HMICFRS

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

National Child Protection Inspection Post-Inspection Review

Lincolnshire Police

7–11 October 2019

Contents

Introduction

The 2018 inspection

In September 2018, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) inspected how well Lincolnshire Police keeps children[1] safe.[2]

In February 2019, we published our findings. We concluded that the chief constable, his senior team and the police and crime commissioner were committed to protecting vulnerable people, including children. This showed in both the police and crime plan and the force's strategic policing plan.

There was evidence that senior officers were improving how the force manages the risks to children. They were also working hard to meet the increase in demand for child protection.

Organisations and interested parties told us that they had strong and effective working arrangements with the force. They said that officers and staff worked well with them, and were open to constructive professional challenge.

For instance, the head of crime had commissioned a review of his resources and structures in March 2018. This highlighted the increasing demands on the public protection unit and resulted in a series of recommendations. These included plans to restructure the unit to improve resilience and, as a result, outcomes for children.

There were examples of good work by officers responding to incidents involving children. Officers and staff we spoke to who managed child protection investigations were committed and dedicated. They often worked in difficult and demanding situations. However, we found that most teams dealing with child protection investigations weren't fully staffed. This meant that some children got a poorer service. The force was aware of this and planned to have all vacant posts filled before the end of January 2019.

Lincolnshire Police had worked hard to safeguard the health and wellbeing of officers and staff. It had a strategy called Wellbeing Matters, which assessed the health and wellbeing of public protection staff. This was done through annual psychological screening and access to an external counselling service. All officers and staff were also given an extra two days' leave that they could use for wellbeing reasons.

Our case audits showed that the force needed to improve how it responded to children who need help and protection. It had made protecting children a priority, and senior

[1] 'Child' in the report refers to a person under the age of 18.
[2] For more information on our child protection inspections, see our website.

leaders were clearly committed to this, but decisions about children at risk weren't yet consistently better as a result. Also, too many officers dealing with child abuse investigations didn't have the skills or experience to manage them effectively. And a diary system used by the force control room (FCR) had insufficient oversight, which meant there were unnecessary delays in seeing some children who were at risk.

The force's performance measurement was another area of weakness. The force didn't know enough about the effectiveness of various interventions. This made it difficult for senior leaders to assess the nature and quality of decision making. They also couldn't be assured that officers and staff were making the best decisions for vulnerable children. The force was aware of this and had plans to introduce a new performance framework.

We made a series of recommendations in our 2018 inspection report, aimed at improving Lincolnshire Police's child protection practice.

The 2019 post-inspection review

In March 2019, the force gave us its action plan. This set out how it intended to respond to our recommendations. Since then, we have continued to check its improvement work.

In October 2019, we assessed its progress in a post-inspection review. The review included:

- examining force policies, strategies and other documents;
- interviews with officers and staff; and
- auditing 33 child protection cases (on the areas for improvement set out in the 2018 report).

Summary of findings from the post-inspection review

Since our September 2018 inspection, the force has taken steps to improve safeguarding practice and outcomes for vulnerable children. It has changed its structures and reviewed its systems, procedures and processes. It has also invested in training for investigators and frontline officers and staff.

The force has worked hard to make sure its restructure took place in January 2019. It has changed shift patterns and created protecting vulnerable persons units (PVPUs) with geographical areas of responsibility. To support this, new terms of reference explained to officers and staff their roles and responsibilities, and what the force expected of them.

There are now three PVPUs. Each should have three detective sergeants supervising 19 detective constables. This means the force has increased the hours specialist officers are on duty to 8am–9pm during the week, and 8am–6pm at weekends. This is significant, as most officers were previously working office hours during the week.

As a result, frontline officers and staff have better access to specialist help and advice when needed. So when response officers aren't able to attend a vulnerability incident

quickly, the FCR contacts PVPU officers to attend. Although this can put more demand on PVPU officers, it offers victims a better service.

The new structure also means senior leaders can use their resources more flexibly. For example, they can temporarily move officers to different locations to help meet demand. However, the benefits of the restructure haven't yet been fully realised.

In 2018, very few officers dealing with child abuse investigations had completed the Specialist Child Abuse Investigators Development Programme (SCAIDP). The force also had no record of who, or how many, had had this specialist training.

We were pleased to find that as well as restructuring resources, the force has invested in making sure that PVPU officers have the necessary skills to do their jobs. A new detective academy now oversees its investigators' training.

