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National Child Protection Post-Inspection Review

Northumbria Police
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Introduction

The 2018 inspection

In January 2018, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) conducted a child protection inspection[1] of Northumbria Police.[2]

This inspection found that the chief constable, his command team and the police and crime commissioner (PCC) shared a clear commitment to child protection. The force had also placed great emphasis on improving the awareness of officers and staff about their safeguarding responsibilities.

Two years before this inspection, in 2016, Northumbria Police had established a new safeguarding department to enhance the co-ordination and provision of services, and to provide better outcomes for both children and adults. A new operating model was agreed in November 2017 and, as part of that change, specialist safeguarding functions (including child protection) had received extra resources and investment.

The commitment to protecting children was evident throughout the force. Officers and staff understood it clearly, and it was reflected in the changes made through the new operating model. We found examples of good work by individual frontline officers responding to incidents involving children, and that the specialist officers and staff responsible for managing child abuse investigations were knowledgeable, committed and motivated. There was also good engagement with partner agencies across the six local authorities.

However, we identified some inconsistencies in the service the force provided to children, and some areas that needed to improve to ensure that the outcomes for children who required help and protection were of a consistently high quality. In particular, we had concerns about:

- the management of missing children assessed as at 'no apparent risk' (absent);[3]

[1] For more information on our child protection inspections, see our website.

[2] 'Child' in the report refers to a person under the age of 18.

[3] This category is typically intended for a person who is not at a place where they are expected or required to be and is assessed as at no apparent risk.

- delays in the attendance of appropriate adults;[4]
- children being detained in police custody;
- inconsistencies in the recording of actions (such as safeguarding and planning decisions); and
- the responses to children at risk of child sexual exploitation (CSE).

In June 2018, we published a report on our findings. This included a series of recommendations aimed at improving the service provided to children in Northumbria.

The 2019 post-inspection review

In 2018, the force gave us its action plan, which set out how it intended to respond to our recommendations. Since then, we have continued to monitor the force's improvement work.

In January 2019, we conducted a post-inspection review to assess the force's progress. The review included:

- an examination of documents, including policies and action plans;
- interviews with officers, managers (including senior managers) and staff; and
- an audit of 37 child protection cases (specifically on the areas for improvement set out in the 2018 report).

Summary of findings from the post-inspection review

Although the force still needs to make further improvements to child protection practice in some areas, it has taken steps to address the recommendations we made in the 2018 report.

We found that the force continues to be committed to reviewing and improving its approach to child protection. An example of this is the decision to remove the use of the no apparent risk (absent) category for missing children, following our previous inspection findings about the force using it inappropriately. This is positive.

Additional training and better supervision are further improving staff awareness of their safeguarding responsibilities. However, we remain concerned that, in a number

[4] Under section 63B of the Police and Criminal Evidence Act 1984, an appropriate adult is a parent, guardian, social worker, or any responsible person over 18 years old who is not a police officer or a person employed by the police.

of cases we saw, there was evidence that the force under-estimated the risks faced by a child, which led to inappropriate decisions about what should happen next.

We found delays in responding to reports of children being exploited online and in completing digital forensic examinations. However, we were pleased to find that the quality of investigations of CSE cases that do not involve the internet has improved. The force is working with a previous victim of CSE to use her experience to support training about exploitation. This has improved the way the force recognises and responds to children at risk.

We were pleased to find that, when a child is detained and charged with an offence, custody staff recognise that they should be transferred to alternative accommodation provided by the local authority and are requesting this. However, we were concerned to find that, in all but one case where this was requested, the child remained in custody because no accommodation was available. This means that children continue to be detained unnecessarily, which is not in their best interests.

In our 2018 inspection, we found that the force had worked with its partners to build effective arrangements for sharing information about children and for collaboratively making decisions about how best to protect those in need of help. Despite increasing demand, we found the force continues to work closely with its safeguarding partners across the counties of Northumberland and Tyne and Wear to improve the protection of children.

Statutory partnership arrangements at a local authority level have changed across England since our initial inspection.[5] The force has responded well to this, working with its partners through the early adopter programme[6] to establish how the new arrangements will work in Northumbria. We found that senior leaders have taken a lead role in the development of proposals for a consistent approach to safeguarding children for all six local authorities within the force area. More work is required to implement these proposals but this innovative approach could provide a good foundation for more effective sharing of information, decision making and protective planning.

