

National Child Protection Inspection Post-Inspection Review

West Mercia Police 18 – 21 August 2015

January 2016

© HMIC 2016

ISBN: 978-1-78655-070-5

www.justiceinspectorates.gov.uk/hmic

Contents

1.	Background	3
	Summary	3
2.	Post-inspection review findings	5
	Initial contact	5
	Assessment and help	6
	Investigation	7
,	Trusted adult	10
	Managing those posing a risk to children	12
	Police detention	13
3.	Recommendations	16

1. Background

HMIC carried out a child protection inspection of West Mercia Police in November 2014 and provided the force with a report of our findings in February 2015. In March 2015, the force provided HMIC with an action plan setting out how it intended to respond to the recommendations in the inspection report. Inspectors carried out a post-inspection review in August 2015 to assess progress with the implementation of the recommendations.

The review included:

- a document review;
- interviews with staff including the chief officer lead, and the head of protecting vulnerable people; and
- audits of 26 child protection cases relating directly to the areas for improvement which were identified in the inspection report and associated recommendations. The force's practice was assessed as good in eight of these cases, requiring improvement in thirteen and inadequate in five.

Summary

West Mercia Police has prioritised child protection and it was clear to inspectors that the force has a strong desire to improve outcomes for children who are at risk of harm.

The force had reviewed its public protection structures, systems and processes and had invested significant extra resources into child protection. Although some of these structures were not yet in place, it was clear that some improvements had been made in relation to investigations of child sexual exploitation (CSE), the supervision and wider governance arrangements for these investigations and in eliminating completely a backlog of work in the Harm Assessment Units (HAUs) in particular, which is a significant achievement.

However, inspectors were concerned to find that assessments in the HAUs often lacked detail and the recording of joint agency plans was often poor. We were pleased to find that the force is addressing these issues by developing the multi-agency safeguarding hub (MASH)¹ structure across the force area.

¹ This is an entity in which public sector organisations with common or aligned responsibilities in relation to the safety of vulnerable people work. The hubs comprise staff from organisations such as the police and local authority social services who work alongside one another, sharing information.

It remains to be seen whether the training programme to support this structure will ensure that staff have sufficient knowledge and confidence to implement the new working practices effectively and thereby improve outcomes for children.

West Mercia Police recognises the challenges it faces and understands what is needed to ensure that effective child protection practice is provided consistently across the entire force area. Some important steps have been taken to address the recommendations made by HMIC in November 2014. However, challenges remain and the force will need to maintain the current focus and momentum of improvement for some time to come.

2. Post-inspection review findings

Initial contact

Recommendation from initial inspection report

 We recommend that, within three months, West Mercia Police ensures that all child protection allegations are referred to and assessed by knowledgeable and experienced staff.

Summary of post-inspection review findings

West Mercia Police had provided some training to staff in the HAUs to improve the way that child protection allegations were referred and assessed. However, inspectors found that the quality of assessments required further improvement. The force had planned further specialist training to improve the quality of assessments. The force had also reviewed processes in the HAUs and the MASH, and a new MASH structure was designed, which was due to be implemented across the force area.

Detailed post-inspection review findings

Staff in the HAUs had received some training to support them in their role. However, as we had found during our initial inspection, staff highlighted concerns about a lack of training and development. Further, specialist training to improve the quality of assessments and to support the development of better protective plans was scheduled but at the time of the review had not yet been provided.

While the HAUs were processing large amounts of information quickly, inspectors found that many of the referrals sent to partner agencies, such as children's social care services, lacked detail and did not always take account of the full range of relevant information. As a result, assessments were inconsistent and the effectiveness of referrals was undermined.

Our attention was drawn by staff to the imminent implementation of a new MASH structure, within which HAU staff would be required to work, and to the additional responsibilities that this would entail (such as attending strategy discussions).² HMIC acknowledges that implementation of a MASH structure across the force area may

-

Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm there should be a strategy discussion involving local authority children's social care services, the police, health services and other bodies such as the referring agency. This might take the form of a multi-agency meeting or phone calls and more than one discussion may be necessary. A strategy discussion can take place following a referral or at any other time, including during the assessment process. *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015 (latest update), pages 36-37, available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

result in further improvements in the referral and assessment of child protection concerns. The force is also committed to providing further specialist training for the current HAU staff as they move into their new role. This may help to make joint planning with partner agencies more effective and provide further opportunities to undertake prompt and meaningful assessments with them, thereby providing better outcomes for vulnerable children.

