HMICFRS

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

National Child Protection Inspection

Warwickshire Police

7–18 February 2022

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 Warwickshire, which took place in February 2022.

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.

Main findings from the inspection

The chief constable, her senior team and the PCC are committed to protecting vulnerable people, including children. This is reflected in the PCC's draft police and crime plan and in the force's priorities.

The force is effective in its professional relationships and contributions to multi-agency work. It works with other safeguarding organisations at both a strategic and practitioner level. This is a real strength.

Following the end of its alliance with West Mercia Police, the force has had to re-establish some of its specialist functions, such as child protection teams. This has led to some challenges in service delivery and skills gaps in its workforce.

Senior leaders understand how well officers and staff carry out their work. There is a regular and thorough internal inspection programme. Findings are reported back through force governance processes and used to inform business planning.

But the force needs to improve some of its responses to children who need help and protection. It has made protecting children a priority and senior leaders are clearly committed to this. However, decisions about children at risk aren't yet consistently better as a result. To improve this, the force should make sure that there is appropriate and effective supervision of child protection work.

We saw examples of good work, including:

- effective responses by the multi-agency child exploitation and missing team to children harmed by, or at risk of, exploitation;
- quality child-focused investigations by specialist investigators;
- a child-centred policing strategy with a clear focus on children in the design of services; and
- effective partnership working between police, probation officers and social workers to reduce the risk from registered sex offenders.

Specific areas for improvement include:

- use of the diary appointment system in the operational communications centre (OCC);
- responses to children missing from home or care, including the initial assessment of risk and the quality and timeliness of enquiries;
- investigation of the online sexual exploitation of children; and
- the treatment of children detained in police custody, including making timely requests for appropriate adults and the use of alternative accommodation when children have been detained after charge.

During our inspection, we examined 74 cases in which the police had identified children at risk. We assessed the force's child protection practice as good in 23 cases, requiring improvement in 23 cases, and inadequate in 28 cases. This shows that the force needs to do more to give a consistently good service for all children.

Conclusion

It is clear that child protection and wider vulnerability is a priority for Warwickshire Police. And the force is committed to improving its services for children who need help and support.

Throughout the inspection, we found dedicated officers and staff, often working in difficult and demanding circumstances. The force has invested a significant amount of time and focus on the welfare of its officers and staff.

But in too many cases, we found inconsistent practices and decision-making. The force needs to do more to make sure that its commitment to improving the service, leads to better results. It has the necessary governance and scrutiny arrangements in place to monitor the impact of changes and improvements it needs to make.

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) 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

Warwickshire Police provides policing services to the county of Warwickshire. The police force area covers 763 square miles in the west midlands of England and includes the towns of Warwick, Nuneaton and Rugby.

At the time of our inspection, according to government figures, Warwickshire Police had a workforce of approximately:

- 1,053 police officers;
- 734 police staff;
- 74 police and community support officers (PCSOs);
- 103 members of the special constabulary; and
- 58 police support volunteers.

The force serves a mainly urban population of around 600,000 people. The resident population is increased by university students and the large numbers who visit or travel through the area each year.

Warwickshire Police had previously been in a strategic alliance with West Mercia Police. However, in October 2018 West Mercia Police notified the force that it intended to end the alliance in October 2019. This has led to a period of significant change for Warwickshire Police as it re-establishes itself. Although the transition is nearing completion, it was still taking place during our inspection.

The force has worked with the sole local authority in the area, Warwickshire County Council, and Coventry and Warwickshire Clinical Commissioning Group to establish a new safeguarding partnership, as required by the Children and Social Work Act 2017.

The most recent Ofsted judgment of the service Warwickshire County Council offers children who need help and protection was provided in February 2022. They were judged to be good.

An assistant chief constable is responsible for child protection throughout the force's area. He is supported by a detective chief superintendent who is the head of protective services, and a detective superintendent who is head of the vulnerability and safeguarding branch. This consists of specialist teams responsible for protecting children and vulnerable adults.

There is one multi-agency safeguarding hub in Warwickshire, called the Children and Families Front Door (CFFD), which represents a range of organisations. This makes sure that information is shared effectively.

As part of the national police uplift programme we were told that Warwickshire Police officer numbers have increased by 30 percent since 2018. This is positive. But it also means that many frontline officers are inexperienced. It is challenging for the force to make sure that these officers have the necessary skills and training required to deal with vulnerable children. This has been made more difficult as many officers were recruited during the pandemic, when most training took place virtually.

3. Leadership, management and governance

There is a strong commitment to child protection by senior leaders

We found a clear commitment by Warwickshire Police to the protection of children. This is reflected in the police and crime commissioner's draft police and crime plan, and the chief constable's strategic *Fit for the Future 2020-2025* priorities.

Most officers and staff we spoke to understood the importance placed on protecting vulnerable people, including children.

The force's contribution to partnership working arrangements to safeguard children is strong

Senior leaders in organisations the force works with to safeguard children described the professional relationships, contributions to multi-agency working and commitment at both a strategic and practitioner level as very good. We found an ability to work together and challenge at all levels. The force has appropriate representation on the Warwickshire safeguarding board, the Safer Warwickshire Partnership Board, and it is actively involved in various committees and subgroups. This is a real strength and credit should be given to the senior leaders who have nurtured and led this approach.

The force is open to independent oversight and advice to help improve its response to vulnerability and child protection. For example, in March 2021, a SafeLives review of multi-agency risk assessment conference (MARAC) processes in Warwickshire reported that Warwickshire Police contributed effectively to improve the safety of those at high risk from domestic abuse.

A representative from the corporate communications team meets fortnightly with their counterparts in other safeguarding organisations. They also attend partnership groups which focus on thematic areas such as vulnerability and child exploitation, where consistent messages are agreed for use throughout the partnership. For example, the Something's Not Right campaign helps parents, children and professionals recognise child exploitation and understand what to do if they are concerned about a child. This is a good example of how Warwickshire Police is working well with other organisations to protect children who have been harmed or are at risk of harm.

There is structured oversight at senior and operational levels

A system of boards and steering groups holds senior leaders to account for their performance. This system also monitors the capability of, and demand and capacity for, services to protect vulnerable people, including children, throughout the force's teams. The detective superintendent holds regular meetings with team managers in the vulnerability and safeguarding department. The detective chief inspector with responsibility for child protection runs a working group to improve practice. This governance structure should make sure child protection work is managed effectively.

Performance information and quality assurance processes to understand outcomes for children are well developed

Performance data about how the force responds to children at risk provides information about the demands the force faces. This is supported by a regular schedule of qualitative auditing in other areas of work.

The statutory and major crime review unit (SMCRU) is a team of current or retired experienced detectives. The team completes regular qualitative audits of child protection work. The team also provides additional oversight of cases involving child deaths and non-accidental injuries to children under three years old. This is a real strength. Learning is shared throughout the force using a variety of methods, such as bitesize learning and fortnightly bulletins. This aims to make sure that practice improves.

Together, the performance information and audit processes help the force understand if they are consistently making the best decisions for vulnerable children.