The focus on safeguarding and working to improve outcomes for children that we found in 2018 remains, supported through projects such as ‘Think through the eyes

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[5] The Children and Social Work Act 2017 replaces Local Safeguarding Children Boards and requires each safeguarding partner in a local authority area (specifically the local authority, the clinical commissioning group and the chief officer of police) and any relevant agencies (schools, for example) to make arrangements that they consider appropriate to work together in exercising their functions. The arrangements must include those for the safeguarding partners to work together to identify and respond to the needs of children in their area.

[6] Early adopter projects, funded by the Department for Education, Department of Health and Social Care and Home Office, are working to develop and implement new arrangements for multi-agency safeguarding as set out in *Working Together* 2018.

of a child', which concentrates on the impact of domestic abuse on children. We also found examples of good work by individual officers responding to and investigating incidents – but this was not consistent in all the cases we reviewed.

In 2018, we found that the force needed to include more information on the outcomes for children at risk of harm as part of its oversight of performance. At that time, the available information was limited, partly because the force's IT system did not make it easy to access. However, we also found that performance information was focused on the number or timeliness of child protection incidents, rather than on whether the decisions being made were the right ones. This meant that senior leaders could not reassure themselves that the nature and quality of decision making were in line with their expectations.

On our revisit, we found evidence of refreshed and well-defined governance arrangements with clear processes for agreeing priorities and ensuring oversight. However, some of the limitations we found in our initial inspection remain. Some of these continue to be because of the IT system. The force has made interim alterations to its system to improve the situation, but more needs to be done to ensure that the alterations are having the desired impact. As a longer-term solution, the force has commissioned a new IT system. This is being designed to improve access and availability of data.

While the force has undertaken dip sampling of some cases to understand the quality of investigations, current performance and internal audit and assurance measures remain under-developed. Senior leaders therefore still do not have sufficient information about the quality of the decisions made to protect children or whether outcomes for them are improving.

The force recognises that further work is required in this area. We are confident that it will continue to refine its ability to test, and thereby improve, the quality of its response to children in need of help.

Northumbria Police has taken some important steps to improve its practices since our 2018 inspection. It must maintain this momentum and, in particular, make sure that it is compensating for the problems caused by its current IT system while the new one is being developed and implemented. More widely, the force should continue to make progress against our recommendations in order to provide a more consistent response to children in Northumbria who are in need of its support and protection.

Post-inspection review findings

Initial contact

Recommendation from the report of the 2018 inspection

> Within three months Northumbria Police should review its processes to ensure officers and staff draw together all available information from police systems to inform their responses and risk assessments about missing children.

Summary of post-inspection review findings

In 2018, we found some good examples of officers responding quickly to clear and specific concerns about children. When appropriate, officers completed a child concern notification to make a referral to children's social care services. However, we found that the quality of THRIVE[7] risk assessments was inconsistent and the decisions made by the resolution without deployment (RWD)[8] team when children were reported missing lacked supervision. There was a lack of consideration given to the wider risks posed. In particular, a significant number of looked-after children were classified as being at no apparent risk (i.e. absent rather than missing).

In 2019, we found that the force had provided new and additional training to staff to enable them to recognise and respond to risk more effectively. We also found that this training placed emphasis on ensuring that the police response was child focused. In addition, we found evidence of improved supervision of child protection incidents and improvements to the way in which children who are reported missing are responded to.

Detailed post-inspection review findings

The force has continued to invest in training its officers and staff

The force has continued to invest in training its officers and staff about their role in safeguarding and has produced further packages to support this. Examples include:

- the 'Think through the eyes of a child' project, providing training and awareness campaigns to reinforce the message about considering the impact on children who live in homes where domestic abuse takes place regularly;

[7] THRIVE is a risk-assessment tool that considers six elements to assist in identifying the appropriate response grade based on the needs of the caller and the circumstances of the incident, namely: threat, harm, risk, investigation, vulnerability and engagement.

[8] The RWD deals with incidents that have had a THRIVE assessment identifying the threat, harm and risk as low, and the likelihood of reoccurrence of any threat of further harm as low.

- use of the acronym ‘VIP’ in communications and on internal posters to reinforce the message that safeguarding is everyone’s business and involves protecting the vulnerable, providing quality investigations and applying problem solving; and
- adopting a ‘Mastermind’-style quiz whereby senior officers, including the chief constable, face a series of questions that cover safeguarding topics among others. The force puts video clips from these on its intranet for officers and staff to view.

