funding has been used to create multi-agency teams with the intention to establish and address causes of vulnerability, and to intervene to prevent unnecessary calls for the services of the police and other safeguarding organisations (such as children's social care services). Since January 2017, some 60 percent of cases dealt with through this initiative have involved children.

The early action team does not deal with child safeguarding matters specifically; it is a preventative unit that works with both adults and children to recognise the signs of vulnerability at an earlier stage, and provide access to services intended to prevent the identified risks from escalating or becoming acute. The team recognises the importance of both joint-working and breaking down professional barriers to meet the needs of children, young people and families. In 2017, a total of 75 constabulary

officers and staff were moved to the early action teams. However, we found that in some cases duplication of effort had occurred – for one particular family, the early action team provided a similar intervention to the children in the family as that of the multi-agency CSE team, which was also working with the family.

10. Managing those posing a risk to children

At the time of inspection, there were 2,742 registered sex offenders (RSOs) in Lancashire, of which 2,101 were being managed within the community. Of those being managed within the community, 321 were graded as high-risk, and 5 as very high-risk. In December 2016, the sex offender management units (SOMU), like other specialist roles, were devolved to local areas; this enabled the reallocation of area officers and staff into teams to manage the previously disproportionate number of overdue visits to RSOs. Each area benefitted from increased staff numbers, with some using integrated offender management (IOM) staff, in addition to a further staff of 10 specifically allocated across the constabulary to deal with this demand. This new approach allowed the offender mangers to undertake ARMS assessments which, at the time, were extremely low in a national context.

In October 2016, the completion rate of ARMS was only at 18 percent. This is has since been improved upon; at the time of inspection the proportion of completed assessments was at 70 percent. In January 2017, the National Police Chiefs' Council (NPCC) agreed that the management of RSOs would use both active and reactive processes. For offenders whose ARMS assessment indicates a low level of risk, and for whom the offender manager is satisfied that they have committed no offences nor presented any concerns for a 3-year period, the constabulary may move from active management (i.e. where visits are prescribed) to reactive management (i.e. prescribed visits do not occur). The application of the management process is kept under regular review, and would transfer if there was a significant change in circumstances. These strict requirements and the slow ARMS completion rate have resulted in the inability of the constabulary to use both active and reactive management methods to their full potential, with only 12 RSOs under reactive management in the county at the time of inspection. Although still in its early stages, the effective use of the reactive form of management would provide a greater ability of the constabulary to focus on those posing the highest levels of risk, and would assist in reducing demand.

It is positive to note that the constabulary has obtained a large number of civil orders to restrict the activity of RSOs and limit the opportunities for them to commit further offences. However, these orders (i.e. sexual harm prevention orders and sexual offences prevention orders) are not co-ordinated centrally, therefore there is no oversight of their use. The lack of oversight is limiting – an RSO cannot be considered for reactive management whilst the subject of a civil order.

As with other areas of work described previously, the effect of devolving RSO management to the responsibility of each BCU is leading to different approaches being adopted in different areas. One BCU is focused upon a 'catch-and-convict' approach to RSOs, while the other areas use more risk-management style approaches. In the West BCU, the system for helping to manage offenders and the risks they present (ViSOR) is not being used effectively, with some details of cases being kept solely on paper records. As a result of this weakness, potentially vital information may not be accessible when risk is being reviewed or assessed. Additionally, in that particular BCU area, the offender managers do not have individual responsibility for named RSOs, rather the management of offenders is pooled and undertaken collectively; this adversely affects managers' abilities to build knowledge and trust with individual RSOs (which is useful in acquiring information used to mitigate risk). Such an approach also impairs the constabulary's ability to assess the ratio of offenders to offender managers, aside from the basic overall numbers.

A basic calculation indicates that there is an average of 68 offenders for each offender manager; this is above what is generally accepted to be reasonable (i.e. 50 offenders per staff member). Moreover, the constabulary lacks the ability to calculate the percentage of those offenders who are high-risk; this is important to ensure that the management of such offenders is shared equitably across team members. National guidance recommends that for every 50 offenders, approximately 10 (i.e. 20 percent) should be high-risk. The lack of available data means that the constabulary is unable to assess and review the level of risk and demand being managed by each officer and, as a result, one offender manager could be responsible for a disproportionate number of high-risk offenders (and high-risk levels) compared with others.

