HMICFRS

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

National Child Protection Post-Inspection Review

Lancashire Constabulary
3–7 December 2018

April 2019

ISBN: 978-1-78655-786-5

www.justiceinspectorates.gov.uk/hmicfrs

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Introduction

The 2017 inspection

In May 2017, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) conducted a child protection inspection of Lancashire Constabulary.

In March 2018, we published the report of our findings. This concluded:

> 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 had 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). The central public protection unit (PPU) continued to oversee some force wide responsibilities such as policy development and quality assurance.
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> HMICFRS found that both the constabulary's recent efforts and its focus on vulnerability were translating into better child protection work and thereby improving outcomes for some vulnerable children. In particular:
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> - Work to streamline processes in each of the multi-agency safeguarding hubs (MASHs)[1] was 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.
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> - The multi-agency child sexual exploitation (CSE) teams were improving outcomes for children through early intervention and prevention activity. The Pan-Lancashire CSE Strategy 2015–18 set out the strategic aims of

[1] The MASH 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, exchanging information and co-ordinating activities, to help protect the most vulnerable children and adults from harm, neglect and abuse.

the multi-agency collaboration to deal with CSE, which was helping to draw together all local safeguarding agencies and police areas, and was increasing the consistency of approach towards children in need of protection.

- The constabulary had a clear focus on reducing the vulnerability of children and young people through its Early Action initiative. This multi-agency approach identified the initial trigger points for vulnerability, and worked 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, we also discovered weaknesses in the constabulary's approach to child protection, some of which were significant, resulting in children being left at unnecessary risk:

- Governance of child protection was under-developed. The level of oversight needed to make sure that the constabulary's strategic vision was leading to better frontline practice did not yet fully reflect the new operating model. Moreover, performance management was under-developed, meaning senior leaders were unable to reassure themselves about the nature and quality of frontline services.

- Frontline officers did not always recognise children in need of safeguarding at the earliest opportunity. This left some children exposed needlessly to the risk of harm.

- Many frontline officers saw their responsibility for safeguarding children limited to the submission of a PVP[2] form. This could result in missed opportunities to put in place vital protective measures at the earliest opportunity.

- Some of the constabulary's basic processes for recording child protection incidents were weak. They often failed to ensure that risks were assessed, and safeguarding interventions were implemented at the earliest opportunity. The supervision of PVP and DASH[3] forms was also weak, leading to poorer quality referrals and an inconsistent approach to their submission.

[2] PVP (protecting vulnerable people) is a term that the police and other safeguarding agencies use when dealing with welfare concerns for a child or other vulnerable person, and when recording information about them on police systems and exchanging it with partner agencies.

[3] DASH is a checklist to help professionals determine the level of risk faced by victims of domestic abuse, stalking, harassment, or 'honour-based' violence.

- Many of the departments responsible for child protection experienced high levels of demand, which were not always being managed effectively. Supervisors struggled to manage these demand levels because of workload pressures. This resulted in delays in investigations, which were of a poorer quality.

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

The 2018 post-inspection review

In February 2018, the force showed us its action plan, which sets out how it intended to respond to our recommendations. Since then, we have continued to monitor the force's improvement activity. In December 2018, we conducted a post-inspection review to assess progress.

The review included:

- an examination of force policies, strategies and other documents;
- interviews with officers and staff; and
- an audit of 30 child protection cases (relating specifically to the areas for improvement identified in the 2017 inspection report).

Summary of findings from the 2018 post-inspection review

Since the October 2017 inspection the force has taken significant steps to address the recommendations and improve the protection of children. This commitment to improvement has been visible from the chief officer group, the senior management team, local managers and officers and staff.

The force has prioritised child protection in various ways. It has:

- introduced the 'Think Child' campaign;[4]
- provided further training for all frontline officers and staff;
- developed a qualitative audit process to better understand the performance and decision-making of officers and staff engaged in child protection investigations;

[4] An internal communication campaign to raise awareness of child protection issues.

- introduced child protection coaches;[5]
- developed a child protection app;
- implemented a revised and improved governance structure; and
- supported the introduction of a business intelligence performance dashboard. This can draw management information directly from various systems to help with the day-to-day management of investigations and understanding of demand, including whether a case involves child protection.

The force has introduced a comprehensive audit regime which allows senior leaders to better understand the performance of officers and staff engaged in child protection investigations. Findings are reported to the monthly Protecting Vulnerable People meeting, and action is taken to address areas for improvement or to publicise good practice.

To supplement the audit process, in October 2018, senior leaders commissioned an internal inspection which has shown senior leaders areas where further improvement is required.

The force has also worked hard to improve the culture of its workforce. We have seen, through our case audits, that this clear commitment has already had a positive effect on decision-making and outcomes for children. Where previously frontline officers felt their role was “limited to the submission of a PVP”, we found that in most cases they now understand their responsibility to safeguard and to be child-focused. There was evidence of a clear effort from officers to speak with children, to understand their concerns and make decisions accordingly.

