HMICFRS

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

National Child Protection Inspections

Staffordshire Police

13–24 September 2021

Foreword

All children deserve to grow up in a safe environment, cared for and protected from harm. Most children thrive in loving families and grow to adulthood unharmed. Unfortunately, though, too many children are abused or neglected by those responsible for their care; they sometimes need to be protected from other adults with whom they come into contact. Some of them occasionally go missing, or end up spending time in places, or with people, harmful to them.

While it is everyone's responsibility to look out for vulnerable children, police forces – working together and with other organisations – have a particular role in protecting children and meeting their needs.

Protecting children is one of the most important things the police do. Police officers investigate suspected crimes involving children and arrest perpetrators, and they have a significant role in monitoring sex offenders. They can take a child in danger to a place of safety and can seek restrictions on offenders' contact with children. The police service also has a significant role, working with other organisations, in ensuring children's protection and wellbeing in the longer term.

As they go about their daily tasks, police officers must be alert to, and identify, children who may be at risk. To protect children effectively, officers must talk to children, listen to them, and understand their fears and concerns. The police must also work well with other organisations to play their part in ensuring that, as far as possible, no child slips through the net, and to avoid both over-intrusiveness and duplication of effort.

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) is inspecting the child protection work of every police force in England and Wales. The reports are intended to provide information for the police, the police and crime commissioner (PCC), and the public on how well the police protect children and secure improvements for the future.

Contents

Summary

This report is a summary of the findings of our inspection of police child protection services in Staffordshire, which took place in September 2021.

We examined how effective the police's decisions were at each stage of their interactions with or for children. This was from initial contact through to the investigation of offences against them. We also scrutinised how the force treated children in custody. And we assessed how the force is structured, led and governed, in relation to its child protection services.

We adapted this inspection because of the COVID-19 pandemic. Working within national guidelines, we agreed with the force to carry out our inspection both safely and effectively.

We worked remotely, using video calls for discussions with police officers and staff, their managers and leaders. And we reviewed incidents and investigations online.

Main findings from the inspection

Staffordshire Police has recently changed its senior leadership team. In May 2021, a new police, fire and crime commissioner was elected. And during this inspection, the commissioner appointed a new chief constable.

While we found some areas of effective practice, and there are dedicated officers and staff who are committed to keeping children safe, overall we found the force's child protection arrangements aren't consistently providing a good enough response to effectively safeguard children in Staffordshire.

On the positive side, chief officers and senior leaders participate in multi-agency safeguarding partnership arrangements. They attend and contribute to multi-agency meetings and activities. But we found no evidence of the force escalating cases or challenging other organisations when child protection arrangements aren't benefiting children.

The force has established harm reduction hubs, where police and staff from other organisations work together to keep people safe. This progressive and ambitious model shows the force understands the benefits of working closely with other local safeguarding organisations. The hubs provide early help and intervention for vulnerable people and communities. This means support and safeguarding for vulnerable victims, including children, is often highly effective. The hubs also allow the force to use a problem-solving approach to disrupting criminals and preventing them from exploiting children.

In parts of its area, the force also works proactively to support children at risk from gangs and others who exploit them. But this approach isn't yet fully in place, and it still needs to address the risk to children from county lines in some districts.

A strategic overview board for missing children considers ways of reducing the number and frequency of missing children incidents. It prioritises approaching staff in children's care homes. The board has recorded a reduction in the number of looked after children being reported missing. But we found that the force's overall response to missing children is confused and ineffective. The workforce is unclear about its role and responsibility. And at times, the force doesn't have the right procedures in place to find high-risk missing children. In some cases, the force takes far too long to recognise the risk and respond in the right way.

We found the force doesn't clearly prioritise the safeguarding of children in all investigative activity. The arrangements in place to investigate the risk from those suspected of distributing indecent images of children online aren't clear enough. These need to change so that officers' focus is always prioritised on protecting children.

Investigations into sexting offences among children are sometimes confused. This is where a child makes and/or sends indecent images of themselves or another child. We found evidence of the force sometimes allocating these investigations to officers who don't have the right training. In these instances, little, if any, investigation takes place. Officers don't always seize the devices containing images. This means those devices can't be used for evidence or to help identify other victims. It also means officers can't permanently delete indecent images.

We also found evidence of delays in non-specialists getting support from the digital forensic unit. The force also misses opportunities to work with other agencies to assess the offender's risks and vulnerabilities.

When children are held in police detention, officers often complete reviews remotely. It means that inspectors don't fully consider the voice of the child (VoC) and assess the impact of detention on the child's welfare against the need to continue the detention.

Officers throughout the force do not always understand the importance of speaking to children, listening to them and recording their vulnerability. This is clear in the quality of information officers give when recording their concerns in both public protection notices (PPNs) and referrals to children's social care (CSC) services.

Information technology (IT) at Staffordshire Police isn't good enough to support the force's needs. Senior leaders are aware of this, and some measures are in place to improve it. But not all problems are being addressed quickly enough. For example, the force doesn't have reliable video conferencing equipment and technology. This means the daily management meeting (DMM) is often inefficient. (The purpose of this meeting is to inform senior leaders and colleagues across the force about critical incidents and high-risk investigations.)

We found that supervision is often ineffective. Sometimes this is due to the workload of supervisors. But more often it is because there isn't a culture of checking and managing processes such as decision-making. This results in delays in the force's

response to missing children, calls of concern not being investigated, and lower-quality risk assessments in the control room.

The force doesn't effectively use its systems for managing registered sex offenders (RSOs) in the community. This means there are significant backlogs in supervisors' assessments of cases, and leaders aren't aware of the performance of their staff.

During our inspection, we examined 77 cases in which the police had identified children at risk. We assessed the force's child protection practice as good in 19 cases, requiring improvement in 23 cases, and inadequate in 35 cases. This shows the force needs to do more to give a consistently good service for all children.

Specific areas for improvement include:

- improving data-management and performance-management processes to better understand the quality of service and improve outcomes for children;
- making sure the force effectively risk assesses and allocates calls for police assistance;
- speaking to children, recording their behaviour and demeanour, listening to their concerns and views, and using that information to make decisions about their welfare;
- making appropriate referrals to CSC services and early help practitioners;
- recognising that missing children are particularly vulnerable;
- sharing information about online child abuse promptly;
- supervising investigations more consistently to make sure it pursues opportunities and avoids delaying cases unnecessarily;
- making sure children in police detention are supported by health care professionals and appropriate adults.

Conclusion

Staffordshire Police urgently needs to make fundamental changes to improve many of its child protection arrangements and practices. The force should support this with a clear structure for overseeing and scrutinising all aspects of child protection activity. This will also allow it to monitor the impact of the changes it makes.

We found that the officers and staff who manage demanding child abuse investigations are committed and dedicated. But we are concerned that some frontline and specialist officers don't have enough knowledge or understanding of good child protection practice. We are also concerned about the effectiveness of the force's systems and processes, which should better support its staff.

We have therefore made a series of recommendations. If the force acts on them, these will help improve outcomes for children.

1. Introduction

The police's responsibility to keep children safe

Under section 46 of the Children Act 1989, a constable is responsible for taking into police protection any child they have reasonable cause to believe would otherwise be likely to suffer significant harm. The same Act also requires the police to inquire into that child's case. Under section 11 of the Children Act 2004, the police must also keep in mind the need to safeguard and promote the welfare of children.

Every officer and member of police staff should understand it is their day-to-day duty to protect children. Officers going into people's homes for any reason must recognise the needs of any child they meet and understand what they can and should do to protect them. This is particularly important when officers are dealing with domestic abuse or other incidents that may involve violence. The duty to protect children includes those detained in police custody.

The National Crime Agency's (NCA) *National Strategic Assessment of Serious and Organised Crime* (2021) established that the risk of child sexual abuse continues to grow, and is one of the gravest serious and organised crime risks. Child sexual abuse is also one of the six national threats specified in the *Strategic Policing Requirement*.

Expectations set out in the *Working Together* guidance

The statutory guidance published in 2018, *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*, sets out what is expected of all agencies involved in child protection. This includes local authorities, clinical commissioning groups, schools and voluntary organisations.

The specific police roles set out in the guidance are:

- identifying children who might be at risk from abuse and neglect;
- investigating alleged offences against children;
- inter-agency working and information sharing to protect children; and
- using emergency powers to protect children.

These areas are the focus of our child protection inspections. Details of how we carry out these inspections are in Annex A of this report.

2. Context for the force

Staffordshire Police is responsible for policing the county of Staffordshire and the city of Stoke-on-Trent.

Staffordshire Police has a workforce of 3,651, comprising:

- 1,813 police officers;
- 1,450 police staff;
- 207 police community support officers (PCSOs); and
- 181 special constables.

The force serves more than 1.1 million people in an area of 1,000 square miles, including the rural Moorlands and major urban areas such as Stoke-on-Trent.

Child protection and safeguarding within the force are mostly the responsibility of the Investigations Directorate and the Neighbourhoods and Partnerships Directorate.

There are ten Neighbourhood Policing Teams (NPTs) based on districts/boroughs at Cannock Chase, East Staffordshire, Lichfield, Newcastle, Moorlands, South Staffordshire, Stafford, Stoke North, Stoke South and Tamworth.

The force control room, known as the force contact centre (FCC), is based at the headquarters in Stafford. There are two custody suites: the Northern Area Custody Facility in Stoke-on-Trent and Watling Street custody suite in Stafford.

The force published five priorities in its Policing Plan (2018–19):

- modern policing;
- early intervention;
- supporting victims and witnesses;
- managing offenders; and
- improving public confidence.

Safeguarding partnerships are required by the Children and Social Work Act 2017.

Staffordshire Police works closely with other organisations to safeguard children, including the Staffordshire Safeguarding Children Board and the Stoke-on-Trent Safeguarding Children Partnership. The other statutory partners are the local authorities for Staffordshire and Stoke-on-Trent, and the Staffordshire clinical commissioning groups.

Recent inspections

The most recent Ofsted inspection (February 2019) of children's social care services provided by Stoke-on-Trent City Council reported:

Judgment	Grade
Overall effectiveness	Inadequate

Ofsted continues to monitor the progress of the council.

The most recent Ofsted inspection (February 2019) of children's social care services provided by Staffordshire County Council reported:

Judgment	Grade
Overall effectiveness	Good

3. Leadership, management and governance

The force's governance arrangements for child protection aren't fully effective

The force recently experienced significant changes in its senior leadership. Its chief constable retired and the assistant chief constable, who held responsibility for child protection, transferred to another force. A new police, fire and crime commissioner was elected for Staffordshire shortly before this inspection, and the commissioner appointed a new chief constable while we were inspecting the force.

We found the current Staffordshire Policing Plan is out of date, the most recent one being for 2018–19. The revision of this strategic document is overdue. The force intends to refresh this plan to reflect the views of the new senior leaders and the commissioner's police and crime plan. This is an opportunity for leaders to explain how they will support their communities, reduce vulnerability and protect children.

Staffordshire Police is organised into directorates headed by senior leaders. This means the force can dedicate specialist skills and experience to complex policing matters when it needs to. One example of this is child abuse investigations; another example is investigations into high-risk online offenders, where the approach needs subject matter and technical expertise.

