Appendix 3

HMICFRS

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

National Child Protection Inspection Post-Inspection Review

North Yorkshire Police

5–16 December 2022

Contents

Introduction

Our 2021 inspection

In November 2021, His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) inspected how well North Yorkshire Police keeps children safe. We made ten recommendations in the *North Yorkshire – National child protection inspection* report.

In December 2022, we returned to the force to undertake a post-inspection review.

During this inspection we:

- examined force policies, strategies and other documents;
- interviewed senior leaders, managers and spoke with frontline staff; and
- audited 33 child protection cases (11 cases were good, 8 required improvement and 14 were inadequate).

Summary of findings from the 2022 post-inspection review

After we published our 2021 inspection report, North Yorkshire Police made an action plan to co-ordinate work to improve its child protection services.

Leaders established a gold-silver-bronze structure to allocate management responsibility and strategic oversight for all aspects of the action plan. We found the force had made some positive progress but not all the actions were fully implemented and completed.

During our inspection, the force held the first meeting of its new vulnerability board. Positively, this meeting's agenda included themed vulnerability topics, such as missing children, and gave the assistant chief constable and senior managers an opportunity to scrutinise the quality of the force's responses to risk in these areas. The force is clearly committed to using this forum to help it be more effective in how it protects children.

North Yorkshire Police collects performance data about crime, incidents and responses. This information is available on force systems. The force also has an intelligence capability and analysts. But managers aren't making best use of this data to understand demand and allocate resources to deal quickly with problems.

The latest force exploitation profile is dated September 2020. This means much of the information is too dated to be of use.

The lack of qualitative information from the force systems means leaders and managers can't be sure of the progress staff are making against priorities. For example, in improving investigations or managing the risk of registered sex offenders.

Officers aren't always using systems effectively to support routine operational work. For example, automated systems aren't used to tell schools about pupils affected by domestic abuse incidents. And there can be delays in telling the local authority when a missing child is returned home. We also saw officers completing paper booklets about risks to children who had run away from home, rather than using electronic systems so the information can be seen immediately by other staff.

Staff have reacted positively to vulnerability training, and we found control room responses to calls where children may be vulnerable had improved.

But not all decisions in the force control room about incidents with vulnerable children are fully supported by intelligence from force systems. This is because specialist intelligence officers aren't included in the current control room arrangements. And it means some risk assessments are incorrect. So, there are delays in getting the right response to vulnerable children. This is also reflected in how some missing children investigations are allocated to area-based officers who don't always have the resources to assess risk and act quickly.

Leaders have prioritised training to help their workforce understand why it is vital to speak to children and record their views. Staff we spoke to have enthusiastically adopted the AWARE principles. They told us it gave them a clear structure and helped them record their concerns in better detail. This approach is also praised by senior managers from both local authorities.

AWARE principles

A checklist to encourage staff to develop their professional curiosity and record information about children's vulnerability in a structured way.

- A – appearance;
- W – words;
- A – activity;
- R – relationships and dynamics; and
- E – environment.

There has been a notable increase in the quality and number of referrals for children to the local authorities. But even so there are no delays in the system. The force's own review of all these reports means that good quality information about risk and vulnerability is shared with the safeguarding partnership at an earlier stage. This is promising practice.

We are concerned about delays in the force's digital forensic unit (DFU) and that some complex investigations into online sexual abuse of children are allocated to inexperienced officers. There are delays in some online indecent image investigations before referrals are sent to partner agencies. This means that these children can remain at risk unnecessarily.

The supervision of most investigations has improved and the force has introduced a new template to structure this. But more work is needed to make sure that investigations remain focused on the best results for the children involved and that all safeguarding concerns are addressed.

The force's offender management unit (OMU) hasn't improved its operational practice enough. Registered sex offenders in the community need careful and professional management by the police and statutory partners. The force follows national guidance and College of Policing approved professional practice. But we found significant weakness in the way this team operated.

Initial contact

Recommendations from the 2021 inspection report

> 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.

Summary of post-inspection review findings

Control room staff have been given focused training, which has improved the understanding of the voice of the child (VoC) and THRIVE assessments for missing children.

There is good supervision of calls and responses to vulnerable children and those reported as missing. Supervisors manage and review control room processes and give feedback to staff.

But control room decisions and responses to vulnerable children still need to be better informed by intelligence and information held on force systems.

The force is training its workforce to use the AWARE principles and substantially improving the quality of how they record the VoC. As a result, the number and the quality of referrals for vulnerable children to safeguarding partners have increased. But supervisors and line managers don't check their staff's public protection notice (PPN) reports.

Detailed post-inspection review findings

The force has improved control room practice and supervision

We inspected how control room staff and supervisors responded to calls where there were concerns for children. We found they made good quality risk assessments and allocated incidents to response staff without delay. Decisions are recorded on force systems and are clearly focused on getting positive outcomes for children. We saw effective supervision and improved processes, which are helping staff respond better to vulnerability and assign appropriate responses to calls for help. In one case we saw an effective escalation to a detective inspector, who immediately reviewed the incident. They told officers to preserve the crime scene and protect another vulnerable person.

Managers have introduced 'power hour' training for control room staff. This makes sure that staff are trained in key subjects without having to wait for formal training days. And it avoids removing them from their main role for long periods. Specialist officers also provide training and guidance about responding to risk for control room staff and supervisors.

Control room staff told us VoC training was informative and helped them in their roles.

We also saw control room staff identifying vulnerability and risk for children and then appropriately grading responses to incidents. They use THRIVE assessments effectively. When new information is received about ongoing incidents, the THRIVE assessment is repeated. This means good decisions can be made quickly to assign officers to calls about children at risk of child sexual exploitation (CSE) or when children are reported as missing.

Control room managers complete monthly call monitoring, including at least two child protection cases.

The force has introduced a new policy that means control room staff can't downgrade calls without a supervisor's approval. And calls where there are concerns for a child's welfare aren't assigned to the force's initial inquiry team, as these staff don't have the necessary skills to deal with these incidents. Positively, the force doesn't use a diary appointment system for responses to vulnerability incidents. But we were told this policy is under review.