Officers are taking time not only to check on the welfare of children, but also to gather comprehensive comments from them about their feelings and concerns. This is helping with assessments of need and management of risk. What the child says is sometimes providing evidence of offences – even when victims are reluctant to make a disclosure.

This type of cultural change is difficult to achieve and performance in the force is now significantly improved. In particular, the commitment and dedication to change displayed by the chief officer team is impressive. This was widely recognised by the officers and staff we spoke with as part of this post-inspection review.

[5] Frontline officers who have received additional training to provide advice and guidance to their colleagues.

There are still areas in which the force is aware it needs to improve. These include:

- children detained in custody;
- children who go missing;
- recording information or action taken; and
- ensuring consistent supervision of cases.

However, all of these areas for improvement have been identified by the force through its own audit and governance arrangements, and plans are in place to address them. This gives us confidence that the force will continue with the progress made so far.

Post-inspection review findings

Leadership, management and governance

Recommendation from the report of the 2017 inspection

> 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.

Summary of post-inspection review findings

The force has invested significant time and effort in improving the knowledge of its officers and staff in respect of child protection. It has done this through training all frontline officers and staff, and by providing enhanced training for some to act as child protection coaches. It has also carried out an internal communications campaign and introduced a mobile child protection app, both designed to raise awareness of child protection responsibilities and the standards officers and staff are expected to meet.

The force has introduced monthly PVP meetings to improve its governance of child protection issues and has increased its focus on child protection in the daily 'threat and risk' meetings, changing the agenda to give greater prominence to child protection. Investment in business intelligence software has improved the ability of managers to provide effective oversight of investigations.

Detailed post-inspection review findings

The force has invested significant time and effort in improving the knowledge of its staff regarding child protection

All frontline staff have received two days' face-to-face training, given by specialist officers. The training emphasised that safeguarding is everyone's responsibility, and included training on child protection, children who go missing, exploitation, the role of the MASH, and the voice of the child.

To supplement this training, and in order to be able to provide advice about child protection 24 hours a day, the force has recruited 100 officers to act as child protection coaches. These officers have each received ten days' in-depth child protection training, and work on the front line within response and neighbourhood teams. They are expected to mentor colleagues, raise awareness

and spread messages, while also raising with managers issues concerning practice and improvements. This is a positive and creative initiative and is expected to help improve outcomes for children. The initiative began in May 2018. A staff survey and internal inspection, in August and October respectively, suggested that staff were not fully aware of the support available and therefore not making best use of the mentors. The force has responded by publicising the role of mentors and the support offered. This took place shortly before our inspection, so we were not able to test the effectiveness of the programme or whether staff were making better use of it.

To reinforce what constitutes good practice, the force has produced a video using body-worn camera footage from a real incident, along with interviews of the officers involved. This shows that risk to children is not always obvious; staff should be child-focused and professionally curious to make sure children are safe. All staff are required to watch this highly effective video.

A mobile app has also been developed with the help of frontline officers. This gives officers quick and easy access to advice and guidance through their mobile device. It also provides contact details for support services for children.

All these initiatives have been brought together in the force's 'Think Child' campaign. This is a prominent and consistent internal communications campaign to raise awareness of child protection issues.

The force has introduced monthly PVP meetings and increased focus on child protection in daily 'threat and risk' meetings

Monthly PVP meetings are now held in each geographical area. They are supplemented by a central meeting to keep consistency throughout the force. Area meetings are chaired by the local detective superintendent and attended by both uniformed and detective managers from the area. Discussion is concentrated on public protection issues and is child-focused. Updates are expected on performance, audit outcomes and areas of good practice. The meetings also cover areas for improvement, and any main messages to be given by managers.

The central meeting has a similar format with a whole-of-force focus, and is chaired by the head of safeguarding and investigation. These meetings offer senior leaders the opportunity to monitor performance and identify practice issues.

The agenda for the daily threat and risk meeting has also been amended so that discussion of child protection issues is given priority. This increases the focus of those attending the meeting on the safeguarding of children, particularly on cases of domestic abuse, missing children, exploitation, trafficking and county lines criminality.

The force has invested in business intelligence software

This new software can draw management information directly from various systems. Importantly, this can identify any investigation that is related to child protection, and whether the investigation has been supervised. Managers are encouraged to use this software, to make sure cases involving children are given the appropriate attention.

This software has only recently been introduced and technical problems need to be resolved to improve its usefulness. The software is a positive development, because it allows managers to better understand the demands on their team and which cases need immediate attention. However, the system does not allow qualitative assessment of supervisors' input, or indicate when their input was. The force is aware of this and is working to better understand the quality of supervisory oversight through the audit process.