The separation from the alliance with West Mercia Police has created challenges in service delivery

The end of the alliance with West Mercia Police left a skills gap and a shortage of experienced accredited detectives for child protection work. In June 2020, the force started putting specialist child abuse, trafficking and exploitation (CATE) teams in place. These replaced the previous multi-disciplinary investigation teams. By October 2020, all CATE teams were in place throughout the county. This is good progress. But the force needs to do more work to make sure officers in these teams are trained appropriately and have the correct accreditation.

Inconsistent use of IT systems could leave children at risk

The separation from the alliance has been a gradual process. Some force IT systems were being moved to a new network during our inspection. The staff we spoke to found this process frustrating as the systems required to work effectively had been frequently disrupted. We were told about case file work being lost, emails disappearing and a lack of connectivity with other safeguarding organisations the force works with.

Most of the staff we spoke to didn't use the force Athena system the way it should be used. They preferred to rely on a legacy system which they found easier to use. This means that important information about children and families is spread throughout different systems, and it is difficult to see what the overall picture is. This could leave children at risk. The legacy system is no longer supported (as from the end of March 2022) and should no longer be used. Some OCC staff didn't yet have Athena login details and hadn't been trained. The force is aware of this risk, but more needs to be done to support staff to use the IT systems correctly.

Officers and staff involved in protecting children are dedicated and enthusiastic

Throughout the inspection, we encountered highly motivated officers and staff who talked with enthusiasm about their work.

Those who manage child-related investigations show clear commitment. However, they often work in difficult and demanding circumstances and some specialist officers expressed concerns about the volume of work and the level of training they had received.

The force has invested significantly in the health and wellbeing of its staff

We recognise that the force has heavily invested in the health and wellbeing of its staff through its wellbeing offer. Officers in the CATE team were given pre-screening checks to make sure they were suitable for the role. There are also mandatory counselling sessions and wellbeing drop-ins for officers working in the vulnerability and safeguarding teams.

4. Case file analysis

Results of case file reviews

For our inspection, Warwickshire 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. In most of the cases the force reviewers found similar areas of strong practice and areas requiring improvement as the inspection team. This is positive as the force can be confident in its ability to independently assess how it is responding to children. But in some cases, where gaps identified had mitigating actions requested by managers, we found that these hadn't been completed.

Cases assessed by both Warwickshire Police and us

Force assessment:

- 12 good
- 10 require improvement
- 11 inadequate.

Our assessment:

- 7 good
- 11 require improvement
- 15 inadequate.

Our inspectors selected and assessed 41 more cases during the inspection.

Additional 41 cases assessed only by us

- 16 good
- 12 require improvement
- 13 inadequate.

Total 74 cases assessed by us

- 23 good
- 23 require improvement
- 28 inadequate.

Breakdown of case file audit results by area of child protection

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

- 7 good
- 5 require improvement
- 1 inadequate.

Common themes include:

- inconsistent recording of the views, wishes and feelings of children in child risk assessment forms;
- good supervisory oversight of investigations by CATE supervisors;
- recording of investigative tasks outside the force IT system, meaning an audit trail of what work has been completed and when is difficult to understand; and
- delays to some investigations caused by delays in examining digital devices.

Cases assessed involving referrals relating to domestic abuse incidents or crimes

- 5 good
- 3 require improvement
- 2 inadequate.

Common themes include:

- risk was appropriately identified by OCC staff, in most cases;
- good use of body-worn video by frontline officers to record their initial interactions at domestic abuse incidents;
- little evidence of children being seen and spoken to by officers at domestic abuse incidents; and
- inconsistent service provided to domestic abuse victims depending on which team was overseeing their case.

Cases assessed involving referrals arising from incidents other than domestic abuse

- 5 good
- 1 requires improvement
- 4 inadequate.

Common themes include:

- when initial calls are graded for deployment, officers usually arrive promptly;
- some cases were graded for a diary appointment which was inappropriate given the risks outlined;
- delays in submitting child risk assessments (CRAs); and
- inconsistency in the recording of detail about what children had said, or what they were feeling.

Cases assessed involving children at risk from or harmed by child exploitation

- 0 good
- 6 require improvement
- 8 inadequate.

Common themes include:

- delays in dealing with child sexual abuse online cases;
- failure to notify children's social care services early enough in child sexual abuse online cases;
- some good investigations where children were being exploited criminally or by county lines gangs; and
- multi-agency processes to divert children away from exploitation and disrupt perpetrators.

Cases assessed involving missing children

- 2 good
- 2 require improvement
- 4 inadequate.

Common themes include:

- some risk assessments didn't reflect known risks to children who were missing;
- poor investigations that didn't reflect risk and had limited enquiries to trace missing children;
- repetitive supervisory reviews that don't progress investigations;
- inconsistent recording of information in police systems; and
- risk management plans in place for children who are at risk of exploitation or are regularly missing when appropriate.

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

- 3 good
- 0 require improvement
- 3 inadequate.

Common themes include:

- inconsistent decision-making about taking children into police protection leaving some children at risk unnecessarily;
- children weren't always spoken with to gain their views about what had happened and what they wanted to happen next;
- children being taken to police stations inappropriately as a place of safety; and
- some good joint working with social workers leading to better outcomes for children.

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

- 1 good
- 3 require improvement
- 2 inadequate.

Common themes include:

- the frequency of home visits to registered sex offenders isn't in line with national guidance;
- the use of reactive management isn't always in line with national guidance;
- good partnership working with probation officers and social workers to reduce the risk from registered sex offenders; and
- the violent and sex offender register (ViSOR) database isn't always being used in line with national standards.

Cases assessed involving children detained in police custody

- 0 good
- 4 require improvement
- 3 inadequate.

Common themes include:

- attendance of appropriate adults at the custody office is timed to coincide with other events, such as interviews, rather than for the welfare of the detained child;
- reviews of detention for children aren't always child-centred;
- children aren't being transferred to alternative accommodation when they have been charged and denied bail; and
- children in custody aren't always referred to statutory safeguarding organisations.

5. Initial contact

The force has worked hard to train frontline officers and staff, but some require more training

Many frontline officers in Warwickshire are new recruits with little experience. Training is therefore critical to make sure they provide an effective service to the public. Most of the basic training provided during the pandemic was completed online without supervision. This means that it is difficult for the force to assess the effectiveness of this or how well students understand the material – and therefore where there are gaps in their knowledge.

More recently, due to changes in police recruitment methods, much of the initial training has been provided by a university online. We were told by senior officers, new recruits, and their tutor constables that they didn't believe basic training had provided newly appointed officers with the skills they need to deal effectively with vulnerable people.

The force has therefore provided additional training opportunities to frontline officers, including:

- domestic abuse matters training;
- Sherlock training – an interactive session focusing on a crime scene and vulnerability; and
- vulnerability bitesize learning – topics include child risk assessments (CRAs) and adverse childhood experiences. These can be targeted to specific individuals where the learning is needed most.