Child protection and safeguarding are mostly the responsibility of the Investigations Directorate and the Neighbourhood and Partnerships Directorate. The force uses governance meetings to monitor and review the performance of:

- teams;
- staff involved in operational responses; and
- investigations such as those involving missing children or child protection.

But the other directorates are also responsible for helping the force effectively protect children.

Police forces with effective governance structures can understand how well their child protection arrangements work. In these cases, leaders know if the force's activity, and the end results for children, correspond with their plans. They can also tell if they need to make changes to address problems as they arise. Staffordshire Police's governance is directorate focused. This structure means senior leaders can't easily review how all parts of the force contribute to effective child protection services.

Practice and supervision in the FCC are inconsistent

Not all staff in the FCC are well trained and routinely using the THRIVE model to assess incidents and respond in the right way. And THRIVE isn't routinely recorded either by the operators or by supervisors when they reassess open incidents. When we randomly sampled outstanding domestic abuse incidents, we found a significant number with no appropriate police response where children were known to be present. Weak assessment processes in the FCC mean the risk for these children stays unknown and unassessed for too long. This results in delays in suitable interventions and referrals to CSC services.

We did see some incidents in the FCC where the force used its intelligence capability well. But despite being responsible for supervision, force incident managers (FIMs) often work inconsistently on cases involving high-risk missing children. FCC staff don't consistently use or update trigger plans, which should be in place to help find frequently missing children. It isn't always clear who is responsible for leading investigations to quickly find these children. We didn't find a rigorous audit or management process in the FCC. This means force leaders are unaware of inefficient processes and inconsistent responses to high-risk incidents.

Poor data quality and recording are limiting the value of the force's intelligence research and its understanding of risk and vulnerability

The force's intelligence analysts help managers with problem profiles on themes such as domestic abuse and child exploitation. Where possible, they include information from other safeguarding organisations to add context to these profiles. The profiles mainly rely on data from the force's own systems, so it is vital this information is accurate and comprehensive.

The force should record information about victims' and suspects' ethnicity and cultural heritage – particularly if this is a factor in the incident they are involved in. Some individuals and communities are more vulnerable to harm from specific risks because of their family background or cultural heritage. Examples of this are so-called honour-based violence and female genital mutilation. But we found staff aren't routinely recording this information. The analysts are aware this is a problem.

Some officers fail to make separate reports about crimes against children when they are dealing with other incidents at the same premises. For example, in cases involving adults, officers don't always realise when children are also victims of assault or neglect. We also saw incidents where the force didn't record crimes of blackmail. These involved people threatening to circulate indecent images of children online.

Officers are not consistently recording concerns about children and making referrals using PPNs. The workforce is unclear about its responsibility to complete PPNs.

Frontline supervisors don't always tell their staff to submit PPNs before closing incidents or investigations involving vulnerable children. And they don't always make sure PPNs are submitted. When officers do complete PPNs, supervisors don't authorise them before the PPN goes the local authority. And the force has no process to check the standard or content of PPNs.

When a force's safeguarding plan is effective, people become victims less often. Staffordshire Police showed us data it had gathered on how often children are victims of crime, and its analysis of repeat child victims. But this analysis relies solely on crime reports and doesn't include all the other incidents, below the level of crime, that could affect the safety of children. Therefore the current analysis isn't a complete picture of what the force knows about a child's vulnerability. Managers need good-quality data so they can act in the right way. The force doesn't have the right processes in place to gather this data.

The workforce isn't fully aware of its responsibility to prioritise the welfare of children and protect them from harm

Managers in the Investigations Directorate keep accurate training records for their staff. It was positive to see officers on specialist child protection teams are either fully trained or progressing on suitable programmes.

All new staff receive College of Policing vulnerability training. Leaders told us every member of the workforce must complete the national police online level 1 safeguarding training. But we checked force records and saw only 56 percent of staff and managers had completed this training.

General awareness of safeguarding and child protection throughout the force is too low. In the cases we audited, we rarely found good records of officers focusing on the children's situation. Even specialist units too often fail to focus on the child. Often, they don't record the VoC. This means officers aren't speaking to children or listening to them enough. This would help officers understand children's vulnerability.

Some staff and officers told us they hadn't heard of the term VoC. And some don't know about adverse childhood experiences (ACEs). Continuing professional development (CPD) training in the force doesn't cover these subjects well enough. When staff approach incidents such as missing children, or when they report domestic abuse, they don't always understand the risk to children.

The force doesn't understand this gap in its safeguarding capability. Supervisors and managers aren't identifying the problem in quality assurance processes, and they are not addressing it. The force's approach to child protection needs to improve so it understands and prioritises safeguarding.

The force's systems and IT aren't reliable enough to support effective operational activity

The force knows its IT and communication systems aren't good enough. It has recorded this concern on its risk register. But this problem is of longstanding, and it stops the force from approaching vulnerability and risk well enough.

Systems frequently fail, interrupting the efficiency of vital meetings such as the DMM. The DMM we attended was affected by a systems failure. Officers and staff from across the force couldn't virtually attend, so the meeting chair had to contact every individual in turn to gather their contributions. We were told that this is often the situation.

Staffordshire Police has struggled to give its staff reliable IT systems, so remote working isn't yet well established. This is in comparison to other organisations and police forces, which have developed new and more efficient ways of working during the COVID-19 pandemic.

To their credit, officers and staff are dedicated and resourceful about developing 'workarounds'. Staff often use their personal computers to avoid IT problems because they want to do the best they can. The force knows of these practices, and we are concerned that staff may not always be able to protect sensitive information on their personal devices.

The force's main systems for crime and intelligence records aren't fully effective

The force replaced its old crime and intelligence system about 18 months before this inspection. Members of the workforce told us of their frustration with the way the system works. For example, markers for risk and vulnerability (such as the address of a sex offender or details about a child on a child protection plan) aren't routinely in place. This means the system can't alert responding officers or neighbourhood intervention teams.

We found a similar situation with the force's use of the Violent and Sex Offender Register (ViSOR) system, which is used to manage high-risk offenders in the community. The system has been in use across the UK since 2004, but Staffordshire Police isn't using it effectively. This means the force isn't properly supervising records or routinely gathering performance-management information.

The force understands the advantages of working closely with other safeguarding organisations

The force invests in neighbourhood policing to prioritise crime prevention, early intervention and better investigations. Leaders saw the benefits to the community of working closely with partners, particularly government agencies and local authorities, to safeguard people.

There are ten local policing teams aligned with the Staffordshire districts. Each district has a harm reduction hub, where police and staff from other organisations work together to reduce vulnerability, prevent crime and support the community. This progressive and ambitious model shows the force understands the benefits of multi-agency early intervention.

We were impressed by the integrated approach we saw between the police and other organisations in the hubs. Local police and their partners act quickly and flexibly as risk for vulnerable people, including children, changes. As a result, people receive the help they need faster and teams can disrupt offenders (such as domestic abuse perpetrators), reducing or preventing harm.

Case study: effective multi-agency safeguarding partnership work

The parents of a 15-year-old girl called police and reported their daughter had assaulted her mother and caused damage to their property. They told the responding officers that their daughter's behaviour had become erratic after she became friendly with an older male who was a drug abuser. They wanted to press criminal charges and didn't want their daughter to return home.

The officers arrested the girl and quickly contacted CSC services explaining the situation. Social workers arranged for the girl to be looked after by other members of her family.

The officers referred the case to the youth offending services to consider the best course of action to take. And it was decided that a youth caution was appropriate.

Harm reduction hub staff reviewed the incident and arranged for a child abduction warning notice to be served on the male. This served to protect the girl from his influence.

But staff in NPTs and those working in the hubs aren't trained in child protection and many don't have detective experience. The force sometimes inappropriately assigns investigations to non-specialists. We also saw many examples, including within specialist teams, of inadequate investigation supervision. The force needs to make sure it allocates crimes to those with the right skills. It also needs to put in place robust supervision.

Arrangements to manage risk from domestic abuse are very good

Each hub regularly holds multi-agency risk assessment conferences (MARACs). This means risk assessment isn't delayed. Other organisations attend and contribute, improving the quality of safety plans. The force updates and monitors these plans using SharePoint so partner organisations can see the assessments and add new information. The force has appointed a dedicated MARAC quality assurance officer. It also places information from MARAC on force systems so officers responding to incidents can use it.

The way the force responds to missing children needs to improve

Force leaders know children missing from home are vulnerable. Some missing children may be at risk from abuse within the family and others may be at risk from those who want to exploit them.

The arrangements we saw for missing children are inconsistent. And on too many occasions, the operational response is ineffective. Staff told us they are unsure about their responsibilities and about who oversees missing children investigations. We found delays in the FCC, and we saw incidents where the force didn't prioritise high-risk children. The force's missing persons unit is under-resourced, meaning it can't play the vital role it should in co-ordinating and improving missing person investigations.

Arrangements for assessing risk and referring concerns to other organisations are ineffective

So they can safeguard effectively, police forces must efficiently assess information about risk and send it to partner organisations. Although the force assigns a substantial number of police officers and staff to the multi-agency safeguarding hub (MASH), the system is ineffective.

Officers don't research or triage any PPNs before sending them, as single pieces of information, to the local authority. Most of the force's PPNs record single incidents, so they are often below the threshold for statutory intervention by CSC services. As a result, CSC doesn't act on these referrals. So, officers' attempts to get help for some children are fruitless.

The force understands the benefits to children of providing early help and intervention to prevent the escalation of risk. So it should have a process in place to assess PPNs and direct them to the right safeguarding organisation. This would allow children to receive the help they need without delay. This is a partnership problem. The force needs to work with other organisations to better manage notifications about children's welfare and child protection referrals.

The force understands the need to support the wellbeing of its workforce

Safeguarding children and vulnerable people, and tackling offenders, affects police officers and staff. Staffordshire Police recognises this. The force provides good, layered support, including psychological screening for specialist officers who repeatedly work on child abuse investigations. The force has developed an online mental wellbeing aid, which its workforce can use for advice and support.

Recommendations

- We recommend that Staffordshire Police immediately improves the effectiveness of its IT and communication systems. This is so operational staff can access the information and resources they need to effectively protect vulnerable people.
- We recommend that Staffordshire Police immediately reviews its governance and performance-management arrangements for child protection. This is so it can improve the force's approach and the end results for children.
- We recommend that Staffordshire Police immediately reviews the training it gives its workforce. This is so all staff have the right skills to support them in their duties to investigate crime and protect vulnerable children.

4. Case file analysis

Results of case file reviews

For our inspection, Staffordshire Police selected and self-assessed the effectiveness of its work in 33 child protection cases. Under HMICFRS criteria, the cases selected were a random sample from across the area.

Our inspectors also assessed the same 33 cases.

Cases assessed by both Staffordshire Police and us

Force assessment:

- 17 good
- 10 require improvement
- 6 inadequate.

Our assessment:

- 6 good
- 12 require improvement
- 15 inadequate.

Our inspectors selected and assessed 44 more cases during the inspection.

