HMICFRS

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

National Child Protection Post-Inspection Review

Bedfordshire Police
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Introduction

The 2017 inspection

In July 2017, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)[1] conducted a child[2] protection inspection of Bedfordshire Police.

In November 2017, we published the report of our findings. This concluded that Bedfordshire Police demonstrated a strong commitment to improving its services for the protection of vulnerable children, and this was visible at all levels of the force – from the chief constable to frontline officers and staff. We met specialists[3] responsible for managing child abuse investigations who were knowledgeable, committed and motivated. There were examples of good work by individual frontline officers who responded to incidents involving children.

However, we also found inconsistencies and areas requiring improvement (in some cases as a matter of urgency) to the force's provision of its services to children. This was particularly the case for children who were exposed to domestic abuse, those who went missing, and those at risk of sexual exploitation. Some of the weaknesses were attributed to ineffective and inefficient processes. However, many came from the difficulties of managing increasing demand on the force's specialist teams.

We also highlighted the poor standard of record-keeping and supervision throughout the force's child protection areas. This was compounded by an inconsistent understanding of the effect of cumulative and escalating risk to children, particularly those who are exposed to domestic abuse. The lack of supervision in many investigations meant that officers did not realise that children were at risk, and the force lost opportunities for early intervention.

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[1] During this inspection, on 19 July 2017, HMIC also took on responsibility for fire and rescue service inspections and was renamed HM Inspectorate of Constabulary and Fire & Rescue Services. The methodology underpinning our inspection findings is unaffected by this change. References to HMICFRS in this report may relate to an event that happened before 19 July 2017 when HMICFRS was HMIC. Citations of documents which HMIC published before 19 July 2017 will still cite HMIC as the publisher.

[2] 'Child' in the report refers to a person under the age of 18.

[3] Bedfordshire Police has several specialist teams responsible for protecting children: the child abuse vulnerable adult abuse team, the child sexual exploitation and missing investigation team, the public protection unit support hub, the 'emerald team' for investigating domestic abuse and serious sexual offences, the violent and sexual offender management team and the internet child abuse investigation team.

The force also needed to make sure that children in custody were not detained unnecessarily. Despite the efforts of the chief constable to work with local authorities to improve the provision of alternative accommodation, custody officers and staff were still making requests for the wrong type of accommodation, resulting in children remaining inappropriately in police custody.

We concluded that senior leaders were committed to improving outcomes for vulnerable children. But although the force had made some improvements, these had not yet resulted in consistently improved outcomes for all vulnerable children. The force needed to do more to improve its safeguarding practices and protect those children most at risk of harm.

The report of the 2017 inspection made a series of recommendations aimed at improving child protection practice by Bedfordshire Police in relation to children affected by domestic abuse, children missing from home, child sexual exploitation and children in police detention.

The 2018 post-inspection review

In November 2018, we conducted a post-inspection review to assess the progress the force has made against our recommendations.

The review included:

- an examination of force policies, strategies and other documents;
- interviews with officers and staff; and
- an audit of 37 child protection cases focused on the recommendations from the 2017 inspection.

Post-inspection review – summary of findings

Bedfordshire Police has taken steps to improve safeguarding practice and outcomes for vulnerable children.

The force has reviewed the structures, systems and processes it has in place to recognise and respond to children in need of help and made changes to make them more effective. It has also introduced better and more innovative training to make sure that members of the workforce are more aware of the signs that a child might be vulnerable.

We found this meant that officers and staff had a better awareness of their safeguarding responsibilities. The quality of information the force exchanges with other agencies about children at risk has also improved.

Bedfordshire Police recently updated its computer systems. This has created some difficulties for officers and staff as they familiarise themselves with new processes

and ways of recording information. We were pleased to find that the force recognised quickly the problems this caused (such as a decrease in the number of child protection referrals), and took effective action to resolve them.

