HMICFRS

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

National Child Protection Inspection

North Yorkshire Police

1–12 November 2021

Foreword

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

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

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

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

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

Contents

Summary

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

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

We adapted this inspection because of the COVID-19 pandemic. Working within national guidelines, we conducted an onsite inspection, agreeing with the force to carry it out both safely and effectively.

Main findings from the inspection

North Yorkshire Police has recently made some changes to its senior leadership team. During our inspection, the county was electing a new police, fire and crime commissioner (PFCC), and the force appointed a new deputy chief constable.

The force's child protection arrangements aren't consistently providing either the quality of service or a good enough response to effectively safeguard children in North Yorkshire. In the months before this inspection, senior leaders commissioned thematic reviews into how the force manages some child protection areas. They identified areas for improvement. Several of our findings mirror those identified by the force.

Chief officers and senior leaders participate in multi-agency safeguarding partnership arrangements. They attend and contribute to multi-agency meetings and activities. But there is little evidence of effective multi-agency operational activity to safeguard children. We found examples where the force poorly assessed or recognised risk, and where the supervision of investigations was of low quality. We also found inconsistent information sharing with other organisations involved in safeguarding children.

The standard of investigations in child protection cases, such as missing children or chid sexual exploitation (CSE), is poor. This is because the force allocates cases inconsistently. In some cases where highly vulnerable children went missing from children's homes, officers recorded those children as cause for concern, rather than missing. So officers didn't look for them.

The force doesn't prioritise safeguarding and child protection highly enough in operational activity. It has an inconsistent approach to the risk from those suspected of sexually exploiting children. This shows officers don't always understand their primary role, which should be to protect children. Officers don't always share information

quickly enough with safeguarding partners. And supervisors don't oversee investigations well enough, mainly because they lack the training, skills and experience.

Staff in the custody suites often determine vulnerability when they see children in police detention. But they think investigating officers should be responsible for making referrals to children's social care (CSC) services – even though some children's vulnerability only becomes apparent in police detention.

We found some specialist units don't understand their safeguarding responsibility well enough. Online abuse team (OAT) officers see their primary role as focusing on offenders, rather than protecting children. But officers usually act promptly to trace those sharing child abuse images. They follow up with investigative opportunities and they regularly review systems to identify potential offenders. The force usually manages these cases within its timescales.

During our inspection, we examined 73 cases where children had been at risk. We assessed the force's child protection practice as good in 13 cases, requiring improvement in 34 cases, and as inadequate in 26 cases. This shows the force needs to do more to give a consistently good service for all children.

Specific areas for improvement include:

- speaking to children, recording their behaviour and demeanour, listening to their concerns and views, and using that information to make decisions about their welfare;
- considering the wider risks to children when they are missing. The force needs to make initial risk assessments more effective. It needs to consider why a child has gone missing, who they are with, where they have been, and whether their absence is linked to exploitation or other forms of abuse. This will enhance protective planning;
- supervising investigations to make sure the force pursues opportunities and avoids delaying cases unnecessarily; and
- promptly sharing information with safeguarding partners when risk is known. This will help safeguarding children faster.

The force also needs to improve the way it measures how well staff perform. Although it has reviewed various aspects of its work involving children, it doesn't do this routinely. As such, it doesn't know how effective its interventions are. This makes it difficult for senior leaders to assess how good decision-making is, and to be sure officers and staff are always making the best decisions for vulnerable children.

Until now, staff training and awareness measures have relied on the use of email and online training packages. A large proportion of the officers dealing with child abuse investigations have had no specialist child abuse investigation training. The force has recognised this, and it has booked specialist courses for officers in early 2022.

Conclusion

Senior leaders in North Yorkshire want to protect children and give them better outcomes. The force knows it needs to do more to help its officers better understand how to safeguard children. It knows it needs to help them look beyond obvious risk factors to identify wider or underlying problems that need addressing.

In our inspection, we found that the officers and staff who manage child abuse investigations are committed and dedicated, while often working in difficult circumstances. But in too many cases, practice is inconsistent. The force needs to make sure senior officers' ambitions to improve the service lead to better outcomes in practice.

We found some good examples of the force protecting children in need of help. At times we saw it working well with other organisations, and operating in a child-centred way, effectively combining investigative and safeguarding approaches. But we found most cases we examined to be inadequate or requiring improvement. The force made similar findings.

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

1. Introduction

The police's responsibility to keep children safe

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

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

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

Expectations set out in the *Working Together* guidance

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

The specific police roles set out in the guidance are:

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

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

2. Context for the force

North Yorkshire Police has a workforce of around:

- 1,562 police officers;
- 1,214 police staff;
- 212 police and community support officers (PCSOs); and
- 113 special constables.

The force provides policing services to the county of North Yorkshire. It covers around 3,208 square miles in the north of England, including 6,000 miles of roads and 55 miles of coastline.

North Yorkshire is England's largest policing county. Mainly rural, it has an estimated population of 824,000 people (ONS 2018) spread across its villages, towns and cities.

North Yorkshire is a popular tourist and cycling destination. It includes the North York Moors and Yorkshire Dales National Parks, coastal hubs such as Scarborough and Whitby, and the historic city of York.

Together with the force and local clinical commissioning groups, the county's two local authorities, North Yorkshire County Council and City of York Council, have established safeguarding children partnerships (replacing local safeguarding children boards), as required by the Children and Social Work Act 2017.

The most recent Ofsted judgments of children's services provided by the local authorities are set out below.

Local authority	Judgment	Date published
North Yorkshire County Council	Outstanding	August 2018
City of York Council	Good	February 2017

Ofsted also visited both local authorities more recently. It found senior leaders and managers at North Yorkshire County Council had made sure children's services continued to develop positively. But in the City of York in July 2019, it found the quality of services for children in need of help and protection had deteriorated.

Organisation

North Yorkshire Police has three policing areas: York & Selby, Scarborough & Ryedale, and Harrogate & Craven. Each area is responsible for local crime, including neighbourhood and safeguarding investigations.

Child abuse investigations are managed by either the criminal investigation department (CID) or investigation hubs, which are situated in each of the three policing areas. The force has specialist teams for online child abuse, and for managing offenders who pose a risk to children.

An assistant chief constable (ACC) is responsible for child protection throughout the force area. She is supported by a detective superintendent, who is the head of safeguarding. Their remit includes overseeing improvements to child protection across the force.

3. Leadership, management and governance

Senior leaders have a clear ambition to give children better outcomes

North Yorkshire Police has recently made changes to its senior leadership. And during our inspection, the county elected a new PFCC for North Yorkshire. The previous PFCC and current chief constable set the *Police and Crime Plan 2017–2021*. It has four priorities, the first of which relates to safeguarding vulnerable people, including children. The current commissioner and chief constable plan to revise this document, but reducing vulnerability and protecting children will continue to be a priority.

North Yorkshire published its force management statement (FMS) in February 2021. The statement explains how the force expects to meet local needs, and how it will change and improve its workforce to cope with that demand. The force predicted more violence and sexual abuse crimes against children, and identified some approaches to manage that demand. This includes "increasing effective learning" so officers can improve the quality of public protection notice (PPN) submissions, and "retaining effective capability" in child safeguarding to build knowledge and efficiency.