Senior leaders confirm that all investigators working within the PVPU will have professional investigation programme (PIP) level 2 accreditation and SCAIDP training. This is a significant commitment. Training is being carried out externally and as quickly as possible. The aim is for 90 percent of investigators to have completed it by January 2020.

But this has meant that there have been many absences from the PVPU teams. The situation has been compounded by sickness absence, and by annual leave that had been authorised when officers and staff were in previous roles. In the week of our revisit, there were ten detective constables (DCs) and two sergeants in Lincoln. This was about half the amount of resource there should have been. Many officers told us that they are also still managing enquiries from their previous roles. Because these enquiries are older, they are given less priority than new offences being reported.

During our 2018 inspection, the force was reviewing its performance framework. At the time, performance data wasn't being reported to the PVP managers' meeting. There is now a new performance pack, which is reported monthly to the PVP managers' meeting. It includes data relating to outstanding Niche[3] tasks, and cases with outstanding suspects. This allows managers to better understand their teams' workload, and where more support is needed.

The performance pack also has performance data on the paedophile and online investigation team (POLIT) and the management of sexual offenders and violent offenders team (MOSOVO). Senior leaders now better understand workload and potential risk within these teams.

However, the data doesn't include qualitative information about the standard of practice and outcomes for children. Therefore, senior leaders still cannot be assured that officers and staff are making the best decisions for vulnerable children in all cases.

Senior leaders recognise this and are developing a case audit regime, which will be reviewed by a crime scrutiny panel. Audits will be reported to the panel and themes identified, enabling good practice to be shared and areas for improvement to

[3] Niche is a single police information management system.

be addressed. The force should reassure itself that those who audit cases have the skills and experience to be effective and objective.

To help bring cultural change, Lincolnshire Police recently introduced a vulnerability delivery group. This group includes PVPU officers and staff from the media, IT, performance and audit teams. The terms of reference for the group weren't set when we visited, but the aim is that it will manage improvements relating to vulnerability generated from national action plans, inspections and internal audit. This is an encouraging initiative that should help promote and communicate change.

However, several new initiatives have yet to be implemented or fully implemented, so haven't yet had an effect. These include:

- Vulnerability: Everyone's Business – a web and app-based guide for officers dealing with problems involving vulnerable people;
- the vulnerability delivery group;
- crime scrutiny panels to audit and scrutinise practice;
- Operation Encompass – when the force is called to a domestic abuse incident at a child's home, officers now tell a key adult at the child's school before 9.00am the next morning (or before 9.00am on the Monday morning, if the incident takes place over a weekend). This helps the school to support the child(ren) involved and offer practical help and information; and
- better mapping of registered sex offenders.

During our revisit, we audited the force's work in 33 case files. We assessed the force's practice as good in six cases, needing improvement in 18, and inadequate in nine.

We remain concerned about the standard of investigations. We found that cases lacked effective supervision, investigative opportunities were missed, decisions to take no further action were made too soon and there was unnecessary drift and delay in progressing enquiries. As a result, we will revisit the force within 12 months to carry out a further assessment of its progress.

Post-inspection review findings: Initial contact

Recommendation from the 2018 inspection report

> We recommend that Lincolnshire Police should immediately review its processes regarding incidents relating to child protection, paying particular attention to the response decided on by staff in the FCR.

Summary of post-inspection review findings

The force has improved training, oversight and quality assurance. As a result, its initial response to incidents involving vulnerable children is better.

Since our inspection, it now oversees its diary system. This means that appointments aren't created for cases involving vulnerable people. We saw risk assessment tools being used well, and incidents were usually graded correctly. We didn't see any significant delays in responding to incidents involving vulnerable children.

Detailed post-inspection review findings

Further staff training has improved risk assessment

Since our inspection, call-takers have had more training on the THRIVE risk assessment process.[4] They have also received Concern for Welfare training. This improves their knowledge of vulnerability issues.

When incidents involving concerns for children are reported, the risk is consistently recognised by FCR staff and the response is usually graded correctly. In most cases, officers attended quickly, although we saw some examples when response was delayed because of other demands and the unavailability of resources.

The diary system is no longer used when vulnerability is identified

We were told that when a THRIVE assessment identifies a child is vulnerable, their case is no longer added to the diary system. Instead, the incident resolution team now reviews all decisions to make appointments to make sure that the right decisions are made. We examined the diaries and were pleased that appointments weren't made for vulnerable children.

[4] THRIVE stands for threat, harm, risk, investigation, vulnerability and engagement. This model assesses the appropriate initial police response to a call for service. It helps call-takers to judge relative risk and puts the victim's needs at the heart of that decision.

