National Child Protection Inspection Post-Inspection Review

Nottinghamshire Police
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1. Background

HMIC carried out a child protection inspection in Nottinghamshire Police in September 2014 and provided the force with a report of our findings in December 2014. 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 the progress made by the force in implementing the recommendations.

The review included:

- a document review;
- interviews with staff, including the chief constable and the head of public protection; and
- audits of 32 child protection cases relating directly to areas for improvement identified in the inspection report and associated recommendations. Ten were assessed as good, 10 required improvement and 12 were inadequate.

Summary

Nottinghamshire Police is committed to improving the way it protects children. We were encouraged to find knowledgeable staff dedicated to improving outcomes for children who are at risk of harm. Important steps had been taken to implement some of the recommendations made in the 2014 inspection report. At the time of our review in August 2015, improvements in services within the multi-agency safeguarding hub (MASH)[1] were evident, there was better supervision of incidents where children had been reported missing from home and no child had been detained in police custody under section 136 of the Mental Health Act[2] since April 2015. However, we were concerned to find that other recommendations had yet to be implemented, such as those relating to the oversight and management of cases involving children at risk of sexual exploitation, and police attendance at child protection conferences, neither of which had improved. Nor had the force conducted regular audits of practice to improve services.

[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.

[2] Section 136 of the Mental Health Act 1983 allows a constable to remove an apparently mentally disordered person from a public place to a place of safety for up to 72 hours so that they can be examined by a registered medical practitioner and be interviewed (by an approved mental health professional), and any necessary arrangements for treatment or care can be made.

Although some progress has been made, challenges remain, and the force will need to maintain its focus on improving services to protect children for some time to come.

2. Post-inspection review findings

Initial contact

Recommendations from initial inspection report

> We recommend that Nottinghamshire Police immediately ensures that in domestic abuse incidents, officers see and speak to children (where possible and appropriate) and record their observations of a child's behaviour and demeanour so that better assessments of children's needs are made.

Summary of post-inspection review findings

Nottinghamshire Police had taken steps to improve its response when attending domestic abuse incidents where children might be at risk and some improvement was evident. However, there was more to do to ensure that officers consistently record the effect of exposure to domestic abuse on a child's welfare.

Detailed post-inspection review findings

Domestic abuse procedures in Nottinghamshire Police had been updated in May 2015 to emphasise that the welfare of children should be checked, they should be spoken to and their demeanour recorded by officers on domestic abuse, stalking and harassment (DASH) risk assessment forms,[3] or child notification forms.[4]

Training had been provided for staff in the control room, police community support officers (PCSOs), and student police officers, highlighting the risks to children living with domestic abuse. Inspectors were pleased to find that in the majority of cases control room staff identified children who might be at risk and passed information to officers attending the incident. However, there had been limited recent training to all other staff in frontline roles that protect vulnerable people from harm, although there is computer-based training and guidance on the force intranet system while new training programmes are being developed.

Nottinghamshire Police had amended its policy so that child notification forms were submitted (alongside a DASH assessment) in cases of significant risk, assault or injury to a child. In all other cases, relevant information relating to the child was recorded on a DASH form.

[3] These are a common checklist for identifying and assessing risk used by a large number of partner agencies across the UK and implemented across police forces in 2009.

[4] Police notifications for children at risk: locally, police officers must notify children's social care services on an agreed form, providing information about their concerns. This referral must be made as soon as possible when any concern of significant harm becomes known.

However, the form did not include a prompt or narrative to describe a child's demeanour. Information about a child's behaviour is important to both police and partner agencies, such as children's social care services, when assessing risk and deciding what support might be needed.

Inspectors examined nine domestic abuse cases and found that changes to the policy to record the details of children at significant risk had led to some improvements in practice. Four cases related to incidents prior to the change in policy. Children had been checked to ensure that they were safe and well in only one of these cases. Five cases related to incidents after May 2015 (when the policy changed); three of them recorded that the child was safe and well. The child's demeanour was also captured in two of these cases. Information on the case records was inconsistent and did not capture the experiences of children living with domestic abuse. We concluded that this was, in part, due to limited training for frontline officers and because the DASH assessment did not require officers to record a narrative for the child.