Additional 44 cases assessed only by us

- 13 good
- 11 require improvement
- 20 inadequate.

Total 77 cases assessed by us

- 19 good
- 23 require improvement
- 35 inadequate.

Our judgments focus on the outcomes for, and experiences of, children who come to the attention of police when there are concerns about their safety or wellbeing.

- In many cases, we found officers don't record the VoC.
- Focusing on a safe outcome for the child, or other children affected by the incident, isn't often a clear priority.

- In some cases, officers don't consider or fully deal with the offender's risk to children directly affected by the incident, or other children.

Many of the cases we judged as good were straightforward and the force concluded them quickly. In other cases, there was poor supervision. Managers often fail to make investigation plans and they don't focus closely enough on progressing cases. This means the best outcomes for children aren't always at the forefront of investigations or responses to incidents.

The force's self-assessments didn't always identify that officers aren't effectively recording or understanding the voices of children. Nor did they recognise that safeguarding activity is insufficient. In many incidents and investigations, the force's response is superficial. Often, officers focus on the initial concern without considering the wider risk presented by offenders. The force also often fails to consider the vulnerability of all those affected by the incident.

Breakdown of case file audit results by area of child protection

Cases assessed involving investigations under section 47 of the Children Act 1989

- 3 good
- 3 require improvement
- 6 inadequate.

Common themes include:

- in most investigations, there are prompt strategy discussions with CSC;
- but the force doesn't record investigation plans well with actions and updates;
- the force does make joint visits with other organisations, but in many cases, officers tell social workers to visit alone and then to decide how to continue the investigation;
- officers are inconsistently recording the VoC;
- officers don't always identify and address wider safeguarding risks;
- the force inappropriately assigns some investigations to non-specialists; and
- investigations often lack the right supervision.

Cases assessed involving referrals relating to domestic abuse incidents or crimes

- 1 good
- 2 require improvement
- 5 inadequate.

Common themes include:

- most responses are prompt;
- the force sometimes gives officers information about risk and vulnerability to help their approach; but

- in most cases, officers don't speak to children, or record their demeanour and accounts;
- officers don't use body-worn video (BWV) consistently;
- in some cases, officers make no referrals and send no Operation Encompass notifications;
- officers sometimes miss offences of neglect, and they often fail to hold strategy meetings with CSC, which they should be using to plan safeguarding arrangements for the children; and
- supervisory guidance and endorsement are inconsistent.

Cases assessed involving referrals arising from incidents other than domestic abuse

- 4 good
- 2 require improvement
- 4 inadequate.

Common themes include:

- officers don't always submit PPNs or make referrals for children quickly enough;
- this delays safeguarding activity;
- supervision is inconsistent;
- officers fail to speak to some children, or to record their demeanour and wishes; but
- officers do contact harm reduction hubs to get additional support for children from partners from other organisations.

Cases assessed involving children at risk from child sexual exploitation

- 2 good
- 8 require improvement
- 9 inadequate.

Common themes include:

- officers don't always speak to children or listen to them;
- officers don't always complete PPNs to record risk and vulnerability;
- officers often miss golden hour opportunities to gather evidence;
- there are often delays to actions that would benefit investigations or safeguarding;
- in online abuse investigations, the force doesn't record supervisor direction; but
- we saw some good supervision in other exploitation cases;
- Child Protection and Exploitation Team (CPET) officers held strategy discussions with partners from other organisations;
- we saw evidence of good initial research and prompt responses; but
- later case management often suffers from delays and a lack of focus on the best outcome for the child.

Cases assessed involving missing children

- 2 good
- 1 requires improvement
- 5 inadequate.

Common themes include:

- control room staff always make new records on the force's missing person COMPACT system;
- but in most of the cases, staff don't record a THRIVE risk assessment;
- some incidents are wrongly graded, and managers' decisions are delayed;
- supervision is ineffective and doesn't escalate activity to find children;
- investigating supervisors don't quickly oversee high-risk missing children incidents;
- staff complete PPNs inconsistently;
- staff use warning markers and intelligence poorly; and
- there are delays in sending officers to find vulnerable children.

Cases assessed involving children taken to a place of safety under section 46 of the Children Act 1989

- 1 good
- 5 require improvement
- 1 inadequate.

Common themes include:

- in most cases, police attend incidents quickly and safeguard children well;
- designated officer entries are inconsistent, but we did see some good supervision and decision-making;
- later supervision is less effective;
- officers record the voices of children and use BWV;
- officers speak to CSC, but they don't take or record formal section 47 of the Children Act 1989 strategy meeting decisions;
- in some cases, officers don't recognise crimes (in particular neglect);
- in some cases, officers don't record crimes correctly; and
- officers don't always submit PPNs.

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

- 5 good
- 3 require improvement
- 1 inadequate.

Common themes include:

- officers work well with probation officers to assess risk and complete joint visits to offenders;
- officers act appropriately when offenders commit offences;
- officers make referrals to CSC when they have concerns for children;
- we saw some records of strategy discussions, but sometimes safeguarding is delayed without explanation; and
- supervision isn't consistently in place.

Cases assessed involving children detained in police custody

- 1 good
- 1 requires improvement
- 4 inadequate.

Common themes include:

- officers give detained children their rights and entitlements when first in custody;
- there are long delays in appropriate adults attending to see detained children;
- in most cases we saw, there were delays before health care professionals saw children;
- inspectors review detention, but these reviews are often conducted remotely, without the inspector speaking to the child;
- this shows the force doesn't consider the VoC;
- officers don't routinely complete PPNs to refer children to CSC; and
- custody officers don't fully understand the need to find appropriate alternative accommodation – not just secure accommodation – for some children after they are charged.

5. Initial contact

The force has a single control room. Its Contact and Response Directorate is responsible for governance and leadership of the control room.

Contact and response staff aren't fully trained in safeguarding

Senior leaders told us all staff and new recruits had completed the College of Policing vulnerability training. But the force's training data showed only 48 percent of the 777 staff in the Contact and Response Directorate had completed this training.

Some staff told us they hadn't received any CPD on vulnerability or safeguarding. This means the workforce isn't fully familiar with the additional vulnerability of children who have had ACEs.

We saw examples of officers contacting social workers directly about children who were at risk and agreeing action to protect them. But officers are inconsistent in their approach to seeking out children at risk, speaking to them and considering wider safeguarding risks beyond the immediate incident. This often means they don't record the VoC or submit PPNs.

Officers aren't consistently recording all safeguarding incidents or all incidents where there are concerns about a child's welfare

Staffordshire Police uses PPNs on its Niche system to record concerns about vulnerability or risk to children. The force expects officers to make referrals about vulnerable children by sending PPNs to CSC. But officers are generally uncertain about when they should record or submit PPNs. Some officers told us they thought there was no need to record incidents on PPNs if they spoke with social workers on the phone.

We didn't see supervisors checking incidents or crime reports or instructing staff to complete PPNs. Officers' own supervisors don't review incidents or advise responding staff to record the voices of children or complete PPNs before incidents are closed. Supervisors based in the FCC don't do so either. This means the force has an incomplete record of children's vulnerability, and it misses referrals to other organisations that help children.

Risk assessment in the FCC is inconsistent

The force reports that it trains FCC staff to risk assess all calls using the THRIVE model. Forces use THRIVE to determine the level of response to new and continuing incidents. Leaders said their staff follow the national contact management learning programme when using the National Decision Model.

But in the incidents we examined, staff had recorded very few THRIVE assessments. They should have recorded these assessments to support decisions about the response a call should get. And supervisors should have recorded reassessments of continuing incidents and cases in which responses were delayed.

Supervisors in the FCC aren't effectively managing risk. This is a systemic problem. Incident records don't contain clear THRIVE assessments, so it is difficult for supervisors to understand the call-takers' decisions. It is also difficult for supervisors to check whether responses are appropriate. Members of the force told us there is a quality assurance process in the FCC, but this is ineffective.

We examined six FCC concerns for safety incident records, which had recently been closed. These cases all involved different vulnerable children, but officers had only submitted a PPN for one child. In three of the incidents, we were concerned the children might still be at risk, so we asked the force to review these to make sure the children were safe.

Case studies: two concerns for safety incidents in the FCC where children may have remained at risk

Summary of the concern for safety incident

The force received a report from an informant about historic sexual abuse against three victims, who are now adults. The suspect currently has contact with an eight-year-old child.

Police response

- A response officer attended, but the informant wished to speak to a specialist officer.
- The force didn't identify the child or arrange any safeguarding.
- No one from the force contacted CSC services.
- The force did obtain some family and address information.
- But no specialist officer visited the informant.
- No PPN was submitted.

The force reviewed this case and is satisfied the child is safe and no evidence of sexual abuse was found.

Summary of the concern for safety incident

A neighbour reported a child screaming and said the child's parents were screaming back and not consoling him. The neighbour said they then heard a slap sound, followed by a scream.

Police response

- Officers attended and saw the child.
- The parents told the officers the child was ill with an infection.
- The officers accepted the parents' explanation.
- The incident was closed without any checks with CSC services.
- No PPN was submitted.

The force reviewed this case and referred it to CSC. It had no records of previous incidents with this family.

The force doesn't always attend domestic abuse incidents affecting children quickly enough

Staff making decisions in the FCC don't always grade responses to domestic abuse incidents in the right way. We saw incidents where staff didn't deploy officers soon enough. We saw other incidents that were downgraded without good reason. And we saw incidents where officers' attendance was delayed without a new risk assessment justifying the delay. In some of these downgraded cases, the force still didn't meet the extended response time.

We randomly sampled some unresolved domestic incidents in the FCC. These incidents had been in the unallocated queue since the previous week. None of these incidents were graded as high risk. But many had children associated with the address where the incident took place. The delays in the force attending meant it couldn't assess the risk to children or act on it. Nor could the force gather information and pass it to other safeguarding organisations.

The force has a significant number of unresolved domestic abuse incidents, where risks to children are unknown and/or unassessed.

The force doesn't always support responding officers with full and prompt information about risk

The force trains its frontline staff to respond to domestic abuse incidents. But we saw only a few cases where the FCC helped responding officers by giving them more information. The force holds information on its systems that can be useful to responding officers. Examples of this are:

- when the address officers are attending is home to a child on a child protection plan; or
- when a court order is in place to stop offences being committed.

The force needs to make sure warning markers are in place and information from its systems is passed quickly to responding officers.

The initial response to domestic abuse is generally good, but officers don't always identify vulnerable children

The force's responding officers generally deal well with the immediate domestic abuse risks. But they sometimes miss wider risks and safeguarding opportunities.

Responding officers should record domestic abuse incidents, and complete a DASH assessment to establish the level of risk. If children are found at the address, officers should record their school details, so information can be sent to the school's safeguarding lead through a system called Operation Encompass.

Officers at Staffordshire Police don't always identify or record all children connected to the address, or all the adults involved in the incident. This means they sometimes fail to make Operation Encompass notifications.

The force's responding officers rarely record the voices of children. Too often, officers don't speak to the children, or record their demeanour and wishes on the DASH risk assessment or on a PPN.