The force has provided additional training and guidance on both THRIVE and a RE-THRIVE process to all officers and staff who work in the communication centres and at police enquiry counters. This has been complemented by the introduction of THRIVE champions to help spread and support the use of THRIVE, and by audits of THRIVE that the force made in May, September and October 2018.

There is an evident improvement in communication centre staff’s use of THRIVE to assess threat, risk and harm in order to determine the best response to an incident. The force reported that the use and recording of THRIVE that met the required standard had increased from 59 percent to 92 percent during the period November 2017 to September 2018. The force has also seen increases in the number of incidents where officers and staff have identified vulnerability.

A 17-year-old boy who was in the care of the local authority had been reported missing twice in months, after failing to return for his curfew.

Both times, the call handler carried out a good assessment using THRIVE. This resulted in officers being allocated to find the child. There is a clear record of the identified risk, together with the tasks and actions raised to locate the child.

A child concern notice was completed on the boy’s return, which led to a multi-agency meeting to agree how to safeguard and support him. This activity was appropriately recorded in his police records.

There is improved supervisory oversight

There is now improved supervision of developing incidents and staff are documenting the summaries of assessments, the instructions to officers and the actions that officers take. Specifically, in cases of missing children, we found evidence of officers and staff applying THRIVE at the point of contact to inform their decision making.

Reports of missing children are now all investigated by response teams that have received training

In the past, we reported that there was insufficient oversight of the decisions that the RWD team made when children were reported missing. The team also failed to consider the wider risks, which resulted in a significant number of looked-after children being classified as at no apparent risk (i.e. absent rather than missing). The team no longer manages reports of missing children and, as we mentioned earlier, the force has ended the use of the no apparent risk (absent) category for children. It now assesses children as being at high, medium or low risk of harm.

Response teams now investigate all 'missing' cases. All these teams have been trained to understand that they should treat a missing episode as an investigation and should submit child concern notifications for all missing incidents.

Assessment and help

Recommendation from the report of the 2018 inspection

> Within three months, Northumbria Police should improve its practice in cases of children who go missing from home. As a minimum, this should include improving officers' and staff awareness of:
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> - their responsibilities for protecting children who are reported missing from home and those cases where it is a regular occurrence;
> - the links between children going missing from home and the risk of sexual exploitation; and
> - the significance of drawing together all available information from police systems, including information about people who pose a risk to children, to better inform risk assessments.

Summary of post-inspection review findings

In 2018, we found that the force was working with partner agencies to develop multi-agency safeguarding arrangements within all six local authority areas in Northumbria. At that time, these arrangements were at different stages of development and, as a result, there were a range of practices in place to manage referrals about potential risks to children.

We were concerned about the protection provided to some children who regularly go missing from home. We found that the force's assessment of risk often focused on the most recent missing episode, rather than taking account of information that it held about previous incidents.

In a significant number of the cases we reviewed, there was no record of any police involvement in the assessment of longer-term risk or in the development of protective plans. Moreover, there was often no evidence of a strategy discussion or meeting having taken place, and no detail of what (if any) joint assessment of need had been made.

In 2019, we found that while the force's response to missing children is improving, it is still inconsistent. Senior officers recognise that they need to do further work in this area.

There is limited capacity for missing person co-ordinators to problem solve. However, the force has introduced a new approach to sharing information with schools about children who go missing.

There is improved attendance at initial child protection conferences (ICPCs)[9] with three local authority areas seeing 100 percent attendance.

Detailed post-inspection review findings

The response to missing children is improving but is still inconsistent

Although the force is making progress, it still does not demonstrate consistent practice and recording. Senior officers recognise that they need to do further work in this area. They propose to dip sample cases to get a better idea of where they need to do further work.

In risk assessments for missing cases, we found minimising language such as "it is a lifestyle choice", "this is not unusual behaviour" and "she regularly goes missing". This fails to recognise either cumulative risk or the links between sexual or criminal exploitation and repeat missing episodes. We can see the impact of this culture in cases such as the following.

[9] An ICPC enables professionals to form several partner agencies to meet and share information about a child for whom there are significant harm concerns.

A 17-year-old boy was reported missing. He was a looked-after child (a child in the care of the local authority) with markers for being suicidal, he was at risk of sexual exploitation and he was on a child protection plan.

