National Child Protection Inspection Post-Inspection Review

West Yorkshire Police
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1. Background

HMIC carried out a child protection inspection in West Yorkshire Police in August 2014 and provided the force with a report of our findings in January 2015. In February 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;
- an overview of progress since the inspection in August 2014, presented by the force;
- interviews with staff including the chief officer lead, the head of protecting vulnerable people, and frontline staff from response and neighbourhood teams; and
- an audit of 34 child protection cases relating directly to areas for improvement identified in the inspection report and associated recommendations. The force's practice was assessed as good in 11 of these, requiring improvement in 20 and inadequate in 3.

Summary

HMIC recognises that West Yorkshire Police is committed to improving the protection of children. The force has prioritised child protection and has a strong desire to improve outcomes for children who are at risk of harm. At the time of our post-inspection review in August 2015, some improvements were evident. The force had deployed a significant number of additional staff to work on the protection of vulnerable people (including child protection), it had established multi-agency safeguarding hubs[1] covering the force area and had put in place child sexual exploitation teams to investigate allegations of non-recent sexual abuse.

However, we were concerned to find that inconsistencies in workloads and practice remained across the force and that most of the recommendations from HMIC's National Child Protection Inspection report published in January 2015 had not been implemented, for example:

[1] A multi-agency safeguarding hub (MASH) 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.

- recording standards remained very poor;
- children continued to be detained unnecessarily in police custody;
- the timeliness of specialist medical examinations of children had not improved;
- important information about children was not always available to frontline officers; and
- the force was not recording the views of children in child protection matters.

HMIC also had grave concerns that West Yorkshire Police had made no progress in recording all relevant information regarding the welfare of children to ensure that good quality decisions were made to safeguard children at risk. As a result, some children will continue to be at risk, and potentially at significant risk.

HMIC acknowledges that West Yorkshire Police has taken some steps to improve child protection practice, but its overall progress was disappointing. There is still much to be done before the force can be confident that it is providing a consistently good service to children who are at risk of harm. Force leaders will therefore need to accelerate the pace of improvement and monitor progress for some time to come.

2. Post-inspection review findings

Initial contact

Recommendation from initial inspection report

We recommend that, within three months, West Yorkshire Police improves staff awareness of the importance of understanding and assessing a child's demeanour; ensures that a child's demeanour is recorded in domestic abuse incidents; and ensures that this is used to assess the risks to the child and his needs.

Summary of post-inspection review findings

West Yorkshire Police had made some changes to the risk assessment form that is completed by officers at domestic abuse incidents. In particular, the force had recently included a specific section for recording the demeanour and behaviour of any children who had been present. However, the implementation of these changes had not yet become routine practice for officers throughout the force.

Detailed post-inspection review findings

West Yorkshire Police had amended its domestic abuse, stalking and harassment (DASH)[2] risk assessment form to include a question which directed officers to speak to children to assess their demeanour and assess the impact of the incident on them.

However, when inspectors examined records relating to six domestic abuse incidents, we found that the behaviour and demeanour of the children had not been recorded in any of the five cases in which children had been present. In one case, a woman required hospitalisation as a result of a serious assault by her ex-partner. Five children had been present at the incident and the alarm had been raised when one of the children went to a neighbour's house to tell them what had happened. Officers attended the incident but did not record the children's demeanour or behaviour in the incident report or on the DASH risk assessment form. In addition, police records showed that children's social care services had not been informed about the full details of the incident until 10 days after the assault.

An encouraging development involved daily meetings that took place in Bradford and Leeds to review domestic abuse reports received over the previous 24 hours. These provided an ongoing review of child protection concerns identified at domestic abuse incidents. We were pleased to find that the force was working towards implementing this model across all districts.

[2] A risk assessment form which the police and other agencies use to identify high-risk cases of abuse, stalking and harassment and so-called honour-based violence.

Assessment and help

Recommendation from initial inspection report

We recommend that West Yorkshire Police immediately undertakes a review, together with children's social care services and other relevant agencies, to ensure that the police are fulfilling their statutory responsibilities set out in Working Together to Safeguard Children. As a minimum this should cover:

- attendance at and contribution to initial child protection conferences; and
- recording and communicating decisions reached at meetings.