Assessment and help

Recommendation from initial inspection report

- We recommend that within three months West Mercia Police takes steps to eradicate the backlog in the HAUs and puts in place systems to ensure that all cases can be assessed promptly.
- We recommend that West Mercia Police immediately reviews cases where children had been identified as being at risk and, with partner agencies, takes appropriate action to safeguard the children.

Summary of post-inspection review findings

West Mercia Police had cleared the backlog of work in the HAUs and cases were being assessed promptly, which is a significant achievement. Cases involving children who had been identified as at risk had been reviewed by the force. In addition, the force had improved its processes to ensure that appropriate action is taken to safeguard children.

Detailed post-inspection review findings

During our initial inspection in November 2014, inspectors were concerned to find delays in the assessment of cases and their onward referral in the HAUs. Since then, West Mercia Police had reviewed the arrangements for managing this work, increased staffing levels and improved processes. This had resulted in the backlog being eradicated and the timeliness (though not always the quality) of assessments had significantly improved. In November 2014, inspectors had found 200 domestic abuse assessments awaiting review. In contrast, at the time of this review in August 2015, there was no backlog of work and HAU staff were generally working on cases that had been referred to it in the previous 24 hours. The force is to be commended for this achievement.

West Mercia Police had also improved its approach in cases involving children who were identified as being at risk, to ensure that appropriate action was taken. Staff carried out a daily scan for incidents that involved children potentially at risk, including where there might be links to CSE, so that action could be taken. In addition the protecting vulnerable people (PVP) team reviewed all child protection cases daily to ensure that these cases were being dealt with appropriately.

Cases that were assessed as involving a high risk were discussed at daily meetings to provide additional oversight. This provided further assurance that children at risk were identified and appropriate action taken.

Inspectors examined four cases referred by the force to children's social care services in light of concerns about the children. The handling of these cases by the force was judged as good in two cases, requiring improvement in one and inadequate in one. Elements of good practice identified in these cases included officers responding quickly, children being spoken to and immediate safeguarding measures being put in place.

Investigation

Recommendation from initial inspection report

- We recommend that within three months West Mercia Police takes action to improve child protection investigations, including those of suspected child sexual exploitation. This should include ensuring:
- every referral received by the police is allocated to a team with the skills, capacity and competence to undertake the investigation;
- investigations are planned (with partner agencies when appropriate). Plans should include consideration of all the likely evidential requirements and when evidence gathering activities should be instigated; and
- investigations are supervised and monitored and, at each check, the supervisor reviews the evidence and any further enquiries or evidence gathering that may need to be done.

Until such time as West Mercia Police is assured of these changes being embedded, the force should conduct regular reviews of practice that include the quality and timeliness of investigations.

Summary of post-inspection review findings

 West Mercia Police had taken steps to improve its child protection investigations, including those investigations involving CSE. Investigations were allocated to staff with the appropriate skills and were generally planned effectively. The force had improved its supervision of these investigations, although this was not adequate in all cases. Inspectors found that some cases were delayed unnecessarily.

Detailed post-inspection review findings

West Mercia Police had recognised that additional staff were necessary to deal effectively with child protection cases, and it had increased the number of people working in the PVP department. The force had also created dedicated teams for CSE investigations, with co-ordinators across the force area. The co-ordinators were responsible for assessing all relevant investigations. They then helped to develop an initial risk management plan and provided ongoing support to assist officers in safeguarding the child. In addition, the force had established multi-agency panels to support longer-term safeguarding work.