Assessment and help

Recommendations from initial inspection report

- We recommend that, within three months, Nottinghamshire Police 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.[5] As a minimum, this should include:
    - attendance at, and contribution to, initial child protection conferences; and
    - recording decisions reached at meetings on police systems to ensure that staff are aware of these and of all relevant developments.
    - We recommend that, within three months, Nottinghamshire Police undertakes a review, together with children's social care services, of how it manages child protection referrals to ensure a timely response to initial concerns, that action is subsequently taken, concerns are followed up and cases are regularly reviewed.
    - We recommend that, within three months, Nottinghamshire Police undertakes a review of the level and quality of supervisory activity in cases involving children missing from home.

[5] *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 from: www.gov.uk/government/publications/working-together-to-safeguard-children--2

Summary of post-inspection review findings

Nottinghamshire Police had undertaken a review, together with children's social care services and other relevant agencies, to ensure that the police were fulfilling their statutory responsibilities set out in *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*.[6] Inspectors were disappointed to find that police attendance at initial child protection case conferences had not improved. However, the timeliness of responses to child protection referrals had improved, as had the supervision of incidents involving children who go missing from home.

Detailed post-inspection review findings

In our inspection in September 2014, we found that Nottinghamshire Police attended about half of all initial child protection conferences.[7] During our post-inspection review, almost 12 months later, we saw no discernible improvement: police attendance remained at a similar level. Attendance at initial child protection conferences was at the discretion of the officer involved in the case. This resulted in an inconsistent approach to attendance. Where police are not present at case conferences, important information about a child may not be shared and officers will have no input into, or influence on, the decisions.

Nottinghamshire Police had one MASH where police were co-located with staff from Nottinghamshire County Council's children's social care services and other partner agencies. Staff from Nottingham City Council's children's social care services were not part of this arrangement but police also worked with Nottingham City Council staff in an integrated domestic abuse referral team.

Inspectors were pleased to find that processes within the MASH to manage the timeliness of child protection referrals had improved since the initial inspection in September 2015. We found more effective partnership working; managers from all agencies provided daily oversight and jointly agreed an appropriate safeguarding response in child protection cases. Furthermore, cases in which children were considered to be at high risk were immediately reviewed for further action and in August 2015, there were no child protection assessments awaiting review.

Inspectors examined six child protection cases referred to children's social care services and found that in most cases officers responded quickly where concerns for children were raised. For example, two children were found at home living in squalor.

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[6] Ibid.

[7] An initial child protection conference brings together family members (and the child where appropriate), with the supporters, advocates and professionals most involved with the child and family, to make decisions about the child's future safety, health and development. If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth.

The children were spoken to and immediate safeguarding measures put in place with children's social care services. There was effective information sharing, with child notification forms being completed. However, beyond the initial response, inspectors were concerned to see that four cases did not have investigation plans or robust supervision. We were therefore unable to establish whether actions had been agreed and completed.

Inspectors were concerned to find delays in other aspects of child protection work, although some improvements were apparent. In domestic abuse cases graded as high or medium risk the response was timely. Nonetheless, on 6 August 2015, 870 standard reports of domestic incidents awaited action by police, such as the submission of DASH forms to children's social care services. This backlog meant that unless a child notification form had been submitted (for children at high risk of significant harm), children at risk in domestic abuse cases reported as 'standard' were not identified at the earliest opportunity. As a result, joint action to safeguard them would be delayed or might not take place at all. Although the cases awaiting action had been assessed as lower risk, it is likely that some might require more immediate attention, for example, where a child may have been exposed to repeat domestic abuse and the cumulative risk had increased following previous incidents. The oldest case in the backlog was over six months old.