Case study: responders overlook risks to children

An adult male suffering from a mental health illness, and under the influence of alcohol and drugs, attempted to assault his partner while she was holding their seven-month-old baby and a six-year-old child was present.

Concerned neighbours called the police. Officers responded quickly and arrested the adult male, taking him into custody. Ambulance staff examined the baby, who didn't need hospital treatment.

Officers didn't seek advice from emergency social workers or from child protection specialist investigators. They didn't hold a strategy discussion to share information or make joint plans with CSC services to safeguard the children.

The force bailed the suspect to the family address, but he had existing bail conditions not to go there.

The baby had a bruise, but nobody from the force arranged a child protection medical examination. Officers didn't record the voice of the six-year-old child, and they didn't make an Operation Encompass referral.

A social worker contacted the force the following day. The force had no clear record of the outcome of the incident, so staff asked the social worker to call back later when the officer returned to duty.

There was a delay in commencing the child protection investigation.

The force responds inconsistently to reports of missing children

The force's FCC system gives staff a set of questions, which should prompt them to gather and use information in a structured way. But staff in the FCC rarely use it.

We established that staff add information from the intelligence desk to the incident record. This includes adding warning markers to the COMPACT record. But warning markers on the force's systems aren't always in place as quickly as they should be. The force uses some markers, such as child sexual exploitation and self-harm, inconsistently. And warnings on one system aren't always present on another. For example, warning markers on Niche and COMPACT don't always correspond.

The force uses trigger plans to hold information about children who are frequently reported missing, so it can find them more quickly. It is vital that forces regularly update these plans, so they accurately reflect the risks and vulnerability of the child.

We saw some incidents where the force used trigger plans to help find missing children. But this isn't always the situation. In some cases, despite a trigger plan being in place, there is no marker on COMPACT to show where the plan is on the

force's system. The information contained in trigger plans is also inconsistent. For example, one trigger plan hadn't been updated for more than a year, even though the child had been reported missing a further 27 times in that period.

Case study: an ineffective response to a high-risk missing child

A 13-year-old girl was reported missing from home. She was upset because a male, who had nude images of her, was blackmailing her. He threatened to post these images on social media if she didn't send him more pictures.

FCC staff didn't risk assess the incident. They didn't deploy a response for more than an hour, and they didn't take swift action to start a criminal investigation.

The FIM carried out a risk assessment but inappropriately graded the incident as medium risk. They assigned the investigation to the missing person investigation team (MPIT), which was at the end of its duty.

Officers then reassessed the incident as high risk, but didn't put in place specialist investigator supervision, despite this being the national guidance.

The girl returned home, but no one at the force made a crime report about the blackmail. And no one at the force obtained evidence or removed the images from the child's phone.

The force hadn't fully considered the safeguarding of the child, and it made no referral to CSC services.

The force acted on the concerns we raised.

The force doesn't always complete risk assessments for missing children accurately or quickly enough

The force follows the College of Police Missing Persons authorised professional practice when assessing risk for missing children.

FIMs should review all missing person reports and complete their own risk assessments. But some FIMs' assessments don't identify or consider risk factors such as a child's recent threats to self-harm, or a child who may be at risk of exploitation.

In some cases, the response to high-risk missing children is delayed while the FIMs complete their assessments. This means the force doesn't always act promptly, so it misses early opportunities to find vulnerable missing children.

Overnight, the force has no investigations supervisor on duty for high-risk missing persons incidents. This is against national guidance. It means specialist investigation supervision isn't immediately available for high-risk cases that come to the force's attention overnight. Investigations are delayed until these officers are available. We saw an example of this: actions to locate a high-risk missing 13-year-old were delayed by more than 4 hours until investigation staff came on duty in the morning.

The force is trying to reduce the number of times children go missing

A strategic overview board for missing children considers ways of reducing the number and frequency of missing children incidents. The board holds missing child intervention meetings to discuss ways to stop individual children going missing. Its methodology involves holding meetings quickly when a child is reported missing 3 times within 90 days.

Force leaders told us missing children incidents had decreased by 24 percent. They said this is partly due to actions the force has taken, such as targeted approaches to staff in children's care homes. According to the force, there are 166 children's care homes in its area, and it assigns a local officer to each one as its point of contact.

Most reports about missing children are for those in care. But the way care homes in Staffordshire approach incidents when their children are missing is inconsistent. The force implemented the Philomena protocol in June 2021. Under the protocol, carers, staff, family and friends are asked to identify children at risk of going missing from care, and to record vital information that can be used to find them quickly and safely.

The force has created a children in care pack to help staff understand what information they need to establish, and what action they need to take, before making a report about a child missing from care. Officers told us the force isn't using the pack consistently yet. The force recognises it needs to do more to make sure staff use the pack, including implementing training.

It is often unclear who is responsible for managing missing person investigations

Supervision of missing children investigations isn't always in place. During office hours, the MPIT leader is generally in charge of supervision. But officers told us there is no back-up when the MPIT leader isn't there.

Outside office hours, and when the team leader is absent, MPIT officers aren't directly supervised. But the force expects them to progress actions for all medium-risk missing person incidents and to reassess risk in other unresolved missing person investigations. Due to ill health or other personal circumstances, all MPIT staff are on desk-based restricted duty.

Due to job vacancies, there aren't enough staff available to progress investigations. These investigations sometimes stall because response-team officers assigned to work on investigations are re-assigned to higher-priority incidents.

The lack of clarity about who controls missing person investigations results in poor communication across the force. Officers, FCC staff and supervisors are often unsure who is responsible for certain actions. This means they are also unsure what priority those actions should have.

Case study: poor supervision of a high-risk missing child incident

Staff at a care home reported a 12-year-old boy missing. He was vulnerable, with learning disabilities, epilepsy and behavioural problems. They thought he was at high risk because he had recently said he intended to jump in front of a train.

The FCC operator recorded the incident but didn't use a THRIVE assessment. The FCC referred the incident to the FIM because the operator assessed it as potentially high risk. The FIM was unavailable, so the control room manager decided to grade the incident as high risk.

No police response was deployed until the manager graded the incident. Then several units were allocated to the incident. Control staff quickly requested assistance from the British Transport Police (BTP), but were informed there weren't any officers available at Lichfield or Stafford railway stations.

A detective sergeant reviewed the report. But they didn't record any immediate actions or direct the assigned units to carry out specific actions such as directing officers to train stations.

The incident record did not specify who had command of the investigation and what the priority actions were. A later entry by a specialist search officer considered contacting BTP but noted they had no officers present.

The missing child returned home of his own accord. He was unharmed.

The force shares information about missing children with other organisations, but it is inconsistent in the way it records intelligence that helps to reduce risks

The force works with the local authorities and the Office of the Commissioner for Staffordshire to provide a specialist service that supports children who go missing. Trained workers speak to children, listen to them, and support them after they return home. They obtain information about the child's vulnerability and risks that affect them. They pass this information to the force, which includes it on its systems.

But the force isn't always transferring information from individual COMPACT records on to its Niche records-management system. This reduces the force's understanding of the risk to children. For example, in one case we saw, the force failed to add information to Niche about an adult male who was arrested for abducting a high-risk missing child. Nor did it associate the information with the child's record.

The force makes COMPACT records available to other safeguarding organisations, so those organisations are informed about vulnerable children, their associates and those who are a risk. But officers submit PPNs for missing children incidents inconsistently.

Recommendations

- We recommend that Staffordshire Police immediately improves supervision and processes within the FCC so that:
    - it effectively identifies risk and vulnerability;
    - it correctly grades and assigns responses;
    - FCC staff receive training and understand their responsibility to safeguard vulnerable people and children;
    - flags and warning markers are accurate, and are used to inform and prompt responding officers;
    - supervisors check decisions and open incidents, and escalate responses when they should; and
    - an audit process is in place to identify concerns and inform learning.
- We recommend that Staffordshire Police immediately improves its arrangements and practices for responding to incidents of missing children.
- We recommend that within six months Staffordshire Police makes sure staff and officers responding to incidents don't overlook vulnerable children at the location of the incident, or at other locations associated with the adults who are causing concern, by:
    - training officers and staff to understand the VoC;
    - clarifying when staff should complete PPNs, and what information PPNs should contain; and
    - making sure incidents are supervised effectively.

6. Assessment and help

The force uses effective multi-agency arrangements to safeguard victims of domestic abuse

The force regularly holds a MARAC for domestic abuse referrals at each of its ten harm reduction hubs (which are described on page 18). In eight hubs, MARACs take place weekly. In the other two, where case volume is lower, they take place at least monthly. This means case reviews aren't delayed.

We saw partner organisations joining police at MARACs, and we saw attendees making positive contributions. So safety planning is of a good quality. The force uses SharePoint to hold case records, so all organisations involved in the MARACs can access and update safety plans.

The force understands the importance of effective safety plans to reduce harm from domestic abuse. It commissioned a leading domestic abuse charity to give specialist training to police and partners. This has been vital in making sure MARACs are well organised.

A team of problem-solving specialists at the force gives tactical advice to local early intervention officers. The team also advises those with responsibility for thematic concerns such as child exploitation, modern slavery and domestic abuse. This helps the force and its partners assess complex risks to children's safety and make lasting interventions.

The force works with other organisations to assess and support victims' needs

The force automatically refers victims of crime (unless they decline the service) to the Staffordshire Victim Gateway. This independent service contacts victims of crime to assess their needs and identify the right organisation to help them.

Multi-agency child exploitation (MACE) meetings and child abduction warning notices (CAWN) help the force and the organisations it works with assess and reduce risks for vulnerable children

Senior detectives and social care managers chair MACE meetings, which take place in the North and South parts of the force area. The meetings are well attended by representatives from safeguarding organisations. The meetings focus on individual children who are at high risk of exploitation. In 2020, they discussed 449 children. During the meetings, they also identify risks and persons of concern, and assign actions to the most appropriate service. This improves outcomes for children.

We saw that the force also makes effective use of CAWNs to disrupt suspects they assess as a risk to some vulnerable children.

The force assesses information with other organisations in a MASH, but processes are inefficient

Statutory guidance in *Working together to safeguard children* 2018 states:

> Everyone who works with children has a responsibility for keeping them safe. No single practitioner can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.
>
> Anyone who has concerns about a child's welfare should make a referral to local authority children's social care and should do so immediately if there is a concern that the child is suffering significant harm or is likely to do so. Practitioners who make a referral should always follow up their concerns if they are not satisfied with the response.

Under the current MASH model, staff from Staffordshire local authority work with the police. They also work closely with organisations including the National Probation Service, Midlands Partnership Foundation Trust and North Staffordshire Combined Healthcare Trust. Staff from Stoke-on-Trent local authority were recently withdrawn, and MASH staff now work remotely with them.

There is a substantial police MASH team with a dedicated manager, police sergeants, and police staff supervisors and staff. The force is currently increasing the number of sergeants and staff in the MASH team. This will extend its operating hours and improve its capacity for assessing referrals and providing safeguarding advice.

Strategy meetings take place through video conferences. But currently, the force's system doesn't allow the police to use this technology. Instead, they participate by phone.