- The force had established a central strategic team to bring about and support improvement. Some training had been provided, more was planned and there was a proactive approach to learning lessons. This was helping to ensure that teams who had the appropriate skills and had sufficient capacity were in place to deal with cases more effectively. Cases were regularly reviewed and if needed were re-allocated or specialist support was provided. In general, this meant that cases were being dealt with by appropriately skilled officers.
- In the cases assessed by inspectors for this review, we found that investigations were often handled well: the children were interviewed by specialist officers, medical examinations were arranged and suspects arrested when appropriate, and material was taken for forensic analysis. In most of the cases examined, the force had put clear risk management plans in place and there was evidence of plans to provide the safeguarding support that was needed. The initial response to reports was swift, and in most cases alleged offenders were arrested promptly and bail conditions imposed.
- Plans for investigations were routinely completed by officers and were generally of a good standard. While in some cases the plans were generic, inspectors also found good examples of child protection work by the force, with investigators displaying a mix of investigative and protective approaches. There was evidence of good quality supervision in many of the cases examined. In these cases, investigations proceeded quickly, in a co-ordinated manner and with attention both to the child's welfare and to obtaining evidence.
- However, we found that joint planning of investigations, with children's social
 care services and other partners, was not fully effective. Inspectors found few
 strategy discussions taking place at the start of incidents to agree both
 safeguarding measures and how to progress the case on a multi-agency
 basis. Minutes of meetings were not always attached to police records,
 compromising the effectiveness of decision making.

It was clear in the cases that inspectors assessed that the CSE teams had the skills and experience to progress investigations into suspected child sexual exploitation effectively. Inspectors also found some evidence of a stronger safeguarding approach and improved decision-making, in comparison to our findings in November 2014. For example, in our initial inspection, the force's practice in all but one of the cases of this nature that we reviewed was considered to be inadequate; during this review only 2 out of 7 such cases we assessed was deemed to be inadequate. However, not all CSE investigations were of a consistently good standard and they were not always done in a timely manner. Inspectors also found that joint working with partners to safeguard children at risk of CSE was not always sufficiently robust.

Inspectors examined seven cases relating to children who were at high risk of sexual exploitation. The force's approach was considered good in three of these, requiring improvement in two and inadequate in two. Three children were subject to ongoing (CSE) panel meetings (described above) and longer-term multi-agency work. However, in all seven cases children had been reported as being at risk of sexual exploitation and there was no record of strategy discussions in relation to any of the specific events which had caused them to be at risk. This meant that opportunities to intervene and provide joint safeguarding support at the earliest possible point had not been taken.

This was particularly evident where the child did not co-operate or where several issues needed investigation before a decision could be reached about the right course of action. For example:

Long delays occurred in an investigation into a 16-year-old autistic girl's relationship with a 47-year-old man on Facebook. Eight months after this had come to the force's attention, she had not been interviewed or her computer and phone analysed. During that time, no safeguarding measures had been put in place.

There had been no improvement since our initial inspection in the delays incurred in the analysis of computers. At the time of the review, the force had 150 computers awaiting analysis, compared to 142 computers in November 2014, with the longest having waited five months. West Mercia Police was addressing this through the deployment of additional staff and had recently outsourced some of the work to reduce the backlog and process cases more quickly. However, in the meantime, investigations were significantly delayed: in one case, this involved a five month delay in analysing devices seized from a 41-year-old alleged offender who had been arrested for the rape of a 15-year-old girl.

In terms of supervision and monitoring, the force had reviewed its performance management framework and had developed quarterly reviews to audit the quality and timeliness of decision making in child protection cases. Governance to oversee investigations had also been strengthened by a recently established PVP Accountability Board. Inspectors found that this had improved oversight by senior

officers, but this was not yet consistently reflected at management levels below this. The force had disseminated learning for staff through the PVP communication strategy, but not all staff were aware of this. At this early stage of implementation, strengthening the arrangements for assessing how effectively decisions are made could enable the force to improve how safeguarding is planned, and thereby deliver better outcomes for children.

The force was aware that, for the longer term, its current child protection structures lacked the capacity to meet increasing demand. At the time of the revisit the force was carrying out a major review of resources and assessing how to deliver its priorities to protect vulnerable people and safeguard children from harm. HMIC recognises the significant challenge of this work and acknowledges the commitment shown by the force.

Trusted adult

Recommendations from initial inspection report

- We recommend that within six months West Mercia Police evaluates the impact of its investment in tackling child sexual exploitation – in particular, the extent to which the new approaches lead to improved investigations, improved protective plans and greater levels of confidence in the police and partner agencies shown by children at risk.
- We recommend that within three months West Mercia Police takes action to improve the timeliness of submissions to the CPS and works with the CPS to reduce timescales for charging decisions.