A member of staff carries out quality assurance within the FCR. Five calls are reviewed each month for each call-taker. The results are reported to the management team, and individuals or teams receive feedback as necessary.

Recommendation from the 2018 inspection report

> Lincolnshire Police should act within three months to make sure that officers obtain and record children's concerns and views (including observations of their behaviour and demeanour), to help influence decisions made about them.

Summary of post-inspection review findings

The force trains its officers in recognising vulnerability and completing DASH[5] risk assessments. Improved guidance was due to be launched at the time of our revisit, and forms were to be improved. However, we found officers still didn't speak to children and record their views often enough.

Detailed post-inspection review findings

The force has invested in more training for officers and staff

Since October 2018, the force has been giving face-to-face vulnerability training to all officers and staff who meet the public. This one-day training course covers child sexual exploitation (CSE), as well as stalking and harassment.

This was taking place when we visited. A total of 233 officers and staff had completed it, and 126 more were booked onto the course before March 2020. It will be around two to three years before all personnel have received the training, however.

In addition, all officers and staff who are expected to deal with domestic abuse are trained in completing DASH risk assessments. This is part of initial training and includes recognising risks to children, speaking to them and understanding their concerns.

The force intends to introduce new guidance and better forms

The force has created a guide called Vulnerability: Everyone's Business. It offers clear and comprehensive advice for all officers who deal with safeguarding issues, and highlights relevant legislation, support services and what to consider when making decisions – for example, the views and concerns of children.

The guide hadn't been launched when we visited. The plan was to do this by the end of October 2019, supported by internal communications and an app on officers' mobile devices.

The force is also working with Niche to improve its public protection notice (PPN)[6] so that extra questions remind officers to speak to children and record their views,

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[5] DASH is a checklist to assist professionals in identifying the level of risk to a victim of domestic abuse, stalking, harassment and so-called 'honour-based' violence.

[6] A form used to record concerns for vulnerable people and to make referrals to other safeguarding agencies, such as children's social care.

concerns, demeanour and behaviour. The force expected to have completed these improvements by December 2019.

Officers still don’t gather and record children’s views enough

Our case audits revealed that officers still rarely speak to children or record their concerns, behaviour and demeanour. This was particularly evident in cases of domestic abuse. This means they can’t use this information when initially assessing the child’s needs and deciding whether to refer them to children’s social care services.

Officers generally now use body-worn video. However, its benefits for capturing the experiences of children are limited if officers don’t speak enough to them.

Post-inspection review findings: Assessment and help

Recommendation from the 2018 inspection report

Immediately, Lincolnshire Police should improve practice in cases of children who go missing from home. As a minimum, this should include a review of how missing episodes are recorded, and making officers and staff more aware of:

- their responsibilities for protecting children who are reported missing from home, especially where this happens regularly;
- the importance of investigating where a child has been, and who with;
- their responsibilities for conducting and recording prevention interviews when children return home; and
- the importance of sharing information with partner organisations.

Summary of post-inspection review findings

The force has rewritten its procedures for dealing with missing people. They now clearly explain what it expects when officers and staff respond to reports of missing people.

It has improved its practice when children are reported missing. However, many incidents still aren't recorded properly; and when we visited, it wasn't reviewing information from independent return-home interviews.[7]

Detailed post-inspection review findings

In 2018, we found that the FCR consistently used THRIVE and a structured question set to allow the FCR inspector to adequately assess and grade risk. However, the missing-from-home episode was then often incorrectly managed on the NSPIS[8] command and control system and not transferred to the COMPACT[9] system. This meant demand was not properly understood and automatic notifications to children's social care were not made.

[7] When a child is found, they must be offered an independent return-home interview. Such 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. More information is available in the *Statutory guidance on children who run away or go missing from home or care*, Department for Education, 2014.

[8] NSPIS is a system for managing calls received, and the response to them.

[9] The COMPACT system is a police database that records the detail and history of missing people.

The enquiries made also often didn't reflect the risk. For example, when a child was found, the investigation stopped. There was no recognition of the risk posed to them while missing because of where they had been or who they had been with. This was made worse because prevention interviews were often brief or not held at all. Also, information from return-home interviews wasn't routinely recorded.

Missing-from-home procedures have been rewritten and are comprehensive

We were pleased that the force has reviewed its missing-from-home procedures. These now give clear guidance to officers and staff about what is required of them when a child is reported missing.