However, we found that some areas of practice remain poor and require improvement. We remain concerned about the detention of children in police custody. We found the consistency and accuracy of information recorded on children's custody records is still variable, as is the force's understanding of the role of appropriate adults.[4] A failure to recognise and respond to risk means that children might not be provided with appropriate support and care while they are detained.

We found that where specialist units deal with either high-risk missing children or investigations, there is generally a good response to locate the child. But within some case records, where there were clear signs of risk and children were vulnerable to sexual exploitation, we found there were delays in the force sending referrals to the local authority. In some cases the record of strategy meetings (where a joint safeguarding plan is agreed) was poor, with no evident actions or outcomes. This meant it was often unclear what safeguarding plan, if any, was in place to safeguard a child at risk.

We also found that the work of child protection officers was difficult to manage because of high workloads and problems with staffing levels. We were told that of 12 officers assigned to investigate child sexual exploitation (CSE), only seven officers were in post. Five of these officers have been assigned full-time to protracted non-recent sexual abuse investigations. This means the capacity of staff to investigate incidents to the appropriate high standards is reduced.

The multi-agency safeguarding hubs (MASHs)[5] are the main focal points for exchanging information throughout the force. The police staff in the MASH exchange large amounts of information with partners for the most part quickly and efficiently. However, there are no supervisors from the force working with the team. As a consequence, opportunities to contribute to joint decision-making and to develop protective plans at the earliest stage are missed. This is because such decisions need to be referred back to the force in order to obtain the agreement of a supervisor.

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

[5] The MASH is a hub in which public sector organisations with responsibilities for the safety of vulnerable people work together. It has staff from organisations such as the police and local authority social services, who work alongside one another, exchanging information and co-ordinating activities, to help protect the most vulnerable children and adults from harm, neglect and abuse.

Procedures in the force contact centre (FCC) for responding to children missing from home, especially those who are regularly reported as missing, have been improved. Up-to-date trigger plans[6] are available to help in finding missing children.

Bedfordshire Police has consulted with partners as part of its review of child protection and used this feedback to change its approach. We found the force was increasingly using the skills of non-police professionals to help in tackling domestic abuse, CSE and children missing from home. This approach has allowed police officers to focus more on activities which only they can carry out. It has also given the force opportunities to engage with and support children's homes to reduce repeat missing episodes from a small number of children, and the associated demand on response policing.

Since our initial inspection Bedfordshire Police and its senior leaders have clearly prioritised making progress against our recommendations. We were pleased to find evidence of improvements being made and some innovative work taking place to improve the protection of children. The force recognises that it still needs to improve in some areas. It understands what is required for a consistently good child protection response for the community it serves, and it is working hard to achieve this. However, the capability and capacity of specialist child protection teams remains a significant problem. Until these teams are fully resourced, the force will not be able to make the progress it wants as quickly as it would like to.

[6] A trigger plan is a police force document outlining the plans to find a child quickly when he or she goes missing.

Post-inspection review findings

Initial contact

Recommendation from the report of the 2017 inspection

> HMICFRS recommends that within three months Bedfordshire Police ensures that it improves the quality of information recorded by officers (including their observations of a child's behaviour and demeanour) in records of domestic abuse incidents so that better assessments of a child's needs are made.

Summary of post-inspection review findings

In 2017 frontline officers told us about their confusion as to when they should submit a 'child at risk' form. This lack of understanding led to information being inconsistently recorded, or not recorded at all.

Bedfordshire Police has taken clear steps to promote an improved service and response to families affected by domestic abuse. The force has introduced new training and body-worn video to make sure officers and staff are better able to recognise and respond to children at risk from domestic abuse. Additional training and an internal 'Think-CHILD' communications campaign is leading to a better sense of awareness about vulnerability and more child-centred approaches from officers and staff.