Summary of post-inspection review findings

West Yorkshire Police had worked with children's social care services to assess the need for officers to attend all case conferences. A protocol had been agreed that included criteria to determine when the police should attend. However, attendance at case conferences remained inconsistent across the force. Inspectors also found that there had been little progress in recording and communicating decisions reached at these meetings.

Detailed post-inspection review findings

We were concerned to find during our initial inspection that West Yorkshire Police did not attend all child protection case conferences when required to do so. The presence of a police officer at these meetings, particularly a supervisor, is vital in many circumstances and demonstrates an important commitment to information sharing and collective decision making about children who are in most need of help and protection.

Following our report, West Yorkshire Police had worked with children's social care services in the five local authorities across the force area and had agreed a protocol for child protection case conferences in March 2015. This was designed to reduce the demand on the force while complying with principles set out in Working Together to Safeguard Children. Criteria had been agreed to determine when officers were required to attend them. However, HMIC found that police attendance had continued to vary across the force and this meant that children received different levels of service.

For example, in Kirklees negotiations took place between police and children's social care services in each case to ensure that the officer involved in the investigation could attend the case conference. However, this did not happen in other areas of the force and attendance was inconsistent.

During our review, inspectors examined four cases that involved child protection conferences. In all four the force had submitted a written report but in only one had an officer attended a case conference. In the remaining three an officer had not

attended when required to do so. One of these three cases involved an eight-week-old baby who had sustained a fractured skull, tibia and ribs. Police did not attend the case conference, contrary to the criteria set out in the protocol. Police attendance at this conference would have been critical to effective decision-making and safeguarding the child.

Inspectors were concerned to find that as a result of the new protocol, West Yorkshire Police had been invited to only 298 of the 772 child protection conferences held between January 2015 and June 2015, and that there had been no evaluation of the effectiveness of the new criteria.

Overall, a number of the problems in police attendance at case conferences that we identified in our initial inspection report persist. HMIC remains concerned that West Yorkshire Police does not always fulfil its responsibilities to attend initial child protection conferences when required to do so, in accordance with the statutory guidance Working Together to Safeguard Children.[3]

Recommendation from initial inspection report

We recommend that, within three months, West Yorkshire Police:

- identifies the range of responses and actions that the police can contribute to multi-agency plans for protecting victims and children in high-risk domestic abuse cases; and

- provides information (e.g., history of abuse, number of children in the family) to other agencies before a multi-agency risk assessment conference takes place.

Summary of post-inspection review findings

West Yorkshire Police had taken steps to identify a range of responses to protect victims and children in high-risk domestic abuse cases. Multi-agency safeguarding hubs (MASHs) had been established across all five districts of the force area and a specialist multi-agency domestic abuse service had been implemented in Leeds. The force had amended its policy on domestic abuse and provided guidance to police officers and staff on the action to be taken to safeguard victims of domestic abuse and their children. Nevertheless, we found inconsistencies in the force's response in practice to children in high-risk domestic abuse cases.

[3] *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). Available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

Detailed post-inspection review findings

During our review, inspectors examined five cases of domestic abuse, all involving a high-level of risk. Practice in all five cases were assessed as requiring improvement, although we found some examples of agencies working together, identifying risks and making plans to reduce these risks, and supporting children and families.

Two of the five cases were from Leeds, where a specialist multi-agency service for victims of domestic abuse had been established – the Front Door Safeguarding Hub. The hub is intended to support the sharing of information between partners to improve assessments and the safeguarding of victims and children. In both of the cases we examined, we found effective and early assessment of cases in the hub and that joint actions had been agreed.

In the other three cases of high-risk domestic abuse that we examined, which were from other areas in the force, there was no evidence in police records in two of them of a referral to children's social care services. For example, in one case a woman had disclosed abuse by her partner over a long period of time. We found no evidence of a referral to children's social care services or of a joint assessment of the risks to the children.

We found some evidence of effective police action being identified in cases discussed at multi-agency risk assessment conferences,[4] such as applications for domestic violence protection orders[5] and the identification of high-risk perpetrators. However, minutes of the meetings only covered the actions that had been agreed and therefore it was not possible for HMIC to assess what information the force had shared or what action it had taken in high-risk domestic abuse cases.