Control room staff give a better response to reports of missing children

Call handlers should complete missing child questionnaires and THRIVE assessments for all missing children. This includes initial intelligence research of force systems to establish risks, warning markers or other information to help find the child quickly. But we found that records holding detailed information to help find missing children weren't always clearly accessible on the force's systems. This means vital information isn't always used to assess risk correctly. Or, used by officers to find children without delay.

Control room staff send all reports of missing children and calls about concerns for the safety of children to the force incident manager (FIM) for review and grading. FIMs review the quality of assessments and record decisions and supporting rationale. They feed back to staff about the quality of the initial reports and assessments.

Missing children are graded as either high or medium-risk. High-risk children are assigned immediate responses.

Medium-risk children are given a priority deployment. They are assigned to area critical incident inspectors (CIIs) who are then responsible for each missing child's investigation and safeguarding approach.

The force still needs to improve some control room practice

Control room managers told us that their training is focused primarily on improving responses to incidents of missing children. They acknowledged more training was needed to improve responses for children at risk of CSE, child criminal exploitation (CCE) and online abuse.

We found call handlers weren't always telling callers how to keep evidence secure on their mobile devices when they or their children were victims of online abuse.

We also found that control room staff didn't always use information held on force systems to inform risk assessments and allocation decisions. This means that sometimes responding officers aren't aware of important information about risk and vulnerability when they need it.

Force leaders also haven't established a specialist 24/7 intelligence capability. This is a weakness and means it isn't always able to quickly understand the full extent of risk and act appropriately.

The force has introduced the AWARE principles to give its workforce guidance about the voice of the child

All staff must use PPN templates to record children they are concerned about and to make referrals to local authorities about them.

Frontline staff and their supervisors have been trained by specialist officers in scheduled continuing professional development days. VoC training has been prioritised. This includes how to use body-worn video to record children's demeanours, their home circumstances and their views.

Detailed guidance on the force intranet supports this training. This includes a helpful video based on a police response to a domestic incident that is reported by a child.

The intranet also has accessible information to help the workforce respond better to children in different scenarios. For example, when they are missing or at risk of exploitation. It reinforces force policy about staff recording their observations of children's vulnerability and making appropriate referrals using PPNs. Hyperlinks are given to detailed PPN guidance and two example proformas are easily found on the system.

Case study: officers identify vulnerable children and act to protect them

Officers responded quickly when a woman called the police after her partner assaulted her in their home.

The partner was arrested. The officers used body-worn video to record the scene, the woman's injuries and the voices of the children in the household. They took a statement of complaint and made a referral for the children using a PPN that contained details about the children's demeanours and their living conditions. This information was shared with the children's schools, local authority early help services and domestic abuse support workers.

The officers' supervisor gave clear direction and instructions on safeguarding. This included obtaining a Domestic Violence Protection Notice. The offender was bailed with conditions in place to protect his family. Enquiries were also made with the housing provider to gain help and support for the victims.

A specialist team checks the quality of police referrals before they are shared with safeguarding partners

The force's vulnerability assessment team (VAT) check every PPN. They told us that use of AWARE principles has improved officers' recording of the VoC. When AWARE isn't used, VAT staff contact the reporting officers to get the missing information and remind them of the force policy.

Overall, we found a much-improved approach to understanding children's vulnerability. But staff aren't yet consistently using the AWARE principles or identifying all vulnerable children. For example, we saw some children at risk from online abuse weren't included in PPNs when they should have been. This may be because the force doesn't require line managers or supervisors to check the quality of PPNs before they are completed.

This means the force now sends better information to its safeguarding partners. And this helps professionals understand more clearly and quickly what services are needed to help children.

Children's social care managers told us the improved quality of information in the PPNs helps them to work better with families. And the force told us it recently received feedback from a North Yorkshire social care manager who said:

> "It's really positive that the child's and parent's views are now being recorded, and how consideration has been given to the impact on the family. I feel that should a child or parent in the future wish to see their files and see this new format they will feel valued and supported by the police. Thank you for the positive changes that are being made for the families in North Yorkshire."

The number of PPNs the force is sharing with safeguarding partners has substantially increased. Partners haven't told the force that these are inappropriate or unnecessary. Therefore force leaders can be confident that their investment in staff training is working. Officers are using vital information about vulnerable children to reduce risk. And so, early help and child protection measures can be implemented before crisis is reached. This is promising practice.

Assessment and help

Recommendations from the 2021 inspection report

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.

Summary of post-inspection review findings

The force's response and assessment of risk for missing children is inconsistent. Inquiries to find them aren't always effective enough and safeguarding action isn't always prioritised. The force's specialist missing team is under-resourced and officers use inefficient processes to record information about vulnerable children.

Information about missing children's vulnerability and risks to them is still not consistently recorded on force systems.

The force works with its safeguarding partners to reduce risks of exploitation to vulnerable children. In both local authority areas there are structured multi-agency child exploitation (MACE) meetings.

The force doesn't have accurate intelligence profiles or a clear strategy for CSE or CCE. The latest CSE profile was completed in September 2020.

The force isn't using its data on exploitation risk to direct resources effectively against child exploitation.

The force's risk assessment process for PPNs and referrals is currently effective. But arrangements for referrals to schools for children affected by domestic abuse are inefficient and ineffective.

Detailed post-inspection review findings

Analysis of children missing from home audits

We audited six children missing from home incidents. Of these, we assessed that the management of one incident required improvement and that of the remaining five was inadequate.

Staff didn't respond to the risk and safeguard vulnerable children effectively enough due to:

- initial risk being inconsistently graded;
- investigation plans being inconsistently recorded;
- inquiries not being supervised well enough;
- investigations being allowed to drift; and
- information about these incidents not being recorded fully and accurately.

