Northamptonshire Police Child Protection Arrangements

Interim inspection findings

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Executive summary

This report summarises the interim findings from the first three phases of a continuing inspection of Northamptonshire Police's child protection services. Fieldwork was conducted by Her Majesty's Inspectorate of Constabulary (HMIC) in January, March and June 2013.

The methodology used during these inspections is detailed in Annex C.

Phase 1: Multi-agency child protection inspection pilot

In January 2013, HMIC inspected the child protection services provided by Northamptonshire Police. This was part of a wider, multi-agency examination of child protection arrangements in the county, with Northamptonshire County Council, health service providers, and probation services also inspected (by Ofsted, the Care Quality Commission, and Her Majesty's Inspectorate of Probation, respectively).

This was a pilot inspection, which aimed to help develop the methodology for a major programme of multi-agency inspection in this area (which is due to start in 2014).[1] Northamptonshire volunteered to take part in the pilot.

HMIC found that Northamptonshire Police was not giving sufficient priority to the protection of children in the county. It was not allocating enough resources to child protection, and staff had received insufficient training in the critical area of safeguarding children. Inspections of the other agencies in Northamptonshire resulted in similar conclusions. The pilot therefore found that child protection arrangements in Northamptonshire were wholly inadequate, and that children at risk within the county were not being properly protected by the police and other agencies.

The failings relating specifically to Northamptonshire Police included:

- unacceptable delays in or failing to share all relevant information about families with partner agencies (for example, children's social care);
- missed opportunities to work closely with partner agencies to protect children at risk of significant harm, and those who were missing from home or care;
- police officers not recognising potential risk to children when they attended incidents (particularly those relating to domestic abuse), and failing to make the necessary referrals to either police child protection specialists or to other agencies, in order to help safeguard these children;
- where further concerns about children were identified, this information was not shared with partners, resulting in missed opportunities for agencies to assess jointly whether there was an increased risk of harm;

[1] This work is the result of recommendations made in the Munro Review of Child Protection, which was published in May 2011, and is available from the Department for Education's website.

- significant delays in analysing seized computers to establish whether they held indecent images of children in cases where child abuse was suspected;
- insufficient staff in the team managing registered sex offenders, resulting in increased risks to children in the county; and
- children being inappropriately detained in police custody after they had been charged with an offence.

As a result of these findings, HMIC wrote immediately to the force and requested details of the remedial action it would put in place to address the issues.

Phase 2: March 2013 re-inspection

Due to the significant concerns about the standard of child protection provided by Northamptonshire Police, Northamptonshire County Council and health agencies visited as part of the January 2013 pilot:

- Ofsted conducted an unannounced inspection of the county council child protection arrangements in late February 2013; and
- HMIC (with the agreement of the Chief Constable and Police and Crime Commissioner) re-inspected Northamptonshire Police at the beginning of March 2013.

The terms of reference for this phase of HMIC's inspection work can be found at Annex B.

In March 2013, we found that the force had developed a plan for how it would improve its approach to child protection. However, this had not been communicated to staff, which had led to them trying to implement changes of their own, based on an incomplete understanding of the findings of the January 2013 pilot inspection.

Although the force had made improvements to some areas of child protection, HMIC considered that more progress should have been made, given the seriousness of the risks posed to some children as a result of the force's failings. We therefore could offer no assurance that the situation for children at risk in the county had improved.

Phase 3: June 2013 re-inspection

In June 2013, HMIC visited the force again, to review whether further progress had been made.

We found that Northamptonshire Police has made extensive changes:

- it has invested significantly in child protection (for example, by increasing the number of staff within its specialist teams);
- it has developed a comprehensive plan designed to ensure the required improvements are made. HMIC considers the timescales in this plan to be realistic, and the priorities correct; and

- chief officers have also worked with strategic leads in partner agencies to develop a joint improvement plan, and have shown a strong commitment to improving the police response to child protection.

Northamptonshire Police has demonstrated that they take child safeguarding seriously. However, there is still much work to do before it can offer assurance that children at risk are being adequately protected.

In particular, all specialist staff need to be trained within the multi-agency safeguarding hub (MASH, see glossary of terms) to identify risk to children. The systems and processes that have been put into place since March 2013 need to be used by all staff, so they make consistent decisions and record information in the same way. Cases also need to be quality assured to ensure proper risk assessments have been completed, and full information passed to children's social care in every case. Frontline officers and staff should receive training to help them understand both the need to safeguard children, and the role they play in recognising risk to a child or children.

Conclusion and next steps

A number of the force's planned improvements will take time to implement – especially those around developing and maintaining greater knowledge in specialist staff, and better educating the entire workforce about their role in child protection. The force is committed to delivering these improvements within agreed timescales**.**

By June 2013, there had been improvements in the child protection arrangements within Northamptonshire Police. Work was still continuing to make and embed these changes across the organisation. The force structure had recently been changed, which should improve the management and governance for child protection work.

However, it is too early to say whether the force is doing enough to protect properly children at risk within the county.

As this is the case, HMIC will conduct a full re-inspection in October 2013, to assess whether there has been sufficient improvement in the way in which child protection is delivered by the force, and if these improvements can be sustained.

Recommendations

Immediately:

The force should continue to review its handling of child protection information within the MASH, to ensure that all referrals where children are at risk of harm are identified for strategy discussions with children's social care.