Initial contact

Recommendations from the report of the 2017 inspection

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

Summary of post-inspection review findings

A new IT system called Connect has been introduced which allows all information to be stored within a single database. This includes crime investigations, intelligence reports, missing person enquiries, referrals to partner agencies and briefings to officers and staff. It is expected that this will allow quicker and easier access to information, but its effectiveness has not yet been assessed.

The force has also added a new flag to incident logs to identify cases involving children. Frontline and force control room (FCR) supervisors can then quickly identify child-related cases and make timely decisions.

With clear leadership from the chief officer group, the force has begun a comprehensive campaign to educate officers and staff about being child-focused, and safeguarding being everyone's responsibility. The culture of the force is becoming increasingly child-focused, leading to better decisions. Officers and staff are now more confident about speaking with children so that better assessments of their needs can be made.

Detailed post-inspection review findings

A new IT system called Connect had been introduced which allows all information to be stored within a single database

At the time of the 2017 inspection the force was using multiple systems to record information, and part of the PVP system was restricted. Following the inspection, the force made all areas of the PVP system available to all officers and staff, and issued comprehensive guidance on how to access it.

Since then the force has introduced Connect, which allows all information to be stored within a single database. At the time of this review, full use of Connect had just begun, so its effect could not be assessed. But it is expected that access to all information will be much easier and quicker, and it will therefore aid better decision-making.

A new flag on incident logs quickly identifies cases involving children

The force has also introduced a marker on incident logs which highlights when a child is linked to the incident. Frontline and force control room (FCR) supervisors can then quickly identify child-related cases and make timely decisions about the kind of response required.

Our case audits also demonstrated, especially in response to domestic abuse, that FCR staff are routinely conducting research and recording important information on the incident log. This means officers attending are better informed about the family background and whether there have been previous incidents or concerns.

The culture of the force is becoming increasingly child-focused, leading to better decisions

During the 2017 inspection, a view expressed by many of the officers and staff was that some frontline officers regarded their safeguarding role as being limited to submission of the PVP form. Any further activity to promote the welfare of children and victims' safety was regarded as the responsibility of others. We were informed that this view and culture were widespread and deeply embedded.

We were pleased to see, during the post-inspection review, that the force had gone to significant lengths to change this culture. With clear leadership from the chief officer group, the force has begun a comprehensive campaign to educate officers

and staff about being child-focused, and safeguarding being everyone's responsibility. This has been achieved by briefings to officers and staff from senior leaders, the investment in training mentioned previously, and the 'Think Child' campaign.

In addition, a manager within the PPU has written a blog talking about his own experiences as a child, and how a positive intervention from a police officer had a profound effect on the rest of his life. Numerous staff members have commented positively about this, both on the blog and in discussion with inspectors.

While there remain some areas, such as missing children and children detained in custody, which require further attention, we have seen through case audits and interviews with officers and staff that policing in Lancashire is increasingly child-focused. This means that officers and supervisors are making better decisions when dealing with cases involving children, as the following example shows.

A woman called the police to report that her estranged husband had threatened her with a knife. She was at home with her nine-year-old daughter. The risk was quickly identified by the control room staff, and officers attended promptly. The offender was arrested at the address.

The mother's English was limited, and the officers spoke at length to the nine-year-old girl, who assisted in communicating with her mother. Officers established that there were two other siblings, aged five and four, who were at school. They also established that the offender's brother owned the house in which they lived.

The nine-year-old was interviewed that day to better understand what had happened and how she felt. The investigating officers recognised the risk posed by the offender's extended family to the woman and her children. They made the decision to place the family in hotel accommodation with safeguarding measures in place, until a longer-term placement could be found by Children's Social Care.

The decisions made, and their rationale, were clearly recorded along with meeting minutes and joint plans.

Officers and staff are more confident about speaking to children

The force has worked hard to improve the culture of its workforce, as already described. During the post-inspection review we audited some cases. In most, there was evidence of a clear effort from the officers involved to speak with children, to understand their concerns and make decisions accordingly.

Officers are taking time not only to check on the welfare of children, but also to gather comprehensive comments from them about their feelings and concerns. This is helping with assessments of need and management of risk. What the child

says is sometimes providing evidence of offences – even when victims are reluctant to make a disclosure.

> Officers went to a suspected domestic abuse incident. A man had assaulted his wife in front of their three children, aged ten, seven and two. The officer who went spoke with the children at length. They provided information that their mother had been raped by their father, which in turn prompted their mother to make a disclosure about the continuing abuse she was suffering, including rape.

Assessment and help

Recommendations from the report of the 2017 inspection

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; and
- ensuring there is consistency in how the 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.

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[6] to ensure that cumulative risk is being identified appropriately and that families and children affected by it are benefiting from multi-agency intervention when appropriate.

[6] A MARAC (multi-agency risk assessment conference) is a locally held meeting of statutory and voluntary agency representatives to exchange 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's or child's safety.

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; and
- 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.