Detailed post-inspection review findings

Since 2017 Bedfordshire Police has provided the College of Policing's vulnerability training for all its workforce. It has also established the 'Think-CHILD' internal communications campaign, which encourages officers and staff to consider the incident they are dealing with from a child's point of view. The campaign also sets out the benefits to the child of this approach and promotes a support network for officers and staff that can be accessed for advice and help. Newly recruited officers now also receive additional training about the effect of domestic abuse and how to respond effectively to victims and children who witness domestic abuse. As a result, we found that frontline officers and staff were more aware of their safeguarding responsibilities.

Force control room staff have now been trained to identify if a caller is vulnerable as soon as they make contact, and in using THRIVE[7] risk assessments to evaluate risk and prioritise the response accordingly. We also found that control room staff now have ready access to supervisors for direction and advice.

Since our July 2017 inspection the use of body-worn video has been required at all domestic abuse incidents attended by the police. This is positive because it allows a record of the behaviour of victims and children and how they engage with police, which can then be used to assess risk. This means that the quality of information recorded at domestic abuse incidents is significantly improved.

In addition to further training, police leaders have used the Think-CHILD campaign to reinforce the drive and commitment to improving the service provided to families affected by domestic abuse. This campaign encourages officers to speak with children and record in greater detail the thoughts, feelings and wishes of children exposed to domestic abuse. This type of information allows child protection specialists to make a better assessment of the effect of the often-routine exposure to domestic abuse some children experience.

The 'Relay' referrals system (which alerts schools when police attend a domestic abuse incident at the home of one of its pupils) has been enhanced since the previous inspection. Additional research is now conducted by the police, which is leading to better assessments and protective planning. This is good practice and is highly valued by schools and other safeguarding partners.

In May 2018 Bedfordshire Police introduced the Athena IT system. Implementation and technical problems led to a decrease in the number of 'Relay' referrals (from an average of between 15 and 20 to only 6 or 7). Partners were concerned about not receiving information about children who are vulnerable or at risk and raised this as a concern with the force. We were pleased to find the force responded quickly, and 'Relay' referrals are now at previous levels.

When the force finds evidence of good practice, it praises this and publishes details on the intranet to bring this good work to the notice of all its workforce.

[7] The threat, harm, risk, investigation, vulnerability and engagement (THRIVE) model is used to assess the appropriate initial police response to a call for service. It allows a judgment to be made of the relative risk posed by the call, and places the individual needs of the victim at the centre of that decision.

One evening in May 2018 a radio dispatcher in the force contact centre answered a 999 call from a terrified young boy. His father was hitting his mother and the boy didn't know what to do.

The dispatcher could hear the boy's father shouting and his little sister crying. The dispatcher reassured the boy and kept him as calm as possible with advice prioritising the safety of the children. The dispatcher asked the boy to take his sister into a bedroom and to lock the door if possible. The dispatcher asked the boy to take responsibility for his sister, which the dispatcher thought would help to keep him calm and focused. The dispatcher reassured the boy that the incident wasn't his fault, speaking as calmly as possible. This became even more difficult when the father started to kick the bedroom door, demanding to be let in. The dispatcher told the boy that he didn't need to speak and just to listen, so that the father didn't realise that the boy had phoned the police.

The dispatcher stayed on the phone and gave the boy updates on where the police response car was by telling him the names of local landmarks, so he understood where the police car was. He was asked to stay by the window so that the police officers could see him and his sister as soon as they arrived. This information was also passed to the response officers.

The intranet article personalised the story for the audience by including the dispatcher's comments that it had been one of the hardest calls they had ever dealt with, but as they were a parent of a child of a similar age they had thought about how they would have wanted their own child to be treated.

Assessment and help

Recommendations from the report of the 2017 inspection

HMICFRS recommends that Bedfordshire Police immediately undertakes a review to ensure that the force is fulfilling its statutory responsibilities as set out in *Working Together to Safeguard Children*. As a minimum, this should include a review of referral processes to ensure that risk is being identified effectively and shared in a timely manner with external agencies.