Police systems showed that 84 previous child concern records had been submitted and there were 59 missing records.

On the last two occasions the boy was reported missing, he was assessed as low risk. The supporting rationale stated that he was a 'streetwise' young man and posed no threat to himself or others. This was despite over 150 pages of information about risk on the police systems that indicated otherwise.

Reviews by response sergeants were present on every record we examined but the quality of these was inconsistent and did not challenge the minimising language we saw. In addition, when the force receives new information that increases the risk to a child, this is not always reflected in a review of the current level of risk. However, we found that subsequent reviews undertaken by specialist detective supervisors were comprehensive, identifying actions to be taken and recognising risk.

The force's missing from home policy outlines a requirement for a superintendent's authorisation to close a missing record if police have not interviewed the child. We found some cases where officers had not recorded this authorisation but had closed the record. Examples included cases where a social worker had seen a child during a missing episode but the child had either not returned home or had returned but had not been interviewed by the police.

A better understanding of why a child has run away can give vital information to agencies and make it possible for them to develop more effective risk-management plans for future safeguarding. Information gleaned from partnership return home interviews[10] with children was not evident on records we saw and there was no indication of anyone having conducted prevention interviews.[11] Interviews with children at this stage can provide a wealth of information about the reasons why they are running away, particularly when they are starting to run away more frequently.

We are concerned at the number of calls that the force control room had received and flagged as missing person cases but which officers had finalised without raising a missing record. In 2018, the force closed 2,358 records as a missing person case without raising an associated missing investigation report. The force is aware of this

[10] Independent return interviews provide an opportunity to uncover information that can help protect children from the risk of going missing again, from risks they may have been exposed to while missing or from risk factors in their home.

[11] 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 may contribute to the person going missing again.

and undertaking further analysis. It needs to find out why this has happened and assess whether there are any incidents that should have resulted in a missing person report, or if this is a recording or classification problem.

There is limited capacity for missing person co-ordinators to problem solve

At present, the force has two missing person co-ordinators. This will increase to three in future. The co-ordinators say there is still a capacity problem in managing their role. Their role consists of administrative tasks such as placing markers and intelligence on police systems, and preparing for and attending all multi-agency missing, modern slavery, exploited and trafficked (MSET)[12] meetings. This means that they have limited time to solve problems proactively.

The co-ordinators also give the three area commands a list of the ten children who are reported as missing most frequently. This local command is supposed to take over the cases of these children and, working with the co-ordinator, try to find out why they go missing so frequently. However, there is no formal feedback or update process about what officers are doing to reduce risk and the number of missing episodes for each child.

There is an aspiration that, when the full team of three missing person co-ordinators (one for each area command) is in place, they will work more closely with the officers and staff in the three areas to provide an effective response to missing persons, particularly those at risk of exploitation.

Notable practice – Operation Endeavour

Since November 2018, Operation Endeavour, a new approach to sharing information with schools about children who go missing, is being piloted in Northumberland. This aims to provide schools with daily information on missing children in the same way that Operation Encompass[13] provides information about children who are affected by domestic abuse. The aim is to give up-to-date information on a missing episode to a trusted professional, so that they can work with the child to support them and reduce further incidents.

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[12] MSET meetings co-ordinate the multi-agency arrangements and response to children and vulnerable adults who are identified as being at risk because of going missing, modern slavery, or being exploited or trafficked.

[13] Operation Encompass involves the force, when it has been called to an incident of domestic abuse at a child's home, informing the relevant local school to enable the school to provide support and help to the child involved.

Improved attendance at initial child protection conferences

In 2018, we reported that attendance across Northumbria at ICPCs varied from 69 percent in one area to 88 percent in another. The force has now moved the police staff who attend the meetings to the multi-agency safeguarding hubs (MASHs).[14] This is seen as positive by staff who now feel that they are part of a team with clear lines of supervision. This has also created greater flexibility and improved police attendance at the meetings. In October and November 2018, there was 100 percent attendance at ICPCs in three local authority areas and more than 90 percent in the others.

Investigation

Recommendations from the report of the 2018 inspection

Northumbria Police should immediately undertake a review, to include:

- how information is shared and the development of joint protective plans; and
- the recording on police systems of decisions reached at meetings, to provide officers and staff with the awareness of all relevant developments.