In May 2015, Nottinghamshire Police undertook a review of 17 cases involving children missing from home and found that supervision required further improvement. As a result, the force made changes to procedures to ensure better supervision of reports when children go missing or are absent. The findings of the review had been shared with the force's missing persons' teams, who were responsible for contacting partner agencies to ensure that all opportunities were taken to implement appropriate safeguarding measures for children reported missing from home. Guidance and training had been provided to control room staff, to enable them to identify those who were vulnerable and most at risk.

Nottinghamshire Police had adopted national guidelines for classifying people as 'missing' or 'absent'.[8] To make sure that young children were safeguarded, the force had decided not use the 'absent' category for children under the age of 13. This means that they would always be identified as vulnerable and a full investigation would take place.

[8] In April 2013, ACPO introduced a new approach to missing persons, involving two categories: 'missing' and 'absent'. A 'missing' person is defined as "anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be subject of crime or at risk of harm to themselves or another." An 'absent' person is defined as a "person not at a place where they are expected or required to be" and people categorised as such should not be perceived to be at any apparent risk. It is expected that cases classified as 'absent' will be monitored by the police and escalated to the 'missing' category if risk increases.

The sexual exploitation investigation unit (SEIU) reviewed all reports of missing and absent children to identify the risk of sexual exploitation and prevent it. If a child was considered to be at risk of sexual exploitation and reported as missing, they would always be graded as high risk and a full investigation would follow.

Awareness had been raised amongst supervisors to ensure that missing children investigations were actively progressed and risk assessments reviewed when appropriate. Inspectors examined five cases of children who regularly go missing from home and found adequate supervision in all five. When children were found, police checked that they were safe and well and recorded relevant details on force systems. In all but one case there was good identification of risk, and children vulnerable to sexual exploitation were classified as 'high risk', in line with force guidelines.

The missing persons' database automatically notified children's social care services when a child went missing. Nevertheless, although four of the children in the cases examined by inspectors were considered to be at high risk of sexual exploitation, only one strategy meeting was recorded as having taken place (and in this case it took place three weeks after the initial missing report). There was a general failure in three cases for police and children's social care services to agree and complete joint actions to reduce missing episodes. Two cases were considered good, and three required improvement.

Nottinghamshire Police was in the process of implementing trigger plans. These plans aim to expedite and improve the response to locate children identified as being at risk of sexual exploitation if they go missing. None of the cases we examined involved preventative work directed at those that posed a risk to children vulnerable to sexual exploitation, such as the issuing of child abduction warning notices (CAWNs)[9].

Investigation

Recommendations from initial inspection report

- We recommend that Nottinghamshire Police immediately develops an action plan to improve CSE investigations, paying particular attention to:
    - improving staff awareness, knowledge and skills in this area of work;
    - ensuring a prompt response to any concern raised;

[9] 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.

- undertaking risk assessments that consider the totality of a child's circumstances and risks to other children; and
- improving the oversight and management of cases (to include auditing of child abuse and exploitation investigations to ensure that standards are being met).

- We recommend that, within three months, Nottinghamshire Police initiates discussions at a senior level with the CPS to improve the timeliness of actions and decisions by both the police and the CPS.

Summary of post-inspection review findings

Nottinghamshire Police had developed a long-term plan in July 2015 to improve CSE investigations in response to recommendations made in a peer review commissioned from the College of Policing. This plan prioritises the most important actions, for example, disrupting, arresting and prosecuting offenders involved in child sexual exploitation and a victim-centred approach. However, the cases examined by inspectors where children were at risk of sexual exploitation were characterised by poor management of investigations and inadequate supervision. We were concerned to find that Nottinghamshire Police had not undertaken an audit of child abuse and sexual exploitation cases to improve standards.