Recommendation from initial inspection report

We recommend that, within three months, West Yorkshire Police takes steps to improve practice in cases of children who go missing from home. As a minimum, this should include:

- improving staff awareness of their responsibilities for protecting children who are reported missing from home and, in particular, those cases where absences are a regular occurrence;

[4] A multi-agency risk assessment conference (MARAC) is a locally-held meeting where statutory and voluntary agency representatives come together and share information about high-risk victims of domestic abuse. Any agency can refer an adult or child whom they believe to be at high risk of harm. The aim of the meeting is to produce a co-ordinated action plan to increase an adult or child's safety, health and well-being.

[5] Domestic violence protection orders can be granted by a magistrate to prevent a perpetrator of domestic abuse from contacting the victim for up to 28 days.

- improving staff awareness of the significance of drawing together all available information from police systems, including information about those who pose a risk to children, to better inform risk assessments;
- ensuring that staff are aware of the need to pass this information on to other agencies; and
- identifying the range of responses and actions that the police can contribute to multi-agency plans for protecting children in these cases.

Summary of post-inspection review findings

HMIC were pleased to find that West Yorkshire Police had taken some steps to improve practice for children who go missing from home. The force had agreed a protocol with the five local authorities in the force area to clarify roles and responsibilities and had reviewed and revised its policy on children missing from home. However, we found that some officers were confused about how to assess the risk to the child, which had resulted in the incorrect categorisation in some missing children cases.

Furthermore, information on children missing from home was recorded on a number of different police systems and we found that West Yorkshire Police had not made progress in drawing together information to better inform risk assessments. There were no 'flags' in some of the systems to identify children who were at risk of sexual exploitation.

Detailed post-inspection review findings

In February 2015, West Yorkshire Police had agreed a protocol with the five local authorities in the force area in relation to children who go missing from home. This defines the roles and responsibilities of parents and carers, residential care home staff, the force, children's social care services and other relevant agencies.

Subsequently, in July 2015, the force had reviewed and revised its policy on children missing from home to respond to the recommendations in our initial inspection report. The policy provides guidance and direction to officers for assessing risk in relation to children who go missing from home, together with guidance on the subsequent action to be taken. However, staff reported they had not received training on the policy and we found confusion about some procedures. For example, staff did not clearly understand the importance of drawing together information on factors which may increase the risk to the child while missing, such as possible sexual exploitation.

HMIC was pleased to find that the police and crime commissioner (PCC) had funded a safeguarding post. The PCC intends this person to work with the five local authorities and related local safeguarding children's boards[6] to lead, deliver and advise on the PCC's strategy for a co-ordinated, cohesive and consistent response to safeguarding, with a specific focus on tackling child sexual exploitation.

A weekly report was produced for each district that identified those children most at risk of sexual exploitation and those who were repeatedly reported missing, to enable action to be taken to reduce the risk to these children. Each district also regularly met with partner agencies to discuss specific cases and agree plans to protect the children involved. Trigger plans[7] were recorded on police systems and this ensured that frontline staff had access to relevant information, including on the risk to children, and lines of enquiry to accelerate activity when children were reported missing.

We found some good examples of cases where agencies had worked together effectively to protect children who frequently went missing and were at risk of sexual exploitation. Information in these cases was well-recorded, timely and easily accessible. It also often took account of intelligence gathered from other agencies and had led to the child being found far more quickly.

West Yorkshire Police had also reviewed cases involving missing children and sexual exploitation over a six-month period. HMIC was told that the findings had been fed back to operational teams to enable further learning.

Inspectors examined six cases involving missing children. We assessed the force's practice as good in three cases, with the risk of sexual exploitation being recognised and effective partnership working.

[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.

[7] A plan to help locate a child quickly when he or she goes missing frequently.

However, inspectors were concerned to find some examples of poor practice in the remaining three cases, assessing practice as requiring improvement in one and inadequate in the other two.

In two of the cases, the risk to the child should have been assessed as high but was incorrectly graded as medium. In the other case, detailed below, the risk level was changed on a number of occasions from medium to low. Although the force has a policy that missing children who are at risk of sexual exploitation are always graded as medium or high risk, the lack of 'flags' on some systems used by the force meant that all relevant information had not been drawn together and that therefore some children were incorrectly graded as low risk.