The revised procedures make it clear that, when a child is reported missing, a THRIVE assessment will use information held on police systems. Support is available from specialist intelligence support officers within the FCR. The FCR inspector should then review the incident along with the THRIVE assessment, at which point they must decide if it meets the missing-person criteria. The FCR inspector will then assess the level of risk and instigate enquiries. A local supervisor will be informed and resources assigned. The FCR inspector is responsible for making sure the incident is recorded on the COMPACT system.

The procedures are clear that conducting prevention interviews is important, and that failure to carry out a visit may lead to serious safeguarding concerns being missed.

Assessing risk, and the response to missing children is usually good when officers and staff follow procedures

Through our case audits, we found that the FCR response and risk assessment is good. There is clear evidence of FCR inspectors reviewing and confirming the risk grading.

Activity to trace missing children when recorded on COMPACT was usually appropriate to the risk grading, and prevention interviews were being done.

A mother reported her 15-year-old son missing when he didn't return home. She believed he was with other people and thought he might be 'up to no good'. The call-taker did a thorough THRIVE assessment and recognised that the boy might be vulnerable to exploitation. This was properly graded as a medium risk, a COMPACT record was created and the matter passed to an officer to investigate.

The officer made prompt and persistent enquiries that had clear supervisory oversight. This was entered onto the COMPACT record. The following day, the boy contacted his social worker and they arranged to go to the police station. Officers spoke to the boy to understand where he had been and who with. The interview was recorded on COMPACT.

The response is much poorer when procedures aren't followed

Missing episodes aren't always recorded on COMPACT. This is despite the revised procedures making it clear that this must be done. FCR staff often don't create a COMPACT record when a child returns home after a relatively short time.

When this happens, the missing-from-home co-ordinators add the episode to a spreadsheet. They use it to prompt a referral to children's social care services when a child has been missing three times in three months.

The new procedures began in March 2019. We examined the spreadsheet and found more than 100 missing episodes relating to children that hadn't been recorded properly. Many of these children were vulnerable, looked after, frequently missing from home and/or at risk of exploitation.

This means that important information that will be relevant when grading risk in future episodes may not be properly understood, and analysis to understand patterns and trends will be flawed.

Important information from prevention interviews[10] isn't always recorded

If a COMPACT record isn't created, it is because either preventative interviews aren't happening, or they aren't being accurately recorded. This could result in valuable information being missed that could help identify those children who are routinely going missing, particular locations where children are found (often known as hotspots), or those who seek to exploit children.

The force isn't recording and reviewing information from return-home interviews

The local authority provides an independent return-home interview service. These are received in the safeguarding hub and viewed by the local authority missing-persons co-ordinator. During our visit, these weren't being reviewed by officers and staff, and information from them wasn't being added to Niche or used to understand future risks.

Recommendation from the 2018 inspection report

> Within six months, Lincolnshire Police, along with its partner organisations, should undertake a review to examine its referral processes and supervisory oversight, to make sure that risk to children is identified effectively and the necessary information shared appropriately. Particular attention should be paid to:
>
> - the cumulative risk to children experiencing domestic abuse; and
> - children going missing from home or care.

[10] The police have a responsibility to ensure that the returning person is safe and well. The purpose of the prevention interview is to identify any ongoing risk or factors that might contribute to the person going missing again.

Summary of post-inspection review findings

A new police safeguarding hub has centralised some functions. Other agencies support this.

The force now meets regularly with children's social care at strategic and operational levels. This has led to better information sharing in relation to children who go missing from home or care. But the response to children repeatedly exposed to domestic abuse still needs to improve.

Detailed post-inspection review findings

In our 2018 inspection, the way information was shared with children's social care depended on the risk to victims rather than the risk and harm to all children. This meant that risk to children often wasn't recognised and cases weren't being referred to MARAC[11] in line with SafeLives[12] guidance.

In addition, because missing-from-home cases weren't routinely entered onto COMPACT, notifications weren't being sent to children's social care.

The force has created a police safeguarding hub, with centralised functions

As part of the PVPU restructure, the force has centralised some functions to create a police safeguarding hub. Along with making use of its own resources, it has brought together some other agencies. These include:

- Future 4 Me workers from the local authority who provide support to children at risk of exploitation;
- the local authority missing-from-home co-ordinator; and
- independent domestic abuse advisers.

It is clear from our case audits that information sharing is prompt. Sometimes, children's social care updates the force on decisions made that fall below the requirement for a strategy discussion. This is good, as it helps decision making and allows the force to challenge those decisions, if necessary.

[11] 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 it believes 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.
[12] SafeLives is a national domestic abuse charity providing MARAC training, review and evaluation.