Summary of post-inspection review findings

We saw some improvement in the way the force deals with children who are reported missing, particularly those believed to be in Lancashire but missing from elsewhere. There was evidence of proactive enquiries taking place to locate children, and longer-term protective plans in some cases. However, progress is being hindered by an outdated policy: the force still uses an old definition of missing, and also uses the absent category. Use of the absent category is inconsistent and was not appropriate in most of the cases we saw. This results in a poor service to some children.

Better research by FCR staff means officers now receive more information before attending domestic abuse incidents. Officers are also better at completing DASH risk assessments, and specialists are available to advise officers and to support victims.

A multi-agency review of the MARAC process was taking place at the time of our review. The aim of the review is to make sure the meeting is as effective as possible, to achieve the best interventions for victims, children and perpetrators. A new MASH process is improving the timeliness of identification of risk, referrals to partner agencies and cases being heard at MARAC. But we found that in some cases cumulative risk may be being missed.

Improvements have been made to the Domestic Violence Disclosure Scheme,[7] with earlier disclosures being made to those at risk. This could prevent repeat incidents. However, there are still opportunities to improve investigations to provide the best outcomes for victims and children.

[7] The Domestic Violence Disclosure Scheme sets out procedures for the police to disclose information about a person's previous violent and abusive offending to their partner, if this may help protect them from violence and abuse.

In 2017 some processes linked to joint working required review to make sure they were operating in the best interests of children and their families. The force has worked with its partners to make sure joint visits can be conducted promptly where necessary.

The force has provided extensive guidance and training to frontline staff to help them identify the range of responses and actions that the police can take to ensure immediate safeguarding, as mentioned earlier in this report.

Detailed post-inspection review findings

We saw some improvement in the way the force deals with children who are reported missing

In interviews with FCR staff and managers, it was clear that the force has changed its approach to children missing from other areas and believed to be in Lancashire. The force now readily takes responsibility for those investigations, and activity to locate missing children is managed through the new Connect system.

We found that staff in the control room now gather more (and better) information than before, resulting in better risk assessments and grading of missing episodes. There are routine checks of all relevant databases to confirm levels of risk. Checks include the PVP system, previous missing person reports and previous incident logs. This wasn't the case last year. However, recording of the rationale for decisions remains inconsistent. Tools such as THRIVE[8] or the National Decision Model[9] would help the force to make further improvements and would lead to more consistent risk assessments that support the development of protective plans.

We saw proactive enquiries and longer-term protective plans in some cases

In our case audits we saw evidence of supervision being completed by frontline managers in the FCR and response teams, although sometimes their comments didn't contain a great amount of detail.

In some cases, there was evidence of proactive responses to locate and safeguard children. These included telephone calls, broadcasts, address checks, and consideration of social media and CCTV. Where risk of CSE was identified,

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

[9] *Authorised Professional Practice on National Decision Model*, College of Policing, December 2014

interventions and support from CSE multi-agency teams were evident, including return home interviews[10] and discussion at multi-agency CSE meetings.

We have also seen evidence of the use of child abduction warning notices,[11] to help reduce the risk posed to missing children by some adults.

Some areas have introduced multi-agency meetings, called missing person panels, specifically to create protective plans and reduce future episodes. This is a relatively recent innovation, which has not yet been formally evaluated.

During training of its frontline and FCR staff, the force has also emphasised officers' responsibilities when children go missing.

An outdated policy is hindering progress

The force's missing people policy is older than the authorised professional practice published by the College of Policing. The force still uses the 'absent' category and an old definition of missing. During the post-inspection review we saw examples of risk that was not identified correctly. In one case a child believed to be at risk of criminal exploitation and with a history of drug and alcohol misuse was categorised as absent for 48 hours.

Case audits demonstrated that prevention interviews[12] are not routinely carried out, particularly when a child returns from a missing episode before anyone is allocated to the search for them, or if they were categorised as absent.

By speaking to children on their return, officers will better understand why they have gone missing. In addition, by discovering where the children have been, officers will be better placed to identify risks they may have been exposed to. As a result, the force will be better able to reduce risk to children in the future or reduce the risk of them going missing again.

[10] When a child is found, the child must be offered an independent return interview. Independent return 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 home. See *Statutory guidance on children who run away or go missing from home or care*, Department for Education, January 2014

[11] 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 their arrest and prosecution.

[12] The police have a responsibility to make sure that the returning person is safe and well. The purpose of the prevention interview is to determine any continuing risk or factors which may contribute to the person going missing again.

Use of the ‘absent’ category is inconsistent and results in a poor service to some children

As well as cases that were recorded as missing, we dip-sampled ten cases in which children had been recorded as absent. We found that six of these cases should have been recorded as missing, for several reasons:

- children were graded as absent when there was clear risk;
- children were graded as absent, then enquiries were made to locate them as if they had been graded as missing. But they were then not recorded as missing, which suggests the system is being used inappropriately to manage demand; and
- children correctly identified as missing and at medium risk, but when found were treated as though they were absent. This meant relevant forms were not submitted, records were not accurate and information was not exchanged with other services.