Within three months, Northumbria Police should improve its child sexual exploitation investigations, paying attention to:

- ensuring a prompt response to any relevant concern raised;
- improving the oversight and management of cases to ensure that standards are being met; and
- ensuring that referrals and investigations are prompt and effective.

Within six months, Northumbria Police should review the provision of the registered intermediary services for children to ensure they are available to be appointed when required, to help improve the quality of the child's evidence.

Summary of post-inspection review findings

In 2018, we reported that we had reviewed a total of 101 cases. Although we did find individual areas of good practice, the overall findings were that 74 of those cases either required improvement or were inadequate.

[14] A MASH brings key professionals together to facilitate early, better-quality information sharing, analysis and decision making to safeguard vulnerable children.

We found that the recording of information about the progress of criminal investigations was poor. Officers recorded information on multiple systems with no evidence of clear or consistent guidance about how and where officers should manage those records. We also found that, despite having shared concerns about children with children's social care services, officers did not record strategy discussions as having happened, or the discussions did not take place at all, with no explanation as to why this was so. This, combined with a lack of recorded supervision or updates from officers, meant that there was very limited evidence that officers contributed to the development of protective plans.

Intermediaries are people who have been trained to support vulnerable victims and witnesses when they give evidence. The force was reported to be experiencing delays in obtaining the services of intermediaries. This had a detrimental effect on the ability of child victims to give accurate and timely accounts to help the police with their investigations.

In 2019, we found that there are delays in responding to online exploitation referrals and digital forensic examinations. CSE investigations not involving the internet have improved and the force is working with a previous victim of CSE to use her experience to support training about exploitation.

We also found that officers and staff demonstrated a good knowledge of when they would consider an intermediary to support and help a child to give the best possible evidence. They reported that they were not seeing the delays previously reported.

Detailed post-inspection review findings

The force has a CSE problem profile but this was produced in 2017 using data from the period January to December 2016. Exploitation of children both on and offline is continuing to evolve. This profile would be better if the force updated it and cross-referenced it with information held by partner agencies such as children's social care services.

The report identifies that offenders used a total of 20 different media platforms in 62 percent (80) of the 129 offences examined. The increasing use of social media platforms and channels to distribute, share and view child sexual abuse images poses a significant and complex problem for policing, together with increased demand for the examination of digital media that the police seize during investigations. We saw this in the cases we reviewed.

Delays in responding to online exploitation referrals

During the inspection we reviewed ten online cases. Of these, we assessed seven as either requiring improvement or inadequate.

We found that, when the force used search warrants in an investigation, it executed them some time after the date when the referral had been made to the police. Officers had not recorded any reason for the delay on the crime file.

The research and intelligence checks that officers make to inform risk assessments are also not recorded on the crime system and are only available to the police online investigation team. Although officers and staff do submit child concern notifications, they do not always do this when children are first identified as potentially at risk. Although there is evidence of strategy discussions having taken place, officers do not always record the outcomes of these.

Northumbria Police received a referral from the Child Exploitation and Online Protection (CEOP) command of the National Crime Agency about indecent images of children that had been downloaded from the internet in February 2018. There was a delay of several weeks before a search warrant was executed at the suspect's address in May 2018 but without any documented explanation for the delay.

Police officers found the suspect, the suspect's partner, and two children aged four and six at the address. Officers arrested the suspect, who admitted the offence and was then released under investigation to an address away from the children. Officers made a referral to children's social care services the same day.

Officers seized several items of digital electronic equipment during the investigation and these items needed to be examined for evidence. At the time we reviewed this case (in January 2019), no one had examined them. Nine months had passed since officers had arrested the suspect.

Although this case did have input from a supervisor, there were delays in the execution of the warrant that potentially left the children in the house exposed to risk, and the continuing delays in examining the digital electronic equipment has resulted in the suspect remaining under investigation without a clear timescale of when the case will be concluded.

There is a lack of investigation plans on crime files and supervisory reviews are limited in adding value to an inquiry. Supervisory reviews are expected to take place at various points within the investigation but officers and staff acknowledge that these are not always completed. There is a current drive to improve investigative standards that is being supported using dip sampling.

Delays in digital forensic examinations

Cases like this increase the demand for forensic examination of digital devices because police are seizing more and more electronic equipment during their investigations. We found significant delays within the digital forensic unit (DFU), which is of concern. In many of the cases we examined, the DFU had triaged[15] devices and found that it was likely that they contained indecent images. However, at the time of the inspection, we found cases where the force had not allocated a DFU examiner to an investigation. Some of these delays were of more than six months.