Although the provision of this extra training is positive, a skills gap remains that is reflected in the response to some incidents. Through the cases we have looked at, we have also found this can leave children at risk.

OCC staff have received training to help them to recognise risk

OCC staff receive all calls for service made to the force. Call handlers get as much information as they can about the incident and the people involved. They then assess how the force should respond.

OCC staff attend dedicated training days each year. In August and September 2021, officers from the vulnerability and safeguarding department provided initial contact training. This aimed to improve the initial response to incidents involving vulnerable people. Topics included the structure of the vulnerability and safeguarding teams, missing person investigations, the role of the SMCRU, the role of the

registered sex offender management unit (RSOMU), domestic abuse, county lines gangs, and child exploitation.

There are inconsistencies in how the force assessed risk when members of the public contacted the police

Although we saw consistent use of the risk assessment of calls in the OCC using the THRIVE model, we found some assessments didn't fully record details of the risk. There are specific question sets for some incidents, such as calls about missing persons, to help make sure call handlers record as much information as possible. But we found that the use of these didn't improve the quality of the THRIVE assessments. This means that inappropriate decisions may be being made about how to respond to incidents.

The availability of a 24/7 intelligence function within the OCC, i24, provides real-time intelligence support. This helps risk assessment processes and decision-making about how to respond to calls. However, this research wasn't always obvious in some of the cases we examined. For example, up-to-date information about the people involved is vital in assessing risk in domestic abuse incidents and missing person investigations but this detail wasn't always available.

The use of scheduled appointments to resolve incidents may leave vulnerable people at risk

In some cases, it is appropriate to make an appointment for the police to visit to deal with a report. For example, in lower-risk incidents or when members of the public aren't immediately available. We inspected how the force resolved incidents by using scheduled appointments.

We were told that scheduled appointments are almost always dealt with over the telephone, rather than by an officer attending in person. This includes incidents involving children, such as the sharing of indecent images of children, and physical or sexual offences perpetrated by children against other children. The appointment is also made with the parent or carer. This means that the children involved won't be seen or spoken to by police. And therefore, they don't have the opportunity to explain how they are feeling or what they would like to happen.

We found that domestic abuse incidents were being dealt with over the telephone. In these circumstances the suspect could be with the victim and there is a risk of disguised coercion and control. There is also no way of checking on the welfare of any children in the household, apart from asking the victim.

There were 218 incidents scheduled for an appointment with Warwickshire Police in the week 8 to 15 February 2022. Of these, 58 were domestic abuse related. The force responded to our concern about this during the inspection by instructing officers not to deal with domestic abuse incidents by telephone. This should also be extended to incidents where there are other risks to children.

There are risks in incidents where officers had yet to be deployed

On one day during the inspection, we examined a snapshot of 60 open incidents waiting for an officer to attend the call. Of these, seven were shown as domestic abuse related and the oldest was several days old.

One case had been graded for priority deployment but had been delayed for over 100 hours. The victim hadn't been seen or spoken to by the police. The perpetrator had a significant history of violent offending in domestic situations, including coercion and control. On this occasion he had threatened to break the victim's windows, assault her mother and blow the car up.

The force has a process in place to assess the quality of a call handler's response

Between April 2021 and January 2022 OCC managers assessed 435 calls. Supervisors use this information to check and track the quality of work including the THRIVE risk assessments. Information from the process can be broken down to team and individual level. Themes are then used to inform management meetings and future training opportunities. OCC managers have previously identified that the quality of THRIVE assessments needs to improve. Further development of the quality assurance process will provide the opportunity for scrutiny to be applied to the areas highlighted in this report.

Officers respond quickly to clear and specific concerns about children

When the concern about a child is clear and specific, officers usually attend quickly. They carry out initial tasks well, such as making sure the children are safe and assessing how best to proceed. We also found officers are good at making initial enquiries and using their powers to arrest or protect when necessary.

Body-worn video can be a useful tool in progressing prosecutions where the victim is unwilling to testify. It can also give insight into the lived experiences of children. Officers told us that it is mandatory to use body-worn video cameras for domestic abuse calls. This means all interactions and observations are recorded. Officers may also use their video cameras for child protection incidents. For example, to record the living conditions of children who are suffering neglect.

Case study: police respond to a call from a worried neighbour

The police were contacted by a neighbour who saw a three-year-old girl being grabbed by the arm and thrown across the room by her father. Checks conducted in the OCC identified that there were three children at the address who were the subject of a child protection plan under the category of neglect.

Officers attended promptly and used their body-worn video cameras to record their initial interaction with the children and their parents. All the children were seen and appeared uninjured and in good health.

A member of the CATE team and an emergency social worker attended and spoke to the children. The children had no visible injuries and said that they hadn't been assaulted.

The father was arrested. He denied the offence and the case was closed. But the family continued to work with children's social care services under the terms of the child protection plan.

Officers don't always speak to children to understand how they are feeling or record their behaviour

How a child behaves or what they say gives essential information about how an incident has affected them. This is particularly important when the child is too young to speak to officers or when there might be a risk if a child spoke with a parent present. Officers should take time to watch how the child behaves and listen to what they say. This will inform both the initial assessment of need and the decision whether to refer a child to social care services.

In the cases we examined, the recording of the voice of the child wasn't always as good as it could be. The force doesn't always take opportunities to understand the lived experiences of the children involved. We also saw cases where the details of the children in families involved in incidents weren't linked to them on police systems. This means there is an incomplete picture of risk if further incidents occur.

Recommendations

- We recommend that Warwickshire Police immediately reviews the OCC response to incidents where children are involved. It should make sure that the response reflects the identified level of risk, including continuing or escalating risk.
- We recommend that within three months Warwickshire Police acts to make sure that children's concerns and views are obtained and recorded (including noting their behaviour and demeanour).

6. Assessment and help

Representatives from the police, children's social care services, education and health services work together in the Warwickshire CFFD to share information and make decisions about children at risk.

When a police officer has a concern about a child, they should complete a CRA. These are submitted to the harm assessment unit (HAU), which is a police-only team based in the CFFD. Its function is to process the CRAs, conduct research and share information. The officers apply a risk grading to their submission. This helps the HAU prioritise how it processes the CRAs.

The quality of CRA submissions, and their oversight, needs to improve

The CRA is a word document with free text fields built around the mnemonic A CHILD. This is designed to help officers consider important factors as part of their risk assessment, such as previous convictions of involved parties (C) or to listen to the child (L). However, we found that the mnemonic doesn't help lead officers in their assessment. Many of the forms we saw didn't include important details such as what the child had said or how they were feeling. Officers decide whether to complete a CRA and the fields within it aren't mandatory. This means the quality of submissions varies. Supervisors should check the submission of their officers' CRAs, but we found this wasn't happening in most of the cases we reviewed.

There are delays in processing CRAs in the HAU

During our inspection we saw backlogs of medium-risk CRAs waiting to be processed by the HAU support officers and, where appropriate, shared with other organisations. High-risk CRAs are dealt with as a priority and we found no backlogs of these, which is positive. Standard-risk CRAs aren't sent to the HAU and are kept by the officers.