Action had been taken by the Crown Prosecution Service (CPS) to reduce delays in charging decisions on cases of sexual assault on children under 10 years old and in new cases of child sexual exploitation involving institutions or multiple victims and defendants. In other cases, the timeliness of actions and decisions by both police and CPS remained unchanged.

Detailed post-inspection review findings

Nottinghamshire Police had recently developed a long term plan (July 2015) to improve child sexual exploitation investigations. The force was in the process of constructing an intranet site for child sexual exploitation, where staff could access this plan.

Training had been delivered to student officers and police community support officers (PCSOs) about children at risk of sexual exploitation. Frontline staff had received limited recent training, although there is computer-based training and guidance on the force intranet system while new training programmes are being developed.

Child sexual exploitation and the risk to children missing from home had been prioritised in a multi-agency training programme. Police had access to multi-agency training arranged by Nottinghamshire Safeguarding Children Board, which included internet-based learning on the risk of sexual exploitation and training to raise

awareness of child abuse and neglect. Police take-up of this training had increased in 2014-2015.

Nottinghamshire Police had collated information about children who were considered to be most vulnerable from sexual exploitation, and the control room had access to a list of children at risk to assist in prioritising and directing the police response. In addition, the SEIU had provided guidance to officers who provided the initial response to reports of child sexual exploitation. The guidance set out the minimum requirements to be fulfilled by officers prior to the case being passed to specialist units, such as the child abuse investigation team or the SEIU.

Inspectors examined six cases relating to children aged between 10 and 14 years who were at high risk of sexual exploitation: one case was assessed as requiring improvement and five were inadequate. In four cases, the initial response to reports was prompt. However, there was a 5-day delay in responding to a report of the sexual grooming of a 13-year-old boy and a 10-day delay in the case of a report concerning a 14-year-old girl in a sexual relationship with a 21-year-old man. When officers did respond, they took immediate action to ensure that these children were safe and completed notifications to children's social care services.

We were concerned that non-specialist staff, such as frontline officers, were investigating child protection cases without having received training in how to manage them effectively. For example, in the case of a 10-year-old girl who had been groomed to send indecent images of herself over the internet, there was a 10-week delay in requesting analysis of the suspect's computer because the officer, a non-specialist, did not understand the procedure. During this time the suspect closed his Facebook account and potential evidence was lost.

We found poor supervision in all six cases. Supervisors were focused on administrative tasks, such as the allocation of investigations to staff, and did not provide robust direction or a clear plan to progress an investigation. For example, long delays occurred in an investigation into a 14-year-old girl's sexual relationship with a 21-year-old man. A frontline officer was given the task of completing an initial investigation before transferring the enquiry to the SEIU. It took six months for this initial work to be completed, and a significant delay before the suspect was arrested. During this period, two further offences relating to the suspect, involving the exchange of indecent images with other teenage children, were reported to other forces.

In four of the six cases examined, suspects were known to have access to other children who might have been potential victims but police failed to take action to manage the risk they posed. For example, the delays in arrest noted in the case above meant that appropriate bail conditions, which might have prevented further offending, were not imposed on the suspect. In two other cases, although a child abduction warning notice was considered, no further action was taken.

In four cases, including rape, indecent images, and grooming, children were at significant risk. However, there was no record of any strategy discussions or meetings taking place. Nor had joint safeguarding plans been developed with partner agencies, leaving the children and their families with little or no support. In the remaining two cases, strategy meetings had taken place. However, in one of these cases, the meeting was held a month after the initial report and the police were unable to attend.

As we noted earlier, Nottinghamshire Police had carried out a review of 17 cases of children missing from home, but we were concerned to find that the force had not undertaken an audit of child sexual exploitation investigations, nor were there plans for audits to take place in future. If audits had been carried out, and lessons learned, the standards of management of cases could have been improved.