The initial response to reports of missing children remains inconsistent

The force has clarified its policy so missing children should never be assessed as low-risk. They should be assessed as:

- high-risk, where the control room FIM will retain responsibility for the force's response; or
- medium-risk, where responsibility will be passed to one of the force's three area-based CIIs.

But we saw some incidents where reported missing children returned home before the force made a report on its system. These cases were closed as 'concern for safety' incidents. This means the records about risk to vulnerable children may be incomplete.

Call handlers complete questions to gather vital information to help find the missing child. To help inform the initial risk assessment, staff should also check force systems for warning markers and flags. Children identified by the force as 'priority missing' should have trigger plans containing information to help officers find them quickly.

We saw some examples of control room staff adding intelligence from the force systems to their risk assessments. But this didn't always happen. Sometimes this was because the information wasn't clearly signposted, and other times it seemed that the staff and their supervisors didn't have the skills necessary to find and assess this information.

We also saw records where there were delays in the time it took FIMs to assess missing children incidents and assign investigations to area-based CIIs.

The force doesn't have a 24/7 intelligence capability in the control room. This means that unskilled call operators have to make intelligence checks and assessments so these assessments may be incomplete or inaccurate.

Specialist intelligence staff aren't available to help control room staff and this can mean unskilled call operators make intelligence checks and assessments. These assessments may be incomplete or inaccurate. And high-risk cases can be assigned inappropriately to CIIs who don't have the skills and resources to fully check force systems and reassess risk levels.

CII risk gradings don't always consider all the relevant warning markers and flags on the force systems. And we saw that some CIIs use templated wording in their initial risk grading and when recording actions to find missing children. This means investigations aren't always based upon information relevant to the individual child's circumstances. We also saw inconsistency in how FIMs and CIIs recorded actions and the outcome. Reasons for delays in responses and investigation reviews aren't always recorded.

Case study: inconsistent risk assessment and investigation planning for a missing child

Children's home staff reported a 17-year-old boy as missing. He is regularly reported missing and is at high risk of criminal exploitation. But there is no trigger plan recorded on force systems to help find him quickly.

Control room staff completed an assessment, which included information that the boy is involved in county lines drug supply. Other warning markers indicated risks from firearms, carrying combat knives, mental health vulnerability, and suicide.

The incident was assigned to an area-based CII, who assessed the incident within an hour as medium-risk because of the boy's age. The CII's rationale didn't include all the information about his risk and vulnerabilities such as intelligence about his debt bondage from distributing drugs.

The CII allocated the investigation to find the boy to response team officers but didn't record specific lines of inquiry or actions. Their supervisory direction was superficial, and it meant a delay of over two hours before officers searched the boy's room for information to help find him.

On this occasion, the boy returned home by himself. Officers visited him and recorded information about the incident on a PPN, which resulted in a multi-agency child protection strategy meeting.

We saw records of CIIs using inappropriate victim-blaming language. For example, for a child who was frequently missing and at risk of criminal exploitation, the CII recorded: "This is not out of character for this child to go missing". In another report, for a 15-year-old girl at risk of criminal and sexual exploitation, the CII recorded: "She appears to engage in risky business".

The force hasn't improved arrangements for missing children well enough

Senior leaders are told about missing children in the daily management meeting when the force's three area commanders give updates about investigations, high-risk incidents and safeguarding concerns. This meeting provides a forum for leaders to review the force's responses and allocate additional resources to resolve open incidents.

The force has a small missing from home and exploitation team (MHET). The team is responsible for checking force records to make sure vulnerable children are referred to safeguarding partners that can help them. The MHET staff we spoke to are dedicated and hard-working. But the MHET doesn't have enough staff or resources to provide a consistently effective service.

MHET officers review every reported missing incident and work with children's social care services in a daily meeting. They share information from 'management of return' records completed by responding officers when children are found. But they don't supervise the quality of information within frontline officers' missing from home reports. The content of these paper booklets isn't supervised by line managers or the CIIs responsible for the investigations. Information from the booklets isn't recorded on the force's electronic systems, as the practice is to only scan and attach a copy. This is inefficient and it means the force doesn't quality control the information staff gather about risk to these children. And vital intelligence to help them in the future may be lost.

PPNs for missing children aren't always completed by response officers when other concerns are established. It means MHET staff often have to request that officers complete PPNs retrospectively.

There are often delays in receiving the information from children's services' return home interviews with children. MHET staff request the missing information, but this is an inefficient process. MHET and force leaders haven't escalated this problem to children's social care managers effectively enough.

MHET staff use standalone spreadsheets and master logs to record information about vulnerable children. This is inefficient and causes unnecessary duplication across three separate logs for missing children, exploitation risk and other safeguarding concerns. The MHET detective inspector told us they were trying to resolve this situation.

The force doesn't have a current intelligence profile or a clear strategy for CSE or CCE

The force told us it hasn't updated its CSE profile since September 2020. The information and analysis in that profile are police generated, are clearly out of date and don't represent the wider relevant information its safeguarding partners hold. But the force includes some CSE intelligence in its monthly area-focused contextual safeguarding reports.

This means there isn't a fully co-ordinated and comprehensive police or safeguarding partnership strategy to protect children or disrupt offenders. Individual officers and teams are working hard to protect children but their efforts are narrowly focused. Leaders aren't using data to understand where the critical risks are or to decide the level of resources they need and where to deploy these for best results.

It also means that locations where children are most at risk aren't identified quickly enough and operational resources to deal with the problems can be delayed. For example, we observed a meeting where a disused hotel was discussed because missing children were known to go there. This situation was clearly well known to meeting attendees – but no one had dealt with it. And a suggestion made in the

meeting to create a problem-solving plan was sensible, but this should have been dealt with earlier.

The force works with safeguarding partners to protect children from exploitation

North Yorkshire Police works with its safeguarding partners to reduce risks from exploitation to vulnerable children. In both local authority areas there are structured MACE meetings.