For example, a 14-year-old boy was reported missing by staff in the care home where he was living. The case was initially assessed as involving a medium risk but was later downgraded by a supervisor to low risk. This was an incorrect decision as the boy was known by the force to be at risk of sexual exploitation. However, this information was not drawn together from the force's different systems. Officers were not deployed to the care home until 12 hours after he was reported missing and we found no evidence that there had been a referral to children's social care services or strategy meetings[8] held to discuss the boy's protection.

The force had recently agreed with all five local authorities in the force area to use a standardised risk assessment for child sexual exploitation. It was anticipated that this could contribute to a more consistent approach in practice to identify children at risk from across West Yorkshire.

[8] 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 telephone 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). Available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

Investigation

Recommendation from initial inspection report

We recommend that, within three months, West Yorkshire Police:

- improves the standards of investigation to include: staff awareness, knowledge and skills; supervision; and regular auditing of investigations, (particularly for cases relating to child sexual exploitation), to ensure that these standards are being met;
- takes steps to reduce the delays in analysis of material sent to the high-tech crime unit;
- identifies and reviews all child abuse investigation cases that have taken more than three months to investigate from the first report, and ensures that each child is supported and safeguarded, and that appropriate measures are in place to manage the risk posed by suspects; and
- continues to monitor and improve the timeliness of case reviews and charging decisions with the CPS.

Summary of post-inspection review findings

HMIC found that most staff responsible for managing child abuse investigations were committed and dedicated to providing good outcomes for children at risk of harm. However, a lack of training and high workloads in the safeguarding investigation units (SIUs) and child protection teams had continued to delay some investigations. West Yorkshire Police had undertaken a review of child sexual exploitation cases over six months old but this had not covered all child abuse investigations.

The force had taken some steps to reduce the backlog in the digital forensic unit through outsourcing work and deploying additional staff. Nevertheless, backlogs remained.

West Yorkshire Police had introduced a quality assurance process for all case files being submitted to the Crown Prosecution Service (CPS), to improve the timeliness of charging decisions.

Detailed post-inspection review findings

West Yorkshire Police had undertaken a review of resources within its SIUs and additional staff had been deployed in recognition of the demands on the teams. The number of staff working on the protection of vulnerable people (including child protection) had increased since our last inspection by 122 police officers and 7 police staff. This is a significant investment.

However, inspectors were told that staff levels in the SIUs were at the discretion of senior officers in each of the five districts and that inconsistencies remained in workloads across the force. Some districts had dedicated child protection teams with trained specialist officers. In others, child protection was part of the remit of large SIUs. Although there were specialist child protection officers in the SIUs, there was insufficient capacity to deal with the volume of work and specialist staff were often not on duty when necessary to attend multi-agency meetings. In addition, we found significant differences in the workload of staff in the five SIUs. Staff reported that this could be three times the volume per officer in some areas compared to others. For example, in Calderdale the average caseload per officer for child protection was 15 cases, whereas in Kirklees it was 6 cases.

Furthermore, newly recruited staff had not received specialist training in child protection. Although training was scheduled to take place in the next 12 months, we were told that untrained staff were currently investigating child protection cases.

West Yorkshire Police had undertaken a review of child sexual exploitation cases which had taken more than six months to investigate. However, this review had not covered all child abuse investigations, which we had recommended it should following our initial inspection. Inspectors examined five child protection cases and found delays in two. The investigating officers attributed the delays to high workloads and competing priorities.

The force had introduced guidance stating that all child protection investigations should be regularly reviewed by a supervisor. However, supervision across the force area was mixed. In Calderdale, we were told that all child abuse investigations were routinely reviewed, whereas inspectors did not see any evidence that this took place consistently across all five districts. Some staff reported that this did not take place because supervisors, particularly sergeants, did not have time to supervise investigations due to high workloads. In all of the five cases we examined, there was a lack of supervision and a failure to comply with the force's own guidelines for regular review.