Opportunities to intervene when children are repeatedly exposed to domestic abuse are still being missed

The cumulative risk to children repeatedly exposed to domestic abuse still isn't routinely recognised and acted upon. There were some examples of supervisors upgrading the risk level when reviewing DASH PPNs. This may result in a different response from children's social care than otherwise would have been the case. However, in two cases we audited, there were many incidents reported in a short space of time. All were graded as standard risk, which didn't result in any further assessment or intervention.

The force stated that, in these circumstances, the local authority domestic abuse co-ordinator would make a MARAC referral. But we found no evidence either had been referred to MARAC, and there wasn't evidence that a strategy discussion had been considered or assessed by children's social care. This means opportunities for early intervention or protective planning are being missed.

The force plans to introduce Operation Encompass in December 2019. This will see it inform schools when a pupil has been exposed to domestic abuse.

Sharing information about children reported missing has improved, but intervention meetings aren't always held

The force has recognised that not all missing-children cases are recorded on the COMPACT system. To make sure appropriate referrals are made to children's social care, the missing-from-home co-ordinators check the command and control system daily. They then record on a spreadsheet any missing episodes that aren't on COMPACT. This is used with the COMPACT system to identify repeated missing episodes.

When a child has been missing three times in three months, the local partnership procedures state that the local authority and police should consider having a strategy meeting. If it is decided not to hold a strategy meeting, the reasons should be recorded. In any event, the repeated missing episodes should be considered within a multi-agency forum.

Referrals are being sent, but they don't always result in a meeting. In addition, the reasons for a decision not to hold one isn't recorded on police systems. This means that opportunities to work together and reduce the risks faced by particularly vulnerable children are being missed.

The force now holds regular meetings with children's social care at strategic and operational levels

Since our inspection, the force now has regular meetings with children's social care services at strategic and operational levels. This helps everyone understand each other's perspective, discuss issues and agree on change where necessary.

This is encouraging, but was a new arrangement at the time of our revisit, so it was too soon for us to assess its effect.

Post-inspection review findings: Investigation

Recommendation from the 2018 inspection report

> We recommend that Lincolnshire Police review its approach to risk assessment and allocation of cases concerning those suspected of viewing, downloading and distributing indecent images of children.

Summary of post-inspection review findings

The force has reviewed and acted on all the cases we highlighted in our inspection. It has reduced the number of outstanding cases to manageable levels, and is also offering officers and staff more risk-assessment training.

Detailed post-inspection review findings

The force reviewed all outstanding cases and has reduced the number of unallocated cases

We were reassured that, after our inspection, the force reviewed all the outstanding cases and acted on them.

The force has also worked hard to maintain the numbers of outstanding cases at manageable levels. The queue within POLIT had reduced. Twenty-nine cases were awaiting action and none of these was graded as high-risk, which is good.

Officers and staff are having more risk assessment training, but still miss opportunities to safeguard children

The force uses specialist software programmes to track and investigate the sharing and distribution of indecent images of children. It also receives referrals of similar activity from the National Crime Agency's (NCA's) child exploitation and online protection command.

The main goal is to safeguard children. But there were examples of steps not being taken because it was thought that a prosecution would be unlikely. Opportunities to understand risks to children may have been missed in these cases.

The force has arranged for all POLIT officers and staff to have more risk assessment training. This was taking place during our visit.

Demand is set to increase, but there aren't plans to increase capacity

The force is involved in a pilot with the NCA. As a result, the POLIT team will be allocated more cases than before. In the two weeks before our visit, it had received 14 more to investigate.

The force also expects more cases from the NCA through a national operation to target those who distribute child abuse images. This is likely to put more demand on the digital forensics unit, which is already finding it difficult to keep to timescales. Senior leaders should satisfy themselves that they have enough resources to manage the increased demand and maintain performance.

Recommendation from the 2018 inspection report

> Lincolnshire Police should improve its child protection and exploitation investigations, paying particular attention to:
>
> - improving staff awareness, knowledge and skills in this area of work;
> - ensuring a prompt response to any concern raised;
> - undertaking risk assessments that consider the full range of a child's circumstances and the risk to other children; and
> - improving the oversight and management of cases.

Summary of post-inspection review findings

We remain concerned about the standard of investigations. We found cases that lacked effective supervision and missed investigative opportunities. Some decisions to take no further action were made too soon, and there was unnecessary delay in progressing enquiries.