Researchers within the referral unit and the MASH should receive additional development to assist in identifying referrals where children are at risk of harm.

All Section 47 enquiries (see glossary of terms) should be the subject of structured, recorded and child-focused strategy discussions.
Referrals to children's social care from the Joint Child Protection Team (JCPT) should be of the same standard as those made from the MASH, particularly in relation to the research of police databases and the quality of information supplied.
Within six months:

The force should deliver the actions identified within its improvement plan.

The force should review the newly-introduced custody protocol to ensure that children and young people are not being routinely detained in police custody after being charged with a criminal offence.

HMIC will review the force's progress against these recommendations as part of its re-inspection of child protection arrangements in Northamptonshire in October 2013.

Background and context

The police's role in child protection

The police, working together with partner agencies such as the local authority children's social care, the health service and education department, has a responsibility to protect children from harm. The Children Act 1989 and Government guidance[2] outline how this should happen and what each agency must do to meet this requirement.

In order to ensure that agencies co-operate to keep children safe and look after their welfare, each local authority must establish a local safeguarding children board (LSCB). This has senior representatives from all agencies (including the police), who hold each other to account for safeguarding activities and who ensure that the protection of children remains a high priority across their area.

Every officer and member of police staff should understand their duty to protect children as they go about their day-to-day business. It is essential that officers going into people's homes regarding any policing matter recognise the needs of children they may encounter. This is particularly important when they are dealing with domestic abuse, and other incidents where violence may be a factor. It is also, however, essential that this duty extends to situations where children and young people are detained in police custody.

Other teams within the police also perform important roles in protecting children from harm. Those who manage registered sex offenders and dangerous people living in communities must have sufficient time and capacity to do their jobs effectively. They must be able to visit sex offenders regularly and establish the level of risk they currently pose. Using this information, they can put in place any necessary measures to mitigate this risk. Examples of the measures officers could consider are appropriate housing or mental health support. In Northamptonshire Police, the team performing this role is called the Dangerous Persons Management Unit (DPMU).

Most forces also have a team who analyse computers to establish whether they hold indecent images of children. Again, it is essential that these teams are properly resourced with suitable staff, and that this work takes place as quickly as possible. In Northamptonshire Police, this team is called the Hi Tec Crime Unit (HTCU).

Section 17 cases

Section 17 of the Children's Act 1989 places a general duty on the local authority to safeguard and promote the welfare of children in their area who are believed to be 'in need'. Police may find children who are 'in need' when they attend incidents. They should refer these cases to the local authority.

[2] For example, *Working Together To Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2013.

Section 47 cases

Section 47 of the Children's Act 1989 details the duty placed upon agencies, including the local authority and the police, to make enquiries to safeguard and secure the welfare of any child within their area who is suffering (or is likely to suffer) significant harm.

Multi-agency safeguarding hub (MASH)

In order to deal with cases that are brought to the attention of the police, forces have specialist teams who deal specifically with referrals about children who are suffering or likely to suffer harm. Again, these teams must be adequately resourced with appropriately-trained staff. The teams work very closely with partner agencies (such as the local authority, probation service and health service), and are often located in the same office. This makes it easy for staff to share information, which is essential in the successful protection of children from harm. This kind of joint or multi-agency team is often called a multi-agency safeguarding hub (MASH).

When a section 47 case has been identified, staff from agencies that may hold information about a child or children discuss the case and share what they know. This is called a strategy meeting. Decisions about what is the best way in which to safeguard a child or children are made in this meeting, and must be recorded. Any information which is discovered subsequently must also be shared. This means those actively involved in protecting the child from harm will be in possession of the most complete information available.

Some section 47 cases require further police investigation, and these may be referred to another specialist team dealing specifically with investigations into allegations of crimes against child victims. Again, these teams often work with partners from the local authority children's social care team, and either investigate as a joint agency or as a single agency (see the glossary for an explanation of these terms). In Northamptonshire Police, when a case requires further specialist police investigation it is referred to the Joint Child Protection Team (JCPT), who will make the necessary enquiries into the case.

Phase 1: Pilot inspection

Between 21 and 30 January 2013, a multi-agency child protection inspection pilot was conducted in Northamptonshire. This set out to establish the current standard of child protection arrangements by examining how several agencies (including the police, the local authority, health and probation services) contributed to ensuring the safety of children within the county. The inspection teams comprised inspectors from Ofsted, the Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectors of Probation (HMIP). The force and county council volunteered to be inspected as part of this process.

The pilot inspection identified significant failings in how Northamptonshire Police, Northamptonshire County Council and health providers within the county were working together to protect children. The findings from the pilot were not intended to be placed in the public domain. However, due to the level of concern raised about the standard of child protection in these agencies, it was decided that the results of follow-up inspections to test whether improvements had been made would be published.

The pilot inspection found that Northamptonshire Police was not giving sufficient priority to the protection of children in the county. It was not allocating enough resources to child protection, and staff had received insufficient training in the critical area of safeguarding children. The findings showed the child protection arrangements in Northamptonshire were wholly inadequate, and that children at risk within the county were not being properly protected by the police and other agencies.

Findings from the multi-agency child protection pilot inspection which related specifically to Northamptonshire Police

- When the police referred non-domestic abuse concerns to the children's social care team, opportunities were being missed to work more closely with partner agencies by considering section 47 enquiries. This means that the extent of the risk to children may not have been properly identified or investigated.