Police supervisors in the MASH team aren't specially trained for their role

The Children Act 1989 promotes the benefits of multi-agency contributions to child protection. Different organisations hold complementary information about children, their families and those who are a risk to them. Multi-agency investigations under section 47 of the Act allow organisations to share information and carry out joint investigations to protect children from harm.

Where children are at risk of abuse or neglect, the organisations need to hold strategy discussions quickly. This is so they can understand the risks and plan together to protect children and investigate the incident effectively.

CSC managers call most of the strategy meetings, and MASH sergeants attend them. Outside office hours, duty social workers and police officers can hold meetings together. But we didn't see many examples of these strategy discussions being recorded on police systems. We were told some specialist teams, such as those investigating child exploitation, hold strategy discussions with social workers responsible for children involved with CSC services.

The sergeants in the MASH aren't detectives. Most aren't trained as specialist child abuse investigators. But their main responsibility is to decide which referrals should be progressed as either single-agency or joint-agency child protection investigations. In some incidents with an allegation of crime, we saw some sergeants agreeing with social workers that the social workers would make initial investigations by themselves. For example, in some cases of assault on children by family members, sergeants decided the police would only get involved if the social worker identified additional concerns.

When MASH sergeants decide the police will investigate concerns, they assign the crimes to teams within the force. Sometimes, they allocate investigations into complex crimes to teams or officers who don't have the right experience or capability. For example, incidents involving abusive indecent images of children linked to exploitation have been assigned to NPTs. In other situations, such as domestic abuse incidents, we saw responding officers didn't fully recognise the risk to children, and MASH supervisors didn't request strategy meetings.

Members of the force and staff at its partner organisations told us there isn't a process in place for the MASH to examine how effective its processes are, or how good decision-making is.

The MASH team doesn't assess all police referrals or notifications of concern for children

The police MASH team doesn't see all the PPNs submitted by its colleagues because the notices are forwarded directly to CSC. This means police officers can't assess or supervise the process.

We are concerned about this. Officers and staff in a variety of roles told us they are uncertain about when they should submit a PPN and what they should include on the form. They often don't complete PPNs when they should. Officers told us they

wouldn't submit a separate PPN for children affected by domestic abuse if they also complete a DASH assessment.

The MASH team doesn't review standard-risk DASH assessments, but staff send them to the harm reduction hub responsible for the incident address. Hub staff then send some of these assessments to the MASH team because they identify additional risk.

Instead of reviewing all PPNs and DASHs in a systematic way, police in the MASH only review high and medium-risk DASH assessments. They also research CSC's referrals in preparation for strategy discussions. And they carry out research when social workers need more information to assess child in need cases.

There are delays in the police MASH process. At the time of the inspection, there were 112 tasks on the force system waiting to be reviewed. The force didn't appear to appreciate the risk caused by this backlog.

The force doesn't have any triage in place to identify the level of risk or prioritise the partnership response to the concerns its staff record in their PPNs. When we inspected, the police MASH staff didn't have access to CSC systems. This meant it couldn't check whether children were involved in active cases or pass the information directly to those dealing with the child.

If responding officers don't immediately recognise cases as high risk, or as needing a child protection investigation, the force doesn't always assess them further. MASH managers told us the vast majority of PPNs CSC receives are closed, and no one takes further action. This means the information about risk to children contained in the PPNs is unassessed.

The force doesn't have enough staff to attend child protection case conferences

When there are concerns that a child is at risk of significant harm, CSC holds a meeting known as an initial child protection case conference. This is to identify risks and plan for the safety and wellbeing of the vulnerable child. CSC arranges the meeting and invites police and other safeguarding organisations with knowledge of the child and their family. CSC asks the organisations to provide information from their records so those at the meeting can assess the risks and protective factors. Those attending can then decide if a child protection plan is in the child's best interest.

This initial meeting is a forum for child protection specialists to raise concerns. It is also a chance for them to challenge the level of service organisations are currently proposing to protect and support the child. If those at the meeting place the child on a protection plan, they will periodically hold review conferences to check whether they need to continue the plan or end it. They will also decide on matters such as a lowering the level of support or escalating to court proceedings. Effective decision-making depends on contributions from skilled and knowledgeable professionals. Police participation is vital to this process.

The force has a small child protection conference team, and its priority is to provide reports to child protection case conferences. They told us they provide reports for

100 percent of the conferences. But the team doesn't have enough staff to attend all the conferences across the force's area. Attendance at the conferences is subject to the availability of investigating officers or neighbourhood staff with an interest in the case.

Staffordshire Police attendance at child protection case conferences

Staffordshire CSC provided child protection case conference data for the six-month period of 1 March to 31 August 2021.

During this period, Staffordshire CSC held 691 child protection case conferences about 1,175 children (conferences include multiple siblings). The police provided reports to 99 percent of the conferences and attended just 23 percent of the conferences.

Stoke-on-Trent CSC provided initial child protection case conference data for the six-month period of 1 March to 31 August 2021.

During this period, Stoke-on-Trent CSC held 165 initial child protection case conferences for 334 children (conferences include multiple siblings). The police attended 70 percent of the conferences. However, the data shows a significant decline in attendance over the six-month period: police attendance was 91 percent in March and decreased to 42 percent in August.

At the end of each meeting, the police conference team is responsible for updating force records. This is important because markers about vulnerable children on force systems help frontline staff respond well to incidents. Members of the force told us that sometimes there are delays in receiving conference minutes. This means force systems aren't always updated soon enough.

The quality of information used to assess risk isn't consistent enough

We found officers aren't consistently recording information about people's ethnicity and cultural heritage on force systems. At the time of our inspection, the force hadn't implemented mandatory data fields to collect this information. This information helps forces understand the prevalence of particular crimes and the type of incidents affecting individuals or communities.

The workforce hasn't yet fully understood how Niche works. This is the force's investigation and intelligence system. As a result, the force doesn't always record information in the right way and in the right place. For example, warning flags or markers about risk or vulnerability aren't always available to frontline responders.

The force completes some quality assurance audits, but the emphasis is on process. The emphasis should be on the quality of information, investigation and supervision, as well as the outcome for the child. One effect of this is that officers don't receive feedback from the force, or from partner organisations, about the quality or content of referrals they make on PPNs.

Recommendations

- We recommend that within three months Staffordshire Police reviews its assessment and information-sharing practices so it can:
    - identify vulnerable children at the earliest possible stage; and
    - refer those children without delay to the most appropriate level of support.
- We recommend that within three months Staffordshire Police improves its attendance rate at child protection case conferences held in Stoke-on-Trent and Staffordshire. So that police attend these meetings in person to contribute more effectively to decision-making about the measures needed to protect a child from risk.
- We recommend that within six months Staffordshire Police introduces a process to review all its PPNs:
    - to check the information is complete;
    - to check that any immediate safeguarding action is in place;
    - to include any other relevant information from police systems for context;
    - so that crimes are recorded; and
    - that it is necessary and proportionate to forward the information to the other organisations.

7. Investigation

Specialist officers in the CPET told us their workload was sometimes too challenging

The force's two CPET teams (North and South areas) are staffed by qualified detectives, or trainee detectives working towards detective accreditation. All the detectives are trained in the specialist child abuse investigation development programme. This means they have the skills and knowledge to manage joint child protection investigations with other organisations.

With staff from other safeguarding organisations, officers attend a multi-agency investigative video interviewing course. This means officers know they need to use intermediaries to help communicate with vulnerable children in early-stage evidential interviews. The training helps them avoid significant delays and respond better to victims' needs.

Before the COVID-19 pandemic, the CPET routinely included a social worker from Staffordshire CSC. Officers spoke positively about the immediate benefits of this arrangement. They said it allowed both organisations to check facts and reduce delays when working to protect children.

The force collaborates with other forces in its region and has good access to sexual assault referral centres for victims of all ages. This means a long journey for some children, but officers told us the service provision is good. These centres also support victims who wish to self-refer. They can access specialist support services without first contacting the police.

Staff in the CPET receive an annual welfare assessment. They told us they also have good peer support from colleagues and managers.

Forces need robust and capable investigative teams to deal with child abuse and neglect within the family. This is because children at risk in the family environment are highly vulnerable; they are likely to become victims of exploitation and further abuse.

The CPET has a broad remit and is responsible for investigating complex offences and incidents. CPET staff told us they feel ill-equipped to deal with the increasing numbers of child exploitation investigations assigned to them. This is partly because exploitation investigations often need a proactive investigation. However, the usual focus of the team is reactive investigation into allegations of child abuse and neglect within the family. They said it was problematic to manage both types of investigation at the same time.

CPET officers told us of investigations being delayed because some of them were sometimes assigned to other duties, including public order events. They told us that recently they have also been assigned to investigations involving suspects downloading and distributing indecent images of children.

Staff and supervisors told us their workload was challenging and, in some situations, excessive. Some said they were close to breaking point.

Supervision of child protection investigations is inconsistent

Frontline responders tend to focus on the incident they are called to. They don't always consider wider safeguarding risks and investigative opportunities. This means some officers don't speak to children, and they don't always recognise risks to children such as neglect. They don't always record criminal offences or submit PPNs for vulnerable children. Supervisors don't always identity these gaps, meaning evidence is lost. As a result, some children stay vulnerable.

Supervisors' reviews of some specialist investigations are inconsistent. In these reviews, some entries only note previous entries; other entries are made when authorising case closure. In some cases, the lack of supervisory direction and planning means investigations drift. This means officers don't clearly identify and progress lines of inquiry.

The CPET should deal with all cases where there is an identified risk of child sexual exploitation. This should mean investigators and supervisors have the skills and capability to progress these cases. But we saw – and officers told us – that the force sometimes assigns child sexual exploitation investigations to other units and officers.

In one child sexual exploitation investigation record, we found a five-month delay before a supervisor made an entry. In two other cases, supervision only happened at the point of the case being closed. This means the force can't be sure it is properly overseeing its investigations.

In some cases, despite a record of criminal allegation such as an assault on a child, the force didn't investigate until a social worker visited the child. It was left to the family to decide whether to involve the police.

Case study: failure to investigate child neglect

Officers were called to an incident. A mother and her female friend were intoxicated and pushing a pram containing a three-year-old child. Police arrested the women for drug offences and took the child into police protection. CSC services arranged an emergency foster placement.

Police interviewed the women and later released them under investigation of drugs and theft offences.

But the use of police protection for the child hadn't been authorised by a designated officer, and it wasn't recorded on the force system.

No PPN was submitted for the child or a crime report for the offence of child neglect. It meant there was no record of a strategy discussion or any investigation plan.

A week after the incident, an offence of child neglect was recorded on the force system.

Six days later, the investigating officer made their first entry. It was a note stating the child's social worker believed CSC was likely to start legal proceedings.

There was still no record of a strategy discussion or an investigation update.

No effective child protection criminal investigation took place.

The force acts proactively to tackle gangs who exploit children

We saw examples of proactive investigations where the force acted decisively to protect children at risk from gangs and criminal activity. These investigations were well led and resourced. They show the force works well with partner organisations to help children vulnerable to exploitation. These investigations have been successful in disrupting violent street gangs.