Detailed post-inspection review findings

A restructure was completed in January 2019

In 2018, the force reviewed its resources. It decided to bring together smaller teams dealing with specific types of vulnerability with force-wide responsibility into larger teams. The new teams have smaller geographical areas, but deal with more types of offences.

The force worked hard on this restructure. This included:

- moving many officers and staff;
- changing shift patterns; and
- reviewing flexible working arrangements.

There are now three teams. Each should have three detective sergeants and 19 detective constables.

This means the force can increase the hours that specialist officers are available throughout the week. In addition, workloads should be spread more evenly among officers, giving them more time to deal with investigations.

The force has significantly improved the availability of training for specialist officers

There was a lack of training in 2018. Many officers dealing with child abuse investigations hadn't completed the SCAIDP and the force didn't have a record of who had completed it and who hadn't. Since then, it has created a detective academy that oversees all investigators' training.

The force recognised that bringing together officers from different specialist backgrounds to deal with many types of investigation would have a significant training implication. It therefore commissioned external training services to be able to provide it as quickly as possible. We were told that 90 percent of investigators will have completed this training by January 2020, which is a significant achievement.

Absences within the PVPU are affecting the quality of investigations

Officers and staff in the PVPU told us that there had been a lot of absences since the restructure. This is because many officers are receiving training at the same time, and there have been sickness absences. In addition, annual leave authorised in previous roles now conflicts with leave booked by colleagues in the new teams.

In the week of our revisit, there were ten DCs and two sergeants in Lincoln. This was about half the number of officers there should be.

Officers we spoke to told us that many are still holding enquiries from their previous roles. Because these enquiries are older, they are given less priority than new offences reported.

Investigators feel their workloads are too high and they don't have enough time to commit to their enquiries.

Investigation supervision is poor

Senior leaders' expectations about the standards of supervisors within the PVPU are clearly set out through emails and face-to-face briefings.

A detective sergeant should review each investigation. An investigation plan should be set when it is allocated to an investigator. The sergeant should review the progress of the investigation at intervals of between two weeks and a month. They should then put the details of their review on the Niche system.

The supervisors we spoke to were aware of these expectations, but felt they often didn't have time to comply. Accordingly, we saw very few investigation plans written or endorsed by sergeants, and very few reviews of investigations. This is causing unnecessary delay.

These supervisory expectations don't apply to officers and staff not working within PVPU, such as those in CID or response. Therefore, when those personnel are responsible for investigating child abuse, there is less oversight.

Investigative and protective opportunities are being missed

During our revisit, we audited 13 investigations related to CSE and those involving enquiries under section 47 of the Children Act 1989. Of those, we didn't grade any as good: six required improvement and seven were inadequate.

There were several cases of investigative opportunities being missed or not followed up. There were also examples of a decision to take no further action being made too soon (i.e. before following lines of enquiry that might have led to a better outcome for the child).

In cases where it was believed children were being exploited, there was a reluctance to visit or engage with the child unless they had made a disclosure of abuse. In one case, a PVPU sergeant reversed a decision made at a strategy meeting to carry out a joint visit.

Officers are still reluctant to seize and/or examine devices

Officers remain reluctant to seize devices that might contain indecent images of children. When they are told or believed the images had been deleted, officers didn't arrange for the devices to be examined.

Examining these devices could help identify offenders. It would also mean images could be uploaded on to the national child abuse image database.

As this isn't happening, details of child victims and relevant images aren't being added to the system to help with future investigations. This undermines the police's ability to quickly identify victims, both locally and nationally.

A 15-year-old girl in the care of the local authority reported that she had been raped on ten occasions the previous year by the same man. She provided his first name and an address.

Children's social care told Lincolnshire Police about the report. There was a prompt strategy discussion and the case was allocated to an officer in early August 2019.

During our visit, two months later, there had been no investigative enquiries, a supervisor hadn't reviewed the case and there was no sign that the police had spoken to the child.

A 12-year-old boy was with his grandparents when they received a text message from a third party telling them they had seen the child being assaulted by his stepfather.

Officers attended and spoke to the child. He confirmed he had been assaulted, and officers took photographs of his bruises.

His stepfather was arrested the next day, interviewed and released on bail. But six weeks later, there was no evidence of any further investigative work. The child hadn't been formally interviewed and the investigating officer had reported sick. There was no evidence of supervisory review or consideration of whether the case should be allocated to another officer. During this time, the bail conditions imposed on the stepfather had lapsed.

The force has worked with other organisations to reinstate multi-agency child exploitation (MACE) meetings

MACE meetings are held weekly. Organisations share information about those suspected of being at risk, those who pose a risk to children, and risky places. The aim is to gauge the level of risk, agree a plan and establish who the lead agency should be. When done well, this is a good opportunity for safeguarding organisations to better protect children.