In week 1 of our inspection there were 94 unactioned medium-risk cases. But this did reduce to 61 in week 2. There is no triage process in place for these cases, so the specific risk isn't known until each case is opened.

We sampled ten of the oldest CRAs. In seven of these cases, there was a delay of one to seven days before the officer submitted the CRA. In all the cases there was a delay of four to six days before it was then reviewed in the HAU.

In six cases, it wasn't clear whether the child had been safeguarded between the incident occurring and the CRA being assessed in the HAU. In addition, two cases should have been graded as high risk.

Together, these delays and poor application of risk assessment grades left children at risk.

There is a good multi-agency response to children affected by domestic abuse, but there are some delays in identifying cumulative or escalating risk

In cases of domestic abuse where children are involved, the responding officers record details of the children within the domestic abuse, stalking, harassment (DASH) risk assessment and may also complete a CRA if there are more specific concerns. These cases, at all levels of risk, are reviewed in the multi-agency domestic abuse pathway (DAP) meeting. This is a daily meeting attended by a children's social care services team manager, a detective sergeant from the HAU, and representatives from Warwickshire County Council's Early Help scheme and Refuge, a support service for victims of domestic abuse and their children. This means that children and their families are provided with help and support.

The DAP is also the trigger for the Operation Encompass process. Approximately 90 percent of schools in Warwickshire have signed up to the scheme. The detective inspector in the HAU is undertaking a review with the aim of encouraging the remaining schools to become involved.

But we found a backlog of medium-risk domestic abuse cases waiting to be assessed in the HAU. In week 1 this was 72 cases. This increased to 132 cases in week 2. HAU support officers should carry out research to identify escalating and cumulative risk. Delays in this process could leave victims of domestic abuse and their children at risk.

Warwickshire Police weren't attending all strategy meetings, against *Working Together* guidance

Most strategy meetings take place in the HAU and are attended by one of the detective sergeants from the unit. They are conducted promptly and are well recorded. However, due to the volume of meeting requests, we found that the police couldn't attend all meetings. Instead, a report is sent containing a police view on what the result should be. This practice isn't in line with the *Working Together* guidance. Police should attend all meetings to contribute to joint decision-making about next steps for vulnerable children. We highlighted this to the force during our inspection. The policy was then changed so that the force would attend all meetings.

More positively, we found supervisors from other specialist units attend strategy meetings when appropriate. In these cases, the relevant supervisors are more likely to have the most up-to-date information about the case than HAU staff to help decision-making.

The force is good at contributing to child protection conferences to make longer-term safeguarding plans

Warwickshire Police employs three child protection liaison officers to carry out research for and attend child protection conferences. Force data shows attendance at all but one of the 282 initial child protection conferences during 2021. Reports are prepared for all review case conferences. The force also contributes to longer-term safeguarding plans during these meetings.

If children are placed on a child protection plan, the case is flagged in the force's IT systems. This means that officers attending incidents will be aware of the vulnerabilities of the children involved.

There is a good understanding of children being harmed by or at risk from county lines and criminal exploitation

Threat, harm and risk from exploitation are discussed at a series of force and multi-agency meetings at a strategic and operational level. This helps multi-agency work in disrupting county lines and other forms of exploitation.

The police-only monthly exploitation and county lines meetings are chaired by a detective chief inspector. Representatives from several teams and policing areas attend. Current intelligence and investigations about county lines and exploitation are discussed. This is positive, but the meetings should also address the longer-term plans to safeguard children.

Children discussed at this meeting can be referred to the Warwickshire serious organised crime joint action group. There are strategic and operational level multi-agency meetings and Warwickshire Police has appropriate representation. The group provides a partnership approach to diverting children away from, and disrupting those involved in, county lines and other forms of exploitation. This a good example of how organisations in Warwickshire work together to protect children.

The meeting structures have been designed to consider all forms of exploitation against children. But we found they focused heavily on county lines and criminal exploitation. There are some good processes in place relating to sexual exploitation, but these aren't given the same emphasis as those for county lines and criminal exploitation, and there isn't the same level of cross-team intelligence gathering and proactive responses.

There is a focus on disrupting those involved in exploiting children

The county lines team is clearly focused on disrupting criminality connected to county lines and refers children involved to schemes to support them, such as St Giles Trust and The Prince's Trust.

We found some evidence of child abduction warning notices (CAWNs) being used in relation to sexual exploitation. But some CAWNs were quite old and there were no updates in force systems about the cases or if there had been any change in the level of risk to the children involved.

The standard of missing child investigations is poor

Force policy states that missing children can't be assessed as being at no apparent risk or low risk. Consequently, we found that children are routinely graded as medium risk. But, in some cases, we saw significant concerns such as self-harm, mental ill health and exploitation. In these cases, a high-risk grading may have been more appropriate. No reasons were recorded to show why these cases had been graded as medium risk.

There can be a lack of professional curiosity at the point of reporting and at the time the child is located. This means that not all relevant information to safeguard the child or investigate those who pose a risk to them is available. The initial actions set are often generic and drafted using a standard form, rather than being specific to the child and the circumstances. This means that opportunities to locate missing children may be missed.

Despite regular, and in some cases detailed, supervisory reviews, there was little evidence that the lack of investigative activity was being challenged. Details of all missing children are discussed at the daily management briefing, but there was no evidence this improved the response.

Case study: failure to appropriately investigate a missing teenager known to be at risk of sexual exploitation

A 16-year-old girl was reported missing by her mother late in the evening. The girl had previously self-harmed and was known to be at risk of sexual exploitation.

A THRIVE assessment was completed by the call taker but didn't reflect the known risks. There was a delay of more than an hour before the OCC inspector conducted the risk assessment. This lacked detail and rationale for the application of the medium-risk grading.

During the initial call, the child's mother provided an address where she believed her daughter might be with her 22-year-old boyfriend. Despite this, there were no significant enquiries made to locate her in the 48 hours she was missing.

Duty inspectors completed reviews of the case, but the responses were cut and pasted from previous reviews and weren't specific to this case. There was no clear ownership of enquiries and a lack of direction from supervisors who referenced a lack of resources.

Eventually, the child's social worker contacted the police, and the child was found at the address the mother had originally provided. No enquiries were made about what had happened to the child when she was missing.

Prevention interviews are consistently completed, but sometimes only limited detail is recorded and the voice of the child can be missing. This means valuable intelligence to prevent future episodes and safeguard the child may be missed. Frontline officers we spoke to were unsure of the purpose of prevention interviews and what to record.

There are delays in recording some children as missing

For children who are regularly missing from home or missing from care, we found delays from when the initial call to the police was made until the missing child report was created or actions taken to try to locate them. Supervisors gave inappropriate reasons for this approach. This included, for example, the fact that the child had been missing numerous times before or they usually returned of their own accord. This fails to recognise that these children are often at risk regardless of how many times they have been missing or the circumstances in which they return.

The multi-agency child exploitation and missing team provides a strong response

The team consists of workers from Warwickshire County Council, Warwickshire Police and Barnardo's. They are located together and provide a co-ordinated response to safeguarding children from abuse and exploitation.