In many of the cases reviewed, the approach was often offender-focused, with delays in referrals being made to children's social care services and too little consideration given to longer-term safeguarding support for identified vulnerable children. We also found delays in relation to proactive actions taken against RSOs.

The mother of a 3-year-old girl entered into a relationship with a 24-year-old RSO. The child's mother made an application of enquiry under the child sexual offender disclosure scheme regarding the RSO. The initial authorisation for the disclosure of this information was prompt and appropriate; the child's mother was made aware of the RSO's convictions and status. As a result, initial safeguarding was implemented by which she did not allow any unsupervised access between the RSO and the child. However, there was a delay of two weeks before a referral was submitted to children's social care services. In addition, the RSO had failed to be seen, for the purposes of reassessing his circumstances and relevant level of risk, until 19 days after the initiation of the enquiry.

SOMU officers with whom we spoke as part of this inspection have received the appropriate training to conduct their role, and constabulary resources are made available when required to support their proactive work in monitoring the RSOs of highest risk. However, wider training on child protection, domestic abuse and CSE is not taken up regularly by SOMU officers.

Frontline officers informed us they are not routinely made aware of RSOs living within respective areas, and that they are only given information on RSOs when they are due to be released from prison. As result, there are many occasions in which these officers are unable to provide information about RSOs which could help to manage risk more effectively. There is currently no meaningful performance data being used to monitor the effectiveness of the offender management teams. The PVP meeting receives some data, such as numbers of overdue visits, but nothing of a qualitative nature that can satisfy senior leaders that risk is being managed effectively.

The constabulary has developed a three-day interview skills course for use in relation to RSOs. This course has been used by the SOMU in Lancashire for the last two years, and has recently been accepted by the College of Policing as good practice; it will soon form part of the national management of sexual offender and violent offender (MOSOVO) course. This is commendable, however the lack of performance and quality assurance data means that senior leaders cannot yet be satisfied that risk is being managed appropriately, or that the public (and children in particular) are being protected as required in every instance.

11. Police detention

Many children entering police custody have complex needs, are likely to be vulnerable, and require safeguarding support. The constabulary has provided training to officers and staff in its six custody facilities to recognise vulnerability in children who enter custody, and the circumstances in which there is a need to submit referrals to children's social care services in relation to such children. HMICFRS found mixed results: although some referrals are made when appropriate, the constabulary is not consistently doing so on all occasions when needed.

A 14-year-old girl was arrested to prevent a breach of the peace following an argument with her grandparents who were responsible for her care; she had never been arrested before. When staff were carrying out an initial risk assessment the child disclosed that: she had self-harmed (resulting in her being hospitalised); had thought about committing suicide earlier that day; had been diagnosed with ADHD; and had also consumed alcohol (vodka) that day. The arresting officers reported that she had threatened to harm herself at the time of her arrest. In spite of these disclosures, there was no referral made to a health care professional, no record could be found of an appropriate adult attending to safeguard her welfare, and no PVP form was submitted (even though the child was known to children's social care services, as they were working with her and her family).

In most of the cases HMICFRS reviewed, a health care professional was not called for children detained in custody when one was clearly required. In many of these cases, there were risk factors detected in the initial risk assessment that should have prompted a further assessment of the child. HMICFRS also found that there were long delays in appropriate adults attending to support children in custody, and that these contributed significantly to the amount of time they spent in detention. Once an appropriate adult is identified, they should be asked to attend the custody office as soon as practicable.[30]

In addition to the legislative requirements relating to appropriate adults, the constabulary has a policy stipulating that an appropriate adult must be contacted within one hour of a child being brought into detention, with a maximum time limit of three hours for them to attend the relevant custody unit. Although this policy was implemented in February 2017, it was not adhered to in any of the cases HMICFRS examined.

[30] For more information, see: www.gov.uk/government/publications/pace-code-c-2017

A 17-year-old boy was held in custody for a burglary. The appropriate adult did not attend until the following day, 20 hours after the child had arrived in custody. The child was then charged and denied bail, following which he attempted to commit suicide by tying a t-shirt around his neck. Although the child was placed in a self-harm suite, no referral was made to a health care professional, nor was a mental health assessment requested. Although the child's suicide attempt resulted in a request for post-charge secure accommodation, no such accommodation was available. In total, the child was detained in police custody for 44 hours. No PVP form was submitted and, as a result, children's social care services were not made aware of either his arrest nor suicide attempt and no safeguarding plan was developed.