All of this means a child’s history and circumstances may not be properly understood, and in future episodes opportunities for multi-agency planning will be missed.

Each local authority provides a return home interview service when children go missing. This happens when a child is recorded as missing, but not if they are recorded as absent. Therefore, further opportunities for multi-agency intervention are routinely missed.

We are reassured that the force recognises the need to improve. A review of the response to missing children is currently in progress and in the West area there is a planned pilot of a dedicated missing people team.

Officers now receive more information before attending domestic abuse incidents and are better at completing DASH risk assessments

Our case audits have demonstrated that when officers are called to incidents of domestic abuse, the FCR staff access systems in order to draw together all available information before an officer arrives. This gives officers and staff a better understanding of the family and helps them to make better decisions.

DASH risk assessments are now being completed consistently. If the officer attending is unable to complete one while at the scene, they complete them the next day, at the latest. This is an improvement from the original inspection, which found completion of the forms was inconsistent, and that when they were completed they were often of poor quality.

When officers are sent to domestic abuse incidents they are identifying whether children are living in the premises. We found a significant improvement in the approach to children by officers, as described in the example mentioned earlier.

Specialists are available to advise officers and to support victims

The force has trained 21 officers (seven in each area) to give advice and guidance to their colleagues when dealing with domestic abuse. This includes how to progress domestic abuse investigations, and how to manage or reduce risk. However, at the time of our inspection there had been no evaluation of the effectiveness of this training, or of its effect on victims and children.

When the safeguarding unit is involved in supporting domestic abuse victims, comprehensive safety planning is provided. This is protecting victims and improving the well-being of children affected by these incidents.

A comprehensive multi-agency review of MARAC was taking place during our revisit

A team that includes organisations such as children's social care, Lancashire Victim Services, health, probation, Cumbria and Lancashire Community Rehabilitation Company, and Lancashire Constabulary, has been established to conduct a review of the MARAC process. The domestic abuse strategic group, the local safeguarding children board and multi-agency MARAC steering group are jointly overseeing the review. A representative from SafeLives[13] is also providing constructive feedback as the review develops. The focus of the review is to make sure the MARAC is as effective as possible, to achieve the best interventions for victims, children and perpetrators, to reduce risk and harm. This is positive and has the potential to influence national practice, although the operating model is not yet agreed.

New MASH processes are improving timeliness and identification of risk, but cumulative risk may be being missed

The MASH now makes MARAC referrals based on an assessment of all the circumstances of those at risk. Previously referrals were made when three crime-related incidents occurred in a 12-month period, in high-risk cases or where professional judgment assessed that a referral was appropriate. These criteria have now been replaced by an assessment of the full circumstances and history of those involved to make a professional judgment about the level of risk. This has led to a reduction in the queues in the system, making the management of risk more efficient.

[13] SafeLives is a national domestic abuse charity providing MARAC training, review and evaluation.

The review of the referral system has led to an improvement in the efficiency of the process. However, audits show that there can be multiple incidents before a referral is sent to children's social care. Although the force exchanges information with health services, schools and the independent domestic violence adviser,[14] children's social care can remain unaware of the problems affecting children at risk within the family. Currently, decisions whether to exchange information are not supervised, and senior leaders can't be assured their expectations are being met, or that agreed partnership thresholds are being applied correctly.

Improvements have been made to the Domestic Violence Disclosure Scheme which could prevent repeat incidents

The force assessed the scheme after our inspection and found there was a 45-day gap from application to disclosure. In 11 percent of cases, another domestic abuse incident had occurred. The process has since been streamlined, and disclosures are now taking between four and ten days. Although there is not yet enough data to assess any reduction in incidents, the early signs of this approach are positive.

It is also encouraging that the force is planning to implement Operation Encompass[15] early in 2019.

There are still opportunities to improve investigations to provide the best outcomes for victims and children

Despite improvements in the management of risk and safeguarding when an incident of domestic abuse is reported, the response to some incidents is still not supervised effectively. This means that some investigative opportunities are missed, which in turn compromises the safeguarding of children.

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

[15] Operation Encompass involves the force, when it has been called to an incident of domestic abuse at a child's home, informing a 'key adult' at the relevant local school before 9.00am the next morning (or before 9.00am on the Monday morning, if an incident occurs over a weekend). This enables schools to provide support to the child(ren) involved and practical help and information.

A 16-year-old girl called 999 to report her mother's partner was armed with a knife and shoving her mother around in the street. There were other children in the house and her mother was 11 weeks pregnant. Her mother took the phone to speak to the call-taker and tried to minimise what was happening. She then became extremely frightened when she realised her partner was trying to get into her house by kicking at the door and windows. She said she feared for her life.