An ACC is responsible for the force's response to vulnerability. The force has set out a control strategy outlining the main operational threats and themes. It refreshes the strategy every two years. The ACC scrutinises progress against the strategy's themes at the monthly operations board meeting. The aim of the meeting is for the force to consider how it carries out its work, and identify problems and opportunities for it to improve. We saw that those present at the meeting can raise and discuss any trends or areas to improve, as well as identify actions.

The force has a strategic vulnerability board, which oversees decisions and actions relating to vulnerability, including a safeguarding service plan. It has established this plan with reference to the PFCC's plan. This means the force's arrangements closely align to those of the elected commissioner.

Leaders don't oversee child protection well enough, either strategically or operationally

The force manages risk through an ops board and a tactical and tasking co-ordination group. Chaired by an ACC, these groups meet on the same day, and they oversee the force's main operations. They allow senior leaders to monitor how well staff perform and how much they improve. The force also holds a series of daily management meetings (DMMs) for managers who can direct resources to deal with risk and vulnerability. Area commanders chair local DMMs with a similar structure and focus.

Although these meetings do scrutinise some aspects of vulnerability, such as domestic abuse, the performance measures are not child-focused, or well understood, that is, the number of children affected by domestic abuse. It doesn't hold meetings across its local areas, that focus on child protection issues, such as the quality of investigations, audits, identifying improvements and training frontline officers.

Although problems are escalated to the ops board, we saw that there are few ways of monitoring improvement activity and holding senior managers to account. For example, senior leaders expect members of the force to adhere to the investigation policy, but we found this doesn't always happen. This means staff without the right skills or experience are often investigating child protection cases.

Leaders need to review the way they gather, record and act on information, so they can improve outcomes for children

We saw that the force's business insight team had been commissioned to conduct internal reviews into areas such as custody, CSE and domestic abuse. These reviews were bespoke commissions, as opposed to part of an organisational framework. They gave senior officers the opportunity to scrutinise and analyse the quality of the force's operations, and they included comprehensive recommendations for the force to consider.

But we couldn't see how the force had implemented the recommendations. While not all recommendations or areas for consideration might be a risk for the force, it was unclear how recommendations were progressed, and whether the impact on children was understood. This means senior leaders can't be sure staff are making the best decisions for vulnerable children in all cases.

We noted that the force doesn't always record children's ethnicity. It can't understand risk based on cultural background unless it addresses this problem. Nor can it assess its equity of service based on ethnicity.

Officers responding to child protection concerns aren't always trained well enough

Officers and staff told us there has been a lack of training for several years. The force has used emails, material on its intranet and ad hoc development days to try to give staff some training and information on vulnerability and child protection. But the force rarely gives officers dedicated training days. As a result, a significant number of staff told us they hadn't received enough training.

The force has mainly relied on online training and self-driven continuing professional development (CPD) through emails, as well as depending on supervisors to motivate and train their staff. Apart from training on domestic abuse matters, there has been little specific face-to-face child protection training (beyond initial police training). Department heads establish their own teams' training needs and they make bids for training at the force's ops board meetings. This means some teams receive training on topics such as CSE, whereas others don't. This lack of a co-ordinated approach can cause problems with identifying the relevant staff for the training, while balancing operational duties.

Despite this, we found some senior managers had used specialist officers to give ad hoc training to their teams. We also found that some officers accessed training through the North Yorkshire Safeguarding Children Partnership.

The force has three investigation hubs and three CID teams, managing child protection investigations. The hubs also have some constables on attachment from their regular response duties, as well as police support investigators who conduct child protection investigations. Previously, the force had dedicated child abuse teams, with detectives trained on the specialist child abuse investigation development programme (SCAIDP). Since then, the force has restructured its investigative teams, with each command managing its own CID. It does have specialist teams who investigate online child abuse, and who manage violent and sexual offenders posing a risk to children.

While the force has a list of those who have been on the SCAIDP and specialist sexual assault investigation development programme (SSAIDP), the list doesn't identify where they are working and who is investigating child protection cases. This was reflected in the audits we completed, and officers we spoke to were unclear on who is trained. The force is not sure that the right people with the right skills are in the right place. Force leaders know about difficulties in recruiting and retaining staff for specialist investigation roles. This is a national problem and we have made a recommendation to the Home Office in our *Joint thematic inspection of the police and Crown Prosecution Service's response to rape*. North Yorkshire Police plans to increase the number of SSAIDP and SCAIDP officers by 24 in early 2022.

The force contributes to partnership working arrangements

Senior officers attend the City of York Safeguarding Children Partnership and the North Yorkshire Safeguarding Children Partnership board meetings. Representatives from the force also attend several subgroups that work with the local authority, NHS organisations and other agencies to safeguard children. Throughout our inspection, the force's partners described their relationship with the police as extremely positive. They said the force is both responsive and open to professional challenge when appropriate. Information sharing is appropriate in areas such as multi-agency risk assessment conferences (MARACs).

Officers and staff who manage child-related investigations are dedicated and enthusiastic

The officers and staff we spoke to who manage child-related investigations are committed and dedicated. Their work is often difficult and demanding. Some specialist officers are worried about high workloads, as there aren't enough staff to deal with the number of cases.

4. Case file analysis

Results of case file reviews

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

Our inspectors also assessed the same 33 cases.

Cases assessed by both North Yorkshire Police and us

Force assessment:

- 8 good
- 15 require improvement
- 10 inadequate.

Our assessment:

- 4 good
- 16 require improvement
- 13 inadequate.

Our inspectors selected and assessed 40 more cases during the inspection.

Additional 40 cases assessed only by us

- 9 good
- 18 require improvement
- 13 inadequate.

Total 73 cases assessed by us

- 13 good
- 34 require improvement
- 26 inadequate.

There was a difference in the force's assessments in its self-audits and our inspectors' assessments. But the force did recognise that a significant number of its cases were inadequate. When we analysed our audits, we considered areas such as:

- the recording of children's demeanour and wishes;
- evidence of safeguarding plans for children;

- engaging promptly with other organisations;
- the effectiveness of continuing supervision; and
- the outcomes for children.

Of the 73 cases we assessed, we referred 11 (10 cases and 1 thematic issue) back to the force. In these instances, our analysis of the evidence in case records showed serious problems remained. We found:

- failures by the force to make sure it was protecting children;
- cases where the force should have worked with a partner organisation; and
- cases where it appeared a child might still be at risk of significant harm from an offender because the force hadn't intervened meaningfully.

We also referred back to the force our concern about cases in which it didn't act quickly enough to safeguard children at risk from known suspects. In these cases, it didn't establish a safeguarding plan or share information with partner organisations.

The force responded to all our referrals. Senior managers reviewed the cases, updated risk assessments and, where needed, acted on our concerns.

Breakdown of case file audit results by area of child protection

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

- 2 good
- 8 require improvement
- 1 inadequate.

Common themes include:

- evidence of good initial action by responding officers;
- prompt joint strategy discussions with safeguarding partners;
- missing wider safeguarding concerns for children, for example, the siblings of children involved in cases; and
- a lack of joint home visits or joint investigations.