An analyst from the team produces a comprehensive monthly dataset on missing children and the completion of return home interviews. This includes police and local authority data. This is positive and provides a consistent view of the multi-agency work in this area. This should support future improvements in service delivery.

All children reported missing in Warwickshire are offered a return home interview by the local authority. We saw good evidence of these interviews being completed. This means information and intelligence is recorded which may help the police to find children if they are reported missing again. But we found the recording of this detail is inconsistent which can make it difficult to find. This isn't helpful and reduces the effect of the service.

We saw a good multi-agency response when children have been harmed by or are at risk of exploitation. This included attempts to work with children and their families, where the children were involved in county lines.

However, we also saw a poor response in some cases that were allocated for proactive intervention to other police teams such as CATE. In these, little action was taken or there was no evidence that a plan had been put in place to protect the children.

Processes are in place to problem solve and reduce missing episodes for children who are regularly missing

Multi-agency missing intervention meetings (MIMs) take place when a child has been missing three times in 90 days (stage one) or five times in 90 days (stage two). These are convened under a separate process from strategy meetings held under child protection procedures where there is a risk of significant harm to a child. Positively, children under discussion and their parents and/or carers can be invited to the MIM meeting.

We observed a MIM meeting during our inspection. It was well attended by organisations the force works with and was structured, with good sharing of information. Minutes and actions are generated from meetings. But we saw delays and inconsistency in how the information was recorded.

Children who go missing regularly are allocated to members of the police missing person team (part of the wider multi-agency team). This provides a multi-agency response to problem solving and reducing the number of missing episodes and therefore risk of harm faced by these children.

Police community support officers (PCSOs) are given responsibility to work with care homes and staff and children, with the aim of reducing the number of missing episodes. Problem management plans are being created for each care home which will allow children who are regularly missing to be linked to the plan and records of visits to be added. This will provide greater visibility of risk and indicate where issues are escalating. Although it is too early for us to test the effectiveness of this, it is a good innovation and a good example of child-centred practice.

Recommendations

- We recommend that Warwickshire Police immediately reviews its missing persons arrangements and practices to make sure that throughout the missing episode there is always an effective response.
- We recommend that, within three months, Warwickshire Police carries out a review to make sure that concerns about children are reported to statutory safeguarding partners and organisations effectively.

7. Investigation

Many child protection specialist officers are inexperienced and lack the necessary training and accreditation

There was no specialist response to child protection concerns in Warwickshire when it was in a strategic alliance with West Mercia. CATE teams were put in place between June and October 2020, and all staff were in post by June 2021. The force prioritised filling vacancies in these teams. However, many CATE staff are inexperienced. Work is underway to improve this position, but there is currently a risk about the quality of work carried out to protect children.

Child protection work has increased in volume and complexity over recent years and demand modelling completed by the force in 2019 is no longer relevant. This means workloads have increased. We heard about some officers managing 25 investigations. We were told that a further bid for resources has been made to increase the size of the CATE teams. If approved, this should reduce some of this pressure in the medium term. At the time of the inspection, the county lines team had about 50 percent of its established workforce in place. This means that some identified proactive work to disrupt county lines is allocated to other teams who may not be fully trained. There is a risk that in these cases the response may not be as robust or effective as it should be.

The capability of investigators is also of concern. Many officers in specialist teams such as CATE and the criminal investigation department (CID) haven't received the appropriate training or gained the necessary professional qualifications such as specialist child abuse investigation development programme (SCAIDP) accreditation. They are undertaking investigations that they are not trained to carry out. For example, investigations into the online sexual exploitation of children. We are aware there are plans in place to train more officers this year. But the next SCAIDP course isn't until November 2022 when a further 12 officers can be trained. Therefore, this remains an area of risk for the force.

The bi-monthly skills, capacity and capability board reviews gaps in training and prioritises the areas that pose the greatest risk. There is a dedicated detective inspector for investigative training who also has responsibility for progressing investigators' professional portfolios. Organisational learning is shared with the board for inclusion in future training. The board structure and associated processes are positive but there is more to do to make sure the workforce is appropriately trained.

There are examples of investigating officers using a good mix of investigative and protective approaches

Where offences against children are identified, we saw crime reports being generated and prompt action taken to arrest suspects and apply bail conditions to protect children. We saw some very thorough investigations, with actions completed by police and partner organisations in the best interests of children and regular and meaningful supervision. But we also saw some long delays in investigations. We were told that these can be caused by the pressure of competing investigations and delays in the examination of media devices.

Case study: CATE investigation

A four-year-old boy was brought to nursery by his dad. The child had a visible mark on his face and told staff it had been caused by his mum slapping him. The nursery referred the case to children's social care services. A strategy discussion took place promptly, and a joint section 47 investigation was agreed.

A police officer and social worker visited the boy. He confirmed that he had been slapped by his mum. The boy's mum was arrested. She denied causing the injuries and was bailed with conditions to protect the boy and his siblings. The children were placed initially with their paternal grandmother and later with foster parents.

All appropriate lines of enquiry were followed with good supervisory oversight. There is clear partner organisation decision-making throughout this investigation and the voice and welfare of the children were considered throughout.

Most high-risk domestic abuse cases are dealt with by the domestic abuse unit (DAU). This includes the investigation and safeguarding response and referrals to partner organisations where appropriate. In these cases, we saw good supervisory oversight and investigation plans. We also saw a focus on the wider safeguarding of children. MARAC referrals are made appropriately, and MARAC meetings have a focus on children and their safety. Domestic abuse support officers worked well with victims and their children to safeguard them. We also saw good use of protective measures such as domestic violence protection notices (DVPNs) and domestic violence protection orders (DVPOs).

Case study: DAU investigation

A domestic abuse incident occurred where the suspect was in possession of a knife and hammer as he threatened the victim in the presence of her three children aged 1, 6 and 11. Officers attended and the offender was arrested. Body-worn video was used to record the initial exchanges. A DASH risk assessment was submitted, and referrals made to partner organisations including Operation Encompass.

The DAU supervisor added a detailed investigation plan, outlining the high-risk factors in the case and the impact on the children. A DVPN was issued, which in turn led to a DVPO. The case was referred to MARAC. The DAU officer supported the victim and provided safeguarding advice for her and her children.

At the time of the inspection the case was still ongoing, and children's social care services were completing an assessment.

There are weaknesses in investigations by non-specialist officers

We found weaker supervision in cases managed by non-specialist officers. There was a lack of investigation planning in these cases, and they didn't always consider the wider risk to victims and children.

In medium and standard-risk domestic abuse cases frontline officers have responsibility for the investigation and safeguarding. In the cases we reviewed we saw delays and a lack of meaningful supervision.

Case study: response team investigation

A domestic abuse incident took place between ex-partners. The victim was strangled by the suspect while she was holding their one-year-old daughter. They also have a five-year-old daughter who was at school at the time. The incident was reported three hours after it had occurred by which time the suspect had left.