Summary of post-inspection review findings

- The force's investment had started to improve outcomes for children but, as described in the previous section, it still has more to do to ensure that all children at risk of CSE receive appropriate support.
- During our review, we found that long delays remained in receiving charging decisions from the CPS, but the force was actively working with the CPS to improve the position.

Detailed post-inspection review findings

The force had invested additional resources in the establishment of dedicated CSE teams in January 2015. It had updated its profile of CSE in the force area, developed a plan to tackle this, which it had shared with partners, and set up a tactical group to manage the delivery of the plan. The force had also worked with children's homes to develop a more effective approach to missing children.

Inspectors found that officers and staff better understood how to recognise CSE, which had increased the number of children identified on force IT systems, via a "flag", as being at risk. In the first 6 months of 2015, 454 cases were flagged as potentially involving CSE – a significant increase over the previous 6 months. Inspectors were also told that most of the children identified as being at risk in the force's recent CSE profile were flagged on police systems, when previously this had not been the case. Partners did not provide data to inform the CSE profile, but the force had worked with other agencies to ensure that they had identified the same children. When West Mercia Police has embedded its approach to CSE, the force intends to carry out a formal evaluation of the impact its approach has made.

As previously noted, most of the cases involving CSE that were reviewed by inspectors showed a stronger approach and some improved outcomes. In particular, the work of the CSE teams was resulting in better communication and positive relationships with children, and we saw evidence of their views being taken into account. In two of the cases examined, the CSE team had taken steps to escalate the child's concerns within children's social care services, to ensure that appropriate care and intervention took place.

We found similar delays in cases sent to the Crown Prosecution Service (CPS) to review and decide on prosecution as we had during our inspection in November 2014. Decisions took at least three months and the force reported one case which had been waiting nine months.

West Mercia Police was working with the CPS to address delays and the force tracks the timeliness of charging decisions. The assistant chief constable met the regional chief prosecutor regularly to discuss improvements. We were told that from September 2015, the CPS planned to dedicate more resources to cases involving serious sex offenders to reduce the time taken for decisions in these cases.

Managing those posing a risk to children

Recommendation from initial inspection report

 We recommend that within three months West Mercia Police extends the knowledge and skills of staff working with RSOs³ to those investigating cases of sexual abuse. Those investigating cases of sexual abuse should be knowledgeable about how offenders operate, how to conduct effective enquiries into offenders' activities and what action can be taken to reduce the risk they pose.

Summary of post-inspection review findings

West Mercia Police had increased the number of people working in its offender management unit and was improving the links between specialist teams and frontline officers to ensure the effective management of serious offenders.

Detailed post-inspection review findings

The force had deployed an extra five officers to its offender management unit to ensure that visits to sex offenders were carried out in a timely way and to allow some proactive work to be undertaken. In cases examined by inspectors for this review, we found that officers generally considered the risk an offender might pose to a child, arrested those suspected of child abuse and ensured bail conditions were put in place. Inspectors also found that staff considered the use of preventative measures against those posing a risk to children, such as child abduction warning notices. However, the risks to the siblings of children who were vulnerable, violent or disruptive were less understood. These children were not always spoken to or their needs for help and support individually assessed.

The force had strengthened the links between the specialist teams that manage sex offenders and non-specialist teams. Frontline officers received information on sex offenders, and neighbourhood officers were made aware of offenders living in their area and they reported back any intelligence they gathered. They also took action on behalf of the sex offender team.

³ A registered sex offender (RSO) is a person required to provide his details to the police because he has been convicted or cautioned for a sexual offence as set out in Schedule 3 to the Sexual Offences Act 2003, or because he has otherwise triggered the notification requirements (for example, by being made subject to a sexual offences prevention order). As well as personal details, a registered individual must provide the police with details about his movements, for example he must tell the police if he is going abroad and, if homeless, where he can be found; registered details may be accessed by the police, probation and prison service.

⁴ This is a non-statutory notice issued when the police become aware of a child spending time with an adult who they believe could be harmful to them. A notice is used to disrupt an adult's association with a child or young person and warns an adult that association could result in arrest and prosecution.

The force had recognised the need to increase frontline officers' understanding of the risks posed by RSOs and the work of the specialist offender management unit. No training had taken place on this since our inspection in November 2014. However, the force was developing training that would illustrate how sex offenders operate, how to conduct effective enquiries and what action can be taken to reduce the risk that sex offenders pose.