Service level agreement compliance within the DFU has declined gradually and there is an increased backlog of cases awaiting examination. Some have taken many months to complete. As of January 2019, the DFU is examining 47 CSE cases and 141 cases are waiting to be examined. These include contact offences,[16] distribution of images, grooming and possession of indecent images. All these cases await investigation and analysis by police officers.

Child sexual exploitation investigations not involving the internet have improved

The majority of child exploitation investigations are now managed within the complex abuse team or the child abuse investigation team. All cases are triaged and supervisors identify the most appropriate officer for each case. This means that appropriately trained staff are investigating the right cases.

Attendance by officers and staff dealing with CSE cases that do not involve the internet is generally prompt, ensuring that officers arrange initial safeguarding of children and secure any evidence. There is also good liaison with children's social care services.

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[15] Triage is used to determine whether a device should be prioritised for further investigation.

[16] Criminal offences involving physical sexual contact between the offender and victim.

A 15-year-old girl was sexually assaulted by a group of men. There was a prompt initial response by the police with appropriate action taken to progress the case.

Clear investigation, forensic and safeguarding strategies were put in place. Everything was appropriately actioned and recorded, and effective reviews by the supervisor kept the case on track.

The suspects were arrested, and the victim was provided with help and support from the Sanctuary victim hub (which brings together partner agencies including the police, adult and children's social care services, Barnardo's and other charities).

This investigation was ongoing at the time of the inspection.

Referrals are generally timely and sufficiently detailed for further review and action in the MASH but this is not consistent. In one case, we found the referral consisted of one sentence, when there was a considerable amount of information and concerns that officers should have included.

The MSET meeting is used to provide enhanced support within the multi-agency team and with other agencies if this is appropriate. They also consider the use of civil orders such as sexual risk orders[17] and child abduction warning notices[18] to disrupt perpetrators, which was evident in some cases and is a positive step.

Investigation plans and vulnerability assessments are increasingly detailed in crime reports, but in some cases there were examples of no updates having been made for a considerable period, or of delays in arresting identified offenders.

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[17] Sexual risk orders can be made by a court in relation to an individual who has done an act of a sexual nature and, as a result, poses a risk of harm to children or vulnerable adults. Part 2 Sexual Offences Act 2003.

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

During an unconnected police investigation, officers became concerned about a 12-year-old girl who was a looked-after child and being groomed by a 21-year-old man.

Officers sent a detailed referral to the local MASH and shared the referral with children's social care services. There was then a delay of 26 days between the time that officers made the report and the arrest of the suspect, leaving the girl exposed to risk. The suspect continued communicating with the girl and potentially with other children for 26 days. This delay also caused officers to miss an opportunity to obtain corroborative evidence for the investigation.

However, the subsequent investigation was thorough and appropriately supervised, with officers recording safeguarding and investigative actions on police systems. The investigator sought to identify other children at risk and imposed formal restrictions on the suspect by obtaining a sexual risk order while seeking early investigative advice from the Crown Prosecution Service.

The man is now being managed through multi-agency public protection arrangements (the process through which various agencies, such as the police, prison service and probation, work together to protect the public by managing the risks posed by violent and sexual offenders living in the community). The child is safe in local authority accommodation.

Supervisory oversight was clear and documented in most cases. Early advice from the Crown Prosecution Service is available for investigators. We saw investigators using this to good effect in some cases, particularly when the cases are complex and anticipated delays in the DFU would delay the progress of the case unnecessarily if the perpetrator remained a risk.

We found that a high proportion of suspects are released under investigation after they have been arrested or are dealt with through voluntary attendance. Bail conditions are not generally applied, which can limit opportunities to restrict the behaviour of an offender.

The use of warning markers of those at risk or who pose a risk is inconsistent. Although the direction is clear as to how these are to be recorded, officers do not always do this and there is no audit to assess compliance. This means that the risk connected to individuals is not always visible and therefore the police might miss opportunities to risk assess people who are potentially at risk. This means that officers cannot protect these people, and others, from harm.

Victims’ experience to support training

The force is working with a previous victim of CSE to use her experience to support training about exploitation. The force will provide this training internally to officers and staff, and externally to its partners. Although this is too early for us to assess, the proposal is positive.