When the police attended the man was arrested and eventually charged with criminal damage only, as the mother claimed not to have seen a knife. There was no evidence of supervisory oversight, and other lines of enquiry were not followed. The daughter who had called the police was not asked for a statement, and no enquiries were made with a neighbour who saw the incident.

Further evidence might have resulted in more serious charges and allowed the court to impose a sentence giving the family more protection.

In 2017 some processes linked to joint working required review to make sure they were operating in the best interests of children and their families

When child protection officers and staff required the urgent support of children's social care services to carry out joint visits, they needed to send the PVP referral for assessment by the MASH. Such processes can cause significant delays, and too often resulted in a single-agency police response, when multi-agency input would have been far more beneficial.

Some frontline officers indicated that processes used for assessing domestic abuse incidents lacked structure. We were informed that despite 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.

The force has worked with its partners to make sure joint visits can be conducted promptly where necessary

We completed several case audits relating to joint investigations and found that where joint visits were required, police officers and social workers were available, meaning no unnecessary delays occurred and there was no increased risk to children.

Our case audits also showed that officers are now much more familiar with DASH risk assessments. These were completed with the victim in all cases, and this was done either at the time of the incident or, when this wasn't possible, the next day.

The force has provided extensive guidance to frontline staff

As mentioned previously in this report, the force has provided guidance to its frontline staff through many initiatives, including:

- the ‘Think Child’ campaign;
- training of all frontline staff;
- qualitative audits;
- child protection coaches; and
- the development of a child protection app.

This means officers and staff are now much better informed about the range of options available to them to safeguard children and contribute to joint plans.

MASH processes have been reviewed and efficiency improved

At the time of the original inspection the force was reviewing its MASH processes with partners. This review has now ended and a new operating model implemented. The force told us that this has resulted in swifter assessment of cases. Our case audits did not find any unnecessary delays in assessing cases and exchanging information with partners.

However, as mentioned earlier, there is no regular supervision of the decision to exchange information or not. Therefore senior leaders can’t be assured that either their expectations or those of partners are being met.

Investigation

Recommendations from the report of the 2017 inspection

> Immediately Lancashire Constabulary should take action to improve child protection investigations by:
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> - 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
> - conducting regular audits of practice that include 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; and
- improving the oversight and management of cases (to include auditing of child abuse and exploitation investigations to ensure that standards are being met).

Summary of post-inspection review findings

The force has introduced a comprehensive audit regime to better understand the performance of officers and staff engaged in child protection investigations. Findings are reported to the PVP meeting, and action taken to address areas for improvement or to publicise good practice.

To supplement the audit process, in October 2018 senior leaders commissioned an internal inspection which has shown senior leaders areas where further improvement is required.

Supervision and the quality of investigation are usually good in specialist teams but not consistently good in response teams. This is particularly so when response officers are expected to deal with CSE-related cases, which were previously dealt with by specialists.

The force has made efforts to improve the recording of decisions and outcomes at meetings by providing training and guidance to officers and staff, but this remains inconsistent.

The force has made a significant investment in the multi-agency specialist teams dealing with exploitation of children, doubling the number of police officers in these teams throughout the force. There has also been investment in the force's capacity to examine digital devices.

Detailed post-inspection review findings

The force has introduced a comprehensive audit regime to better understand the performance of officers and staff engaged in child protection investigations

Auditing is managed centrally through the PPU. However, the audits themselves are conducted by chief inspectors, both uniformed and detective, within each area. The auditors have been trained by subject matter experts. To aid consistency, a question set has been developed.

The audit process began in May 2018 and was developed over the following months. An external consultant was used to make sure outcomes from the audits were focused on improving overall performance. Each area audits ten cases per month, selected centrally to ensure an even distribution. The subject matter mirrors that of the nine areas inspected by HMICFRS child protection inspections,[16] with an additional case selected to explore an area of business of interest to the force.

A detective inspector with child protection experience then reviews the audits, moderates them to achieve consistency and identifies themes. Areas for improvement and examples of good practice are fed back to officers and their supervisors, to improve individual performance. In addition to this, the detective inspector responsible reports to the monthly PVP meeting, where thematic findings are discussed and actions agreed to achieve improvement, for example through briefings to officers and staff, email messages to all officers and staff, messages on the force intranet or internal media campaigns.

The current case gradings of 'good', 'requires improvement' and 'inadequate' were agreed in August 2018. To date, there have been two rounds of results based on this methodology. Although it is too soon to measure the effectiveness of this approach, the force has been able to identify areas in which it can concentrate efforts to improve. For example, supervision of the cases audited was poor, with a lack of meaningful oversight. And in the East area there was often no indication of any supervisor reviewing cases. At the time of our visit the force was planning extra training for supervisors to address this.