Cases assessed involving referrals relating to domestic abuse incidents or crimes

- 3 good
- 5 require improvement
- 2 inadequate.

Common themes include:

- evidence of the force control room helping responding officers by giving them up-to-date information, which informs risk assessment and decision-making;
- officers consistently use body-worn video (BWV) at scenes; but
- investigating officers don't always make clear investigation plans;

- officers and staff don't always consider broader safeguarding risks to children; and
- attending officers don't consistently seek or record the voice of the child (VoC).

Cases assessed involving referrals arising from incidents other than domestic abuse

- 4 good
- 3 require improvement
- 3 inadequate.

Common themes include:

- the force promptly allocates resources for immediate and priority calls;
- there is little evidence of a joint approach to investigations;
- officers don't always consider the VoC or wider safeguarding issues; and
- supervision is sometimes limited and ineffective.

Cases assessed involving children at risk from child sexual exploitation

- 1 good
- 6 require improvement
- 8 inadequate.

Common themes include:

- the force uses vulnerability markers, flags and child abduction warning notices (CAWNs) to safeguard children; but
- officers don't always consider risks to other children;
- officers don't always share information with CSC services quickly enough;
- there is little evidence of a joint approach to CSE investigations; and
- officers and supervisors don't always recognise CSE risks.

Cases assessed involving missing children

- 0 good
- 1 requires improvement
- 5 inadequate.

Common themes include:

- the force routinely flags children at risk of harm;
- the force doesn't always share information about missing children with CSC, and there is little supervision;
- officers rarely focus on the wider vulnerability of the missing child;
- officers don't routinely use trigger plans to find children quickly; and
- supervision of activity and records is inconsistent.

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

- 2 good
- 3 require improvement
- 1 inadequate.

Common themes include:

- responding officers consider vulnerable children's circumstances and make effective decisions to remove children with appropriate use of the power;
- officers don't always hold strategy discussions, or record end results or joint plans;
- officers inappropriately use police stations as places of safety; and
- managers don't consistently supervise cases or record when the police protection powers end.

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

- 1 good
- 2 require improvement
- 6 inadequate.

Common themes include:

- visits to offenders are usually unannounced, and officers tailor risk assessments to the needs of each case;
- officers don't assess offenders' risks appropriately or quickly enough;
- specialist officers don't always share intelligence with frontline officers; and
- when officers know about risk, they are inconsistent about sharing the information with CSC.

Cases assessed involving children detained in police custody

- 0 good
- 6 require improvement
- 0 inadequate.

Common themes include:

- officers understand they should only arrest children as a last resort;
- appropriate adults don't always attend custody quickly enough;
- the force doesn't routinely tell CSC or youth justice services about safeguarding concerns; and
- officers don't always listen to or record the VoC.

5. Initial contact

The force control room uses flags well to highlight risks to children

Police officers and staff working in the control room manage the force's response to calls from members of the public. They are responsible for handling calls and dispatching officers. Those working in the control room obtain relevant information from callers, then they search police databases to identify risk and grade responses. The force uses a framework called THRIVE to risk assess each incident. The force incident manager (FIM) decides what resources the force will allocate to an incident. The FIM shares this information with the critical incident inspector, who is responsible for managing and overseeing decisions.

The force's information systems use markers known as flags to highlight to officers and police staff important information about risk or vulnerability. This helps to identify children who may be at risk. This includes those who have a child protection plan, those at risk of CSE or domestic abuse, and missing children. The flag is removed when no longer needed. Flags mean control room staff can alert attending officers to risk.

Case study: the force responds to a call about domestic abuse

The mother of a ten-year-old boy contacted police and said she couldn't cope with her son. While speaking to the operator, she disclosed she had assaulted him.

The call handler rightly graded the call for an immediate response. Officers were dispatched to the home and arrived within 11 minutes.

The call handler conducted checks and found a flag showing the boy had a child protection plan in place for emotional harm. The call handler gave officers this information before they arrived at the home.

Having this information and passing it to responding officers was vital as it meant officers could take safeguarding action to protect the child.

Case study: call handlers carry out a firearms check in a domestic abuse incident

Police were called to a domestic abuse incident, where a woman said she had been assaulted by her partner. She said there were two children, aged seven and nine, at the address. They were asleep in bed.

The call handler did a firearms check, which showed the suspect held a firearms licence. The FIM carried out a good risk assessment and advised attending officers to seize any weapons. Having this information in advance helped officers make decisions while at the incident.

The force sent a detailed referral to CSC services, and it shared information with firearms licensing.

The force's initial response to missing children is inconsistent and leaves some children at high risk

When callers report a person missing, control room staff determine the risk grading and the response. We found the force initially grades missing children as pending assessment. This is based on the question set and THRIVE assessment call takers use. Staff often grade the missing child according to the current incident, not the child's history. The FIM sends the case to the critical incident inspector to add the full grading.

Under the force's procedure, police should assess any missing child at least as medium risk. We found the force routinely grades high-risk children as medium risk, using no context to inform the assessment. This means it isn't effectively using a child's history to manage the risk and respond promptly. This can result in the force leaving children at risk of harm.

Police can use trigger plans as a tool to record important actions and information, which can guide officers' initial action when a vulnerable child goes missing. We found that North Yorkshire Police doesn't use trigger plans consistently. We didn't see evidence of the force using trigger plans in any of the cases we reviewed. This is a missed opportunity, severely undermining how effective the force's response is to the most vulnerable missing children.

There are no routine reviews of how well staff perform in the control room

The force inconsistently reviews how well control room staff perform in relation to officers attending incidents. It doesn't routinely carry out analysis to understand patterns. For example, we saw some incidents where control room staff inappropriately coded missing children as 'cause for concern'. In these instances, they effectively downgraded the incident; they should have coded the child as missing. Inappropriate coding can result in a less effective service. We didn't see a review process to make sure that coding is done well and that the force treats risk in the right way.

The force told us there are no problems with allocating the right resources to incidents, but it carries out no routine checks to confirm this is correct. This means it can't be confident it doesn't downgrade incidents inappropriately when there is no officer available to attend.

The force supervises missing children incidents inconsistently

The force holds DMMs in each of its three areas. Managers sometimes discuss missing children at these meetings. But divisional leaders aren't aware of children at high risk of harm as a result of going missing repeatedly.

We also found most records don't contain supervisors' entries showing they are making sure officers carry out the right inquiries. Instead, we saw supervisors endorsing investigations, without directing officers on how to pursue the case.

We also saw that officers don't routinely submit PPNs for missing children. In some of the cases we saw with PPNs, officers hadn't recorded the VoC well enough, and sometimes they hadn't recorded it at all. The quality of PPNs is variable, and there is little supervision or feedback. So the force may not be carrying out the right activity to find missing children, according to their true level of vulnerability.

Officers inform schools about children present at domestic abuse incidents

We were pleased to see that officers at the force record the school details of children in the household when domestic abuse incidents take place. If a child attends a school in North Yorkshire, the force shares the details of the incident directly with the school. These referrals go via Operation Encompass to the safeguarding lead at the child's school. This lets the safeguarding lead support the child at school, and monitor their welfare and safety.