Intermediaries

Nationally, there has been a significant increase in the demand for registered intermediaries that cannot be met by the current numbers. To tackle this problem, the Ministry of Justice launched a national recruitment and training campaign, which will be completed area by area.

The force advised us that 25 registered intermediaries cover the Northumbria area. Of these, only 15 are currently active and accepting new referrals but this figure changes daily. Not all the 25 will support the same type of witness: some will only support children and some only adults.

Between December 2017 and November 2018, the force made 201 requests for the services of an intermediary. Of these, 187 were matched, resulting in the force using an intermediary.

We found that officers and staff demonstrated a good knowledge of when they would consider an intermediary to support and help a child to give the best possible evidence, and to ensure that the child’s views are heard. They also told us that they were not seeing the delays (previously reported) in obtaining the services of intermediaries.

Decision making

Recommendation from the report of the 2018 inspection

> Within three months, Northumbria Police should take steps to ensure that all relevant information is properly recorded and is readily accessible in all cases where there are concerns about the welfare of children. Guidance should include:
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> - what information should be recorded (and in what form) on systems to enable good decisions; and
> - the importance of ensuring that records are made promptly and kept up to date.

Summary of post-inspection review findings

In 2018, we were concerned by the poor standard of recording on police systems. Northumbria Police had several IT systems on which it recorded information about child protection. This was inefficient. Officers were confused and did not know how to find the most recent details of an investigation. As a result, it was not always clear what decisions had been made to protect a child, or what work officers were doing in an investigation.

In 2019, we found that the force has made efforts to improve recording of decisions and outcomes at meetings but this remains inconsistent, with the current IT system continuing to hinder the accessibility and visibility of information.

Detailed post-inspection review findings

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

As detailed earlier, the current IT system continues to hinder the accessibility and visibility of information. The force worked to increase the awareness of officers and staff about how information about children at risk is recorded by specialist staff in the public protection units. This is intended to improve recording practices in investigations, as well as using the information on the results and the warning screens to help response and decision making for vulnerable and at-risk children. Despite this work to direct staff to the places where relevant information is stored so that they can find it, it is still not always clear in some cases as to what decisions officers and staff have made or what actions they are taking to safeguard a child.

The cases we reviewed often did not provide a record of police involvement in the assessment of longer-term risk or in the development of protective plans. There was sometimes no evidence of a strategy discussion or meeting having taken place, nor detail of what joint assessment of need had occurred or if any assessment had been made at all.

The force advised that the new Connect IT system will enable officers and staff to store and find information within one database. However, this will take time, so the current systems will continue to present obstacles to officers and staff when they need to store and retrieve information.

Police detention

Recommendation from the report of the 2018 inspection

Within six months, Northumbria Police should:

- improve the timeliness of adequate appropriate adult support for children who are arrested;
- ensure that custody staff comply with their statutory duties to complete detention certificates if a child is detained for any reason in police custody following charge; and
- ensure that custody officers, where necessary, make sure that detained children receive appropriate clinical attention in accordance with the requirements of the Police and Criminal Evidence Act 1984.[19]

Summary of post-inspection review findings

In 2018, we found that too many children who had been charged and refused bail remained in police custody, and the local authority had not given them appropriate alternative accommodation. Juvenile detention certificates, which outline to a court the reason for a custodial remand, were also not recorded on the custody system.

Across Northumbria, the provision of appropriate adult schemes, which provide children with support and advice, was inconsistent. We were concerned to find that, in some of the cases we reviewed, officers had not contacted a health care professional (HCP) despite clear risk indicators.

Although the force did gather custody information on children, this was limited to data such as numbers arrested and voluntary attendance. It did not include the number of children detained after charge and appropriate adult attendance.

In 2019, we found that efforts are made to tell appropriate adults about the arrest of a child. However, there were some delays in their arrival at the police station.

Our case audits showed that custody officers know they need to find alternative accommodation. However, children are still being unnecessarily held in police stations when they have been charged with a criminal offence and denied bail.

[19] The Police and Criminal Evidence Act 1984 is an Act of Parliament setting out a code of practice governing police powers of investigation including the arrest and detention of people in police custody.

In general, the appropriate level of observations is set when the custody staff are made aware of the risks to a child. However, there are inconsistencies in the recording of a child in need of being referred to an HCP.

The force is due to begin collecting information to better understand its performance when children are detained. These data should provide the necessary information to support discussions with partner agencies and help to improve the current position.