- Multi-agency work to support and protect children at risk of harm arising from domestic abuse incidents was hampered by the delay in sharing relevant police information with child protection partners. (Four out of ten records examined as part of the inspection showed a delay of over 25 days between the incident being reported, and the information being shared with the children's social care team). Such delays potentially prolong avoidable risk to the children in the family. Information needs to be discussed with other agencies as soon as possible after a risk of harm has been identified in order to protect children properly.

- In cases where domestic abuse victims were assessed as being at high risk within the Domestic Abuse Stalking and Honour Based Violence (DASH, see glossary of terms) risk assessment, children connected to the victim were not

automatically considered for Section 47 enquiries. This prevented early child protection measures being considered by multi-agency partners, and potentially placed children at risk of being harmed.

- Children and young people who were living in an environment where there was domestic abuse were not being checked by police officers attending incidents to make sure they were safe. Further opportunities to help children were being missed because officers did not recognise and report how they were being affected by domestic abuse incidents. This highlighted a lack of understanding amongst frontline staff attending incidents about the importance of identifying risk and ensuring the welfare of children, and about heir responsibilities in protecting them.

- Police referrals to the children's social care team about children and young people at risk of harm from situations which were not connected to domestic abuse did not always contain all the relevant police information. As a result, information that would have been useful for the children's social care team in determining the needs of the child was missing. It is essential that the children's social care team has all relevant information when assessing the level of risk to a child. Only when it is in possession of all information is it able to understand what risks a child faces and put in place suitable support to ensure the child's welfare.

- Police intelligence indicating children were at risk of significant harm was not always being recognised as such and referred to multi-agency partners. Again, this shows that officers attending incidents were not routinely looking at how children in a household were being affected by an incident, or by their surroundings generally. This means that children were not able to access the services to help and protect them, as the risk they face was not being identified.

- Where further concerns were raised over children already subject to child protection plans, opportunities were being missed to assess jointly any new information which indicated an increased risk of harm. For example, where there were repeated calls to police about a child, a further strategy meeting was not held; instead, the information was passed to the children's social care team. This meant there was no understanding within the police of what interventions had been put in place to protect a child, and no opportunities to challenge why these were not working. There was a tendency for agencies to deal with concerns on their own, as opposed to working with others. This limits both the approaches available to agencies, and the opportunities available for children.

- While the police were generally good at recording cases within section 47 enquiries, on occasions the decisions made and actions agreed within strategy discussions and meetings were not adequately recorded on police systems. This means that if there is a further incident, staff dealing with it would not understand what had happened on earlier occasions, and not possess all the facts of the case when making decisions about the risk to a child.

- The welfare of children was being adversely affected by the delays to the evidential analysis of computers within indecent imagery enquiries. Enquiries

lasting more than six months meant that, in some cases, children were affected by restrictions on seeing family members for excessive periods of time.

- The number of staff within the DPMU was insufficient to be able to ensure that child protection risks were consistently identified, thus potentially exposing children to unnecessary risk. Initial visits to registered sex offenders were not conducted in line with force policy (14 days), gaps existed within intelligence analysis, and mandated visits were not conducted in line with national guidance based on risk.[3] Collectively, this can stop the establishment of effective preventative measures around a convicted sex offender where children are at risk of harm.

- Opportunities to identify children at risk of harm were being missed because the police and children's social care team were not working together on information about missing children. Nor were they not conducting systematic analysis of their information, to identify which children and young people were at risk of harm and to work out the best way to protect them. Such analysis can lead to the identification of children who are at risk of sexual exploitation, and mean that early interventions can be put in place in an effort to prevent this happening.

- The issue of children and young people in Northamptonshire being inappropriately detained in police detention after they have been charged was discussed in a 2011 HMIC report;[4] in January 2013, we found the situation had not improved. Children and young people continued to be detained in police cells, and alternative accommodation arrangements had not been arranged by senior leaders from all agencies at a strategic level. Partners had recognised this as an issue but had experienced problems in effecting a practical resolution as appropriate accommodation had proved difficult to identify.

These findings, taken together, show that insufficient resources and training had been given to child protection by the force, and that too low a priority had been given to this area of risk. This meant that children at risk within the county were not being adequately protected by the police and other agencies.

[3] There are national guidelines on how often people should be visited, based on the level of risk they pose.

[4] *Report on an Unannounced Inspection Visit to Police Custody Suites in Northamptonshire*, HMIC/HMI Prisons, February 2012. Available from www.hmic.gov.uk

Phases 2 and 3: March 2013 and June 2013 revisits

Due to the failings identified during the pilot inspection:

- HMIC spoke immediately with the Chief Constable of Northamptonshire Police, and outlined the issues. This was followed by a letter which asked him to inform HMIC of the remedial action the force proposed to take to improve child protection services. An action plan explaining what the force intended to do, covering the points identified, was provided to HMIC; and
- Ofsted undertook a further unannounced inspection of the child protection services delivered by Northamptonshire County Council on 25 February 2013.

HMIC considered it essential to establish that Northamptonshire Police had responded immediately and effectively to the issues raised within the inspection report, and was taking all possible action to protect children and young people in the county. Therefore, with the consent of the Chief Constable and Police and Crime Commissioner (PCC), HMIC conducted a further inspection of the child protection services provided by Northamptonshire Police in March 2013.