We observed a meeting during our visit and reviewed minutes of previous meetings. There was good engagement from many organisations that could contribute to protective planning. But protective planning and co-ordination was inconsistent.

Before the meeting, there is a screening process. This is when it is decided which case should be discussed at the main meeting. During our visit, one case had taken place three weeks earlier. This case should have prompted an immediate strategy discussion and prompt action, but instead this was postponed until the MACE meeting.

In other cases, there was unnecessary delay in completing disruption work such as serving child abduction warning notices[13] or arresting suspects. This means that children are left at risk.

The force should review this process with other child protection organisations. It must make sure that it is applying its obligations within the statutory guidance *Working together to safeguard children*.

[13] A non-statutory notice issued when the police become aware of a child spending time with an adult 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.

Post-inspection review findings: Decision making

Recommendation from the 2018 inspection report

We recommend that Lincolnshire Police ensure that it accurately records all relevant information and makes it readily accessible in all cases where there are concerns about the welfare of children. Guidance to staff should include:

- what information they should record (and in what form) on their systems to enable good-quality decisions; and
- an emphasis on the importance of ensuring that records are made promptly and kept up to date.

Summary of post-inspection review findings

The force is improving its recording practices by creating guidance documents and making the Niche system better. However, these changes are yet to be fully implemented, and we found little improvement in recording information.

When protective powers are used, authorising officers don't record enough information. Details of protective plans agreed at MARAC still aren't accessible to most officers.

Detailed post-inspection review findings

Officers make good decisions to exercise the protective powers, but recording remains poor

We reviewed three cases where officers had exercised protective powers. Officers understood the use of the power and their decisions were correct. There was also good communication with children's social care services when the power was used, and PPNs were submitted to record concerns and activity.

But authorising officers still don't record when and in what circumstances the power had been retracted, or in what circumstances, or where the child was being cared for. This means officers attending later incidents involving the family won't know what protective measures are in place.

New guidance and better forms haven't yet been introduced

The force has developed a Vulnerability: Everyone's Business guide, which includes information on officers' responsibilities and police protection powers. However, this hadn't been launched when we visited.

The force is also working with Niche developers to improve the PPN form. This is expected to be completed in December 2019.

Most officers and staff still don't have access to the protective planning information agreed at MARAC

During our 2018 inspection, the outcomes of MARAC were recorded on the Modus management system. Most officers and staff didn't have access to this.

Although senior leaders believed MARAC actions were now being recorded on Niche, we found this wasn't happening. This means officers and staff still don't have access to information about joint protective plans that would help in decision making.

Post-inspection review findings: Managing those posing a risk to children

Recommendation from the 2018 inspection report

We recommend that Lincolnshire Police act to reduce the number of outstanding visits to registered sex offenders and, within three months:

- review its approach to providing appropriate information on registered sex offenders to response and neighbourhood officers; and
- make sure there is adequate management oversight of performance and risk.

Summary of post-inspection review findings

The force is better at overseeing offender management. It has achieved this by giving more training to the detective inspector leading the team. It also monitors performance data often. As a result, there are fewer overdue visits and a good standard of practice is maintained.

Work is taking place to improve information shared with neighbourhood policing teams. This is done by using flags and markers on police systems to highlight registered sex offenders (RSO).

Work with neighbourhood teams still needs improvement. But the force is creating a new system that will give officers easier access to better-quality information.

Detailed post-inspection review findings

Restructuring and better oversight have reduced the number of outstanding visits

Restructuring the PVPU means that the detective inspector now leads the MOSOVO team and the POLIT. He has also had training to use the violent offender and sex offender register (ViSOR) system and receives regular performance data. This means MOSOVO oversight is better and senior leaders get clearer information about the team's performance.

As a result, we saw there were far fewer overdue visits during our revisit. There were 165 during our original inspection and 75 when we revisited.

We were pleased to see that more than 90 percent of active risk management assessments were current. This means that the level of risk posed by managed offenders is well understood across the force.

However, the length of time visits are overdue isn't reported, which means some risk isn't properly understood.

Supervision was inconsistent from team to team

There was limited supervisory oversight in some investigations, although one detective sergeant regularly reviews investigations and endorses the investigation plan. They have developed a proforma to help with one-to-one meetings with their team. This gives them a good oversight of current risks to assist in prioritising tasks.