To supplement the audit process, senior leaders commissioned an internal inspection in October 2018

The inspection aimed to test the effectiveness of the measures put in place. Some areas were found to require further improvement, such as:

- the accuracy of recording of safeguarding activity on force systems;
- weak practice when children are reported missing;
- first-line supervision of investigations, particularly at smaller police stations; and
- the role of child protection coaches and the child protection mobile app, which are not understood by some officers and staff.

[16] For more information on HMICFRS's rolling programme of child protection inspections, see our website.

The force is addressing these issues through the ‘Think Child’ campaign, a review of how the force deals with missing children, more involvement at daily meetings by the missing from home co-ordinator, and clear messages from senior leaders in their respective areas about their expectations.

This demonstrates the determination of the senior leadership to continually seek ways to improve outcomes for children.

This is a significant improvement and provides senior managers with the tools to monitor and assess the performance of their teams to make sure they meet their expectations.

Supervisory oversight is usually good in specialist teams, but is not consistent in response teams

During this post-inspection review we completed 30 case audits relating to child protection investigations. We found that when a case is being dealt with by a specialist team, supervision is generally good. However, this is not always the case for those investigations allocated to non-specialists, such as those cases of CSE that are investigated by response staff.

There is an established expectation within specialist teams, through the force’s child protection supporting procedures, that a detective sergeant will review child abuse investigations every 28 days. This is not the case for non-specialist investigators, where no guidance as to frequency is provided.

This means the supervision of child protection investigations remains inconsistent and depends on which officer or team is responsible. Non-specialist officers are not receiving the appropriate support to make difficult decisions about the complex risks often faced by vulnerable children.

The force has made efforts to improve recording of decisions and outcomes at meetings, but this remains inconsistent

Officers attending meetings have received guidance and are expected to record outcomes either on the incident log, the investigation log or the associated protecting vulnerable persons form, depending on the particular circumstances. In an effort to improve overall supervision of child protection investigations, the force has added two more detective sergeants per area to oversee child protection investigations. Although we found some improvement in recording in some cases, it remains inconsistent. This may be because of the multiple places that information can be recorded. The new computer system (Connect) may help to improve recording, so that officers attending incidents are in possession of all relevant information and make better decisions.

The force has doubled staffing in the specialist teams dealing with exploitation of children, and increased capacity to examine digital devices

Each of the three policing areas within Lancashire has a dedicated CSE team. These are multi-agency teams in which the police work alongside children's social care, family support, CSE specialist nurses and third-sector agencies.

These teams oversee investigations into children at risk of sexual and (more recently) criminal exploitation. In recognition of the resulting increased demand for and complexity of this type of investigation, the force has invested £1.3m and doubled staffing levels, so now each team has two detective sergeants plus 13 or 14 detective constables.

In addition, the force has trained 200 officers to be media investigators, who are available 24 hours a day to examine digital devices. These examinations can take place in 16 kiosks throughout the county. The ability to gather evidence from digital devices is increasingly important to protect children online. This is another significant investment by the force, and should mean investigative delays are kept to a minimum.

We saw that the quality of investigations by officers within the CSE team was of a high standard, with good supervision

We found good evidence of the voice of the child being taken into account when decisions are made about how to deal with incidents. For example, in one case the child involved was very worried about officers arriving in a marked car, as the suspect lived nearby. This led to officers attending in an unmarked car. In another case, the child did not want to speak to officers while she was in hospital. Their wishes were respected, and officers returned later to obtain the information they needed.

We also saw child abduction warning notices being used as an effective disruption tactic. In several of the cases we examined, the notices were issued to prevent the suspects having further contact with children at risk. However, the suspected perpetrators were then released under investigation, with no bail conditions. Bail in these cases could have been used to safeguard other children. This was a missed opportunity.

In all the cases we examined, referral forms were submitted by the attending officers. In most of the cases this led to an appropriate protective plan being put in place and strategy meetings being held.

When cases were allocated to response officers we found investigations were not as good

The force has changed the way it allocates CSE cases since the original inspection. Cases that were described as not online and between an adult and a child are allocated to the CSE team. Online CSE between an adult and a child is allocated to the online team. Cases involving child victims and suspects are now retained by response officers under the supervision of their sergeants.

In the cases we audited that had been allocated to response officers, we found supervision and investigation were not as good. Devices were not seized or examined, and the risk posed by perpetrators to other children was not fully recognised. This led to delays in investigation and in the exchange of information with partner agencies.

A mother attended the police station, concerned that her 12-year-old daughter had been in contact, via social media, with two older boys believed to be 17 and 15 years of age. The content of the conversations was worrying. The social media accounts of the boys showed that they were also in contact with some of the child's friends. It was not known whether the child or her friends had met or agreed to meet the boys, or if indecent images had been exchanged. It was unclear whether the child's phone had been seized or examined, or what enquiries had been conducted to identify the males involved. There was little evidence of supervision or investigation, and there had been a three-week delay in making a referral to support services.