The inspection took into account the findings of the multi-agency pilot inspection; its terms of reference are at Annex B. It found that, while the force had started to make some improvements, far more could have been done within the time that had passed since the initial inspection.

Following regular contact and discussion with the force, HMIC then completed a one-day review visit on 10 June 2013 (at the invitation of the force and PCC), to monitor the progress being made. This revisit consisted of a briefing from senior officers, meetings with operational leads, and the examination of a small number of case records. We found that while further work is still required there has been an improvement in the way in which services are being delivered, with increased staffing levels and commitment from senior officers. However, it was too early to conclude whether these changes are sufficient properly to protect children at risk within the county.

The areas for improvement identified in the pilot inspection are copied below (in boxed text), together with the relevant findings from the March 2013 and June 2013 revisits.

Governance and leadership

In the pilot inspection, there appeared to be insufficient support from senior managers for child protection work within the force. The representation at the Local Safeguarding Children Board Northamptonshire (LSCBN) (see glossary of terms) was at detective chief inspector level, which is of lower seniority than expected. There were no clear plans in place for how the force would improve and maintain child protection arrangements or how partnerships with other agencies should be developed to improve the welfare of children in the county.

The force has developed a comprehensive action plan, which outlines what it is doing in response to each of the issues raised by the multi-agency child protection inspection. The action plan is specific, measureable and relevant, with timescales set for each action. The actions and timescales are realistic, and – if delivered – should address the areas for improvement raised by HMIC.

The force has worked with other agencies involved in protecting children across Northamptonshire in order to produce a joint improvement plan. If fully implemented within the projected timescales, this should deliver the necessary improvements. Chief officers are working closely with leaders in other agencies to ensure the significant change required is achieved.

Chief officer commitment is illustrated by the force representation on the Local Safeguarding Children Board Northamptonshire (LSCBN), which is now attended by the Assistant Chief Constable (ACC) Specialist Crime and Justice. The ACC will also be part of the LSCBN Executive Board, which sets the strategic direction for child protection within the county.

The force is re-structuring the way it delivers policing. This means the ACC will have all specialist investigation staff under his command, including child abuse investigation teams. This will allow him to influence staff and policy directly relating to child protection.

After the restructure, governance within the force for child protection improvements will be through the monthly performance and accountability meeting, which is chaired by the Deputy Chief Constable (DCC). The ACC Specialist Crime and Justice is responsible for delivering the necessary changes, and will be held to account by the DCC at this meeting.

The PCC is aware of the force action plan, and has taken a keen interest in how the force is improving its response. The crime and policing plan produced by the PCC includes details of the force's response to protecting vulnerable people, within which child protection is addressed. This is a clear priority for the force.

At a partnership level, the delivery of the improvement plan will be monitored by the LSCBN during its bi-monthly meetings. The LSCBN has recently appointed a new independent chair.

During the June 2013 review, it was clear from talking with operational staff within the MASH, HTCU, JCPT and DPMU that senior leaders have demonstrated the importance of child protection to staff across the force. Staff understand that child protection is a priority, and feel supported by senior officers. This was a clear improvement on previous visits.

Working with partners

Where the police were referring non-domestic abuse concerns to the children's social care team, opportunities were being missed to work more closely with partner agencies in the consideration of section 47 enquiries.

When HMIC inspected the force in March 2013, progress had been made within the MASH. However, it was clear that the improvements were due to action taken by MASH sergeants (who were working with the information provided by HMIC about how they could improve), rather than being led and directed by senior managers and leaders. The only manager staff had seen since the original inspection was their detective inspector. Staff members were unaware of the recommendations made by HMIC, and were not due to receive the feedback from the multi-agency child protection pilot inspection until 20 March 2013.

The force had started to implement a planned restructure. The new structure provides additional management and oversight of child abuse referrals and investigations. The ACC who oversees child protection has been a senior investigating officer in the past, and so has an understanding of the work of those involved in this area of business. Support for the DCI (PVP) had been put in place through the provision of a second DCI to manage the day-to-day running of the teams, giving the original DCI the opportunity to ensure the required changes are made.

By June 2013, the force had sought new ideas and different ways of working from other forces and partners across England and Wales. This has contributed to improvements in the way the force delivers child protection services. A good example is the working practice within the police referral unit and the MASH, where processes have been streamlined and better risk assessments are taking place. However, there is still a great deal to do to ensure all staff members are operating at the same level and providing a consistently high standard of risk assessment.

Information sharing

Multi-agency work to support and protect children at risk of harm arising from domestic abuse incidents was hampered by the delay of relevant police information being shared with child protection partners.

During the March 2013 inspection, HMIC conducted a review of recent referrals. This found no delays in information being passed to the children's social care team, or in decisions to instigate strategy discussions – a much improved situation. This was also the case when the force was visited in June 2013.

High-risk domestic abuse cases

Where domestic abuse victims were assessed as being at high risk within the Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment children connected to the victim were not automatically considered for Section 47 enquiries. This prevented early child protection measures being considered by multi-agency partners.