In terms of joint investigations, with partner agencies, HMIC found that in some cases West Yorkshire Police had investigated cases by itself when the investigation should have been undertaken jointly with children's social care services. Staff in some areas reported that there were significant delays in obtaining material from children's social care services. Although there is a national protocol supported by the police, CPS and local authorities,[9] we found that this was not always being followed

[9] The protocol provides guidance on the disclosure of information in cases of alleged child abuse and linked criminal and care directions hearings. *2013 Protocol and Good Practice Model – Disclosure of information in cases of alleged child abuse and linked criminal and care directions hearings*, published jointly by the Association of Chief Police Officers, the Association of Directors of Children Services, the Association of Independent Local Safeguarding Children Board Chairs, the Crown Prosecution Service, the Department for Education, HM Courts and Tribunals Service, the Local Government

and that each local authority in the force area had a different process for requests for material. This contributed to delays in cases going to court and was not in the best interests of children.

HMIC was pleased to find that West Yorkshire Police had committed significant resources to reduce the backlog in digital media awaiting examination. The force was outsourcing work to a company where possible and was also recruiting five additional staff to provide greater resilience within the force itself. The force's digital forensic unit had developed a process for quickly assessing exhibits at the scene of an incident and in the laboratory, and this enabled the unit to identify devices that contained indecent images of children. Despite this investment, 149 cases were waiting to be examined at the time of our review in August 2015, the oldest dating back to May 2015.

In response to the concerns we raised in our initial inspection report about the timeliness of case reviews and charging decisions that the force received from the CPS, West Yorkshire Police had introduced a quality assurance process for all case files being submitted to the CPS. A supervisor based in the CPS's specialist sexual offences team checks each case, to improve the standard of case files and reduce delays. In addition, the CPS has allocated a lawyer to deal with child sexual exploitation cases, and a specialist sexual offences lawyer regularly attends key force management meetings to enhance and further develop joint practice.

Decision making

Recommendation from initial inspection report

- We recommend that, within three months, West Yorkshire Police takes steps to ensure that all relevant information is properly recorded and is readily accessible in all cases where there are concerns about the welfare of children. Guidance to staff should include:
- what information should be recorded (and in what form) on systems to enable good quality decisions;
- the importance of sending the information to the correct police department and/or relevant partner agency; and
- the importance of ensuring that records are made promptly and kept up to date.

Association, the President of the Family Division, the Senior Presiding Judge for England and Wales, and the Welsh Government, October 2013. Available at: http://library.college.police.uk/docs/APPREF/Protocol-and-good-practice-model-2013.pdf

- We recommend that West Yorkshire Police takes immediate steps to ensure that managers quality assure records and provide feedback to police officers and staff.

Summary of post-inspection review findings

HMIC has grave concerns that the force has made no progress against these recommendations and that inconsistencies remain in the way in which its frontline officers refer and record child protection concerns. Referral processes varied across the force and there was no clear route for child protection concerns to be raised. In some cases, referrals to children's social care services had not been made when they should have been.

Detailed post-inspection review findings

During our review, inspectors found a lack of understanding by, and guidance for, police officers about how they should record information when there was a concern about a child. When officers attend an incident where a concern for a child is identified, as well as taking any necessary action to protect the child, they should pass information to the district safeguarding units or partner agencies, such as children's social care services. Information sharing is important because it enables patterns of abuse to be identified. West Yorkshire Police did not have a standard way of assessing risk or a procedure for frontline officers to pass on concerns. Nor did the force have a consistent way of referring incidents to partner agencies. We could not, therefore, determine whether information had been passed on or whether risks had been identified and action taken.

HMIC had found in our initial inspection that the standard of recording on police systems across the force was poor. Important information was missing and there were delays in recording information on the system. Our concerns included: delays in recording the outcome of strategy meetings (minutes were often not taken); and poor updating of records about the progress of an investigation and details about contact with children and families. We were very concerned to find that the quality of recording practices across the force had not improved and that they were generally of a poor standard.

The timeliness and quality of recording new information on police systems was very mixed. We found some examples of investigations where recording had been done to a very good standard, with details of actions from strategy meetings being recorded. For example, one case we examined involved a 13-year-old girl who had told her teacher that she had been physically abused by her father. The response had been prompt and a strategy meeting was held the same day. Details of the strategy discussion, the initial child protection conference and the review conference were all contained within the police record.