There was a delay of 15 hours before officers attended. A DASH risk assessment was completed and reviewed in the HAU. The five-year-old child wasn't mentioned on the DASH, nor was the presence of the younger child. This wasn't picked up by the HAU. A previous incident of strangulation between the two parties also wasn't identified.

There was no evidence of a strategy discussion or meeting taking place.

Two weeks later, the victim reported another incident. But the response was delayed for three days for a diary appointment which was inappropriate given the wider risks in this case.

There was a delay of over a month from the initial report before the suspect was interviewed. There was no evidence of challenge by a supervisor about this. The case was later filed with no further action being taken against the suspect. We referred this case back to the force to seek assurances that the children were safe. We were told that safety planning was initiated at a MARAC meeting, but this was not until five weeks after the first incident.

There are delays in investigations of online child sexual abuse

The online child sexual exploitation team (OCSET) is the force's single point of contact for investigating external referrals about online child abuse.

We found delays in National Crime Agency (NCA) cases waiting to be developed – development is when enquiries are conducted to help identify who is responsible or where the offences have been committed. We also found delays in investigations after this research had been completed.

During our inspection, there were 13 cases in development and 30 awaiting enforcement. We saw that previously backlogs had been larger than this, particularly in the development stage. However, a recent reduction in the amount of research carried out has resulted in a decrease in the number of cases in development. This means that cases are allocated to investigators faster. But a reduction in research also means that it may need to be completed later. In addition, important information about children at risk may not be gathered quickly enough. This has led to an increase in the number of cases awaiting enforcement. We are aware that the force has recognised this and is working to reduce the backlog.

During the research and intelligence gathering phase, information about the cases is updated in a standalone system only accessible to the OCSET team. This means full information isn't available to frontline officers when they are dealing with other incidents. This means officers may not have all the relevant details when making decisions. And this prevents senior officers from being able to fully understand the volume of cases, how quickly they are dealt with and the associated risks.

Lower-risk cases are allocated to investigators outside OCSET

The OCSET team deal with the higher-risk cases. This means that some medium-risk and all low-risk cases are sent to the CID or CATE teams.

The OCSET supervisor provides comprehensive guidance to investigators who are non-specialists. An OCSET point of contact, who can provide advice, is also identified for each case. This is positive. But investigators in CATE and CID are largely untrained in this area of work. Some of the staff we spoke to didn't feel they had the skills they needed and didn't feel comfortable being allocated this work. Supervisors in these teams had similar concerns and we found inconsistencies in the supervisory oversight, direction, and guidance in the cases.

Frontline officers deal with cases where children send or receive indecent images to each other. We found the standard of these investigations was inconsistent. We also saw that where guidance was requested, it was from CID or CATE staff rather than the OCSET team. Response officers and their supervisors also felt they had a lack of training and skills to deal with these cases.

Information about children at risk isn't shared soon enough with children's social care services

When research identifies that a child may be at risk, contact with children's social care services is not taking place quickly enough. We found that CRAs were only being submitted at the point of arrest or the execution of search warrants. This is particularly significant given the sometimes long delays previously outlined. Early information sharing with partner organisations is crucial in establishing the level of risk in each case. This allows joint protective plans to be put in place for these children.

Case study: CID investigation

The force received an NCA package indicating the uploading of several indecent images and videos of children. A KIRAT risk assessment was completed that indicated a low risk. It took five months for the case to be allocated to the CID for investigation, and guidance and investigation advice from the OCSET detective sergeant to be documented.

It was identified that the suspect had two children aged 16 and 11. Enquiries had been made with Warwickshire CFFD, but the children weren't known to them. A further request for information had been made to a neighbouring local authority – but no reply was received.

The suspect wasn't arrested until more than four weeks after allocation – six months after initial receipt. He was interviewed and bailed with appropriate conditions. It isn't recorded whether the children were present at the time of the arrest.

Twenty days after the suspect was arrested CRAs were submitted for the children. A further four days later it was recorded that the children were safeguarded with their mother. There was no detail available about the longer-term safeguarding plan. The suspect has since been released under investigation, so there are no prohibitive conditions preventing him from having unsupervised access to children.

The force is effective in using digital media investigators

The force uses digital forensic triage software so that only relevant items likely to contain illegal material are submitted for examination. This includes the capability to triage devices at addresses. At the time of the inspection, the force had two digital media investigators and there was a plan to increase this to three. This means that the force will have capacity to triage items at the scene of every arrest or search warrant for online child sexual abuse. This is positive.

Since September 2021, the force has worked with West Midlands digital forensics unit to examine digital devices. We found some confusion among staff about the service level agreement between the forces and how it would impact upon Warwickshire's investigations. During the inspection, it wasn't possible to fully test the effectiveness of the arrangements.

Recommendations

We recommend that Warwickshire Police immediately improves its child protection and exploitation investigations, paying attention to:

- allocating investigations to teams with the skills, capacity and competence to carry them out well;
- improving the quality of oversight and supervision;
- reducing delays in investigations; and
- sharing information with children's social care services at the time that a risk to a child is known.

8. Decision-making

The use of police protective powers was inconsistent

Although we found some good examples of officers making decisions to use their powers to protect children, this wasn't consistent. In several cases we found that there were missed opportunities to act and officers had to return when situations escalated or deteriorated. Failure to act in these cases left children at risk unnecessarily and created additional demand for the police.

Case study: failure to use police powers of protection

Police were contacted by a support worker who had concerns for two children aged one and two. Their mother appeared to be having a mental health crisis. The risk wasn't identified in the OCC and the call was delayed for several hours. Officers attended and although they expressed concern for the mental health of the mother, they minimised the risk to the children – a medium-risk CRA was submitted.

A second call was made from the support worker expressing increased concern for the children. Officers didn't attend in response to this call and the log was closed with an inappropriate rationale that an ambulance should be contacted.

Several hours later, a further call was received from the ambulance crew requesting assistance. On this occasion, police attended and did exercise their powers of police protection.

We found designated officers' oversight wasn't always consistent. We saw some very good examples of designated officers writing detailed updates about why the powers had been used, what the views of the children involved were and a good handover between shifts. But we also saw cases where this didn't happen and there was little update about what had happened. In two cases, we found that the power of police protection lapsed after 72 hours without a clear update about the children or whether they were safe.

We saw good evidence of strategy meetings and discussions taking place. There was quick contact with children's social care services and social workers from the emergency duty team. However, too often children were brought to a police station as a place of safety. Often children remained at a police station for long periods of time. This is inappropriate and not in the best interests of the children involved.

Where relevant, in most cases investigations were conducted about the situation children had been found in, for example if they had been neglected or assaulted.

Case study: good and effective use of police protective powers

Police were called to a report of a mother assaulting her eight-year-old daughter. The call handler recognised the risk and allocated officers immediately. They arrived quickly and used their police protective powers appropriately and arrested the mother. An ambulance was called to provide medical care for the injured child. The designated officer attended and spoke to the child, writing a comprehensive update.