HMICFRS recommends that, within three months, Bedfordshire Police improves its practice in cases of children who go missing from home. As a minimum, this should include:

- improving officers' and staff awareness of their responsibilities for protecting children who are reported missing from home, particularly for those children for whom it is a regular occurrence;
- improving officers' and staff awareness of the links between children going missing from home and the risk of sexual exploitation; and

- enabling the information on children's trigger plans to be accessible or made available to all officers and staff to make tracing missing children more effective.

Summary of post-inspection review findings

In 2017 we found the public protection unit (PPU) support hub had a significant backlog of standard-risk domestic abuse incidents awaiting assessment. Many of the referral forms lacked quality and sufficient detail. There were also multiple ways in which information could be exchanged with partner agencies. This was inefficient, created delays in exchanging information and impeded the ability of officers and staff to assess escalating and cumulative risk. This meant that the identification of children who needed assessment and help was not consistent and, in some cases, the PPU support hub failed to make child protection referrals.

Since then, Bedfordshire Police has examined how it can improve joint working arrangements and referral processes. The project management team held a series of multi-agency workshops to review the referrals process. The current system was mapped, which exposed inefficiencies in processes, including delays and duplication. A series of MASH-focused meetings followed, which developed the workshop findings further and developed a series of proposals for improvement for senior leaders to consider. The force identified that a single cross-Bedfordshire referral process including a single MASH would be more efficient and would support better and more timely decisions. The results of these meetings have not yet been finalised and agreed with partners, but one positive achievement is an agreement for a standard MASH form to be used throughout the county. This is a significant decision, and we are encouraged that multi-agency planning focusing on better referral systems has taken place.

Detailed post-inspection review findings

Bedfordshire Police's staffing arrangements for the local authority-based MASHs have not changed since our initial inspection. Staff are attached on a rotating basis from the PPUs. But no police supervisors are present in the MASHs because they remain based within the PPUs. The lack of police supervisors in a MASH can slow down decision-making for the partnership, including the ability immediately to address questions about whether a threshold for statutory intervention has been reached or assigning cases for priority action. This is because the police staff currently working in the MASH cannot make these decisions without the agreement of a supervisor.

The Athena IT system went live in Bedfordshire in May 2018, and for child protection this replaced all existing police systems and formats. Officers should submit all

referrals about vulnerable children on an Athena report regardless of whether a crime has occurred.

After the force introduced Athena, the number of referrals made by the police to the local authority decreased, from an average of 13 per day to an average of eight per day. The force identified this problem and addressed it by providing workforce briefings and feedback, supported by intranet messages from chief officers, and by distributing a pocketbook guide for officers.

We were told that problems with the handheld devices frontline officers and staff use to link to the Athena system contributed to the decrease in referrals. The force is monitoring this to make sure referrals for vulnerable children are not overlooked. This is positive but inefficient and the force should seek a permanent technical solution.

The current force process is for the PPUs to triage all police referrals (within 24 hours) before sharing them with the relevant MASH. The process involves a risk assessment which assigns a status to each referral. On one day during our inspection we found 19 referrals awaiting assessment; these were all less than 24 hours old, which is positive. However, those cases that have not been shared remain 'open' for additional research. This only takes place when there is capacity to complete the checks and reassess risk. There was a backlog of 78 of these cases at the time of our revisit, the oldest being from August 2018.

This means that although a single low-risk incident has been shared, the broader context of risk may not be recognised because the police have not yet made their checks of other standard risk cases related to the same child or children. This limits the ability of those receiving the referral to recognise that there is some cumulative, escalating or hidden risk and to respond accordingly. A swifter response to such referrals would help police officers and social care workers to identify vulnerability more quickly and recommend appropriate intervention.