However, we also found a number of cases which had not been referred to children's social care services when they should have been. For example, a 'flag' had been put against the records of a 14-year-old girl on police systems as being at risk of sexual exploitation and it was reported that she had been the victim of a sexual assault. A referral had not been made to children's social care services, nor had a strategy discussion been held to progress any joint action to provide her with support and protect her from further harm.

In another case an eight-year-old girl had been the victim of a sexual assault by a family member. We found no evidence of a referral to children's social care services or any record of whether any joint discussions or meetings with children's social care services had been held.

HMIC has grave concerns that the force has made no progress since our initial inspection in August 2014.

Trusted adult

Recommendation from initial inspection report

We recommend that, within six months, West Yorkshire Police ensures that:

- staff record the views and concerns of children;
- staff record the outcome for the child at the end of police involvement in a case;
- staff inform children, as appropriate, of any decisions that have been made about them; and
- information about children's needs and views is made available, on a regular basis, for consideration by the police and crime commissioner.

Summary of post-inspection review findings

West Yorkshire Police had taken some steps to ensure that officers recorded the views and concerns of children. As noted previously, changes had been made to the DASH risk assessment form to ensure that the demeanour and behaviour of children were recorded at domestic abuse incidents. However, practice had not yet improved and the force still has much more to do to capture children's views in all child protection matters and to use this information effectively to improve its investigations and practice.

Detailed post-inspection review findings

HMIC was very disappointed that West Yorkshire Police had made little progress in recording the views of the child. We were told that the force was working with the PCC to secure funding to commission a research project to capture the voice of the child. However, this initiative was in its early development stages at the time of our review in August 2015, with no clear timescales for its implementation.

Twenty-four of the cases we examined during the course of our review involved circumstances where the force should have obtained and recorded the views of the child. We found no evidence that the force had listened to or taken into account the child or children's views in just under half of these cases (eleven).

Police detention

Recommendation from initial inspection report

We recommend that, within three months, West Yorkshire Police undertakes a review (jointly with children's social care services and other relevant agencies) of how it manages the detention of children. This review should include, as a minimum, how best to:

- ensure that all children are only detained when absolutely necessary and for the absolute minimum amount of time;
- assess, at an early stage, the need for alternative accommodation (secure or otherwise) and work with children's social care services to achieve the best option for the child;
- ensure that custody staff comply with their statutory duties to complete detention certificates if a child is detained for any reason in police custody following charge; and
- ensure that custody staff make a record of all actions taken and decisions made on the relevant documentation.

Summary of post-inspection review findings

West Yorkshire Police had engaged with children's social care services in all five local authorities in the force area and reached an agreement that non-secure alternative accommodation would be available for children following a criminal charge. This accommodation provides an alternative to the child being remanded in police custody overnight.[10] However, we were told that there was very little provision for those children requiring secure alternative accommodation. We also found a lack of understanding among custody sergeants and officers about the requirements of the Police and Criminal Evidence Act 1984 (PACE) in relation to alternative accommodation, which resulted in the force detaining children in custody unnecessarily.

Detailed post-inspection review findings

Inspectors were pleased to find that the force had improved its compliance with the requirement in PACE for detention certificates[11] to be completed. This had been achieved by integrating the necessary form into the force IT system. We found that a certificate had been completed, as required, in all of the cases we examined where children had been detained in custody following charge.

[10] Under section 38(6) of the Police and Criminal Evidence Act 1984 a custody officer must secure the move of a child charged with an offence to local authority accommodation, unless he certifies it is impracticable to do so or, for those aged 12 or over, no secure accommodation is available and local authority accommodation would not be adequate to protect the public from serious harm from him. Local authorities have a duty to provide alternative accommodation under the Children Act 1989.

[11] 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.

Inspectors were told that the custody inspector in each district now scrutinised on a monthly basis all cases involving children held in custody overnight, and provided feedback to custody officers to reduce unnecessary detention.

Since May 2015, 16 children had been charged and detained overnight. Inspectors examined seven of those cases. We found the force's practice in two of these to be of a good standard and in five to require improvement. All of the cases involved children under the age of 17. In four of the cases, we concluded that children had been detained unnecessarily and that this had resulted from a lack of understanding by custody officers of the requirements in PACE. Custody officers should only request secure alternative accommodation for children under the age of 17 if local authority accommodation would not be adequate to protect the public from serious harm. However, we found that secure accommodation had been requested by custody officers where this threshold had not been met and alternative, non-secure accommodation should have been requested.