The emergency duty team social worker was contacted quickly, and a strategy discussion took place. Although the child was taken to a police station, this was only for a short period of time before the social worker attended and took the child to a foster placement.

A very detailed CRA was completed. This included noting the child's demeanour, the state of the home and the child's interaction with her mother. This was reviewed by the HAU and shared with children's social care services. A strategy meeting took place and an update recorded in police systems.

There are continued reviews from designated officers until the mother is released from custody and bailed with relevant conditions to safeguard the child. The child remained in foster care.

There was good supervisory oversight of the investigation, and a detailed investigation plan was recorded.

Recommendation

We recommend that, within six months, Warwickshire Police should improve the response to children taken into police protection. This should include making sure that, where required, opportunities to protect children are taken and all relevant information is properly recorded and readily accessible.

9. Trusted adult

It is important that children 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. They explore the most effective ways to communicate with them. Such sensitivity builds confidence and creates stronger relationships between the child and/or the parents, carers and police.

Case study: protecting a child who has witnessed domestic abuse

A six-year-old boy witnessed a violent assault on his mother during a domestic abuse incident. This was reported anonymously to children's social care services. The mother had significant injuries and there had been a threat to kill her, also witnessed by the child.

A strategy meeting was held and a detective sergeant from the DAU attended. The child had told a teacher what he had seen. What he had said and how he was feeling was well recorded in the case records. The focus on his welfare was impressive. Disclosure was made to the victim about the suspect's past history under the domestic violence disclosure scheme.

The male was arrested and released on bail but with conditions appropriate to safeguard the child and his mother. An intermediary was secured to help the child to provide witness testimony in the most appropriate way.

A referral was made to MARAC and appropriate interventions were put in place. The child has been placed on a child protection plan to further protect him.

There are several positive initiatives to work with children, seek their views and identify their needs

The force has developed a child-centred policing strategy, having adopted the national child-centred policing model. It has also developed an associated action plan.

The criminalisation of children is scrutinised at monthly out-of-court disposal panels, with a focus on preventative work. Quarterly performance data from the Youth Justice Service is monitored to support this approach and continuing work in this area is reflected in the child-centred policing action plan.

A review of stop and search policies has led to the introduction of a third stage – safeguard. This has been designed to make sure that the vulnerabilities of those encountered (including children) are considered and responded to.

The force has 120 police cadets. They have attended several events, such as in schools, engaging with other young people to highlight issues of concern such as knife crime, county lines and sexual violence. The use of virtual reality media and headsets to reinforce this work has been very well received at these events.

During lockdown periods of the pandemic, the police worked together with the local authority's targeted youth support team. They also worked closely with the OCC and visited areas where children were reported to be gathering. This helped children to understand the restrictions and why people were concerned, without the need for police to attend.

The force has more work to do to implement measures which allow children to give their evidence in advance of criminal proceedings

Section 28 of the Youth Justice and Criminal Evidence Act 1989 introduced measures which would allow vulnerable people, including children, to provide their evidence (as victims or witnesses) in advance of crown court proceedings. This includes any cross-examination by the defence team. Children can give their evidence earlier in the proceedings when their recollection is likely to be fresher. This removes the need for children to attend court for a trial, reducing their stress and anxiety. The provisions of this legislation were implemented at Warwick Crown Court on 23 November 2020. There must be a video recorded interview, in compliance with achieving best evidence in criminal proceedings (ABE), for these measures to be available.

Since 2020, the force has trained 80 frontline and specialist staff and 9 social workers to be able to undertake ABE video recorded interviews. And there are plans to train a further 40 officers and 12 social workers in 2022. This places the force in a good position to fully implement the section 28 provisions. But in the investigations we reviewed, we saw little evidence that this was happening. The force should do more to make sure children are able to provide their evidence earlier.

10. Managing those who pose a risk to children

At the time of our inspection, the Warwickshire Police RSOMU was managing 593 registered sex offenders living in the community. The average number of offenders per manager was 49, which is reasonable and within the tolerance of accepted police practice.

Force processes for visiting registered sex offenders aren't in accordance with national policing practice

The police should visit all registered sex offenders at their home address to assess their current risk. According to national policing practice, the force should decide the frequency of these visits for each individual, with reference to their risk management plan. But Warwickshire Police visited most registered sex offenders according to a visiting regime based on 1, 3, 6 and 12-month intervals. Bespoke risk management plans, as part of the active risk management system (ARMS), allow for flexibility in how often an offender should be visited.

We also found there were 70 offenders who had been placed into reactive management. But the system being used isn't fully compliant with national policing practice as the registered sex offenders are being visited once a year. We were told this was because staff didn't have confidence that they would be notified about events or information to prompt a review of risk.

The proper application of visiting regimes and reactive management processes would also allow the force to concentrate its resources on those offenders deemed to be at highest risk.

The quality of work with partner organisations to reduce risk from registered sex offenders is good

We found that RSOMU officers worked well with partner organisations to manage the risk from registered sex offenders. This included taking part in strategy meetings and conducting joint visits to offenders with probation officers and social workers. We also saw good levels of communication between professionals to discuss risk and management. This is positive.

The quality of work of the RSOMU needs to improve in some areas

We found that ARMS assessments were generally well written, containing good levels of information. But they weren't always in date. We found one case where the assessment was 12 months overdue.

We saw that risk to children isn't always recognised and acted on promptly.

Case study: managing risk with a registered sex offender

A 23-year-old registered sex offender with a conviction for child sex offences completed his initial notification, indicating that he was living with two children. There was a delay in conducting the visit and children's social care services weren't informed until two weeks later. However, this did generate some good joint working with children's social care services and the probation service, including joint visits in relation to the offender's children.

It was later discovered that the child of a neighbour also visited the address. Children's social care services were not notified of this for seven weeks. This child was left at risk during this time.

Sexual harm prevention orders (SHPOs) aren't always being applied for when appropriate. This can make managing offenders more difficult without the prohibitive conditions that the orders can provide. When good quality SHPOs are in place, offender managers are better able to manage risk. We were also told that frontline officers have very little knowledge of SHPOs. And they weren't confident about how to respond when dealing with a registered sex offender that had one in place.

The actions tab function on the ViSOR risk management plan isn't being used as it should be. This means that it is difficult to track what actions have been completed without researching ViSOR and other IT systems. We saw inconsistency about where information was recorded. It is difficult to gain a full picture of the management of the registered sex offender. This means information could easily be missed and lead to an incomplete understanding of risk.

Local police officers aren't routinely aware of registered sex offenders living in the communities they are responsible for

Neighbourhood officers told us they aren't regularly made aware of registered sex offenders in their area. This prevents a full understanding of the risk posed and reduces the opportunities for information to be routinely gathered. This is particularly important for those offenders under reactive management, who should only be passively monitored.

There is a lack of oversight and governance for the RSOMU teams

Senior officers we spoke to weren't aware of the detail of the work of the RSOMU. This is made worse because the force routinely collects only a limited amount of performance data. This data isn't used effectively to monitor team performance and manage risk. We saw no evidence that supervisors carried out qualitative sampling of records to be assured about the quality of work.