In North Yorkshire, these arrangements are clearly described in the safeguarding partnerships' *Multi-Agency Child Exploitation (MACE) and Contextual Safeguarding Strategy for 2020/23*.

For the City of York, the arrangements for MACE and risk management meetings are described in its children's safeguarding partnership arrangements document.

A series of multi-agency meetings are routinely held throughout the force area to discuss the best ways to help children who are vulnerable to exploitation. MACE meetings are held in local authority districts and chairing is usually shared between police managers and those from partner agencies. Partners use the same CCE and CSE risk assessment tool, which means improved joint assessment and better communication for those who attend several meetings.

The MACE meeting agendas are generally pre-arranged and are based on groups of children assessed as at risk. Some meetings include information about hotspot locations and perpetrators.

Local authority managers told us police MHET officers make a positive contribution to these meetings. Officers consistently attended meetings and the information they shared helped partners work to reduce the children's vulnerability.

We saw police officers sharing information about child exploitation perpetrators with other professionals. The force's 'perps on a plan' initiative establishes a useful way to gather and present information about suspected offenders. Information on these plans is regularly updated by an assigned police officer lead. And the plans are available to all other staff on the force's briefing system to build their knowledge of those who are a risk to children in the community. These plans are also used to inform partnership activity to disrupt offenders.

In Harrogate, a police sergeant works closely with the local authority community safety hub staff and has access to some systems. This information helps build a clearer picture of vulnerability and risk in the area and informs joint activity to prevent crime and help the community.

In Scarborough and Harrogate, police staff work closely with the local authority in No Wrong Door schemes that provide help and support to vulnerable children on the edge of care. This is a successful approach and provides opportunities to engage closely with children. This scheme helps reduce the number of times children go missing or are in the presence of people who may exploit them, therefore reducing risk.

The force isn't using its data on exploitation risk to direct resources effectively against child exploitation

We visited all the force's areas. Officers, their supervisors and managers from other agencies told us about their activity to reduce the risk of child exploitation. But there is little strategic oversight. Activity mostly relies on individuals using their initiative or responding to immediate incidents and concerns. Officers and managers told us there was some enforcement activity but it was mainly focused on county lines drug supply. We didn't find evidence that the police and its safeguarding partners were gathering and sharing information about child exploitation in a co-ordinated or systematic way. We asked managers about the force's performance management information for disruption and arrests of child exploitation offenders, but this wasn't available.

The force does have performance data, intelligence and information about child exploitation offences in its area. Safeguarding partners also hold relevant information, and the force should ask for this to be shared to help gain a clearer understanding of risk to children. But the force isn't assessing or using the information available to help it understand what is needed to reduce exploitation risks for children. This needs to change.

Officers are improving the quality of information on PPNs so referrals to help children are better

We saw officers use body-worn video when speaking to children at incidents where they had welfare concerns. The officers also followed the AWARE principles as they referenced the body-worn video, and this improved the quality of the information they referred to safeguarding partners.

The force's training programme has increased the number and the quality of the content of PPNs. In most cases we saw, officers recorded their concerns appropriately and without delay, and this helps vulnerable children get the help they need. In one case, the officer contacted the child's social worker directly to discuss their concerns. This meant a child protection strategy meeting was held without delay.

The VAT provides an effective triage and supervisory function for PPNs. The team works closely with safeguarding partners so they understand which PPNs need to be shared and where to send these.

But officers don't always record children's ethnicity on PPNs and VAT staff don't query this missing information. The force should make sure staff accurately record these details to help it identify children who, due to their ethnicity or cultural heritage, may be at increased risk of harm such as forced marriage, trafficking or female genital mutilation.

The force has an effective risk assessment process for PPNs and referrals

VAT officers are committed and professional and there are no backlogs in their system for processing PPNs. Due to the success of the force's AWARE training, the number of PPNs that VAT receives has increased. VAT staff told us they are concerned about their resilience to continue to meet this demand.

Children's social care service managers for both local authorities told us the VAT contributed to well-organised and effective multi-agency information sharing. And, when appropriate, VAT staff use partnership escalation processes to challenge them about decisions to help children get the best results. These partners complimented the improved quality of PPNs but also raised concerns about their ability to manage the increased number of referrals within existing resources. The VAT is essential to the force's approach to getting early help to vulnerable children and the leaders should make sure its operation is monitored to maintain its effectiveness.

The force relies heavily on its specialists in the VAT to complete all the quality assurance checks for referrals. Other supervisors aren't included in the process. This means that line managers don't have oversight of how well their own staff and officers understand child protection and safeguarding responsibilities. For example, we saw times when PPNs for missing children weren't completed or when they didn't contain enough detail about the child's vulnerability or the need to change a risk assessment.

The force needs to continue to work with its partners to make sure that referrals for contextual safeguarding and exploitation risks to risk management meetings are made at the right time to help vulnerable children.

We found the force wasn't consistent in where it stored information on its systems, such as the records of decisions and actions from strategy meetings. This makes it difficult for staff to quickly find and understand all the information they need to manage risks for vulnerable children. Leaders should provide clear guidance and check practice to make sure it is followed.

Referral arrangements to schools for children affected by domestic abuse are inefficient and ineffective

The force has arrangements in place to review and refer concerns about children affected by domestic abuse to the local authorities.

Most police forces now use an automated electronic system to tell schools and, sometimes, other agencies about children who are affected by domestic abuse. This system is often called Operation Encompass and is widely acknowledged as a vital part of getting help to vulnerable children.

But North Yorkshire Police isn't using automatic electronic notification systems. Instead, domestic abuse incidents are reviewed by officers and in some cases a telephone call is made to the children's school. A detective inspector told us that they personally made some of these calls. This means there are unnecessary delays in providing help and support to vulnerable children. And some calls may not be made at all because there is no system to check these are done. The current situation is very inefficient and potentially leaves children at risk.

Investigation

Recommendation from the 2021 inspection report

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.

Summary of post-inspection review findings

The force is increasing the number of trained detectives in specialist roles. The way investigations are allocated is better, but some complex investigations remain with inexperienced and unskilled officers.