A revised and comprehensive partnership approach to tackling children missing from home is now in place. This is a priority area for the force and it has established a regular multi-agency gold group[8] to co-ordinate internal and partnership activity. It is chaired by the detective chief superintendent and attended by senior representatives from the three local authorities, from the Office of the Police and Crime Commissioner and the youth offending service. A further senior-level meeting focusing on missing children also now takes place. The director of children's services from one of the local authorities chairs this meeting, which is supported by a

[8] A gold group is a meeting designed to add value to the police response to an internal or external incident, crime or other matter. This involves bringing together appropriately skilled and qualified internal or external interested parties who can advise, guide or otherwise support the management of an effective response to the identified incident, crime or other matter.

multi-agency operational CSE and missing group. The force weekly tactical partnership meeting now reviews high-risk missing children and co-ordinates resources to support and protect these children.

Every response officer has received COMPACT[9] training. This includes raising awareness about the links between missing children, CSE and other criminal exploitation. The force asked the National Police Chiefs' Council lead for missing people to lead a peer review so that the force could reassure itself that it was following best practice.

Bedfordshire Police has improved its management of trigger plans (which are used by forces to more quickly locate a missing child). These plans are managed by the CSE and missing investigation team (CMIT) and are accessible to duty supervisors in the FCC. Each trigger plan is reviewed every two weeks by a CMIT officer. We saw that trigger plans are clearly referenced in incident logs and were directing activity and informing the risk assessment. FCC staff use 'THRIVE' risk assessments routinely for real-time prioritisation and management of each missing child case. However, there are still some delays in the timeliness of FCC inspectors reviewing incidents which involve missing children. We also found that on some occasions where the FCC graded missing incidents as 'immediate', there could be delays in officers being deployed if other 'immediate' incidents were prioritised.

The response to those children who are reported missing is still inconsistent. In most cases when there are CSE or other obvious high-risk concerns for missing children there is a good response. In one missing case we saw, the return home interview was of an outstanding quality, but in other cases the recorded information was superficial. In another case we reviewed, there were CSE concerns for a missing 'looked after' child (a child in the care of the local authority) from a different force area. The child's current placement was due to the continued potential risk of harm in the other force area. We were concerned because there was a delay in sending officers to see her and check her welfare.

The CMIT is responsible for tracing all medium-risk missing children following receipt of the initial report. Our case audits found evidence of good practice but also areas that still required improvement. Mostly, the team investigates cases to a high standard, with good supervisory oversight. However, we saw only limited evidence of timely strategy meetings being held for children who go missing regularly.

[9] COMPACT is a missing persons case management system used within many UK police forces.

The force has continued to develop its use of Operation Makesafe[10] and has extended this to include fast-food outlets. Police officers and staff and environmental health staff make joint visits to businesses and staff in hotels and some nightclub door staff have been trained to recognise the signs of CSE. It has been agreed that taxi licences will not be issued until drivers have undergone CSE training.

A 15-year-old boy had been reported as missing from home. He was known to be vulnerable and to have links to gangs. He had entered a hotel with an adult and was taken to a room where four other children had also been taken. The hotel staff were concerned and followed the Operation Makesafe protocol by contacting the police. This resulted in the police attending and intervening to protect the missing boy and the other children.

The force has employed a specialist missing co-ordinator, tasked with reducing the number of instances of children being repeatedly reported as missing from local authority care and children's homes. This work has helped the force to challenge poor practice and has contributed to the closure of one children's home which was being inadequately managed. This is positive and reflects the commitment of the force to improve.

Investigation

Recommendations from the report of the 2017 inspection

HMICFRS recommends that, within three months, Bedfordshire Police improves its child sexual exploitation investigations, paying particular attention to:

- improving staff awareness, knowledge and skills in this area of work;
- ensuring a prompt response to any relevant concern raised;
- improving the oversight and management of cases to ensure that standards are being met; and
- ensuring that referrals and investigations conducted by ICAIT are prompt and effective.

[10] Operation Makesafe is a project to highlight the responsibilities of the community to report any concerns of CSE. It particularly focused on businesses like taxi companies and hotels to raise awareness of staff members.