Officers often don't speak to children, listen to them, or record their behaviour and demeanour

The force encourages officers to speak to children, check on them and record what they say, particularly at domestic abuse incidents. In all domestic abuse audits we completed, officers switched on their BWV. But we found that officers often don't speak to children consistently, or record their concerns, behaviour and demeanour.

How a child behaves gives important information about how an incident has affected them. This is especially true where the child is too young to speak to officers, or where the child may be at risk if they speak to officers with a parent present. Officers should watch how the child behaves. This should inform both their initial assessment of the child's needs and the decision as to whether to refer the child to CSC services.

Case study: officers submit a PPN without considering a sibling's needs well enough

The mother of a 16-year-old male suspect reported a domestic abuse incident. She said he had caused criminal damage at his home address and threatened his stepfather. There was a 17-year-old male sibling at the address.

Control room staff appropriately graded the incident as immediate and officers attended promptly. They used BWV and arrested the suspect.

Officers submitted a PPN, but this was based on the suspect. It didn't consider the sibling's needs well enough.

The force managed the suspect with a community resolution, having consulted the mother and stepfather on their views for this outcome. But it didn't consult the 17-year-old sibling.

Recommendations

We recommend that North Yorkshire Police immediately reviews its processes regarding incidents relating to child protection, paying particular attention to how control room staff make decisions on officer response.

We recommend that within three months North Yorkshire Police acts to make sure officers obtain and record children's concerns and views (including noting their behaviour and demeanour). This will help influence the decisions the force makes about them.

6. Assessment and help

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

> Everyone who works with children has a responsibility for keeping them safe. No single practitioner can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.

The force has developed an efficient system for sharing information with safeguarding partners

The force supports two multi-agency safeguarding hubs (MASHs) in its area: City of York MASH and North Yorkshire County Council's multi-agency screening team. The force's vulnerability assessment team (VAT) oversees referrals to the local authority of children and vulnerable adults at risk of harm. It also makes sure police attend strategy meetings. The force has a clear and well-established process for referral to the MASH so it can share concerns with partner agencies.

Officers generally submit and send PPNs, but they often don't record enough detail

When an officer has a concern for a child, they submit a PPN. The VAT screens the PPN before sharing it with the local authority. We found that officers generally complete and send PPNs, but the quality is often not good enough. Before our inspection, internal reviews at the force had also shown inconsistencies in the way officers submit PPNs.

Although responding officers usually submit PPNs, in online child abuse cases and cases involving the management of violent or sexual offenders, officers don't always submit PPNs promptly enough. In some instances, they don't submit them at all. We found that officers also often share PPNs directly with the relevant social worker, if they find a case is open with the local authority. If they shared those PPNs with the MASH team, information could be fully assessed and the MASH team could consult other safeguarding partners if needed.

We found that the quality of PPNs is inconsistent. Some have good levels of detail with a focus on the children. But some simply outline the circumstances of the case. And in some instances, officers don't submit PPNs when they should.

The force holds strategy discussions promptly when the risk is clear

When a child is clearly at significant risk of physical harm, a supervisor at the force contacts partner organisations (including CSC and health professionals) to hold strategy discussions. In these circumstances, the force clearly documents on its Niche system the details of the strategy discussion and the outcome. We saw contributions from relevant organisations that resulted in decisions as to whether to carry out a joint investigation. The force had clearly recorded those decisions, and had promptly allocated the case to the right team to carry out the agreed enquiries.

When the risk to children comes from outside the family, the force doesn't hold strategy discussions consistently

Working together to safeguard children (2018) states that a strategy discussion should take place when there is reasonable cause to suspect a child is suffering or likely to suffer significant harm. Any safeguarding organisation, including the police, can request this discussion. North Yorkshire Police routinely attends strategy meetings about incidents needing an enquiry under section 47 of the Children Act 1989 (for example, physical harm or neglect). But officers aren't always taking a contextual safeguarding approach in cases such as missing children, child sexual abuse or online abuse. This means they aren't always fully considering the relationships children may have with people outside the home, including online.

Case study: the force doesn't respond well enough to a report of child sexual exploitation

A mother called police to express concerns that her 17-year-old daughter was being sexually exploited by an adult man and woman. She said money had been deposited in her daughter's bank account, and her daughter had received payments for phone top-ups. She also said unidentified men had previously driven the child to a countryside area in a car.

The call taker didn't apply THRIVE to the call and graded it as a concern for safety. They passed it to the neighbourhood desk for a scheduled visit.

The neighbourhood desk allocated it to a PCSO, who spoke to the mother. The PCSO later submitted a PPN, recording the exploitation concerns. They didn't record the VoC as no one from the force had seen or spoken to her.

The force passed the PPN to a social worker without a request for a strategy discussion. There was no safeguarding plan or detective supervision until 15 days after the report.

The force and CSC identified the need for a joint visit, but no strategy discussion took place to plan this or discuss the safeguarding arrangements. The closing supervisor's review didn't consider ongoing safeguarding, multi-agency child exploitation (MACE) referrals or ongoing risk.

A strategy meeting at the outset, with partners, would have helped identify risks and concerns. The force and its partners could have developed a clear safeguarding plan.

The force contributes well to long-term multi-agency safeguarding plans

North Yorkshire Police employs dedicated staff to research for and attend child protection conferences. Members of the force told us they attend almost all initial child protection conferences to discuss and agree long-term safeguarding plans with partners. When a child is made the subject of a child protection plan, the force flags this on Niche, so staff attending incidents are aware of the risks to the child.

The constabulary has developed arrangements that support those affected by domestic abuse

The force has a dedicated domestic abuse team of police staff. They support frontline officers by:

- reviewing PPNs (and requesting them from officers, when needed);
- ensuring safeguarding measures are in place; and
- overseeing domestic violence protection orders and domestic violence disclosure scheme requests.

We found evidence of this team's impact in our case audits. They routinely share important information with officers, and they act as a safety net for the force, for example, when officers don't submit PPNs. But this does highlight the inexperience of many officers working on domestic abuse cases. There are no mandatory child protection training days for officers, some of whom told us there is no formal training or CPD available.

The MARACs are effective when police and partners refer cases

The police and partner organisations, such as CSC and independent services, refer high-risk domestic abuse cases to a multi-agency risk assessment conference (MARAC) to make longer-term safeguarding plans. These conferences take place every two weeks in North Yorkshire county, and weekly in York, where the volume of cases is larger. The meetings are now held remotely, with a good level of attendance from partners. The force uses its escalation policy to highlight matters needing attention. Domestic abuse officers refer cases to the MARAC, and they prepare and present the police information.

We reviewed MARAC minutes and found the meetings are regular and well-attended by police and partners. The minutes are clearly visible in Niche, and we found appropriate plans to help support subsequent safeguarding decisions.

The force's understanding of child sexual exploitation has some weaknesses

The force has a missing and exploitation team responsible for child exploitation, missing persons, modern slavery and human trafficking. The team covers the whole force area, identifying those at most risk of CSE and supporting officers in their investigations. Where there is a CSE concern, the team researches and contributes to multi-agency risk assessments. But with one sergeant and one member of police staff, the team is under-resourced. This means it can't always assist investigators with conducting investigations into offences. The force allocates CSE investigations in the same way as other child abuse investigations, as the team primarily has a co-ordinating function. We saw that teams carrying out CSE investigations don't receive specialist child abuse investigation training.