In September 2014, HMIC found delays of three months or more in some cases sent to the CPS for charging decisions. The force had continued to hold regular discussions with the CPS following our inspection. However, we found little evidence of improvement. Nottinghamshire Police and CPS East Midlands had been selected as one of four areas to take part in a national pilot to reduce inefficiencies in the management of rape enquiries and sexual assaults of children under 10 years old. In these cases, early investigative advice was provided by a lawyer located in police premises and the pilot was subsequently extended to include new cases of child sexual exploitation involving institutions or multiple victims or defendants. However, for those cases not covered by the pilot, we were told that there was still a three-month delay for cases to be reviewed.

Decision making and Trusted adult

Recommendations from initial inspection report

- We recommend that Nottinghamshire Police immediately takes steps to ensure that all relevant information is properly and uniformly recorded, and is readily accessible in all cases where there are concerns about the welfare of children.
- We recommend that, within six months, Nottinghamshire Police ensures that all staff:
    - record the views and concerns of children; and
    - record any available outcomes at the end of police involvement in a case.
- We recommend that, within six months, Nottinghamshire Police ensures that information about children's needs and views are regularly made available for consideration by the police and crime commissioner and to service managers to inform future practice.

Summary of post-inspection review findings

We were concerned to find that Nottinghamshire Police had not taken action to implement any of our recommendations. The force had not provided training and guidance to staff about the importance of recording information or outcomes in child protection cases. Nor had they ensured that children were informed of decisions made about them. As a result, information about children's needs and views were not made available to service managers or the police and crime commissioner.

Detailed post-inspection review findings

In the majority of the cases assessed by inspectors, it was difficult to draw together information from police systems to understand what action had taken place. Nottinghamshire Police had two recording systems for child abuse investigations but these were not integrated; the force was in the process of procuring a new system.

Our initial inspection found that child notification forms were being completed inconsistently and were not always attached to case files. At the time of our review, the force had taken no action to address this and inspectors saw no evidence of improvement. As a result, information was not readily accessible to officers dealing with further incidents.

Officers did not complete records in sufficient detail to describe any concerns about children or to capture their experiences. There was limited recording of a child's views, needs or demeanour, or the effect of an offender's behaviour on the child. Officers also failed to record that they had told children about the outcome or result of cases.

In part, lack of supervision for child abuse investigations contributed to these failings. Records assessed by inspectors contained few meaningful entries to demonstrate that supervisors were actively progressing actions through regular reviews.

Police detention

Recommendations from initial inspection report

- We recommend that, within three months, Nottinghamshire 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:
    - improve custody staff awareness of child vulnerability and child protection;
    - improve risk assessments to reflect the needs of children and the support they require at the time of detention and on release;
    - ensure that all staff act within the law so that all children are only detained when absolutely necessary and for the absolute minimum amount of time;

- assess at an early stage the likely need for secure or other accommodation, and work with children's social care services to achieve the best option for the child;
- ensure that children detained under section 136 of the Mental Health Act are only detained in police custody as a last resort, for a minimum amount of time, are regularly checked and receive the services of the mental health nurse; and
- ensure specific additional consideration is given to using family members as appropriate adults for children detained under section 136 of the Mental Health Act, and parental support and personal attendance at the custody suite are encouraged.

Summary of post-inspection review findings

While some steps had been taken to improve the management of children in police custody, we were concerned to find that Nottinghamshire Police had not reduced the number of children being detained unnecessarily in police custody overnight when they should have been transferred to alternative accommodation. We were pleased to find, however, that the force had taken steps to ensure that children were not detained in custody under section 136 of the Mental Health Act.

Detailed post-inspection review findings

Training had been provided to custody staff to improve the assessment of a child's needs when taken into custody; this included the importance of mental health assessments. Guidance had been provided to staff on the role and responsibility of the appropriate adult[10] to act as an advocate for the child. However, there was no bespoke child protection training for custody staff.

A custody supervisor reviewed detention records monthly to ensure an appropriate adult had attended when a child was detained. However, the review did not cover other important considerations, such as whether the local authority had been contacted for alternative accommodation after a child was charged and refused bail.