The supervision of child protection investigations has improved but there are some inconsistencies.

There are excessive delays in obtaining digital forensic evidence.

The force works to improve staff awareness, knowledge and skills to respond more effectively to child exploitation.

There are multi-agency arrangements in place to review and assess exploitation risk to children. But the force needs a clearer strategy for reducing CSE risk.

Supervision of CSE investigations isn't always effective, so cases drift and safeguarding for all children isn't fully considered.

Detailed post-inspection review findings

Case audits

We assessed 11 investigations:

- three child protection investigations – two were good and one required improvement;
- two child sexual abuse investigations – one was good and one was inadequate; and
- six online sexual abuse investigations –- two required improvement and four were inadequate.

In the cases we assessed as 'inadequate', we found serious failures in practice that resulted in children being harmed or left at risk. Cases assessed as 'requires improvement' had elements of effective practice missing but no widespread or serious failures that left children at risk of harm.

We brought four investigations to the attention of force leaders because we were concerned that the force needed to do more to be assured that children were safeguarded. The force responded immediately and appropriately to these concerns.

The force plans to increase the number of trained detectives in specialist roles

North Yorkshire Police, like other police forces, faces significant challenges in keeping the numbers of trained and experienced detectives at the levels needed to investigate crimes competently. This is difficult because over 50 percent of the force's frontline officers, where specialists are often recruited from, have less than two years of police experience. An assistant chief constable chairs the force's strategic level people board and the head of learning and development chairs a quarterly skills and capabilities board.

Heads of departments are required to regularly update staff numbers and capabilities. They request additional staff and formal training needs annually as part of a costed training plan. The force is training significant numbers of officers as accredited investigators. In the year ending March 2023, 42 officers received College of Policing specialist child abuse investigation development programme training. And, for 2023/24, 2 more courses are already planned for a further 24 officers. The force is training additional supervisors to assess officers' progress on these programmes.

Investigating officers have received other relevant training, such as specialist interviewing, to improve their skills.

The way investigations are allocated is better, but some complex investigations remain with inexperienced and unskilled officers

The force has established a clear crime allocation procedure. A detective sergeant makes decisions to assign cases to teams for investigation. We saw that investigations where child abuse was obvious were allocated to appropriate investigation teams such as criminal investigation departments or the force's area-based investigation hubs.

Most frontline officers don't have the skills or the time to effectively investigate online child sexual abuse or CSE offences. Many frontline officers and their supervisors are inexperienced and don't have the knowledge or skills to understand how to secure forensic digital evidence, implement appropriate safeguarding measures and effectively deal with suspects. We saw this happen in some of the cases we reviewed.

Case study: ineffective safeguarding and missed investigative opportunities

A 14-year-old boy's mother reported that her son had shared naked images of himself on social media with an unknown girl. The girl had threatened to distribute these to two of his named friends unless he sent further images. The boy's mother said that her son was very upset and had talked about suicide.

Officers attended quickly because the call handler recognised the risk to the child. But neither the call handler nor the responding officers advised the mother to preserve the images and call data information on the boy's phone.

The responding officer spoke to the boy and his mother and recorded the incident on a PPN due to the boy's age. But the PPN didn't include details about the boy's trauma or his worries about his images being circulated on social media.

The family weren't told about support groups or materials, which are readily available on North Yorkshire's Safeguarding Partnership website.

The officer considered a subscriber check on the offender's username but didn't progress this because a colleague advised it wasn't possible without a screenshot from the phone. But the phone wasn't taken for evidential examination.

The victim's two friends were known to children's services, but no action was taken to speak to them or their parents about the incident or check on their welfare. Any information they may have had wasn't considered for this investigation. And they may also have been victims of crime in need of help. No PPNs were submitted for either of them.

Positively, a victim identification officer from the force's DFU added a message to the investigation log offering their assistance and how to request it. But this offer wasn't taken up and the investigation was closed by a supervisor.

We asked the force to review this incident and make sure that all the children were safeguarded. It responded positively.

Supervision of child protection investigations has improved but there are some inconsistencies

The force has introduced a template for supervisors to follow in investigations. Most of the investigation records we saw didn't include this template. However, we did find good records of prompt and meaningful supervision directing lines of inquiry and often safeguarding actions. These included making referrals to children's services and making sure that child protection strategy meetings were held without delay to progress effective multi-agency investigations to protect children.

We also saw good supervisory evidential reviews, which meant that investigations where children were suspects were finalised appropriately. This included investigations into online offences where sexual images were sent between children and where those children weren't unnecessarily criminalised.

But in some specialist and non-specialist investigations, supervision isn't always effective. And we saw wider safeguarding risk and that some lines of investigation weren't addressed.

Officers and their supervisors don't always recognise wider risks and vulnerability for both offenders and children when considering investigation priorities. This indicates a lack of experience and training to think beyond the immediate incident. Effective investigative plans and safeguarding strategies should consider wider risks and all the offender's potential victims.

Supervisors in the force's online abuse team use templates to record their directions and reviews. But we found PPN referrals weren't always sent to partners quickly enough. This can delay safeguarding for children.

In five of the six online abuse team investigations we audited, we found unnecessary delays in the time taken to inform children's services about the potential presence of children at addresses. Sometimes officers delayed making referrals until search warrants were executed. In one case, the supervisor inappropriately recorded their decision:

> "PPN to be completed once warrant executed, unable to do this in advance of the attendance at the property as we risk alerting the household and losing evidence".

This decision meant an unnecessary delay of 42 days from when the force had information that children were at risk of harm until they informed children's social care to start safeguarding activity.

Managers routinely audit a sample of investigations. They feed back their findings to officers and supervisors to help improve future performance. But this activity isn't yet making a sustained difference to the quality of investigations and the end results for all victims.

There are excessive delays in obtaining digital forensic evidence

It takes too long for the force's DFU to complete examinations and give the evidence to investigating officers. This problem appears to have got worse since our last inspection and it now routinely takes at least 12 months before forensic digital examinations are started.