On top of this, multi-agency diversionary activity helps stop some vulnerable children being criminalised. The force recognises the benefits of this approach, and it reviews these operations so it can learn from them. It intends to use similar approaches to benefit other children vulnerable to county lines exploitation and gang violence.

The workforce doesn't always understand its role in investigating concerns about exploited children

When the force identifies children at risk of exploitation, frontline staff usually respond quickly. The information on the force's systems generally supports this fast response, showing warning markers have been used effectively. We also saw MASH and CPET specialists directly support officers at the scene. This means risk of child exploitation can be managed at an early stage.

Some officers use BWV to record what they see and what people say. This is the right thing to do. It allows them to distribute this evidence quickly, helping other

professionals understand the risks and make the right decisions to safeguard children. But the use of BWV isn't consistent. And in many cases, we found officers don't pursue basic initial investigations. Meanwhile, supervisors don't direct responders as they are working. This means the force misses golden hour opportunities to gather evidence and safeguard children.

Officers told us they are confused about people's roles and responsibilities in the force's response to child exploitation risk. They feel it is fragmented. Responsibility for different aspects of investigation, safeguarding and disruption activity are held by officers in various teams across the directorates. This sometimes leads to gaps in investigations and duplication of work. Contact between police and CSC services is often delayed. This means the force may be missing strategy meetings and opportunities to promote the welfare of children.

Some officers told us they thought it was their job to decide whether or not to create a PPN for a child concern incident. But when a crime isn't recorded and a PPN isn't submitted, the force is likely to miss a referral and a strategy meeting for an exploited child.

Supervisors should be overseeing initial investigations and directing officers on what further action they need to take. But investigating officers and supervisors rarely complete investigation or safeguarding plans. Without plans, investigations lack focus and direction, and the force isn't carrying out important inquiries quickly enough. In these cases, the force is missing or delaying opportunities to challenge perpetrators and keep children safe.

Case study: missed opportunities in a child sexual exploitation investigation

Officers responded quickly when a 14-year-old child reported an adult male had sexually assaulted her and given her cannabis at his home.

Officers arrested the suspect and used BWV to record the girl's initial complaint. They identified that she was vulnerable and at risk of child sexual exploitation.

Officers interviewed the suspect, who told them the child was suicidal.

They didn't complete a PPN, but they did send a MASH police incident referral form. Nobody reviewed this form until five days later, when it was also sent to CSC.

Officers held a strategy discussion with CSC services. They decided a joint investigation was needed. A week later, they carried out a joint home visit to the child. It was only at this point that they raised the question of suicidal thoughts with her.

We saw unaccounted-for delays in this investigation. These meant the force missed early opportunities to gather evidence and safeguard the child. There was no record of any decision-making about a safeguarding plan for the child.

The supervision was ineffective because it didn't address the delays or prioritise actions.

The force's response to online child abuse investigations is ineffective

The force has a specialist team called Operation Safenet, which manages intelligence notifications about online child abuse offenders from national and international law enforcement agencies.

Intelligence from the NCA, child protection systems and child online protective services (as well as other sources) informs the force of addresses in its area where indecent images of children are being downloaded or distributed. The force must then risk assess the information so it can safeguard children and deal with offenders.

When the force first records this information, its intelligence unit initially screens intelligence and checks social media sites to identify suspects. But it often doesn't carry out checks with other safeguarding organisations quickly enough.

There are too many delays before officers act to safeguard children from online child abuse

The force should be mindful of the statutory guidance *Working together to safeguard children* 2018 when it uses information to reduce the risk to children from online abuse.

We found a backlog of about 90 intelligence notifications. The oldest of these was three months old. The Operation Safenet team knew that approximately 25 percent of these notifications had children associated with the address. But the team doesn't generally give this information to CSC or other organisations until 24 to 36 hours before it acts. So, police and other organisations aren't always assessing the risk to children as quickly as they should. Children are routinely being left at risk of harm when the force could intervene.

When Operation Safenet officers find children associated with the address, they usually refer them to CSC via the MASH after they make arrests. This delays social worker involvement as it takes at least a day to progress MASH referrals.

Operation Safenet officers don't submit PPNs for children when they should. The team submitted one PPN in the ten investigations we reviewed. This undermines the quality of the force's own records. It also means other organisations may not respond in the right way to other concerns about the children.

Officers should hold strategy meetings with other safeguarding organisations so they can share information, assess risk, and plan and prioritise activity together to protect children. But Operation Safenet doesn't routinely follow these statutory arrangements. As a result, the team fails to consider certain vital pieces of information and insight about risk when it makes assessments and plans. And it sometimes misses the chance to communicate effectively with vulnerable children.

Case study: delays in an online child abuse investigation

In October 2019, Staffordshire Police received intelligence about an address where online offending against children was suspected. During April 2020, the force identified two young children were resident there, but it didn't send this information to CSC.

In July 2020, Operation Safenet officers spoke to the suspect, and he let them search his address. They seized his mobile phone and he agreed to a voluntary interview, which was delayed until a solicitor could advise him.

Only at this stage did the force refer the children to CSC.

The suspect didn't fully co-operate, but eventually police digital forensic officers recovered indecent images of a female child victim from his phone. She had been exploited.

The force had received the initial intelligence in October 2019, but officers didn't seize the phone until July 2020. These images had been shared in that period.

The case record didn't explain why officers delayed the investigation, or why they didn't quickly give the information to CSC to build a comprehensive joint risk assessment.

There was no investigation or safeguarding plan in place, and there was no supervision.

The delay in the initial part of this investigation gave the suspect time and opportunity to commit further offences.

The force can't deal with the demand from online child abuse

There are significant delays in investigations due to the backlog in the digital forensic unit (DFU). Apart from the equipment in the DFU, there isn't a forensic facility for investigators to take images from mobile phones.

The DFU's initial triage facility is good, but it is not readily available across the force. The current service level agreement for examining mobile phones doesn't include initial downloads from children's phones. There are three-month waiting times for these examinations. The limited forensic resources mean online child abuse investigations are delayed.

However, the force effectively assesses the electronic devices officers find in searches and when they arrest suspects. DFU specialists work directly with officers and attend scenes of pre-planned investigations. This approach often results in good-quality early evidence of offences. It also helps investigators when they question suspects and identify victims.

But overall, there aren't enough staff, supervisors, or forensic specialists in place to deal effectively with the current level of online child abuse in the force's area.

The single Operation Safenet team sergeant is so overloaded with work, they can't meaningfully supervise investigations.

We found that most Operation Safenet cases lack plans to safeguard children or to structure the investigation activity. So, investigations are focused on the suspect and the clearly recognised victims. Investigating officers often overlook other potential victims. And because of the lack of supervision, no one prompts officers to consider the risk offenders may pose to other children.

The Operation Safenet team doesn't record why it makes policy decisions or risk assessments during its investigations. This means it can't justify delays between the time it identifies suspects, and the time officers apply for search warrants or make arrests.

Officers ask some suspects to voluntarily attend police stations for interviews, rather than arresting them. This means they miss opportunities to thoroughly search suspects' premises to identify evidence of the offence, or of other similar offences. Without making arrests, the police also can't use bail conditions to safeguard vulnerable witnesses or children.

The force isn't contributing enough to national systems to tackle online child abuse

The force has a desktop link to view images from the national child abuse image database (CAID). This can help police identify victims faster when they are researching intelligence or investigating offences. Forces should be using forensic triage systems to help them identify children and offenders. By inputting confirmed information on to the CAID, forces help officers (locally, nationally and internationally) identify new indecent images and children who are at risk.

Officers and their managers told us Staffordshire Police isn't currently using or contributing to the CAID. This means the force isn't using victim identification tools such as facial and crime scene identification to help future investigations. And it isn't adding the details of victims it identifies in images its officers seize. The force should be doing this for all investigations. This is because when officers in other forces seize images of those victims in other investigations, investigators both in the UK and abroad will know those children have been identified by police.

The force knows about a problem with some child protection systems' notifications, which means it receives online abuse cases from two other forces' areas. Leaders told us they had already identified these cases and spoken to the other forces, so the intelligence issue had been resolved. But when we checked the system, this wasn't the case. There was no notification about what action the force had taken. This means the risk to children from this situation is still unknown. Staffordshire Police, the other forces and the system managers should quickly address this problem. This is so they can safeguard children and have a process in place to identify and resolve any future problems.

Officers investigating online abuse don’t always understand their primary purpose is to safeguard children

Specialist officers train staff from the NPTs. The specialists also advise and guide other colleagues about investigating online crime, including abuse involving self-generated images. If supervisors in harm reduction hubs see a need for specialist investigation, they refer cases to Operation Safenet or seek advice from the CPET.

In some cases we reviewed, investigating officers didn’t speak to the child victims. This shows they don’t understand the importance of seeking the VoC.

Case study: the force responds slowly to safeguarding victims from online abuse

An unknown male persuaded a 13-year-old girl to send him self-generated naked images of herself. He sent these images to three other people; whose identities are also unknown.

He then tried to blackmail her by threatening to send the images to all her contacts unless she sent him more pictures and videos of herself.

Another girl contacted her online and said that she too had been similarly abused by the suspect. This was included in the report to police.

The investigation was assigned to an officer on an NPT. There was no investigation plan on the case record, and the officer didn’t submit a PPN or a safeguarding plan.

We found no lines of enquiry in progress to identify the suspect or the other victim, and there was no direction or oversight from supervisors.

We asked the force to review the case and it responded that an investigation was ongoing and both victims are safeguarded.

Recommendations

- We recommend that Staffordshire Police immediately improves child protection investigations by making sure:
    - it effectively supervises investigations, with reviews clearly recording any further work that is needed;
    - safeguarding referrals are prompt and comprehensive;
    - the VoC is clear and included in decision-making;
    - it appropriately supports joint multi-agency investigations;
    - it assigns investigations to officers with the skills, capacity and competence to progress them effectively;
    - it regularly audits the quality of practice, including how effective safeguarding measures are; and
    - it focuses on achieving the best end results for children.
- We recommend that within three months Staffordshire Police reviews its arrangements for investigating online crime against children by making sure:
    - it reduces the backlog of referrals to Operation Safenet from national and international law enforcement agencies;
    - it quickly identifies risks to children by sharing information with other safeguarding organisations;
    - it makes decisions in consultation with CSC to improve the safeguarding response to children;
    - it records and effectively supervises investigation and safeguarding activity;
    - it always considers the VoC in investigations and reflects this in decision-making;
    - it explains and records decisions about how it manages the risk from offenders; and
    - with other safeguarding organisations, it considers and addresses wider safeguarding risks the offender may present to other children.
- We recommend that within three months Staffordshire Police reviews how it manages information about online child abuse from national and international law enforcement agencies. This should include:
    - improving how it uses the CAID; and
    - identifying accurately addresses on other systems that are outside the force's area and passing on this intelligence without delay so other forces can act on it.