Nottinghamshire Police had worked with local authorities to develop a protocol for the transfer of children to alternative accommodation. The protocol had not been implemented at the time of our review and between September 2014 and June 2015 an average of six children a month had been detained in police custody after charge. Inspectors were told by staff that alternative accommodation had never been

[10] An appropriate adult is a parent, guardian or social worker; or if no person matching this description is available, any responsible person over 18. In England and Wales, an appropriate adult must be called by police whenever they detain or interview a child or vulnerable adult. They must be present for a range of police processes, including intimate searches, and identification procedures, to safeguard the interests of children detained or questioned by police officers.

provided by the local authority for children refused bail after charge.[11] As a result, children continued to be detained unnecessarily in custody overnight.

Inspectors examined 6 cases of children aged between 14 and 16 years old who had been detained in custody after charge. One was assessed as good, one required improvement and four were inadequate.

In all six cases, an appropriate adult was contacted to advocate on behalf of and support the child. Because appropriate adults were primarily asked to attend to accompany a child when they were interviewed, there were long periods when children were without support: there were delays of between 10 and 15 hours in three cases before children had access to an appropriate adult.

Inspectors were concerned to find that supervisors were conducting too many reviews of children's detention without the child being present. Six reviews were conducted in the absence of the three children they related to, and there was no record in any of the cases of the children being told subsequently that a review had taken place, or the reason for their continued detention. This does not comply with the requirements of Code C to the Police and Criminal Evidence Act 1984.[12]

Staff had recorded that they had requested alternative accommodation in three of the six cases. In three further cases, a request for accommodation had either not been made or there was no record that a request had been made. Alternative accommodation had not been provided to children in any of the cases reviewed by inspectors.

Four of the cases we reviewed were children in the care of the local authority. Three of these children had been arrested at their care homes: two for common assault on staff members and one for causing damage to the care home. Alternative accommodation was requested in two of these cases but none was provided.

Detention certificates, which outline to a court the reason for a custodial remand are essential for police accountability. Nottinghamshire Police had previously conducted an audit of custody records in relation to those children detained after charge between early December 2014 and mid-February 2015. Of the 13 cases the force examined, 5 related to children under 17 years old for whom a detention certificate

[11] Under section 21(2)(b) of the Children Act 1989 every local authority must provide accommodation for children whom they are requested to receive under section 38(6) of the Police and Criminal Evidence Act 1984. Under section 38(6) of the Police and Criminal Evidence Act 1984, a young person must be transferred to local authority accommodation unless 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.

[12] Police and Criminal Evidence Act 1984 (PACE) Code C, Revised code of practice for the detention, treatment and questioning of persons by police officers, paragraph 15. Available at: www.gov.uk/government/publications/pace-code-c-2014

was required. The audit found that certificates had been appropriately completed in each of these cases. Certificates had been completed in all but one case assessed by inspectors.

A protocol had been agreed between Nottinghamshire Police and Nottinghamshire Healthcare Foundation Trust to ensure that children detained under section 136 of the Mental Health Act 1983 were only taken into police custody in exceptional circumstances. Since the protocol was implemented in April 2015, no child had been detained in custody under section 136. Additionally, Nottinghamshire Police had established a triage team working in the community, where police officers worked alongside mental health practitioners to enable vulnerable people with mental health problems to access appropriate health care and health-based places of safety and avoid the need for detention in police cells under section 136.

Further recommendation

> We recommend that, within three months, Nottinghamshire Police gives full consideration to conducting reviews of children in custody in person.

3. Recommendations

- We recommend that Nottinghamshire Police continues to work to implement in full the recommendations made by HMIC following the child protection inspection in September 2014. The force should review systematically the impact of improvement activity on police practice and the quality of frontline services to protect children at risk of harm, and provide regular reports on progress to the police and crime commissioner.
- We recommend that, within three months, Nottinghamshire Police gives full consideration to conducting reviews of children in custody in person.