In one case we reviewed, the lead time for the initial device examination was extended from 6 to 12 months. In many child protection investigations, digital evidence from suspects' or victims' computers or devices is critical to proving the offences. The delays in getting this evidence can lead to loss of victim confidence. Or, frustration with how the police and safeguarding partnerships protect children from harm. It may leave children at risk as the extent of the offender's activity and abuse can't be checked until the examination results are seen.

DFU staff told us they can progress cases as a priority. But in the case records we reviewed, we didn't see this process used or requested.

In one ongoing investigation into the rape of a child, the forensic examination of digital devices hadn't yet started six months after they had been submitted. Neither the investigating officer nor their supervisors had challenged or escalated this delay.

Positively, we saw the DFU's victim identification officers proactively scan crime records to find online child abuse cases that were investigated by non-specialists. They guide frontline officers on how to preserve digital evidence. And they help inexperienced investigators to identify suspects with open-source checks and inquiries with international policing organisations.

Victim identification officers message investigating officers, telling them who to approach for guidance on the technical aspects of these investigations. But unfortunately in two of the three cases where we saw these entries, the officers didn't respond to the offer of help.

Delays in getting evidence from digital devices and the workforce's lack of knowledge about online child abuse investigations are reducing the force's ability to safeguard children.

The force works to improve staff awareness, knowledge and skills to respond more effectively to child exploitation

In October 2022, the force reviewed and revised its policy for managing child exploitation risk. It also added guidance, linked to the AWARE principles, to its intranet to help the workforce better understand CSE risk and improve their approach to victims. This is helping promote professional curiosity and how the force records concerns for all children.

The force works closely with its statutory safeguarding partners and provides detailed information about multi-agency responses to exploitation risk on its intranet. This helps all staff to record information and make effective interventions and referrals.

The force uses flags and warning markers on its systems to provide information about CSE perpetrators and vulnerable children.

The force lead for exploitation has been accredited by the College of Policing to train officers to investigate modern slavery and human trafficking offences. This increases the force's specialist capability to help victims of exploitation and bring the offenders to justice.

There are arrangements to review and assess exploitation risk to children

MHET officers routinely review intelligence and information about all types of exploitation. Officers work alongside multi-agency professionals in risk assessment panels and they update force systems with information and risk management decisions. Any children assessed as at high risk of exploitation are included on the force's briefing system to alert frontline staff.

The MHET detective inspector co-ordinates the force's approach to disrupting those who exploit children. They use 'perp on a page' briefings to inform the workforce about the risk posed by CSE and CCE offenders in the force area. These suspects are flagged and assigned to a named local responsible officer (usually an area command inspector). The local responsible officer creates a '4P' plan to co-ordinate activity to reduce the perpetrator's risk. These plans are reviewed monthly to check they remain current and relevant to the assessed risk.

The force has created a pilot child exploitation team (CET) to help vulnerable children and victims of exploitation. The team has received training from multi-agency specialists in subjects such as understanding adverse childhood experiences. CET staff work closely with other professionals and volunteers to help vulnerable children and obtain information to disrupt offenders.

The CET told us they were concerned about the approach of some of their colleagues, who continued to treat some children who have been exploited as offenders. This shows some officers lack understanding about the consequences of exploitation for children and force leaders should address this.

The CET initiative has the potential to provide local multi-agency help to very vulnerable children. But because the team is formed of police community support officers there are limitations on their deployment. The CET also told us they don't have enough staff to cover all the work within their terms of reference. So, they felt they weren't as operationally effective as they could be.

Positively, the force commissions services to support families affected by child exploitation. When exploitation happens outside the family, referrals are made to the parents against child exploitation organisation. Some children aged between 10 and 18 who are at risk of, or are currently being, sexually or criminally exploited, and children who are repeatedly reported as missing are referred to the charity Hand in Hand.

The force needs to be clearer about how it reduces the risk of CSE

The force is working with its partners to tackle exploitation but more needs to be done if the response to CSE is to improve. Multi-agency child exploitation meetings are often focused on cases where the primary risk is criminal, rather than sexual, exploitation. And some meetings don't include children who have an allocated social worker although MHET staff told us these children may be included in the force's own meetings.

When responding to CSE, the force should make sure there is better communication and collaboration. For example, the CET doesn't routinely involve the MHET or the VAT. CSE risk can be difficult to deal with because of children's complex vulnerabilities and how perpetrators target their victims. But clear strategies and better management are needed to effectively co-ordinate resources and get better results. This is currently undermined by the lack of a CSE profile to inform strategy.

The force's proactive team, known as expedite, can be assigned to focus on disrupting CSE perpetrators, but we saw little evidence of this happening. Managers and their partners aren't using good performance data to make sure expedite staff consistently prioritise CSE perpetrators. The existing focus is mainly on CCE and particularly on drug supply linked to county lines activity.

Supervision of CSE investigations isn't always effective

Child sexual abuse including CSE is a priority for all police forces. This means extra scrutiny should be in place to make sure inquiries and safeguarding activity are prioritised, so children get the best end results.

Supervisors should review investigations promptly and make sure there are no missed evidential opportunities or unnecessary delays. They should put action plans in place to address any concerns, and these should be recorded and monitored.

But we found sergeants and inspectors weren't consistent in how they reviewed and progressed these investigations.

Case study: ineffective supervision hampers an active CSE investigation

A vulnerable 15-year-old girl known to be at risk of CSE reported that she had been raped by a local man she knew.

She was on a child protection plan and was frequently reported as missing from home. She had left her home one night in early June 2022 without her carers' knowledge to meet friends.

In the early hours of the morning, a 42-year-old local man approached the group of friends. He invited the girl back to his flat and she agreed to go with him. Once there he sexually assaulted and raped her.