Many of the cases HMICFRS examined showed that reviews of children's detention had been carried out in their absence, often because they were asleep or being interviewed about the offence for which they had been arrested. In one case examined, all three detention reviews were done without the child or an appropriate adult present. Moreover, there was often no record on detention logs that children were subsequently informed that reviews had been conducted.

If a child is to be denied bail and detained, the local authority is responsible for providing appropriate accommodation. Only in exceptional circumstances (such as during extreme weather) would the transfer of the child to alternative accommodation not be in the child's best interests. In rare cases – for example, if a child presented a high risk of serious harm to themselves or others (such as the case example given above) – secure accommodation might be needed.

The constabulary, in conjunction with partners, has developed a county policy that provides clear guidance for the transfer of children to local authority accommodation when they are charged with an offence and denied bail. In the cases we reviewed, we found the transfer of children to alternative accommodation after charge took place in two of the three cases in which such action was appropriate. In the third case, a request for accommodation was made but none was available. When a child is detained after charge and is not transferred to local authority accommodation, a detention certificate is required under section 38(7) PACE. We were pleased to find that for children kept in custody, this requirement was completed correctly in all the cases we examined.

The constabulary also maintains a record of those children detained in their six custody suites. This record includes details of those charged and denied bail, and whether alternative accommodation was requested from the local authority. We found inconsistencies in the approaches of custody officers and staff: there were a number of recent instances in which alternative accommodation was appropriate but had not been requested.

Recommendation

- Within three months Lancashire constabulary should undertake a review (jointly with children's social care services and other relevant agencies) of how it manages the detention of children. This review should include, as a minimum, how best to:
    - ensure that all children are only detained when absolutely necessary and for the absolute minimum amount of time;
    - assess, at an early stage, the need for alternative accommodation (secure or otherwise) and work with children's social care services to achieve the best option for the child; and
    - improve awareness among custody staff of child protection (including the risk of sexual exploitation), the standard of risk assessment required to reflect children's needs, and the support required at the time of detention and on release.

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

Lancashire Constabulary demonstrates a strong commitment to improving services for the protection of children, and this is visible at all levels of the organisation, from the chief constable to frontline officers and staff. The chief constable and the PCC have prioritised vulnerability and child protection; it is clear that there is a constabulary-wide focus on safeguarding and improving outcomes for children. However, while we found examples of good work to protect children, this commitment has not yet resulted in consistently improved outcomes for all children.

It is evident that Lancashire Constabulary has good working relationships with safeguarding partners. HMICFRS found some good examples (such as work with the multi-agency CSE teams and the MASH) of the constabulary protecting children who were most in need of help, with good multi-agency collaboration and a child-centred approach.

HMICFRS encountered specialist officers and staff responsible for managing child abuse investigations who are knowledgeable, committed and motivated. However, the overall effectiveness of these teams is being impeded by poor recording and a lack of effective supervision. In a significant number of cases examined, these factors had undermined the constabulary's decision-making and safeguarding measures. If the constabulary is to be confident that it is protecting vulnerable children to the best of its ability, these areas require improvement.

Many frontline officers do not appear to understand their responsibilities or powers to safeguard children from harm. It is clear that some officers believe that their responsibilities are limited to the submission of a PVP referral, and they fail to recognise the vital role they play in assessing risk and taking steps to safeguard children at the earliest opportunity. An inability to meet current demand levels means the CSE teams are focused upon intervention and prevention, with little or no capacity to undertake effective proactive work against perpetrators. In addition, the locally-focused operating model is leading to different processes evolving in each of the three BCUs, creating an inconsistent and potentially contradictory approach. HMICFRS found some good work being done by the constabulary when children are detained in custody – officers and staff often make appropriate referrals to children's social care services and generally ensure children who are denied bail are transferred to local authority accommodation. However, these strengths are undermined by weaknesses such as the lack of access to and use of appropriate adults, and the general failure to refer detained children to healthcare professionals when needed.