For example, a 14-year-old boy was detained at 9.00am and subsequently charged with burglary at 11.30pm. The force made no attempt to seek alternative accommodation before charging him. When he was charged, the custody officer requested secure accommodation from the local authority, which was not available. However, there was no justification for seeking secure accommodation due to the nature of the offence and the case did not otherwise meet the risk of serious harm criteria.

In a further two cases, the force had correctly sought non-secure alternative accommodation. In one of these, accommodation was not provided by the local authority and in the other, although accommodation was made available, it was impractical to transfer the child due to the distance involved. In the remaining case that we examined, the force had correctly requested secure accommodation.

Inspectors also found poor practice in recording reasons for decisions being taken, such as placing a child in a cell and continued detention. For example, a 16-year-old boy was arrested and placed in a cell rather than a detention room. No explanation for this was recorded on his custody log. Alternative accommodation was sought and offered, but it was outside the force area and he was not transferred. Inspectors found no recorded details of where the accommodation was, the expected length of the journey or why it was impractical to transfer him.

Leadership, management and governance

Recommendation from initial inspection report

We recommend that, within six months, West Yorkshire Police develops a force-wide good practice regime that builds on these recommendations and improves its response to child protection issues, so that no child receives a poor service by reason of the place where they live.

Summary of post-inspection review findings

West Yorkshire Police has taken some steps towards protecting the most vulnerable children, such as the significant investment in staff for child protection work noted above. The force has started to develop a regime of oversight, to manage risk better and provide consistency across the force area. However, inconsistencies in practice remain across the force and West Yorkshire Police has much more to do to address this.

Detailed post-inspection review findings

West Yorkshire Police has made some important changes to improve the protection of children. The PCC has provided £3.5m in additional funding to support the creation of child sexual exploitation teams to investigate allegations of non-recent sexual abuse and to create a new safeguarding advisor role in relation to child sexual exploitation.

Senior officers and their staff reported that safeguarding was a priority for the force and inspectors were pleased to find that, since the initial inspection, each district had established a MASH and created missing from home co-ordinators. A child sexual exploitation strategy board has also been established. The board is chaired by the independent chair of the Wakefield LSCB and is attended by police safeguarding leads and directors of children's services.

The force has included child protection among its key threats and priorities. It has also introduced meetings to ensure that its activities are focused on the priorities and to hold managers to account.

HMIC found in our initial inspection that different structures within the districts had created some inconsistencies across the force area. We found that these problems remained and that inconsistencies in practice were evident across the force. Although the central safeguarding team provides some governance, this has not sufficiently ensured consistency across West Yorkshire Police, resulting in a differing level of service to children.

Examples of differences across the force area remaining since our initial inspection include the following:

- While the force has increased the number of its staff working in the child protection area, we found that the rationale for deployment was unclear, which had resulted in an imbalance of staff across the five districts. Resources did not meet the demand in some areas, with a significant difference in workloads for staff across the five districts.
- Inconsistencies persist in the supervision of staff. In some districts, we found little evidence of workload monitoring or supervision of investigations.
- Inconsistencies persist, as noted earlier, in the force's attendance at child protection case conferences.
- Different routes exist across the five districts for referring child protection concerns, both within the force and to partner agencies. This makes it difficult to draw important information together, particularly for identifying cumulative risk.
- Out-of-hours paediatric provision is inconsistent in the Calderdale and Leeds force districts. Children from these areas who had been victims of sexual abuse have to be taken to Manchester for forensic examination. Staff reported that this had led to children experiencing long delays to undergo examination, after suffering serious sexual assault, with the majority of the delay due to the distance travelled to secure a paediatric examination. West Yorkshire Police was working with NHS England and other neighbouring forces to create specialist local services but at the time of inspection there were no timescales for this to be established.

3. Recommendations

Recommendation

We recommend that West Yorkshire Police:

- continues to implement the recommendations made by HMIC following our child protection inspection in August 2014, ensuring that it implements the recommendations in full; and
- reviews systematically the effect that these changes are having on the quality of its frontline services to protect children at risk of harm.