Officers responded quickly to the call and did what they should to secure and preserve evidence. A supervisor gave good instructions and reviewed the initial investigation. The officer made a safeguarding referral on a PPN and a multi-agency strategy meeting was held without delay.

Officers arrested the suspect quickly and he was taken into custody. He made a comment that he would "never do anything like this as I have children of my own". This was recorded on the detention log but officers didn't follow it up, for example by checking if the suspect had access to children or submitting the information on a PPN.

The potential risk was overlooked by officers and their supervisors. The suspect was bailed with conditions not to contact the victim.

But the investigation stalled and supervisors didn't address this.

There were delays before the investigating officer submitted forensic samples for examination. The first forensic submission, made on 5 July 2022, was returned because the accompanying instructions were incorrectly completed. The forensic submission was eventually made in September 2022.

At the end of September, the force was told the examination results were inconclusive. Scientists advised that further tests could now be tried but a new evidential sample would need to be taken from the suspect.

On 18 October 2022, a detective inspector directed that new samples should be taken from the suspect and sent for examination. This happened in November 2022. But these were returned on 2 December 2022 because they had been submitted with the wrong forms.

On 13 December 2022, we reviewed this investigation and the evidence hadn't yet been resubmitted. Nor had the DFU examination of digital devices taken place. The suspect remained on conditional bail.

We asked the force to make sure that all potential risks to children had been addressed and it responded appropriately.

Decision-making

Recommendation from the 2021 inspection report

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.

Summary of post-inspection review findings

Officers protect children and take them to appropriate safe places.

Responding officers don't always investigate offences, but the force review makes sure these are identified and acted upon.

Record keeping about the use of police powers has improved but still isn't consistent enough.

Detailed post-inspection review findings

Case audits

We audited three incidents where police officers used their section 46 Children Act 1989 powers to protect children from significant harm. We assessed the officers' actions as 'good' in two of the incidents and 'requires improvement' in the other.

There is a good child-centred response

In each case, officers arranged for the children to be taken to appropriate places of safety and not police stations. Positively, we saw records of responding officers contacting children's services – including the emergency duty team – without delay. This is good practice because it allows multi-agency information sharing and joint working to help children.

After our last inspection, the force introduced new scrutiny oversight. The VAT detective inspector reviews every incident where these powers are used to protect children. They check all offences are identified and recorded and that records have been properly updated. This helps the force to make sure all safeguarding actions are completed.

Case study: officers protect children

A children's social care safeguarding manager called police because a school teacher reported a mother of two young children had attended to collect them while barefoot and very intoxicated. She was refusing to leave the school without her children. The children were currently on child protection plans because they were at risk of emotional harm.

Officers attended quickly, but the mother had already left when they arrived. The officers took the children into police protection and children's services arranged emergency care for them.

An inspector, acting as the designated officer, recorded the reasons for the police action clearly. The incident was recorded correctly on police systems. And a referral was made to children's services using a PPN, which included comprehensive information about the children and their views.

But the officers didn't investigate the mother's neglect and abuse of her children as they should have done. The force later recognised this omission and took appropriate action.

A monthly meeting is held to review cases and establish any opportunities for learning or good practice to improve future responses. A police superintendent attends with representatives from the two local authorities and other agencies. The force's partners told us that it was a useful and constructive arrangement because the managers bring their own agencies' perspectives.

Records about the use of powers to protect children are inconsistent

Responding and designated officers still don't consistently record the circumstances and rationale for taking children into police protection. In spring 2022, those performing the role of designated officers were briefed on recording this information. And in the three cases we audited, the rationale had been recorded. But we were told that the force's own reviews sometimes find the circumstances aren't recorded at all or there is little detail.

The force uses a Word document – police protection authorisation record – to record the use of police protection powers. But the police protection authorisation record isn't always saved in the same place on the force's system. Sometimes it is attached to the occurrence log and other times it is attached to the person record. This makes it difficult to access this information.

Designated officers are inconsistent in making records, particularly when handing over responsibility or when rescinding the use of the power. In two of the three cases we audited, the transfer between designated officers and the rescinding of police protection powers weren't recorded.

This means the force has no record of the rationale for the end of the use of power or the change in circumstances that means the child is now safe. If this isn't managed, the benefits of the power will simply drift until the statutory maximum 72 hours have passed. The end of the power should be a clear decision within an active child-centred multi-agency plan.

Positively, we were told the force is acting to change its systems so it is clearer for officers to record their use of police protection powers.

Managing those posing a risk to children

Recommendation from the 2021 inspection report

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

- how it records information on its systems;
- how it shares information with frontline officers; and
- how it shares information with children's social care.

Summary of post-inspection review findings

Officers record information about offenders on force systems to help manage responses to risk.

OMU managers aren't effectively supervising and directing staff activity. OMU staff are inconsistent in identifying and enforcing offences. This means an offender's behaviour may not be properly considered if there are future incidents or escalating concerns about the offender's risk.

OMU staff aren't consistently making referrals to children's social care because there are delays and misunderstanding about police responsibilities.

Detailed post-inspection review findings

Case audits

We audited six offender management cases:

- one was good;
- two required improvement; and
- three were inadequate.

We saw incomplete records and breaches of offenders' orders not recorded or enforced by officers. We also found delays in officers making referrals to children's services. And we found delays in the taking of safeguarding action, such as disclosure of an offender's risks to children's parents.

Registered sex offenders are recorded on force systems and information to help manage assessed risk is shared with colleagues and partners

The force's OMU is made up of three area-based teams, who work well with local partners such as the probation service officers. In York, OMU staff attend relevant children's social care meetings where there are concerns about offenders' contact with children. This is good practice and shows a commitment to multi-agency safeguarding.

OMU staff also brief frontline officers about registered sex offenders in their areas to give them the knowledge they need to protect the community and prevent crime.

The force and the National Probation Service jointly fund a member of staff to help inter-agency information sharing about offenders for both organisations. We saw evidence of effective joint working with probation services to complete visits to offenders and share information to improve risk management.