When police identify a child to be at risk of CSE, the force refers the child to the MACE panel, which includes organisations from education, health services, CSC and the voluntary sector. There are multiple MACE meetings across the two local authority areas, with notable differences in both areas. A neighbourhood chief inspector usually chairs the MACE meetings in York, while in North Yorkshire county, CSC services chair the meetings. There can be as many as 12 meetings in total in a week. We found inconsistencies in the meetings, such as different risk assessment processes without any guidelines. Those present at the meetings often discuss risks to children, but there isn't enough clarity on risk management or safeguarding plans.

The force has scrutinised its CSE capability, but it isn't acting on the results

Before our inspection, the force conducted a random sample of its CSE and child criminal exploitation (CCE) cases to better understand how it identifies children at risk. Officers reviewed 70 cases with CSE or CCE flags, and 50 cases where children were marked as cause for concern. It found:

- almost half of the 70 cases it reviewed as CSE or CCE were incorrectly flagged, showing a poor understanding;
- some cases still needed investigation;
- there was often a lack of investigation or safeguarding plan; and
- the force didn't always use THRIVE.

These findings mirror some of the themes we found in our inspection. For example, we found that call takers didn't complete THRIVE assessments in all the CSE cases we audited. While it is encouraging that the force reviews practice and identifies concerns, we didn't see evidence of it implementing its own recommendations.

The force doesn't know enough about the standard of its practice when children go missing

Senior leaders told us the missing team reviews every episode involving a missing person and makes sure a PPN is submitted. But we saw that PPNs are submitted inconsistently, at best. The team reports areas for improvement or good practice to divisional commanders or at the vulnerability board meeting.

But the force doesn't have a framework for regularly assessing how good its overall practice is in cases of missing children. Although strategic responsibility for missing people lies with the protecting vulnerable people (PVP) team, we didn't find a system for consistently reviewing cases involving missing children. A framework would allow the force to better understand how well it responds when people go missing.

Officers and staff in North Yorkshire have had very little training about missing children since joining the police. Officers on the response team haven't had specific child protection training, so they rely on their supervisors and managers for support and direction. The force monitors training via College Learn (formerly National Centre for Applied Learning Technologies/NCALT) packages, but it doesn't evaluate or understand the impact of the training.

The force loses some opportunities to understand why children go missing

Return home interviews (RHIs) uncover information that can help protect children from going missing again. This can include risks they may have been exposed to while missing, as well as risk factors at home. The RHI is a conversation between a child and a trained professional when they return from being missing. Department for Education statutory guidance requires local authorities to offer this service. It must be conducted by an independent person and police must record it on their systems.

In North Yorkshire, when a missing child returns or is found, the officer should have filled in a management of return (MOR) form and electronically shared it with CSC, coupled with the automatic notification of missing children. The force policy says this is to assist the local authority in offering every missing child an RHI. But staff don't always complete these forms. For example, we observed a meeting to discuss missing children, and in half of the cases discussed, staff hadn't completed an MOR to alert CSC. We also saw that staff didn't complete a significant number of PPN referrals to highlight other concerns.

This means important information, which might help with future risk assessments, may not be available. The force doesn't check often enough whether this information is submitted, so it needs to do remedial work later. As a result, children stay at risk of harm. It also means the local authority doesn't know about important information that may help to stop risk escalating, or might inform their response.

The force is trying to improve its response to children who go missing from care, but it doesn't always make information available to officers

North Yorkshire has a scheme called No Wrong Door, which supports people aged 13 to 25 in or on the edge of the county's care system. Historically, when children reach the age of 18, their level of support changes significantly. No Wrong Door aims to decriminalise young people and give them a better chance at a normal life. Social workers refer young people experiencing difficulties to the scheme, and police officers are embedded in two hubs, which combine residential care with fostering. One is in the east of the county and the other is in the west. The scheme, which receives high praise from its partner organisations, had 69 young people on it at the time of our inspection.

Using an approach called Risk, Analysis, Intervention, Solution and Evaluation (RAISE), the force and other agencies identify, consider and manage potential and current risks to young people on the No Wrong Door scheme. Members of the force told us officers create safety plans for the vulnerable children they discuss at RAISE meetings. But we saw that minutes, and actions about young people, are recorded on social care systems, not on police systems. The force told us this is intentional, as when information needs sharing, it is placed on a briefing. But this practice means that when police find vulnerable children, they don't always have important information about that child's circumstances, meaning they may not respond in the right way.

Recommendations

We recommend that North Yorkshire Police immediately improves its missing children arrangements and practices. This is to make sure:

- its response is consistent with the risks it identifies; and
- its supervision of those inquiries is effective.

It should include a review of how it records incidents involving missing children. And it should make staff more aware of:

- their responsibility for protecting children reported missing from home, especially where this happens regularly;
- the importance of investigating where a child has been, and who with;
- their responsibility for conducting and recording safe and well checks when children return home; and
- the importance of sharing information with partner organisations.

We recommend that North Yorkshire Police immediately starts working more closely with its safeguarding partners, and that it reviews the structure and practices of its multi-agency risk management meetings, specifically about children at risk of exploitation.

We recommend that within three months North Yorkshire Police reviews its referral processes and supervision. This is to make sure it identifies risk to children effectively and shares the right information with the right people at the right time.

7. Investigation

The force allocates some investigations to officers without the right skills and experience

North Yorkshire Police doesn't have a specialist child abuse investigations team. It allocates some child abuse investigations to detectives in the CID, and others stay with frontline officers, with supervision by a detective sergeant. But frontline officers aren't trained to conduct child protection investigations, and joint working with other organisations (such as joint visits and joint interviews) doesn't take place often enough. We found limited evidence of contact with CSC services.

There was also very little evidence of cases being supervised, or of meaningful involvement from first and second line managers. These cases often involve CSE offences. We saw that, in these situations, investigations aren't child-centred, and officers don't always consider wider safeguarding.

The force's investigation procedure outlines how it allocates crimes to officers, and how they should investigate them. It also states that PIP 2 accredited detectives should investigate crimes involving children. However, some parts of the procedure are open to interpretation. As a result, we found inexperienced officers, without the proper accreditation or training, managing some child abuse investigations. This includes investigators, supervisors and those responsible for conducting strategy discussions.

Case study: police don't respond quickly enough to a report of child sexual abuse

Police received an email from a concerned father. He reported that his three-year-old daughter was at risk of sexual abuse from the child's mother's partner.

North Yorkshire Police didn't allocate or review the case for 15 hours. Once allocated, officers took too long to contact the father, who lived outside the force area. It was seven days before the force spoke to CSC to make sure the child was seen.

Officers didn't see the child until six weeks after the initial call. During that time, the force didn't know what risk the child was exposed to.