There was a general improvement in knowledge and understanding of risk within the teams involved in child protection during the June 2013 visit. However, one of the referrals reviewed showed that a high-risk domestic abuse case where a young child was present had not been the subject of a strategy meeting, or considered for Section 47 enquiries. This remains an area requiring further improvement.

Children in domestic abuse incidents

Children and young people who are living in an environment where there is domestic abuse are not being checked to make sure they are safe by police officers who attended reported incidents. Further opportunities to help children were being missed because officers did not recognise and report on how they are being affected by domestic abuse incidents.

The force understands that frontline and specialist staff require additional development in a range of policing subjects, including child protection. Training sessions are being prepared and will be delivered to all staff.

During the March 2013 re-inspection, a number of incidents were identified where officers had not filled out referral forms outlining their concern about children present at domestic abuse incidents or crimes. In a number of cases, there was no record within the command and control log (the database that is used to record incidents reported to the police) that the safety and needs of children had been considered by officers attending domestic abuse incidents.

Within the JCPT, there was a tendency for staff to focus disproportionately on investigating the offender, as opposed to assessing the needs of the child. Poor recording standards made it difficult to determine either the quality of the risk assessment, or the appropriateness of the action taken to protect the child or children.

Not all staff within the JCPT had been made aware of the findings of the multi-agency child protection pilot inspection, including the findings that related specifically to the team. This meant no remedial action had been taken.

The June 2013 review found a comprehensive learning and development plan, to encompass both specialist and non-specialist officers, had been devised and a number of staff had been trained. HMIC considers the plans to be appropriate and in line with the recommendations made. The training needs to be delivered to and understood by all staff before significant improvement in consistency of approach and decision-making can be evidenced.

Quality of information shared

Police referrals to the children's social care team in respect of children and young people at risk of harm from situations not connected to domestic abuse did not always contain all the relevant police information regarding the child. Information that would have been useful for the children's social care team in determining the needs of the child was missing.

By March 2013, more specialist staff understood the need to include full and detailed research in referrals to other agencies. This was being completed in more cases, and the resulting information meant that a third-party agency, such as the children's social care team, could understand the circumstances of the child. HMIC reviewed a number of referrals, and found that the details recorded created an understandable picture for other agencies to develop and use to inform their decisions.

By June 2013, the quality of research and information on the referral e-mails sent to the children's social care team by the MASH was much improved (for both domestic abuse and non-domestic abuse referrals). This is now of a good standard. However, the standard of research and information sent through by the JCPT was still not of an acceptable standard, and awareness needs to be raised within the team to rectify this issue.

Identification of risk

Police intelligence that indicates children are at risk of significant harm was not always being recognised as such and was not being referred to multi-agency partners. Children were not able to access the services to help and protect them.

During the March 2013 re-inspection, HMIC found that a small number of the referrals submitted by researchers within the MASH to the children's social care team should have been sent to a MASH supervisor, to decide whether a strategy discussion should take place. Incorrect decisions were still being made over whether cases should be managed as a joint or single agency enquiry. However, when referrals were passed to sergeants, they made correct decisions about whether a strategy discussion was needed.

It was clear that working arrangements still required researchers within the police part of the MASH to recognise cases that required a strategy discussion and bring them to the attention of their sergeant. When they failed to recognise such concerns, the information was passed directly to the children's social care team, and no assurance work was carried out to check the quality of their decisions. The sergeants did not have the capacity to conduct quality assurance checks on their researchers' work, or to work with them to develop their own understanding and inform their decisions.

There were three specific examples where, because risk had not been identified by police, action to protect a child had not been taken as quickly as possible:

- a 13-year-old girl was at risk of being sexually exploited. However, three weeks elapsed without any action being taken to protect her;
- a four-year old boy was taken to a place of safety under police protection powers. It was unclear what the police and other agencies had put in place to make him safe, and there was little recognition of the risks he faced. The enquiry lacked supervisory scrutiny, and missed opportunities to conduct a multi-agency enquiry; and
- in a third case a number of potential risks had not been considered, and enquiries that could have established this were not carried out. The case was finalised too soon, without the true level of risk being determined.

Cases requiring immediate action are sent directly from the MASH to JCPT for investigation, without MASH researchers conducting any research (to ensure this does not delay the referral). The officer allocated to conduct the enquiry is expected to complete the research and add the findings to the investigation log. Within the JCPT, the quality of information was found to be less comprehensive, and did not contain all

the relevant information in a presentable form. This was in stark contrast to those examined in the MASH.

However, there were section 47 enquiries where good, thorough work had been carried out. In these, cases strategy discussions were well recorded, the action taken was thorough, prompt and effective. It was apparent that there had been good supervisory involvement to quality assure the action that had been taken. In June 2013, there were plans in place to disseminate this good practice as part of specialist staff training.

Children subject to child protection plans

Where further concerns were raised over children already subject to child protection plans, opportunities were being missed to assess jointly any new information which indicated an increased risk of harm. There was a tendency for agencies to deal with these concerns on their own as opposed to working with others. This limits the approach by agencies, and the opportunities available for children.

By March 2013, there were an increased number of strategy discussions between police and the children's social care team. However, not all of the cases where HMIC considered a strategy discussion should have taken place had been the subject of one.

For example: there was no strategy discussion in a case where there were repeat concerns relating to a child within a relationship affected by domestic abuse. The initial decision to refer the child to the children's social care team as a 'child in need' was assessed as being appropriate. When further incidents occurred, further referrals were made but there was a lack of assessment of all the cases taken together. There was no challenge or enquiry to ascertain what action the children's social care team was taking to initiate a strategy discussion.