OMU staff make sure the way the force risk manages offenders' criminal and civil orders is consistent. They write the applications for civil orders. And they check custody records daily to make sure that applications for sexual harm prevention orders are attached to case files for those charged with relevant offences.

But there isn't a routine process to monitor when offenders are convicted by courts. This means the OMU isn't aware of the offender's requirement to notify unless the court sends the force a conviction certificate. We saw an example of a delay because the force waited for the offender to register with them, which was after a subsequent sentencing hearing.

OMU managers aren't supervising and directing staff activity effectively enough

A detective chief inspector and a detective inspector are responsible for OMU management, and individual detective sergeants lead the three OMU teams. We found OMU senior managers didn't do enough to review the performance and practice of these teams. And supervisors aren't required to support each other during absence, for example for training or holiday. Instead the supervisory work remains outstanding or falls to an untrained junior member of staff. This can result in poor decisions and inappropriate operational practice.

We found records of supervision on the violent and sex offender register (ViSOR) system used to hold risk management plans. But too often these entries are superficial with basic comments such as "seen", "noted" and "agreed" being used without considered rationale or endorsements.

Too many OMU staff aren't ViSOR trained. Despite this, their managers allow them to use the system. Officers are doing their best, but there are inconsistencies in how information is recorded, and the system won't be used to its full potential. For example, the ViSOR actions section isn't used effectively to track the result of any

activity taken to manage the offender's risk. And we saw inconsistent use of the ViSOR relationship section for recording information about friends, family and associates. This reduces understanding about offender behaviour and opportunities to assess new information against existing knowledge.

Ideally, where appropriate, visits to offenders should be unannounced. But we found offender managers often made announced visits to offenders. And on many occasions managers complete home visits alone. This doesn't align with national guidance and puts officers at risk of grooming and manipulation by offenders. It also reduces the opportunities for extensive inquiries and checks to be carried out.

Offender managers routinely ask offenders to attend their offices for interviews. This means offenders can prepare and plan for meetings and potentially hide incriminating or inappropriate material. And it means the risk assessments may be inaccurate and evidence of escalating risk or criminal offences may be missed.

We saw OMU staff scheduling offender visits on a monthly or quarterly timetabled format. This is against national guidance, which recommends offender visits are planned according to the assessed risk of individual offenders.

It is a statutory requirement for registered sex offenders to make registration notifications to the police at designated police stations. But we found that OMU staff sometimes allowed these to take place at the offender's home or even by telephone. This is poor practice and means that breaches may be unenforceable in the future.

OMU staff aren't consistent in identifying and enforcing offences

Offender managers don't consistently record details of offenders' electronic devices or information about which devices they check during home visits. This means that the force doesn't have accurate records of offenders' online activity.

We saw records where offender managers identified offences, such as breaching sex offender registration conditions. But sometimes these offences weren't recorded as crimes. And supervisors didn't make sure this always happened. This suggests offender managers lack investigative skills to focus on offences. Supervisors and managers should deal with this problem and solve it through training and performance management measures.

Offenders aren't always given written or oral warnings in a consistent way. And these aren't recorded with clear rationale on force systems where they can be seen by others. Failing to record these offences and breaches correctly means an offender's behaviour may not be properly considered if there are future incidents or escalating concerns about their risk.

Case study: ineffective offender management

A registered sex offender, convicted of several sexual offences against girls, was passed by the probation service into police-only management when their supervision licence expired.

The offender made a late notification about changing his address to live with his mother. The offender manager didn't record this crime or deal with the offence.

The offender manager made a home visit and completed the new registration on the offender's behalf. This should have been done by the offender in person at a designated police station.

The offender manager completed a risk assessment and management plan later in an arranged appointment with the offender at a police station. It would have been better practice for two offender managers to make an unannounced visit to the offender's home to complete these tasks.

In a later home visit, the manager found that the offender had breached his sexual harm prevention order by getting a new mobile phone and not notifying the police of it. The offender manager didn't act to enforce this offence or record it as a crime. This wasn't addressed by a supervisor.

OMU referrals for concerns about children to children's services aren't consistent

Offender managers and their supervisors are inconsistent in recognising potential risk and safeguarding children. They also don't consistently make prompt referrals to children's services or disclosures to adults who can protect children such as parents and carers.

Case study: inconsistent OMU safeguarding practice

A registered sex offender convicted for having indecent child abuse material was known to have access to his family's and other friends' children.

Offender managers had previously warned him when he deleted his internet search history, so his behaviour was already of concern.

Despite discovering he had contact with the daughter of his new partner, managers delayed for two days before they informed children's services about their concerns. And they were slow to make sure the child's mother knew about the offender's risk.

We also found there were additional concerns about the offender's access to his nephew and it took two weeks for managers to check that this child was safe. These concerns were never recorded on a PPN or shared with children's services.

Police detention

Recommendation from 2021 inspection report

We recommend that within three months North Yorkshire Police reviews how it manages the detention of children. The force should do this jointly with children's social care 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 children's social care services, when needed; and
- monitor how well the force works with its partners, and the support it gives children.

Summary of post-inspection review findings

This inspection didn't inspect custody arrangements for children in North Yorkshire because between 27 June and 8 July 2022, we completed a joint inspection visit to police custody suites in North Yorkshire with His Majesty's Inspectorate of Prisons and the Care Quality Commission. That inspection report is published.

Next steps

North Yorkshire Police still needs to improve some areas of its work to provide consistently better outcomes for children. There has been some progress, particularly in the way the force has trained its workforce to identify children's vulnerability and make good safeguarding referrals. Staff in the force control room have also made improvements so they are better at identifying risk and providing the right level of response to help vulnerable children.

Despite progress against some of our recommendations, the force has yet to make all the progress necessary to complete its action plan.

The force is developing performance monitoring and its governance systems, so it is clear leaders fully understand what still needs to be done.

As part of our routine monitoring of all police forces, we will continue to evaluate North Yorkshire Police's performance against these recommendations and instigate closer scrutiny if needed.

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