Limited supervision is leading to drift and delay in many investigations

In most of the cases we reviewed, there was little case direction from sergeants. Safeguarding plans were often missing, even when the case was complex. Often, supervisors' first involvement with cases is at the time of case closure. And they often don't discuss the case with the investigating officer. We saw very few cases where an inspector had reviewed investigations, especially cases allocated to response teams. This leads to drift and delay in many investigations.

When the force allocates cases to specialists, the standard of investigation is better

When there is clear risk to children from the outset, the force responds swiftly and attending officers make good decisions. Investigations are child-focused and officers usually record joint actions they agree with partner organisations. But supervision is sometimes inconsistent.

Case study: despite little supervision, officers carry out a good domestic abuse investigation

The force launched a domestic abuse investigation when a woman told police she had been assaulted at home by her ex-partner, causing significant facial injuries. The victim's seven-year-old son was asleep at the time of the incident.

Police submitted a detailed PPN, capturing the child's voice, and shared it with CSC. Staff placed high-risk domestic abuse flags on police systems.

When the suspect was arrested, the force allocated the case to a PIP 2 investigator. Although there was no investigation plan and little supervision, the quality of the investigation was good.

The investigator considered a domestic violence protection notice (DVPN) and appropriate bail conditions for when the suspect was released from custody. The investigator also gave information to support a non-molestation order. The suspect was eventually charged and bailed to court.

Officers often miss investigative opportunities to safeguard children when dealing with CSE

The force uses vulnerability markers and flags to identify children at risk of CSE. Officers also make referrals to MACE meetings. This helps to make sure they discuss these children with partner organisations. But investigations of CSE offences are often poor, as officers don't consider the flags and markers. This is because the force allocates cases to officers without the right skills, experience or training. And supervision is often lacking. This affects the safeguarding of victims and the quality of investigation.

The force also misses investigative opportunities when children are sexually abused online. This may allow perpetrators to commit more offences. The force regularly assigns these cases inappropriately to inexperienced officers, including those in response roles. These officers don't have the technical knowledge, experience, skills or accreditation to investigate these offences. And supervision of these crimes is often poor. We found the force rarely records meaningful reviews, meaning these officers don't receive enough direction or help. This is resulting in poor outcomes for children.

Case study: the force responds quickly to an incident involving a CAWN, but investigators act slowly to safeguard the child

Police were called when an intoxicated 14-year-old female was found half-naked with an adult male. There was a CAWN in place, meaning the man wasn't allowed to be in the company of that child.

The force dispatched officers quickly and they arrived within ten minutes. They identified the CAWN and arrested the suspect. But they didn't consider sexual offences or forensic opportunities. They also didn't give support to the child or her family.

They submitted a PPN ten days late. There was no update from the multi-agency screening team and no request for a strategy meeting.

The child was known to MACE, but this didn't prompt a MACE review, safety planning or sexual health referrals, even though the child had contact with the suspect after the incident.

The MACE review eventually took place six months after the incident. The force allocated the case to a PIP 1 investigator, with no recorded review or supervision by a PIP 2 investigator.

There was no joint approach with CSC services. Officers didn't record any consideration of building a relationship with the victim to support her.

The child eventually moved to another force area. There was no record of a MACE transfer to tell the other force about potential risks.

Case study: police don't speak to a child who may be at risk of CSE

A male, believed to be abroad, contacted a 14-year-old girl. He asked her for a photo and she confirmed her age. He also sent her a nude photo of himself. Over the next five days, he sent money to the girl. Her parents noted a change in the girl's behaviour and called police, having seized her phone.

Police attended and spoke to parents. They didn't speak to the child as she was at school. They didn't consider evidence on the phone as they said it had been reset. They didn't seek expert advice from the digital forensics unit, and they didn't seize the phone.

Without seeing the child, officers submitted a PPN, stating that they didn't believe any CSE was occurring. There was minimal supervision of the case, and officers didn't record any actions. There was no mention of seizing the child's phone or downloading information from it, so they may have missed evidence.

The force passed details of the suspect to the relevant authorities overseas.

The force needs to improve the way it tackles CSE

The force has recognised it must improve the way it tackles CSE. The force recognised this in an internal review it conducted into how it responds to and manages CSE.

The force's CSE unit covers the whole force area, but it doesn't have enough capacity to support other teams' investigations, especially as CSE officers often don't have the right experience. The unit has no set of instructions outlining what the team should be doing. And its staff have had no CSE, child protection or vulnerability training to support them in their role. Officers told us they had no job description, so they didn't understand the role they were expected to perform. Although the unit covers the force's area, other teams (such as CID and response teams) don't share information with it, so there is no force-wide co-ordination of safeguarding activity. This means the force has an inconsistent understanding of those children most at risk and the perpetrators presenting the highest risk.

It is positive to see the force has taken steps to understand better how its officers are responding to CSE, but it needs to do more work to protect children more effectively.

There is little evidence of the force working effectively with other organisations

In some parts of the country, children's safeguarding partnerships respond to vulnerable children and disrupt offenders using multi-agency operational teams. In North Yorkshire, there are strong safeguarding partnerships at a planning level, but operational joint working is inconsistent. We saw little evidence of joint investigations with CSC or safeguarding professionals from other organisations. There were few records of joint visits to children and families in the cases we reviewed. As strategy discussions with partners aren't routine, the force doesn't always consider who is best placed to speak to the child.

The force usually acts promptly to trace those sharing child abuse images, but there are significant delays in downloading from devices

The force OAT investigates the sharing and distribution of child abuse images online. It also deals with referrals from the National Society for the Prevention of Cruelty to Children (NSPCC) and from the National Crime Agency's child exploitation and online protection (CEOP) command.

The force has worked hard to manage how many offences are committed in its area. It regularly reviews its systems to identify potential offenders. We found it usually deals with cases within its timescales.

The digital forensics unit (DFU) is responsible for downloads from phones officers have seized and submitted for forensic analysis. We saw that officers are generally seizing phones, but there are significant delays in downloading from devices in the DFU. These delays average six months but some take as long as a year.

Some investigations stall while officers wait for the results of the analysis. Due to the backlog, some suspects are bailed in this period, however, the force told us that they use conditions to mitigate the risk posed to children. The force knows it needs to prioritise this area of work. It has invested significantly (£2.5m) in the unit, which will increase staff and specialist equipment. This should help the force address the backlog and safeguard children sooner.

The force doesn't share information with its safeguarding partners early enough

We found officers rarely share information with the MASH until activity, such as executing a search warrant, takes place. This is a missed opportunity. The force should be sharing information with partners to better understand the risks to children.

Supervisors told us they expect the team to share information with CSC as soon as they are aware of the risk to children. But officers told us that executing a warrant, or similar action, is what prompts them to refer to CSC. They say this is often because they don't know full details about the case until they have executed the warrant.

Even so, officers are missing opportunities to share information with other organisations, and to take account of known risks to children during intelligence-gathering. This would help them better understand the risks and put protective plans in place before carrying out activity.

Recommendations

We recommend that North Yorkshire Police immediately improves child protection investigations by making sure:

- it assigns investigations to officers with the skills, capacity and competence to carry them out them effectively;
- it effectively supervises investigations, with reviews clearly recording any further work that is needed;
- safeguarding referrals are prompt and comprehensive;
- it gives enough support to multi-agency investigations; and
- it regularly audits the quality of its practice, including how effective its safeguarding measures are, focusing on getting the best end results for children.