Police detention

Recommendations from initial inspection report

- We recommend that West Mercia Police engages immediately with local authorities and LSCBs to:
- develop strategies to equip frontline staff to manage difficult behaviour by young people looked after by the local authority so that detention is a last resort;
- ensure that no child who is looked after by the local authority is denied accommodation by them;
- record and report to the LSCB the number of children held in custody (and their legal status), the efforts made to secure alternative accommodation and the reasons for failing to do so (with plans to address them).
- We recommend that West Mercia Police immediately ensures that all detention certificates are completed with full details of the length of time a young person had spent in custody and the efforts made to find alternative accommodation. West Mercia Police should engage with the West Mercia Criminal Justice Board to discuss establishing collective oversight of this statutory requirement.

Summary of post-inspection review findings

West Mercia Police had made limited progress to reduce the number of children inappropriately detained post charge and held overnight in police custody. By improving the collection of data, the force had a better understanding of why children were being detained, but this information was not comprehensive. Cases we examined for this review showed that requests for alternative accommodation were not consistently made and that children were still being detained in police custody overnight rather than being transferred to local authority accommodation.

Detailed post-inspection review findings

West Mercia Police had developed a better understanding of the reasons for children being detained in custody and had provided updated guidance to custody staff on children being held in detention. Data, though not always comprehensive, was collected routinely and regular audits undertaken on the number of children held overnight and whether local authority accommodation had been provided. While this was a step in the right direction, more detailed analysis could enable the force to identify areas for further improvement. For example, the force could not readily identify whether children detained in custody overnight were looked after by the local authority or if detention certificates⁵ had been completed.

Since our inspection in November 2014, 52 children under the age of 18 had been detained in custody having been charged with an offence. Of these, 13 were under 17 years old and detained overnight when they should have been transferred to alternative accommodation provided by the local authority. The force was in the process of providing information to the local safeguarding children boards⁶ in the force area to support the development of alternative multi-agency responses to children in custody, in particular to avoid the detention of children overnight.

During our review, inspectors examined 6 cases involving children who were detained overnight. The children were aged between 13 and 17 years old. The force's approach was assessed as good in one case, requiring improvement in three and inadequate in two. Four of the 6 cases related to children under 17 years old who were detained in police custody for all or part of the night. Alternative accommodation was sought and provided in the case of a 13-year-old boy who was transferred to a children's home within six hours. In two cases there was no record of custody staff seeking alternative accommodation, and in one case, an approach was made to the local authority but no place was available. Detention certificates had been completed, as required, in these cases.

In all six cases, an appropriate adult was contacted to act as an advocate and support for the child. However, there were long delays in some cases before appropriate adults attended, leaving the child without support.

⁶ A local safeguarding children board (LSCB) must be established by each local authority. LSCBs have a statutory duty, under the Children Act 2004, to co-ordinate how agencies work together to safeguard and promote the welfare of children and ensure that safeguarding arrangements are effective.

⁵ Under section 38(7) of the Police and Criminal Evidence Act 1984, when a child continues to be detained in police custody after charge because there is no alternative accommodation, a certificate must be completed by the custody officer. This is to certify that the continued detention was necessary and to explain the circumstances.

This was of particular concern in a case where a health care professional had recommended an appropriate adult be called for a distressed 17-year-old, who had to wait 15 hours before the appropriate adult attended.

Inspectors also identified that supervisors had on three occasions reviewed a child's detention while a child was asleep but had failed to record whether the child had subsequently been told of the review or reminded of their ongoing rights when awake.

West Mercia Police was unable to provide data on how many children detained overnight were looked after by the local authority. In the sample of six cases examined for this review, two involved children looked after by the local authority, arrested following incidents in their residential homes. Offences included criminal damage and making threats. One of these cases involved a 15-year-old and no alternative accommodation was found.

The force has not yet developed plans or training to enable frontline staff to manage difficult behaviour by young people looked after by the local authority. Discussions were underway with partners to determine how best to provide this.

3. Recommendations

We recommend that West Mercia Police continues to work to implement in full the recommendations made by HMIC following its National Child Protection Inspection of the force in November 2014. The force should regularly review the impact that improved practice is having on the quality of frontline services to protect children at risk of harm. It should provide regular reports on progress to the police and crime commissioner.