In June 2013, there were occasions when this continued to happen in respect of other cases.

Record-keeping

Case recording within Section 47 enquiries was generally good within the police, however on occasions decisions made and actions agreed within strategy discussions and meetings were not adequately recorded on police systems.

In March 2013, strategy discussions were not always being recorded within the case papers. It was therefore difficult to be sure an effective discussion had taken place. Of the six section 47 cases reviewed by HMIC, only two had information recorded that indicated a strategy discussion had occurred.

Where strategy discussions were not recorded, there was a lack of clarity about the objectives of the enquiry, what the police had done or needed to do, the actions agreed, and the timescales involved. In those cases children may have been unnecessarily exposed to risk, and protective measures were not provided as quickly as possible.

In June 2013, the level of detail recorded and the frequency of strategy meetings was better; but this improved approach needed to be applied consistently.

Evidential analysis of computers

The welfare of children was being adversely affected by the delays experienced during the evidential analysis of computers within indecent imagery enquiries. Enquiries lasting in excess of six months meant that, in some cases, children were affected by restrictions on family members for excessive periods of time.

During the June 2013 review, HMIC found that the HTCU had taken action to support and protect children. All cases where there were outstanding child protection issues, for example where computers had been seized during a child abuse investigation, had been reviewed. Each of these is now being dealt with by staff from the unit. Child protection is now given greater priority during the assessment of submissions where decisions are made about which equipment should be analysed first. This should mean that where child abuse is suspected, delays are minimised.

Dangerous Persons Management Unit (DPMU)

The DPMU did not have sufficient staff to ensure that child protection risks were consistently identified thus potentially exposing children to unnecessary risks. Initial visits were not conducted in line with force policy (14 days), gaps existed within intelligence analysis, and mandated visits were not conducted in line with national guidance.

By June 2013, additional resources had been provided to the referral unit, the MASH and the DPMU. New staff members are receiving training and development to meet the requirements of their new roles. There is continuous monitoring of workloads to ensure there are sufficient staff members to manage the cases that are being referred.

The force is exploring the use of appropriately vetted and trained volunteers to work alongside officers in the DPMU, in order to make better use of resources and enable staff to complete more regular visits to sex offenders. Those offenders who are regarded as presenting a lower level of risk to the public may be visited and monitored by trained neighbourhood staff. These measures should improve the management of sex offenders in the county. However, this change has yet to take place, and will need to be reviewed to establish whether it is successful.

Missing children

Opportunities to identify children at risk of harm were being missed by police and the children's social care team not jointly working on information about missing children. The children's social care team and police were not conducting systematic analysis of their information to identify which children and young people were at risk of harm and to work out the best way to protect them.

During the March 2013 inspection, the force had agreed to contribute towards the funding of a new manager for the MASH. This should improve joint working and raise standards.

Children held in police detention

Children and young people continued to be detained and alternative accommodation arrangements had not been addressed at a strategic level. Multi-agency partners had recognised this as an issue, but had experienced difficulties in effecting a practical resolution.

By March 2013, a new procedure for securing beds for children detained in custody after they have been charged had been introduced. The children's social care team had sent the force information about the new procedure on 25 February 2013, with the information being circulated to custody staff on 4 March 2013. It was however too soon for HMIC to assess the success of the new system.

Two occasions were identified (on 18 and 25 February 2013) when the same 15-year-old child was detained in police cells after charge because accommodation could not be provided by the local authority. On both occasions, custody staff contacted the Emergency Duty Team (EDT, the department which deals with these requests outside normal office hours when the children's social care team is not available), and requested that accommodation be provided. The EDT was unable to provide suitable accommodation on either occasion.

There are no juvenile detention rooms within the Northampton custody centre.

In the June 2013 review, the response to children who are required to be kept in custody after being charged had improved. A much clearer understanding exists between the police and local authority. The protocol introduced in February 2013 is reviewed regularly, and continuing dialogue between key agencies is dealing with any difficulties as they are identified. This will need to be reviewed to establish whether the new arrangements are working, and providing the required accommodation for children.

Conclusions

The initial pilot inspection into child protection arrangements in Northamptonshire showed that Northamptonshire Police needed to make significant improvements to the way in which it worked in this area of high risk activity. The inspection highlighted a number of specific actions which needed to be acted upon as a matter of urgency, and others which required action over the coming months.

In response to the findings of the pilot inspection, the force has developed a comprehensive action plan that has been assessed as being able to deliver the required improvements. The timescales appear to be realistic, and actions have been prioritised appropriately.

In addition, chief officers have worked with strategic leads in partner agencies to develop a joint improvement plan. This will help ensure the approach to protecting children in the county is coherent and consistent.

Governance arrangements within force and the LSCBN will monitor and comment upon progress. The delivery of the plan within the timescales appears achievable.

The force has displayed a significant commitment to improving its child protection arrangements. The chief officer team has provided additional resources and demonstrated the importance of this aspect of policing to all members of the force, through direct support to the specialist teams and messages to the force about their role in child protection.

The force has sought out best practice from across England and Wales. It is now developing new working arrangements to provide children and young people with a good level of support and protection.