Detailed post-inspection review findings

The force has worked hard to reinforce messages to its custody officers and to all staff who work in custody suites. It does this by providing training and through articles in its 'Custody matters' bulletin, which it introduced in February 2018. The force makes staff aware of the importance of the attendance of appropriate adults and concentrates on the vulnerability of children who come into custody. This is positive.

In January 2019, the force updated its electronic custody records to include the collection of information on the number of children detained after they had been charged, and on appropriate adult attendance.

Children in custody are not provided with early access to an appropriate adult

Provision of appropriate adult services (which is the responsibility of the local authority) remains inconsistent. This is despite the assistant chief constable having contacted local authorities about the timeliness of notification and the attendance of appropriate adults. We heard that sometimes out-of-hours requests for appropriate adults are not met. The agencies that provide appropriate adults should work with the force to ensure that they provide appropriate adult services for children effectively.

Generally, officers and staff do make efforts to ensure that they tell appropriate adults about the arrest of a child when the child arrives in custody. However, in some of the cases we reviewed, there were delays in the adult's arrival at the custody suite, which often coincided with the time of the interview. This prioritises the needs of the investigation and the management of demand over the welfare of children in custody. Children remain in custody without having an independent person to give them support and advice.

In the cases we reviewed, the statement of rights and entitlements that officers and staff should give to a child in the presence of an appropriate adult had not always been countersigned by that adult. Therefore, it was not clear that officers and staff had repeated the rights and entitlements in the adult's presence once the adult had arrived, as the law requires. It was also not evident in some cases whether an appropriate adult was present when a child was charged with an offence, because officers had not always documented this in the detention log.

Children are still being unnecessarily held in police stations when they have been charged with a criminal offence and denied bail

When a child is charged with an offence and the custody officer authorises their continued detention after charge, the Police and Criminal Evidence Act 1984 places a duty on the police to make arrangements for that child to be taken into the care of a local authority until their appearance in court. This duty applies equally to a child charged during the daytime as well as to those to be held overnight.

Local authorities also have a duty, under the Children Act 1989, to provide accommodation for children who are transferred out of custody. The local authority decides what type of accommodation it provides and the accommodation might be secure or non-secure.

In most of the cases we examined, the child was still detained in a police station after they had been charged. If, when charged with an offence, a child is to be denied bail and detained, the local authority is responsible for providing appropriate accommodation. Only in exceptional circumstances (such as during extreme weather) would the transfer of the child to alternative accommodation not be in the child's best interests. In rare cases – for example, if a child presented a high risk of serious harm to others – secure accommodation might be needed. We found evidence of custody staff asking local authorities for suitable accommodation, which shows that custody staff have a good understanding of the need for children to be transferred out of police detention. The law does not recognise or allow for a situation in which secure accommodation is not required and yet a child remains in police cells. However, in those applicable cases we reviewed, except for one child, no children were transferred from police custody to non-secure accommodation because of a lack of available local authority accommodation.

When officers and staff made appropriate requests, and the local authority did not provide accommodation, there was little evidence of escalation to senior officers or of officers making subsequent requests to the local authority during the time the child was in custody. This resulted in children remaining in detention for long periods after they had been charged.

In reviewing cases where officers should have completed a juvenile detention certificate (outlining to a court why bail was refused), the response was varied. At the time of the inspection, the force had recently introduced (in January 2019) an electronic system that should now improve this position, ensuring that officers complete and record detention certificates for all cases where one is required.

There are inconsistencies in the recording of a child in need of being referred to a health care professional

Officers and staff made risk assessments and documented them in all the cases we reviewed. In general, the appropriate level of observations was set when the custody staff were made aware of the risks to the child, which included disclosure of medical matters. This is positive and in line with the Police and Criminal Evidence Act 1984 codes of practice.

However, there remain inconsistencies in whether a child is referred to an HCP. In some cases we reviewed, where a child disclosed medical issues or there were clear risk indicators, there was no documented evidence to suggest that they had been referred to, or seen by, an HCP.

The force is to begin to collect information to better understand its performance when children are detained

The force told us that it was to start collecting data on the number of children detained after charge and on appropriate adult attendance, and it will share the data with partners. This data should provide the force with evidence of the scale of the problem to support the discussions it has with local authority providers in relation to appropriate adult services, and secure and non-secure accommodation, to improve the current position.