Many of the problems we found arise from a lack of effective governance and oversight at a strategic level; this is leading to disparate and inconsistent approaches in the protective practices of each of the three respective BCUs. The absence of effective performance management tools means senior leaders cannot reassure themselves that all children across Lancashire are being protected from harm.

Next steps

Within six weeks of the publication of this report, HMICFRS will require an update of the steps taken by constabulary in acting upon the immediate recommendations made.

Lancashire Constabulary should also provide an action plan within six weeks of the publication of this report to specify how it intends to respond to the other recommendations made in this report.

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

Annex A – Child protection inspection methodology

Objectives

The objectives of these inspections are:

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

The expectations of agencies are set out in the statutory guidance *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, the latest version of which was published in February 2017. 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 these inspections.

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 service has helped and protected children and investigated alleged criminal acts, taking account of, but not measuring compliance with, policies and guidance. In the inspections, consideration is given to how the arrangements for protecting children, and the leadership and management of the police service, contribute to and support effective practice on the ground. HMICFRS inspectors consider how well management responsibilities for child protection, as set out in the statutory guidance, have been met.

Methods

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

The purpose of the self-assessment is to:

- raise awareness 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 in need of help and protection, e.g., children being neglected;
- information-sharing and discussions about children potentially at risk of harm;
- the exercising of powers of police protection under section 46 of the Children Act 1989 (taking children into a ‘place of safety’);
- the completion of section 47 Children Act 1989 enquiries, including both those of a criminal and 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.

Below is a breakdown of the type of self-assessed cases we examined in Lancashire Constabulary:

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

Annex B – Definitions & Interpretations

In this report, the following words, phrases and expressions in the left-hand column have the meanings assigned to them in the right-hand column. Sometimes, the definition will be followed by a fuller explanation of the matter in question, with references to sources and other material which may be of assistance to the reader.

child	person under the age of 18 years
multi-agency risk assessment conference (MARAC)	locally-held meeting of statutory and voluntary agency representatives to share information about high-risk victims of domestic abuse; any agency can refer an adult or child whom they believe to be at high risk of harm; the aim of the meeting is to produce a co-ordinated action plan to increase an adult or child's safety, health and wellbeing; agencies that attend vary, but are likely to include the police, probation, children's, health and housing services; over 250 currently in operation across England and Wales
multi-agency safeguarding hub (MASH)	working location in which public sector organisations with responsibilities for the safety of vulnerable people collaborate; it has staff from organisations such as the police and local authority social services, who work alongside one another, sharing information and co-ordinating activities, to help protect the most vulnerable children and adults from harm, neglect and abuse
Office for Standards in Education, Children's Services and Skills (Ofsted)	non-ministerial department, independent of government, that regulates and inspects schools, colleges, work-based learning and skills training, adult and community learning, education and training in prisons and other secure establishments, and the Children and Family Court Advisory Support Service; assesses children's services in local areas, and inspects services for looked-after children, safeguarding and child protection; reports directly to Parliament
multi-agency public protection arrangements (MAPPA)	multi-agency public protection arrangements (MAPPA)

police and crime commissioner (PCC)	elected entity for a police area; responsible for securing the maintenance of the police force for that area and ensuring that the police force is efficient and effective; holds the relevant chief constable to account for the policing of the area; establishes the budget and police and crime plan for the police force; appoints and may, after due process, remove the chief constable from office; established under s. 1 of the Police Reform and Social Responsibility Act 2011
registered sex offender	person required to provide his details to the police because he has been convicted or cautioned for a sexual offence as set out in Schedule 3 to the Sexual Offences Act 2003, or because he has otherwise triggered the notification requirements; notification requirements can, for example, be triggered by being made subject to a sexual offences prevention order; as well as personal details, a registered individual must provide the police with details about his movements, for example he must tell the police if he is going abroad and, if homeless, where he can be found; registered details may be accessed by the police, probation and prison service; the notification requirements imposed on such offenders were extended by Sexual Offences Act 2003 (Notification Requirements) (England and Wales) Regulations 2012; the 2012 Regulations introduced requirements including that notification must be provided by offenders to the police in relation to their bank, credit card and passport details, and when they are living with a child under the age of 18 years