8. Decision making

The force used police protection powers well in all the cases we audited, but record-keeping is often poor

It is a very serious step to remove a child from a family by way of police protection. When there are concerns about children's safety, such as parents leaving young children at home alone or being intoxicated while looking after them, officers handle incidents well. When assessing the need to take immediate action, they use their powers well to remove children from harm's way.

In the cases we examined, decisions to take a child to a place of safety were well-considered and made in the best interests of the child.

Responding officers record information on the force's police protection form. They say why they needed to use the power, explaining:

- the scenario;
- the parents' attitude;
- the child's demeanour, behaviour and appearance; and
- the risks they feel are likely to cause harm.

Officers also record these incidents on their BWV cameras. But they don't consistently complete PPNs to pass this information to other safeguarding organisations.

Forces can use police protection powers for a maximum of 72 hours; officers should make a record when the powers end. However, when the powers are rescinded before the maximum time has elapsed – such as when a child goes into the care of a family member – officers at the force rarely record these details. Nor do they record details of what the longer-term protective plan is likely to be.

The records we saw of children in police protection show it often takes some hours before designated officers review the use of the power and the need for it to stay in place. In some cases, designated officers don't review the situation either after the initial decision, or on handover at the end of a shift. They are not always balancing the need to keep the power in place against the effect on the child's welfare. Also, it isn't always clear why the use of the power is being stopped, and officers don't always state the reason on the police record.

There is good early communication between frontline officers at incidents and CSC staff, but officers aren't always recording it properly

We saw that responding officers often speak to staff in the MASH at an early stage, or to emergency duty social workers outside office hours. But it often isn't clear if these interactions are formal strategy discussions or just responders seeking advice.

Police records of these incidents are frequently incomplete. In most of the cases we saw, there was no subsequent record of a strategy meeting with CSC.

On some occasions, children at risk aren't taken into police protection. But after CSC direction, officers quickly place them with other family members on a voluntary agreement basis. Although this may be practical in some situations, in others, the voluntary agreement doesn't prevent a parent from reasserting their right to take control of the child. Also, officers don't always check to make sure the people at the placement address are suitable. When they do make these checks, they don't always record them.

Neglect is a serious risk for children and officers don't always recognise it

We saw cases where officers appropriately used police protection powers to prevent harm to children. Removing children to a place of safety is an important first step.

A joint-agency child protection investigation should start with a strategy discussion held promptly with CSC services. Trained child abuse investigation officers should progress these investigations.

In many of the incidents we reviewed, we found that officers protected the children. But officers don't always identify the incidents as crimes, particularly in cases of neglect. They don't always hold strategy meetings and they don't always effectively pursue child protection investigations.

Case study: officers take children into police protection, but they don't make adequate records

After a call from a neighbour, officers responded quickly to a domestic abuse incident in a house where two children aged two and four were known to be on child protection plans. The force records showed the children's mother was a victim of previous domestic abuse incidents. Officers established she was unable to care for the children.

The officers contacted emergency social workers, who attempted to find other family members to look after the children. These attempts were unsuccessful, so the officers took the children into police protection. CSC services found them an emergency placement.

The officers recorded the incident on the force's police protection forms and submitted a PPN. A designated officer oversaw their actions and endorsed their use of the power. But we found no further records.

This means police didn't oversee the end of the use of the power. There was no record of a strategy meeting or child protection investigation taking place. There was also no record of whether officers had considered criminal offences.

Case study: officers act decisively about police protection, but they don't record or investigate child neglect

Neighbours reported that a one-year-old child was in danger from his parents, who were abusing alcohol and drugs. Officers responded and saw the child was at risk. They acted decisively and took the child into police protection.

The officers spoke to a duty social worker. They decided to take the child to its grandparents. A designated officer endorsed the decisions and recorded the end of the use of the power.

But officers didn't hold a strategy meeting with CSC or complete a PPN. The criminal offence of child neglect wasn't recorded on force systems. So there was no investigation.

Recommendation

We recommend that within three months Staffordshire Police improves its practices for when children are taken into police protection, making sure:

- it always holds strategy discussions with CSC;
- officers accurately record relevant information and decisions;
- it investigates and records criminal offences; and
- inspectors regularly review and endorse the use of protective powers.

9. Trusted adult

It is important children feel they can trust the police. We saw that, in some child protection cases, officers carefully consider how best to approach a child and/or their parents or carers. In these cases, they explore the most effective ways to communicate with them. Such sensitivity builds confidence and creates stronger relationships between the police and children, parents and/or carers.

Staffordshire Police works well with other safeguarding organisations and professionals to protect children when they need immediate safeguarding.

The force uses its existing structures to build stronger relationships with vulnerable children

The force promotes its voluntary police cadet scheme as a way of engaging with children. There are currently more than 200 cadets, with a waiting list of about 180 young people wishing to join. The cadets are based at each of the force's ten neighbourhood policing areas. The scheme encourages children to apply themselves. But the youth offending team may refer children at risk of being involved in crime.

The cadets meet weekly, and officers and guest speakers train them on subjects such as safeguarding and dangers. Some cadets have supported policing projects and activities. These include operations involving the test purchase of age-restricted products, and weapon sweeps (looking for weapons that have been discarded or hidden) at events.

The force understands the benefits of working closely with schools to engage with children. Frontline staff on NPTs make links with schools in their areas. This builds trust and helps the force communicate and respond more effectively when it believes children are vulnerable or at risk. This approach means the force doesn't need to assign specialist schools liaison officers. The force also encourages contact between the harm reduction hubs and school staff.

The force works with other organisations to reduce the risk to children from criminalisation

The force doesn't want to unnecessarily criminalise children. We saw this in its strategies to tackle county lines and gangs that exploit vulnerable children in parts of the force's area.

Leaders clearly prioritise identifying the people who pose the greatest threat to children. In Stoke-on-Trent, proactive policing operations tackle gangs involved in drug supply and violent offences. Working with staff from other organisations allows the force to identify vulnerable children and to give them support instead of charging them with criminal offences.

10. Managing those who pose a risk to children

A dedicated specialist team manages the risk from RSOs

The sexual offence management unit (SOMU) manages RSOs in the community. At the time of this inspection, Staffordshire Police was managing 1,655 RSOs. The number of RSOs increases yearly by about 7 percent. The force recently increased the size of the SOMU team, adding one more detective sergeant and six offender managers. This means its supervision ratios of about 50 RSOs to each offender manager is within the national guidelines. SOMU officers told us the unit contains a good level of specialist trained staff.

The unit also supports multi-agency public protection arrangements (MAPPA). Representatives from all appropriate agencies attend and contribute effectively to MAPPA meetings. SOMU officers work closely with probation officers from the National Probation Service, who manage offenders subject to court-imposed licence restrictions.

SOMU staff generally work well with other policing teams and multi-agency partners, but communication and risk management aren't always effective

SOMU staff make risk assessments before visiting RSOs. The police use the active risk management system (ARMS) to determine how they manage RSOs in the community. This means it uses more resources on the offenders causing greatest concern. It can mean the police visit these offenders more often than those it assesses as a lower risk.

During the COVID-19 pandemic, the unit has been resilient. It has continued to visit offenders in person unless there is a valid reason not to do so. Some other forces severely restricted visits. As a result, they missed opportunities to fully understand the risk from offenders they didn't see, or who they only contacted remotely.

We saw some good examples of SOMU staff acting quickly when they received information that RSOs were a risk to children. This included promptly notifying CSC and probation. SOMU also works with NPTs to arrest offenders for breaching sexual harm prevention orders (SHPOs).

The SOMU team often includes neighbourhood policing officers, PCSOs and some special constables when visiting offenders. This means SOMU officers can complete more visits and assessments. It also means local officers gain an understanding of

this specialist work, and of the risk to children in their communities. It is a good arrangement, but supervisors need to quality assure these visits to make sure offenders can't manipulate their managers' assessments.

SOMU adds information to the force's knowledge hub system to share intelligence about RSOs. But this information is removed after a few days and staff don't upload it to the offender's Niche record. This means officers can't use it in the future. Losing this information could make the force's response to future incidents involving offenders less effective.

We saw some examples of SOMU staff communicating well with professionals from other organisations.

Case study: effective multi-agency communication reduces risk to children

An RSO told his offender manager that he didn't have a fixed address.

The offender manager contacted the probation service to discuss the best way to jointly manage the offender. They were concerned the offender was deceitful and hiding information from them.

It was discovered the offender was in regular contact with a woman and her four children, who had received support from CSC services. A joint home visit to the woman's home resulted in the arrest of the RSO after finding him in the house under a bed.

The RSO was charged with offences and remanded in custody. A multi-agency strategy meeting was quickly held where a safeguarding plan for the children was put in place.

But we also saw examples of police offender managers inconsistently recording information. This included:

- not recording outcomes of joint activity by police and probation officers; and
- not recording discussions with probation officers when they are jointly managing offenders.

Case study: failure to record information about a high-risk offender

The SOMU team visited and assessed a high-risk offender in May 2020. He was a former teacher and had been convicted of a sexual offence against a child. A probation officer was still supervising the offender. So, in its assessment, the SOMU team concluded the next police visit should be 12 months later.

The team recorded no further updates or information on the police system. In July 2020, the probation service recorded a note saying it had advised the offender not to proceed with booking a holiday at a family resort.

Between July 2020 and September 2021, neither the SOMU team nor the probation service recorded any other information or assessments. So the force had no current knowledge of the risk the offender posed to children.

We asked the force to make sure the offender's risk was being properly managed. They obtained more information from the probation service, which was continuing supervision alone.

The force has an agreed process with the National Probation Service when probation officers are no longer supervising offenders. When they hand over responsibility, probation officers complete a risk assessment, which Staffordshire Police continues to use. This is contrary to national guidance, which advises police managers to make a new assessment of the risk the offender poses. This is because the circumstances have changed.

Another local practice also contradicts national guidance. The guidance directs that newly supervised offenders should receive a joint visit and assessment within 15 working days. Under the force's policy, unless the case is assessed as very high risk or managed at MAPPA Level 2 or 3, it should carry out the visit and assessment within 6 weeks.

SOMU staff don't use PPNs to notify CSC of safeguarding concerns. Instead, they use a person posing a risk to children form to tell CSC about children at risk from RSOs. But some staff told us CSC had asked them not to send these forms when they believed officers' actions had addressed the safeguarding concerns. This means staff don't record all the information on force systems. And they fail to tell other safeguarding organisations about some risks to children.

The force doesn't always follow national guidance in the way it assesses offender risk

National Police Chiefs' Council guidance from 2017 states forces may use active or reactive management approaches for RSOs. Using both approaches well should allow forces to focus on the RSOs posing the greatest risk.

Active management means visiting the offender. National practice is for officers to complete an ARMS assessment as follows:

- at least every 12 months; or
- when something happens that may result in a major change to the current overall assessment and risk management plan for the offender.

Forces may move offenders from active to reactive management. They can do this if an ARMS assessment suggests the RSO presents a low level of risk. The offender manager must be satisfied the offender hasn't committed offences or presented any risk for three years.

The Staffordshire Police SOMU reactively manages RSO cases where there is an SHPO. This isn't College of Policing approved professional practice. At the time of our inspection, SOMU was reactively managing 145 RSOs. There wasn't a process in place to review the status of these offenders.