The RSOMU isn't involved in the child sex offender disclosure (CSOD) scheme process

When members of the public contact Warwickshire Police to report concerns that a person with access to a child may pose a risk of sexual harm to them, the CSOD process may be instigated. But the RSOMU isn't involved in it. The HAU deals with all such enquiries. This means that the wealth of knowledge held by the offender managers won't be drawn upon when a decision is made about whether to make a disclosure or not. This is particularly important given the problem we identified about information not being recorded appropriately in the ViSOR system.

Equally, when the CSOD process has been completed by the HAU the RSOMU isn't told about the result. This can have an impact of the continuing management of relevant offenders if their offender manager isn't aware of all the information.

Recommendations

We recommend that Warwickshire Police immediately acts to improve its management of registered sex offenders, paying particular attention to:

- how it monitors offenders through home visits;
- how it uses reactive management processes;
- how information is provided to local officers about the registered sex offenders causing concern in their area;
- how it records information; and
- how the CSOD scheme is managed effectively.

11. Police detention

The number of children arrested in Warwickshire is low. In the three months from October to December 2021, only 103 children were arrested – just over one per day. We found that children are arrested as a last resort and officers are encouraged, where appropriate, to consider alternatives to bringing children into custody. This is positive.

The welfare of children detained in police custody isn't considered well enough

In the cases we reviewed, we found that risk assessments are completed for every child arrested. They include questions about the child's welfare and mood. Any concerns are communicated between custody staff and regular 30-minute observations are completed for all children in custody. This is also positive. But there are no youth detention cells available. Children who are in custody for short periods of time can sit with their parent or an appropriate adult in a side room, but children detained for longer periods are placed in an adult cell. This can be intimidating and frightening for children, particularly if the custody suite is busy with other adult detainees. We also found in some cases that food and drink wasn't being offered to children for long periods of time and there weren't always opportunities to exercise.

Healthcare assistants are available 24/7 for those detained in police custody, including children. However, we saw cases where children weren't having their health needs assessed when it would have been appropriate to do so. Similarly, we found that liaison and diversion workers don't see all children in custody, particularly out of hours. However, it is positive that healthcare assistants and liaison and diversion workers have direct access to the force's IT system to update custody records directly.

There are delays in the attendance of an appropriate adult

Appropriate adults should support the child's overall welfare needs, rights and entitlements from the start of the custody process. But, in some cases we examined, rather than arriving promptly to advocate for a child, they came at the start of the interview. We saw delays of up to 16 hours.

The reviews of children being detained aren't always child centred

Inspectors should regularly review the need for the continued detention of detained persons. During this process they should seek and consider the views of the detainee. In the cases we examined, we saw that reviews were often completed away from the custody suites without speaking to the children or their appropriate adult. We also saw no evidence that the children were then updated about the review or what was likely to happen to them. The reviews didn't fully consider the welfare of the child either, or bail as an alternative option. Many reviews didn't recognise that the detainee was a child. These are not child-centred practices and improvements should be made to make sure that children's views are taken account of, and decisions made in their best interests.

Children aren't being transferred to alternative accommodation when they have been charged and denied bail

The local authority must provide somewhere suitable to stay for children who are charged with offences, denied bail, and detained. This is known as alternative accommodation. Only in exceptional circumstances would this not be in the child's best interests. In rare cases – for example, if a child presented a high risk of serious harm to others – secure accommodation might be necessary.

We found that few custody staff understood the threshold between alternative and secure accommodation. In the cases we reviewed, we saw examples of secure accommodation being requested where it couldn't be justified. We also saw examples of secure accommodation being requested for children arrested for breach of court bail – secure accommodation isn't applicable in these circumstances. Detention certificates are usually completed but they often contain incorrect information about the required accommodation.

The force daily management briefing provides oversight of the overnight detention of children. However, we didn't see any evidence of escalation to the local authority when alternative accommodation wasn't found.

CRAs aren't being completed for children detained in custody

In the cases we reviewed, we didn't see any CRAs being completed. The failure to submit a CRA for these children means that information about the circumstances of their arrest or risks identified while in custody aren't shared with statutory safeguarding partners. This means that these children won't always get the help they need when they need it.

Case study: missed opportunities to protect the welfare of a child in custody

A 14-year-old boy was arrested in a stolen car. He was in the care of the local authority and had been reported missing. There was a delay of 16 hours before the appropriate adult arrived, just before he was interviewed.

The inspectors reviewing his detention didn't wake him when conducting the review or to let him know that his further detention had been authorised. These were missed opportunities to consider his welfare and take account of his views.

The boy was charged with taking a motor vehicle and refused bail. The emergency duty social worker was contacted and asked to provide secure accommodation. This wasn't justified in this case and the social worker challenged the request arguing that the boy should be bailed. A detention certificate was completed outlining that secure accommodation was unavailable.

The child spent over 61 hours in custody before appearing at court where he was released on unconditional bail.

A CRA wasn't completed for this event.

Multi-agency review processes could be improved

The force holds a regular monthly meeting with partner organisations to scrutinise how children have been dealt with in custody. This is attended by a detective inspector from the vulnerability and safeguarding team, and representatives from the Youth Justice Service and liaison and diversion. The panel considers the statutory requirements of holding a child in police detention and reviews the child's experience while in custody, and subsequent outcomes. Through this process, the panel has found similar areas for improvement as in our inspection.

Learning points from the cases have been raised individually with custody sergeants and inspectors and messages distributed more widely to enhance the learning. This is a positive step but we are yet to see consistently good practice when children are detained.

Recommendations

We recommend that, within six months, Warwickshire Police should carry out a review of how it manages the detention of children. The review should include, as a minimum, how best to:

- make sure that appropriate adults attend the police station promptly;
- make sure officers fully consider the welfare of children when in custody and refer them to children's social care services, when necessary; and
- strengthen its working methods with local authorities to ensure that children charged and refused bail are moved to appropriate alternative accommodation and not held in custody overnight.

Conclusion

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

Child protection and wider vulnerability is a priority and the force leadership team is committed to improving its services for children.

The force works very well with statutory safeguarding partners and other safeguarding organisations throughout the area.

Senior leaders have acknowledged that there are some inconsistencies and areas for improvement in the service provided to children. The force is acting quickly to address areas of concern identified through child protection case audits carried out during our inspection. We welcome this positive response.

As highlighted earlier, there were some examples of good work by individual frontline officers responding to incidents of concern involving children. We also found specialist child protection staff to be committed and highly motivated while operating in an increasingly complex and demanding environment to keep children safe.

Despite the efforts of senior leadership, the force isn't yet achieving consistently good outcomes for children. This affects the provision of safeguarding and potentially leaves children at risk.

Those investigations which had the appropriate supervisory oversight, joint working and effective safeguarding plans in place provided the opportunity for a positive outcome for the child. If this is replicated in all areas, the force will achieve consistency of service and improved outcomes for all children.

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 the recommendations where we have asked for immediate action.

Warwickshire 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 the force 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 interagency 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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