It is critically important that officers have the necessary skills and experience to effectively manage child protection and safeguarding investigations. Their supervisors should receive sufficient training, guidance and support to be able to oversee investigations effectively and support their staff.

Decision-making

Recommendation from the report of the 2017 inspection

> 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[17] is properly recorded and is readily accessible in all cases where there are concerns about the welfare of children. Guidance to staff should include:
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> - what information should be recorded on systems to enable good quality decisions; and
> - 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.

Post-inspection review findings

Since our inspection the force policy has been updated, and simplified guidance given to officers and staff, but recording remains poor

New processes to record and quality-assure decision-making have been introduced. This is accompanied by clear advice on officers' individual responsibilities.
We examined a small sample and found some evidence that recording of activity has improved, but record keeping about outcomes and the details of longer-term protective planning remains poor. This means officers attending subsequent incidents involving the family will be unaware of what protective measures are in place.

The new Connect system provides an opportunity to improve recording when a police protection order is issued. However, as the system is new we did not see any examples.

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

Police detention

Recommendation from report of the 2017 inspection

> 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.

Summary of post-inspection review findings

Since our inspection, all custody staff have received child protection training to help them better understand children's needs and vulnerabilities. Along with new guidance and an increased child focus, this has led to fewer children being detained.

We found that support from liaison and diversion services[18] and from healthcare professionals is available to children in custody. But opportunities for longer-term safeguarding are being missed, because officers rarely report safeguarding concerns for detained children to children's social care.

Our case audits showed that custody officers know they need to find alternative accommodation for children refused bail, but planning of this is often left until after the child is charged. It could be done earlier and therefore with a better chance of being successful. On occasions when alternative accommodation could not be found, this was not routinely escalated at the time to senior leaders.

[18] NHS liaison and diversion services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders. The service can then support these people through the early stages of the criminal system pathway, refer them for appropriate health or social care, or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required.

Detailed post-inspection review findings

Child protection training has been provided to custody staff supported by new guidance which is reducing the number of children detained

Since our inspection all custody staff, including those employed by G4S, have received child protection training. The aim was to help them better understand the needs of children and their vulnerabilities. New standard operating procedures have been published giving clear guidance to officers and staff about the standards the force expects when detaining children. This is supported by posters making it clear that custody is a last resort for children, and reinforcing the child-focused policing message of the 'Think Child' campaign. This has resulted in a reduction in the number of children detained in police custody: 169 children were detained in May 2018; this reduced to 128 in November.

Support is available for children in custody, but opportunities for longer-term safeguarding are being missed

The force has also produced a guide for children entering custody that explains in simple terms their rights and entitlements. This means that when children are detained they have a better understanding of what is happening and what support is available to them. This is positive and reflects a child-centred approach.

In the cases we reviewed we found a healthcare professional was available and was called to see children when necessary. In addition, referrals to the liaison and diversion teams within custody offices was commonplace, providing children with access to mental health services if needed.

However, in the cases we audited we could find no record of PVP referral forms being submitted to alert the local authority of safeguarding issues. This was even the case when the grounds to refuse bail were because a 17-year-old boy was at risk of harm because his offending was believed to be caused by coercion from older associates. This means that in cases where clear signs of risk are present (such as criminal exploitation), children may not receive multi-agency intervention or support after leaving custody. It also means that opportunities to avoid unnecessarily criminalising children who are coerced to commit crimes are being missed.

The force is using its audit process to better understand its performance when children are detained

Data is now gathered to improve the ability of senior leaders to oversee the management of custody issues, such as how long it takes for an appropriate adult to attend. This is currently done manually, but there are plans to perform this data-gathering activity using the business intelligence software.

The force audits include cases of children who have been detained, with the findings reported to the strategic management board and the quarterly custody policy meeting. Multi-agency arrangements, such as the availability of appropriate adults or the provision of alternative accommodation, are now overseen by a recently created multi-agency custody board, which should allow partners to improve joint working in relation to detained children.

Custody officers know they need to find alternative accommodation for children refused bail, but planning and escalation need to improve

Our audits show that custody officers are aware that they must seek alternative accommodation when a child is charged with an offence and bail is refused. But we found the planning of this is often left until after charge, when a discussion could have taken place earlier. The result is that requests for accommodation are often made very late at night, by which time obtaining a place for the child would take too long and it would not be practicable (or necessarily appropriate) to wake the child and move them.

In these circumstances, or when a place could not be found, we found no evidence that the matter was escalated at the time internally or with children's social care. Although these cases are regularly reviewed at multi-agency meetings and partners are committed to improve the availability of alternative accommodation it is still the case that, at present, children are still being unnecessarily detained in police custody.

We also found that in such circumstances the required juvenile detention certificate (which outlines to a court why bail was refused) was either not completed, or not attached to the custody record, or the rationale was absent.