The force has made a positive contribution to child protection in Northamptonshire by establishing the MASH, and locating police and children's social care team resources together in the Criminal Justice Centre. Similarly, the decision to make the ACC the force's representative on the LSCBN is seen as an important statement, illustrating the force's commitment to multi-agency child protection working.

During the re-inspection in March 2013, there appeared to be a lack of contact between the senior leaders and operational staff within the MASH and JCPT. Staff were largely unaware of the findings from the multi-agency child protection pilot inspection (despite the information being provided to the force on 1 February 2013). By June 2013 this situation had been remedied with improved communication between leaders, managers and staff. This needs to be maintained.

Discussion between police and children's social care team staff was also found to be patchy during the March 2013 inspection. Some cases did not show any consultation with the children's social care team, while others showed some involvement but failed to indicate what the children's social care team were going to do when the case was passed to them. The quality of the information supplied, its timeliness, and the use of

strategy discussions for referrals made to the children's social care team in respect of children affected by domestic abuse have all improved since the multi-agency pilot inspection; but this must happen consistently across the specialist teams.

Improvement activity continues in key areas, such as the MASH, JCPT and custody. Within the MASH the outcomes for children and young people have improved and joint working is more apparent. However, there are areas where progress has been slower than expected, and significant improvements have not yet been made. For instance, HMIC found:

- a number of cases where strategy discussions should have been conducted within the MASH (but were not);
- a lack of domestic abuse risk assessment information on referrals to the children's social care team; and
- a lack of recording of strategy discussions within the JCPT.

HMIC also identified a small number of cases where children may have been exposed to an avoidable risk of harm. These cases were highlighted to the force for immediate remedial action.

Further improvements should be made to increase the levels of knowledge of police researchers within the MASH. This should improve their ability to identify risk, and help ensure staff from both agencies feel confident in challenging decision making.

HMIC found a number of examples where good quality child protection enquiries had been completed, and children were promptly and effectively protected by the police and the children's social care team working together. Officers had also been involved in thorough section 47 strategy discussions, which had led to children being protected and evidence for criminal investigations gathered.

However, in other cases there were significant gaps in how the police had responded. For instance, the March 2013 inspection found strategy discussions were not recorded in four out of six cases reviewed, and that the same cases lacked structure and a full understanding of the risk being faced by children. As a result, the response put in place by police and the children's social care team to manage risk was slow. It was not possible to review this further during the June 2013 re-visit, but it will be an area of focus for the planned re-inspection in October.

A new protocol to provide accommodation for children and young people who need to be detained after charge has been introduced. The information was passed to police custody staff in early March 2013. It was however too early for HMIC to assess the success of the new system.

A number of improvements will take longer to implement, although the force is committed to delivering these within agreed timescales. HMIC will re-inspect the child protection arrangements in Northamptonshire Police in October 2013, to ensure that there are further improvements and that children and young people in the county are adequately protected by the police.

Recommendations

Immediately:

The force should continue to review its handling of child protection information within the MASH to ensure that all referrals where children are at risk of harm are identified for strategy discussions with the children's social care team.

Researchers within the referral unit and the MASH should receive additional development to assist in identifying referrals where children are at risk of harm.

All Section 47 enquiries should be the subject of structured, recorded and child focused strategy discussions.

Referrals to the children's social care team from the JCPT should be of the same standard as those made from the MASH, particularly in relation to the research of police databases and the quality of information supplied.

Within six months:

The force to have delivered the actions identified within its improvement plan including:

- Training front line and specialist staff to identify children at risk and understand their role in protecting them;
- Training all staff to identify high risk missing people and child sexual exploitation
- Achieve consistent recording on police systems;
- Achieve consistency in the quality of information passed to the children's social care team from all teams;
- Development of all JCPT and MASH managers to ensure they have the required knowledge for their roles.

The force to review the new custody protocol, to ensure that children and young people are not being routinely detained in police custody after being charged with a criminal offence.

A further HMIC inspection is scheduled during October 2013 to assess further whether Northamptonshire Police has delivered the necessary improvements to child protection.

Annex A: Glossary

Children at risk of significant harm – A child is defined as being at risk of subject of significant harm where there is ill-treatment or impairment of health or development:

- 'ill-treatment' includes sexual and emotional abuse as well as physical abuse;
- 'health' means physical and mental health;
- 'development' means physical, intellectual, emotional, social or behavioural development;
- 'significant harm' turns on the question of the harm suffered by a child in respect of his health and development compared with the health and development reasonably expected of a similar child. (Children Act 1989, section 31(10))

Children in need – A child is defined as being a child in need if:

- He is unlikely to achieve or maintain, or have the opportunity of achieving, or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority; or

- his health or development is likely to be significantly impaired, or further impaired, without the provision of such services;
  or
- he is disabled. (Children Act 1989, section 17(10))

Child protection plan – When a child protection case conference decides a child or young person is at risk of abuse or support they are known as a 'child subject of a child protection plan'. This plan outlines what each agency will do to keep a child or children safe.

Children's Social Care (CSC) – The dedicated team within a local authority social care department which deals specifically with children who are in need or at risk.

Dangerous Persons Management Unit (DPMU) – A specialist team which manages those who are required to register on the sex offenders register, as well as other people who are categorised as 'dangerous'. This team will undertake visits and otherwise manage sex offenders, informed by the level of risk they pose to communities.