The SOMU relies on flags on the force's intelligence system, Niche, to alert managers to new concerns about the offender. SOMU staff don't routinely use the Police National Database to check on offenders' activity that isn't on the force's own system. So they are unlikely to see information about incidents that happen out of the force's area. This means offender managers don't include that information in their decisions.

The force's performance data for offender management is incomplete and unreliable

The force doesn't use the ViSOR to provide performance data as much it could do. Instead, leaders expect SOMU staff to manually record information about their own activity each month. They gather these entries into a master document, which makes part of the force's performance-management data.

But if an offender manager isn't available when the team collects entries, their information isn't included. For example, in August 2021, the data collected was missing information from ten offender managers. This means the force's data is incomplete and of little value. The force is unaware how to routinely extract this information directly from the ViSOR.

The ViSOR central point of contact (CPC) is a management role. That person is responsible for maintaining data standards and the integrity of the system. In many forces, CPCs work closely with ViSOR users and give technical advice. This results in better quality data. The CPC in Staffordshire isn't responsible for managing administrative staff. This means the CPC can't influence compliance well enough with national standards. Also, SOMU staff don't use the ViSOR actions tab. They aren't using an alternative system, so supervisors can't consistently direct or oversee case work.

Supervision in the SOMU is ineffective

We found significant and worrying delays in supervisors seeing and approving their staff members' ViSOR entries. This backlog contained 5,022 entries. It included:

- 1,961 risk assessments;
- 1,374 risk management plans; and
- 1,687 visits to offenders.

This means supervisors aren't agreeing or checking offender managers' case work as they should be. It also means they are not properly overseeing the work to reduce risk from offenders in the community known to be a risk to children.

When offender managers leave the team, supervisors don't quickly re-allocate offenders on the ViSOR to other officers. For example, we found eight RSOs in the community were still assigned to an officer who retired from the force in 2020.

Recommendation

We recommend that Staffordshire Police immediately reviews its arrangements for sex offender management, including its supervision and management information systems, so it is satisfied the unit is fully effective.

11. Police detention

The force understands children should only be detained in custody when absolutely necessary

Officers should arrest a child only when it is absolutely necessary. Staffordshire Police officers arrest and detain fewer children than they did in previous years because they now find other ways of dealing with children who commit offences.

Before children enter the force's custody facilities, police assess them for risk and whether they need to be detained. Supervisors scrutinise each situation. They consider whether the arrest is necessary, and whether there are alternative ways of dealing with the investigation.

The number of children in the force's custody in the 12 months from July 2020 to June 2021 was 593. The previous year, the number was 838. This is a 29 percent reduction.[1]

There are two custody facilities in Staffordshire. One has a dedicated child wing with bespoke child detention rooms. The force is designing a similar arrangement for the other facility. Staff in the facilities support children's needs by giving them child-friendly meals and distraction items.

Custody staff need more training, so they understand their role in reducing risk and supporting vulnerable children

Many children in custody have complex needs. They are often vulnerable and need support to keep them safe. Custody staff need to recognise vulnerability, then reduce risks and refer concerns quickly to specialists who can help the child. This means speaking to children, noting their demeanour and recording the VoC.

Officers who review children's detention must visit them, speak to them and listen to them. This way, they can balance need to detain them against the child's welfare needs. In too many cases, inspectors are completing these reviews when the child is asleep or completing them remotely. This means they aren't considering the VoC as they should.

[1] The impact of the COVID-19 pandemic is likely to have reduced the number of children arrested and held in custody throughout the UK, but a full analysis is not yet available.

Custody staff have only two training days a year. This training is mostly first aid and officer safety. Force leaders told us they had approached a charity to give custody staff awareness of exploitation training. But some custody staff told us the only safeguarding or vulnerability training they had received was through the online National Centre for Applied Learning Technologies.[2]

Some inspectors told us they didn't receive an induction or instructions on how to conduct reviews for children in detention. Staff were also uncertain as to whether they should record a PPN for all children in police detention. The force needs to do more to make sure its custody staff are fully trained. It also needs to make sure they understand their responsibility for the welfare of children in police detention.

The force is collecting performance data about children in custody. Inspectors told us they randomly sample custody records to check their quality. But in the cases we reviewed, we found staff don't always understand how they can improve outcomes for detained children.

The force doesn't always give support to detained children quickly enough

Children detained in the force's area don't always receive early support from an appropriate adult. Guidance under the Police and Criminal Evidence Act 1984 states police should ask appropriate adults to come to the custody facility as soon as possible.

In some cases we examined, there were long delays before an appropriate adult arrived. They arrived before officers interviewed the child. But they often weren't there early enough to meet the child's welfare needs, rights and entitlements.

Health care professionals, who assess the health and welfare of children, are on duty in both custody facilities 24 hours a day. Liaison and diversion (L&D) staff are also present from 8.00am to 8.00pm. They assess children and consider the most suitable outcomes within and outside the criminal justice system. L&D staff review all children who are arrested, even if they don't see them while in custody.

Health care and L&D professionals can make entries on the force's systems about assessments of children's vulnerability and risks. Before the COVID-19 pandemic, the Youth Offending Service attended the custody facilities to see detained children. But at the time of our inspection, it hadn't resumed this practice.

During our inspection, we found appropriate adults weren't always attending quickly enough to support children. We also saw some long delays in health care and L&D staff seeing children. These delays mean the force and other professionals aren't always identifying risks to children early enough. The force may be detaining children for too long or unnecessarily, and missing opportunities not to criminalise them.

[2] College Learn has now replaced the National Centre for Applied Learning Technologies.

Case study: a child in custody experiences delays before seeing a health care professional or appropriate adult

Officers arrested a 16-year-old girl for shoplifting and breach of bail.

The force knew the child was vulnerable because she suffered from depression and asthma. She also had a history of self-harm.

There was a delay of seven hours before a health care professional saw her. There was a delay of 18 hours before an appropriate adult arrived to give her support and to advocate for her.

She was detained for 23 hours, then she was charged and released on conditional bail. An inspector twice reviewed the need for continued detention. They carried out both reviews when she was sleeping, meaning no one spoke to her about either review.

The health care professional and L&D officer made referrals to the girl's local CSC services. Police made a separate referral about the risks of exploitation and trafficking.

Custody officers don't understand well enough when alternative or secure accommodation for children is needed

Between July 2020 and June 2021, there was a 22 percent reduction in children detained overnight in the force's police cells. But during the main period of COVID-19 pandemic restrictions, the average time children stayed in the force's custody increased to 12.7 hours. According to the force's analysis, this increase is because the new virtual court proceedings took longer to complete. Virtual proceedings are no longer in use for children, and average detention times have now reduced to seven hours.

In the same 12 months, the force detained in custody about a third of the children it charged up to the time they appeared in court. This is because those children had been charged on warrant for bail offences. But on average throughout the year for non-bail offences, the force denied bail to less than one child per week.

The local authority is responsible for giving suitable alternative accommodation to a child charged with offences and denied bail. Only in exceptional circumstances is this not in a child's best interest (for example, if bad weather makes it impossible to transport them). In rare cases, such as when a child is at high risk of causing serious harm to others, they may need secure accommodation.

Custody staff at the force don't fully understand the statutory guidance in the *Concordat on children in custody*. This includes the thresholds for requesting secure accommodation. This means children sometimes have no contact with the local authority until after they are charged. Also, staff at the force don't always make the request properly. Staffordshire police couldn't give us examples of any children who, after officers charged them with offences, received accommodation from a local authority where they stayed until the time of their court proceedings.

When local authority accommodation isn't available, custody officers don't ask their managers for help finding an immediate solution. And leaders don't escalate these cases with the local authority. Officials from the two Staffordshire local authorities and the children's safeguarding partnerships told us that in recent meetings, the force hadn't asked why alternative accommodation hadn't been provided.

Recommendation

We recommend that within three months Staffordshire Police works with its safeguarding partners and makes better arrangements for children in police detention. The force should:

- train all custody staff so they fully understand their safeguarding responsibilities;
- quickly provide appropriate adults for detained children;
- make sure every detained child is seen promptly by a health care professional;
- make sure it notifies CSC services about every detained child;
- promptly assess the need for alternative accommodation (secure or otherwise); and
- have an escalation process for cases when alternative accommodation isn't readily available.

Conclusion

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

We found that the officers and staff who manage demanding child abuse investigations are committed and dedicated. But we are concerned that both frontline and specialist officers have variable knowledge and understanding of what makes child protection practice effective. We are also concerned about the effectiveness of the force's systems and processes, which should support its staff.

The force urgently needs to make fundamental changes to improve many of its child protection arrangements and practices. It should support this with a clear structure for overseeing and scrutinising all aspects of child protection activity. It should also use this structure to monitor the impact of the changes it makes.

We are encouraged that immediately following our verbal feedback to the force, senior officers took action to develop an extensive action plan to drive improvements to its child protection arrangements.

We have also made recommendations that will help improve outcomes for children if the force acts on them.

Next steps

Within six weeks of the publication of this report, we require an update of the action the force has taken to respond to those recommendations where we have asked for immediate action.

Staffordshire Police should also provide an action plan, within six weeks of the publication of this report, setting out how it intends to respond to our other recommendations.

Subject to the update and action plan received, we will revisit Staffordshire Police no later than six months after the publication of this report to assess how it is managing the implementation of all the recommendations.

Annex A – Child protection inspection methodology

Objectives

The objectives of the inspection are:

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

The expectations of organisations are set out in the statutory guidance *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*. The specific police roles set out in the guidance are:

- the identification of children who might be at risk from abuse and neglect;
- investigation of alleged offences against children;
- inter-agency working and information sharing to protect children; and
- the exercise of emergency powers to protect children.

These areas of practice are the focus of the inspection.

Inspection approach

Inspections focus on the experience of, and outcomes for, children following their journey through the child protection and criminal investigation processes. They assess how well the police service has helped and protected children and investigated alleged criminal acts, taking account of, but not measuring compliance with, policies and guidance.

The inspections consider how the arrangements for protecting children, and the leadership and management of the police service, contribute to and support effective practice on the ground. The team considers how well management responsibilities for child protection, as set out in the statutory guidance, have been met.

Methods

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

The purpose of the self-assessment is to:

- raise awareness in the service about the strengths and weaknesses of current practice (this forms the basis for discussions with HMICFRS); and
- initiate future service improvements and establish a baseline against which to measure progress.

Self-assessment and case inspection

In consultation with police services, the following areas of practice have been identified for scrutiny:

- domestic abuse;
- incidents in which police officers and staff identify children who are in need of help and protection (for example, children being neglected);
- information sharing and discussions about children who are potentially at risk of harm;
- the exercising of powers of police protection under section 46 of the Children Act 1989 (taking children into a ‘place of safety’);
- the completion of section 47 Children Act 1989 enquiries, including both those of a criminal nature and those of a non-criminal nature (section 47 enquiries are those relating to a child ‘in need’ rather than ‘at risk’);
- sex offender management;
- the management of missing children;
- child sexual exploitation; and
- the detention of children in police custody.

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