We recommend that within three months North Yorkshire Police improves its understanding of CSE, in particular:

- improving staff awareness, knowledge and skills in this area of work;
- making sure it responds promptly to all concerns;
- carrying out risk assessments that consider all the child's circumstances and risks to other children; and
- improving the way it supervises and manages cases.

8. Decision making

The force used police protection powers appropriately in all the cases we audited

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

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

Officers don't always properly record their use of police protection powers

Although we saw cases where officers made enquiries to safeguard children promptly and effectively, there isn't always a full record of it on police systems. Officers don't always record details of strategy discussions with CSC, including the actions they agree to safeguard and promote the welfare of the child.

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

Case study: police use protection powers well, but they don't make good enough records

A 12-year-old boy in a park reported to a third party that he and his siblings had been assaulted by both parents. Police attended promptly and exercised their powers appropriately and quickly.

But they didn't properly record or document the use of the powers. It wasn't clear when the powers ended, or whether the force consulted CSC about emergency protection orders, for example. There was a lack of clear direction from the designated officer, and handover documents weren't available.

Officers take steps to avoid taking children to police stations while in police protection

The force's policy states: "A police station is not suitable accommodation. A child under police protection should not be brought to a police station except in exceptional circumstances." We found in our audits that officers are making early contact with CSC services when seeking suitable accommodation for children, to avoid bringing children to a police station. However, this doesn't occur in all instances. And when it does occur, it is unclear whether the force is escalating these matters with CSC services.

Case study: officers put the child's welfare first, but they don't make good enough records

A 15-year-old boy was found in the early hours of the morning. The child didn't speak English and officers had concerns about his mental health, which made their job more difficult.

They established that the child had been abandoned by his mother. Putting the child's welfare first, they quickly used powers of protection to safeguard him. Although there was some discussion with CSC, they didn't find a placement for him, so officers took him to the police station.

Officers didn't record or document:

- the review of the child at the police station;
- a review of continuing grounds for the protection powers;
- any handover documents;
- details of when the powers ended; or
- the outcome for the child.

Recommendations

We recommend that within three months North Yorkshire Police works with its partner agencies to make sure:

- it takes children to an appropriate place of safety when it uses police protection powers;
- it properly investigates offences; and
- it properly records, and makes accessible, all relevant information.

9. Trusted adult

North Yorkshire Youth Commission (NYYC) was established in 2015 with funding from the PFCC to give young people a voice on police and crime issues that matter to them. NYYC supports, challenges and informs the work of the PFCC and North Yorkshire Police.

It is important children feel they can trust the police. We saw that, in some (though not all) child protection cases, officers consider the impact of their actions and explore the most effective ways to communicate with children.

Case study: officers respond sensitively and effectively to a suicidal child

Police received calls about a suicidal 14-year-old girl in the sea. The police dispatcher graded the call for officers to arrive immediately.

Police used CCTV and officers arrived within five minutes. Officers approached the girl, talked to her and encouraged her out of the water.

An ambulance was requested. When it arrived, an officer accompanied the girl in the ambulance, listening to her account of entering the sea. She also made a disclosure about an assault by another child.

At the hospital, the girl received help from mental health services. Officers made sure staff from the girl's care home were supporting her, and they spoke to her social worker.

Officers also made a detailed referral, recording the child's wishes, and they shared it with CSC services.

Such sensitivity builds confidence and creates stronger relationships between the police and the child, parents and/or carers. We found the force works well with external organisations, family members and other people to protect children when they need immediate safeguarding. In the cases where this happens, the force's carefully considered and sensitive approach brings about good safeguarding outcomes for vulnerable children.

The force engages well with children in the community

The force has adopted some youth diversion schemes. These aim to keep children out of the criminal justice system and reduce the number of children who are criminalised. These schemes include:

- Operation Choice – an educational pathway for under-18s involved in drugs possession, working with support services across the county; and
- Operation Divan, which involves officers holding knife-crime awareness sessions, engaging with young people in schools or other venues.

The force also supports the national Volunteer Police Cadets (VPC) programme. It aims to encourage good citizenship among its members and inspire young people to participate positively in their communities. In North Yorkshire, there are currently around 37 cadet leaders and 80 to 90 volunteer cadets aged 14 to 18. Cadets support community events such Armed Forces Day, the Tour de Yorkshire cycle race and Remembrance parades, as well as contributing to joint events with the army cadets.

The force also encourages cadets to offer ideas about how to help raise awareness in the community about crime. It encourages cadets to list their ideas and create a campaign brief, working closely with the force's communications team. This is a good example of the force promoting children's voices.

10. Managing those who pose a risk to children

Staffing levels in the team are good

The force has a management of sexual offenders and violent offenders (MOSOVO) team, which is dedicated to multi-agency public protection arrangements (MAPPA).

At the time of our inspection, there were 1,180 registered sex offenders (RSOs) in North Yorkshire, with 757 managed in the community. (Not all offenders convicted of sexual offences are subject to supervision.) This is an average ratio of about 50 to 55 RSOs to one offender manager. This is within national recommendations (approximately 50:1). Those supervising offender managers organise their tasks well, and their workloads are manageable.

The force employs a MAPPA administrator. The administrator has access to both police and probation systems, which makes it easier for those agencies to share information. The force also has a dedicated civil orders officer, who scans arrests daily and seeks opportunities to apply for orders, where officers identify this as the right response. These might include sexual harm prevention orders (SHPOs) and sexual risk orders (SROs). This proactive work shows good initiative and it protects children.

All offender managers are trained in the MOSOVO. Staff working in the unit should also be trained to use the Violent and Sex Offender Register (ViSOR), but we found some staff hadn't been trained to use the platform, and there was little time available for training. Staff told us they also need more training in the active risk management system (ARMS).

The force uses risk management processes consistently

When the police are the lead agency for managing an RSO, they should complete an ARMS assessment within 15 days. Based on the risks they identify, offender managers should develop a risk management plan, setting out how they will manage the risk the RSO poses and what actions they will take. This might include regularly visiting the offender. Officers should complete police ARMS assessments at least every 12 months, or when something happens that may significantly change the current assessment and risk management plan for the offender.

We found North Yorkshire Police has a good understanding of ARMS processes and its responsibilities when it is the lead agency. But there are no routine performance tasks in place to measure how well staff complete ARMS assessments, and supervisors don't fully oversee reviews and completions. This means officers aren't always relying on risk management plans that are current.

Better briefing of neighbourhood police teams would enhance the force's intelligence-gathering

We found that links between the MOSOVO and neighbourhood teams were under-developed throughout the force's area. Offender managers brief neighbourhood teams and allocate them tasks on an ad hoc basis to gather intelligence about individuals. But offender managers don't routinely share information about RSOs in briefing material. And staff in neighbourhood teams don't report intelligence collection as part of their day-to-day duties. Neighbourhood teams can use Niche to search for RSOs in a particular area, and the force has promoted this function. But we found teams are rarely doing this. We also found frontline officers add very little intelligence to Niche. If the MOSOVO team briefed the neighbourhood teams more effectively, it could lead to better information gathering across the force, allowing it to better protect children.