Replicating this approach across the teams would give the detective inspector and senior leaders a more in-depth oversight and a reassurance that their expectations are being met.

Links with neighbourhood teams have improved, but need more development

The force is increasingly using critical registration markers on the addresses of registered sex offender. This alerts the FCR that an offender lives there, should an incident be reported. This means officers going to incidents have more information when making decisions.

In the cases we reviewed, registered sex offenders were flagged on the Niche system to alert officers if they should be checked.

The force has invested in a new intranet-based system. It will allow officers and staff to easily see which registered sex offenders live in the area they are responsible for. The system will also brief officers about the level and type of risk these individuals pose. Although this is several months from being finished, it will significantly improve local officers' knowledge. This will help them make better decisions.

However, contact between offender managers and neighbourhood teams was generally still ad hoc. It is concentrated on bulletins about recent releases from prison, rather than involving neighbourhood resources in risk management plans.

Post-inspection review findings: Police detention

Recommendation from 2018 inspection report

We recommend that Lincolnshire Police should undertake a joint review with children's social care services and other relevant organisations of how it manages the detention of children. This review should include, as a minimum, how best to:

- make sure that children are only detained when necessary and for the absolute minimum amount of time;
- make sure that an appropriate adult attends the police station promptly;
- make sure officers consider the needs of the child and make referrals to children's social care when necessary;
- 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
- when alternative accommodation cannot be found, escalate the issue so as to seek a resolution.

Summary of post-inspection review findings

The force has worked with partner organisations to introduce oversight meetings, which aim to review and improve how it manages the detention of children. It is also trying to create a child-focused culture in custody. It hopes to achieve this by improving training for new custody sergeants, internal messaging and meetings with officers and staff.

Children are usually treated well, and fewer are now detained. But timely attendance of appropriate adults, referral to children's social care, and ways to find other places to stay still needs to be improved.

Detailed post-inspection review findings

The force has worked with others to create a multi-agency oversight meeting

The force has set up a quarterly oversight meeting with agencies that have a responsibility for detained children. This includes children's social care.

Members review decisions about children in custody to make sure they are consistent with guidance and legislation, and look at areas of good practice or that need improvement. The meeting is also an opportunity to challenge practice.

Fewer children are being detained after charge

After our inspection, the force reviewed its training for newly appointed custody sergeants. The changes it made emphasise the importance of treating children as children first when they are detained in custody. This was reinforced to officers and staff through messaging and by managers visiting custody suites to brief all personnel.

As a result, the number of children detained after charge went down from 45 between September 2017 and August 2108 to 28 in the same period the following year. This is a reduction of 38 percent.

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

We found that when children were detained, they were put in detention rooms with CCTV monitoring, away from adults in custody. A healthcare professional was available and saw children when necessary. When an inspector needed to review a child's detention, this was done in person when possible.

However, the submission of referral forms to alert the local authority of safeguarding problems was inconsistent. For instance, we reviewed a case in which a 14-year-old boy was arrested for wounding and for possessing an axe. He admitted to using drugs before arrest, was seen to wrap his T-shirt around his neck in custody and had to be taken to hospital for assessment. A referral form wasn't submitted. This means that in cases where there are clear signs of risk, children may not receive multi-agency intervention or support after leaving custody.

Children still don't receive an appropriate adult's support soon enough

When a child is arrested, an appropriate adult should be asked to attend the police station as soon as possible. This is to support the child's welfare needs, rights and entitlements.

We found that appropriate adults were contacted quickly. However, they generally arrived only at the time of the child's interview, which might well have been many hours later.

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

Custody officers know they must look for somewhere for a child to stay when they have been charged with an offence and refused bail. But this is often left until after charge, instead of being planned for earlier.

This means requests for accommodation are often made very late at night. By then, finding a place for the child would take too long, and it wouldn't be practical (or appropriate) to wake the child to move them. At these times, or when a place

wasn’t found, there was no evidence that it was escalated internally or with children’s social care.

The multi-agency oversight meeting reviews these cases, and organisations are committed to making accommodation available. But children are still being held in police custody when they don’t need to be.

Custody officers are aware that they need to complete a juvenile detention certificate. This explains to a court why bail was refused. These were completed in all the relevant cases we audited.

Next steps

The force has made some progress. But it needs to do more to provide consistently good outcomes for vulnerable children, who need help and protection.

The force continues to focus on child protection matters. However, we remain concerned about the areas outlined in this report. Also, many initiatives weren't in place when we visited. Therefore, we will revisit the force no more than 12 months after the publication of this report to assess its progress.

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