DASH risk assessment – Domestic Abuse Stalking and Honour Based Violence risk assessment is made up of a number of questions (based on academic research and work with victims of domestic abuse), which are designed to identify the level of risk faced by a victim of domestic abuse. These are usually categorised as standard, medium and high risk.

Joint Child Protection Team (JCPT) – A specialist team comprising police and children's social care staff who complete further investigations to establish whether a child is at risk, and deal with the protection of children from harm.

Joint or Single agency investigations – Where a case requires further investigation a decision is made during the strategy discussion to determine who should do this. In some cases, for example where a crime has been committed, the case work is likely to be completed by the children's social care team and police working together. In other cases (where, for example, parenting skills are highlighted as an issue within a family), this would be dealt with by a single agency (i.e. the children's social care team)

Multi Agency Safeguarding Hub (MASH) – A joint or multi-agency team comprising children's social care workers, police and other agencies (such as local health, probation and education services). Within these teams, staff members are able to share information easily, which is essential in the successful protection of children from harm.

Section 17 enquiries – Section 17 of the Children's Act 1989 places a general duty on the local authority to safeguard and promote the welfare of children in their area who are believed to be 'in need'. Police may find children who are 'in need' when they attend incidents. They should refer these cases to the local authority.

Section 47 enquiries – Section 47 of the Children's Act 1989 sets out the duty placed upon agencies, including the local authority and the police, to make such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard and secure the welfare of any child within their area who is the subject of an emergency protection order, or is in police protection, or if they have reasonable cause to suspect is suffering or likely to suffer significant harm.

Strategy discussions – When a section 47 case has been identified, staff from agencies that may hold information about a child or children (for example the police, the health service and the local authority) discuss the case and share information. This is called a strategy discussion or meeting. Decisions about what is the best way in which to safeguard a child or children are made within this meeting, and must be recorded.

Annex B: Terms of reference for the March 2013 re-inspection

- Review how the force has responded since 1 February 2013 and assess if it has taken timely, appropriate and effective action to improve how it works to protect children and young people.

- Review the force's proposed improvement plan to assess the viability and sustainability of delivering the improvements required.

- Examine how the force intends to implement the action plan and assess if the steps planned will provide the intended outcomes within the projected timescales.

- Review how the force manages information relating to children affected by domestic abuse incidents and crimes, in particular the timely transfer of information to and decision making with children's social care team staff.

- Review how the force manages information relating to children suspected of being at risk of harm; in particular, the timely transfer of information to and decision making with children's social care team staff.

- Review the performance of police resources within the Northamptonshire MASH; in particular the research of previously recorded information, the identification of risk and joint working between police and children's social care team staff.

- Review the quality of section 47 joint investigations conducted by the police and other key partners, to determine if the police are contributing fully and ensuring that children and young people are fully protected.

- Examine the arrangements in place to manage the accommodation needs of children and young people who are required to be detained after charge.

- Identify steps the force has taken to develop how agencies work together to ensure children are helped and protected more effectively.

Annex C: Methodology

This report summarises the interim findings from the first three phases of a continuing inspection of Northamptonshire Police's child protection services. Fieldwork was conducted by HMIC in January, March and June 2013:

- the first phase was part of a wider, multi-agency examination of child protection arrangements in the county. The agencies involved in the inspection were Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Probation and HMIC; while
- The second and third phases were single agency visits by HMIC.

During the visits to Northamptonshire Police, the methodology used by the inspection teams included an examination of different types of police incidents and case files, a review of relevant documents and interviews of key individuals including police managers and supervisors.

HMIC examined the following case files during the multi-agency inspection:

- 25 cases relating to children known to Child Social Care across different levels of concern. The cases were identified by Ofsted from within Child Social Care records and the relevant police reports and records were reviewed;
- ten domestic abuse incidents or crimes where children were part of the family;
- ten crimes or incidents where children were identified as being in need of support or at potential risk of harm;
- five high-risk domestic abuse cases where children had been identified as being part of the family, including any multi-agency risk assessment conference (MARAC) minutes;
- five multi-agency public protection arrangements (MAPPA) Level 1 or 2 cases where children had been identified within the risk assessment or risk management planning;
- five Missing Children cases where children had been identified as being at risk of harm;
- five custody records or arrest records where children or young people had been detained under Section 136 of the Mental Health Act 1983; and
- five custody records where children and young people had been remanded in custody post-charge.

HMIC reviewed the following documents during the multi-agency inspection:

- minutes of force governance meetings on child protection, for the preceding 12 months;

- minutes from the Local Safeguarding Children Board, for the preceding12 months;
- force policy on child protection;
- force guidance/procedure document(s) on child protection; and
- performance documents that related to child protection for the preceding six months.

HMIC reviewed the following case files during the single agency inspections:

- domestic abuse incidents or crimes where children were part of the family;
- cases where children had been identified as suffering or likely to suffer significant harm (section 47);
- custody records where children and young people had been remanded in custody post-charge; and
- multi-agency public protection arrangements (MAPPA) Level 1 or 2 cases where children had been identified within the risk assessment or risk management planning.

HMIC reviewed the following documents during the single agency inspection:

- Northamptonshire Police Improvement Plan; and
- Northamptonshire Police document pack supplied June 2013.