The force doesn't record information about RSOs consistently

ViSOR is a national database used for:

- recording and sharing information about RSOs; and
- recording activity to reduce the risk they pose.

In North Yorkshire, we found that officers view the recording of information on both ViSOR and Niche (the force's records management system) as duplication. This means they don't always record information on both systems. They should be doing this. When an offender moves to another area or travels between areas, other forces can see the records on ViSOR if the information has been recorded properly. Officers in North Yorkshire don't consistently record information on both systems, so when an offender travels from the area, other forces don't have all the information they need.

The force doesn't always share information with children's social care

We found several cases where the force identified a child as potentially at risk from an RSO, but officers didn't submit a PPN, or they submitted it after an unacceptable delay. In several cases, the offender manager judged the child to be not at risk without consulting CSC services.

Case study: officers record concerns about an RSO, but they don't act quickly enough

An RSO convicted of several online offences against children was released from custody after a prison term. During his initial notification, he told officers he intended to frequently visit the home of some friends, who have two young children.

The offender manager visited the address and spoke to the occupants. They confirmed they had been friends with the RSO for several years. They said he had already visited them since his release from custody. They said they had told him he couldn't visit again, and that he couldn't have contact with their children. But the offender manager didn't record details of the children or consider a referral to CSC.

When the offender manager conducted a joint visit to the RSO with a member of the probation service, they noted that the RSO appeared to know a lot about the children's routine. Again, the records show no consideration of a referral or further enquiries.

The RSO was later arrested for breaching his SHPO. He was subsequently charged and recalled to prison.

Officers recorded the case on Niche but not on ViSOR.

There was no effective supervision of the case, meaning action to safeguard children was delayed.

Recommendations

We recommend that North Yorkshire Police immediately improves the way it manages RSOs, paying particular attention to:

- how it records information on its systems;
- how it shares information with frontline officers; and
- how it shares information with CSC.

11. Police detention

Custody staff don’t fully understand their role in safeguarding vulnerable children

The force works actively to reduce the number of children it arrests and brings into police detention. This is encouraging. But it still needs to be more consistent in the way it prioritises safeguarding and children’s welfare throughout the detention process.

Members of the force told us training for custody staff isn’t widely available, especially training on vulnerability and the VoC. As a result, they don’t consider submitting a PPN to be part of their role.

If any safeguarding concerns become clear when a child is in custody, custody staff rely on investigating officers to make a referral to CSC on a PPN. For example, in some cases, custody staff did record the child’s vulnerability, but they didn’t make any referrals.

When one child was detained for more than 20 hours, the healthcare practitioner (HCP) recorded concerns about self-harm and mental health on the child’s custody record. But no one then referred the child to CSC or shared information with youth justice services.

Appropriate adults aren’t attending quickly enough to support children in custody

Guidance under the Police and Criminal Evidence Act 1984 (PACE) states that once an appropriate adult is identified, officers should make sure that person attends the custody centre as soon as possible. In some of the cases we examined, there were long delays before appropriate adults attended. They usually arrived when the officers interviewed the child, so they couldn’t give early support. That support might include helping with overall welfare needs and informing children of their rights. As a result, children often don’t see anyone other than the police for too long.

The force recognises this as an issue: an internal review had made recommendations to address this concern (as well as others). But we didn’t see any evidence of the force implementing its own recommendations.

Case study: officers risk assess and investigate a case involving a child well, but there are delays in an appropriate adult attending

Officers arrested a 15-year-old boy on suspicion of robbery and possessing a knife. They promptly completed and recorded an appropriate risk assessment.

More than 12 hours after his arrest, only police staff had seen the child. Despite the child's history of self-harm and problems with reading and writing, no one from the force contacted an HCP. The appropriate adult attended in person about 14 hours after detention.

Supervisors documented the main lines of enquiry and allocated the case to an experienced investigator. They then supervised the investigation in detail.

The young person was found non-secure accommodation and detained for court the following day, where he pleaded guilty to all charges.

The force gives children in custody inconsistent welfare support

Liaison and diversion (L&D) staff are available seven days a week between 8.00am and 8.00pm. They work across the three custody suites: York, Scarborough and Harrogate. They assess the vulnerability and needs of young people who come into custody. Where appropriate, they refer the person to the relevant health or community-based services. North Yorkshire Police couldn't tell us how many children and young people L&D staff had seen.

PACE and its codes of practice set out a statutory framework for custodial care of young people. They require police forces to give care and treatment to those held in custody. Members of the force told us the contract with the HCP provider specifies that an HCP will only see children when the custody sergeant has raised a medical issue. HCPs can engage directly with a child in private, especially those reticent to disclose to officers, issues or concerns specific to their welfare and wellbeing. As a trusted adult, who is not a police officer, a child may feel more comfortable with disclosing information to an HCP that impacts on their risk assessment and safeguarding needs outside custody.

An internal review carried out by the force suggested it would potentially be good practice for an HCP to visit all children in custody. This was put forward as an area for consideration. The review also found that HCPs see very few children unless there is an obvious physical injury.

The force works to divert children away from custody

The force has measures in place to make sure it doesn't unnecessarily bring children into custody. Operation Choice is a force-led initiative that helps to keep children and young people out of custody when they are found in possession of drugs. The force's intranet explains Operation Choice, giving staff guidance on support services, the need for an appropriate adult and other matters. Operation Divan is a knife-crime initiative, through which the force shares information with school liaison officers.

Recommendations

We recommend that within three months North Yorkshire Police reviews how it manages the detention of children. The force should do this jointly with CSC services, youth offending services and other partner agencies. The review should consider, as a minimum, how best to:

- make sure appropriate adults promptly attend the police station;
- make sure officers consider the needs and voices of children, and refer them to CSC services, when needed; and
- monitor how well the force works with its partners, and the support it gives children.

Conclusion

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

During the inspection, we held daily meetings with senior officers and gave feedback from our initial findings. The leadership team is committed to protecting children and giving them better outcomes. The force is committed to improving how it protects vulnerable people, and it recognises it must safeguard children better. It needs to do more to help its officers and staff understand:

- the need to safeguard children; and
- the need to look beyond the obvious risk factors to identify and address any wider or underlying problems.

The force works well with safeguarding partners from both local authority areas. It is an active member of the multi-agency safeguarding children partnerships and is represented at the right level on boards and subgroups, often leading the strategic direction.

We found some good examples of the force protecting children in need of help, with good multi-agency work and a child-centred way of operating. In these cases, the force effectively combined investigative and safeguarding approaches. But we found that most cases we examined were inadequate or requiring improvement. The force had similar findings.

North Yorkshire Police should continue to review its child protection arrangements and practices to make sure they focus on improving outcomes for vulnerable children. It should also put in place a clear structure for overseeing, and taking responsibility for, all aspects of the force's child protection activity.

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

Next steps

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

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

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

Annex A – Child protection inspection methodology

Objectives

The objectives of the inspection are:

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

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

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

These areas of practice are the focus of the inspection.

Inspection approach

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

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

Methods

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

The purpose of the self-assessment is to:

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

Self-assessment and case inspection

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

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

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