HMICFRS recommends that within six months Bedfordshire Police improves its investigations into domestic abuse and children affected by it. As a minimum this should include:

- improving processes to ensure that investigations are timely and that all opportunities to mitigate risk are exploited (e.g. domestic violence prevention notices/orders); and
- ensuring that specialist staff and officers are appropriately trained to apply safeguarding measures effectively for children affected by domestic abuse.

Summary of post-inspection review findings

In our initial inspection we had concerns about the quality of some investigations (those related to CSE and domestic abuse) and the effectiveness of supervision.

A review of the internet child abuse investigation team (ICAIT) led to changes to how it operated, so that it could concentrate on children who might be at the highest risk of harm. In our last inspection we were concerned that when the ICAIT suspects indecent images are being viewed or distributed from an address, a referral to children's social care is not being made (in cases where children are present) until a search warrant has been executed. We were pleased to find that this is no longer the case. Referrals are now made once it is known that children are at an address, rather than waiting for a search warrant to be executed. This is a positive step. Strategy discussions now take place at a more appropriate stage of the investigation.

The force's policy for domestic abuse follows the nationally recognised 'Safelives' guidance to refer all high-risk cases of domestic abuse to a multi-agency risk assessment conference.[11] We found that the force has increased its use of the domestic violence disclosure scheme (DVDS) to protect victims of abuse.

However, despite evidence of some progress, workforce shortages and high workloads are undermining the overall effectiveness of the force's response to children at risk from domestic abuse.

[11] A multi-agency risk assessment conference (also known as a MARAC) is a locally held meeting of statutory and voluntary agency representatives to exchange information about high-risk victims of domestic abuse, to which any agency can refer an adult or child whom they believe to be at high risk of harm. The aim of the meeting is to produce a co-ordinated action plan to increase an adult or child's safety.

Detailed post-inspection review findings

Our case audits found varying quality within investigations. Investigations conducted by members of the CMIT are of a better standard, but referrals to children's social care for strategy meetings were not always timely. Delays can lead to less effective interventions for victims of crime. We also found the quality and timeliness of information on police records was inconsistent. This was compounded by a lack of meaningful supervision. Records of multi-agency strategy meetings were often poor, with little or no evidence of any agreed actions and outcomes. This means that police records are often unclear about the details of a multi-agency plan to safeguard children at risk of CSE.

Bedfordshire Police understands the benefits of close joint working with children's social care for investigating CSE and have arranged for a social worker from each of the three local authorities to be based one day a week within the CMIT. We were told that this project had improved relationship-building with some children who had been reluctant to engage with support services, and had reduced the number of children assessed as being at high risk.

We were told that the force was investigating four large long-running CSE enquiries and this was affecting its capacity to deal with other cases. Senior managers had recognised this weakness and told us that recruitment to fill the vacancies was in progress.

Bedfordshire Police has increased the number of detectives working in the ICAIT. The force has also changed working practices, so that strategy discussions take place at an earlier stage, and social workers are present for the execution of warrants to support children and families. A dedicated intelligence officer is responsible for developing investigation packages and checking information, so that the presence of any children who might be at risk can be established as quickly as possible. The previous backlog of work has been much reduced, and we found no outstanding high-risk cases.

The emerald team was established to provide victims of domestic abuse with an enhanced service. However, we found that the team was significantly below strength and this caused some delays to investigations. The full team was intended to include 70 officers, made up of detective constables or trainee investigators. We were told there were currently 35 in the team, supported by 21 student officers (newly recruited officers undergoing initial training) on attachment to the team. Consequently, investigators have high caseloads. Detective constables have 18–20 investigations and police constables 10–12 investigations at any time. Higher workloads contribute to delays and drift in investigations. This means that decision-making and protective plans do not always lead to better outcomes for vulnerable children.

We were told that although the presence of student officers in some cases added to the work and responsibility of supervisors in the team, they returned to frontline duty with an enhanced understanding of vulnerability and better investigative skills.

The shortages of investigators meant that there were delays in dealing with some of those suspected of committing domestic abuse. The force's weekly tactical meeting considers high-risk cases and assigns additional resources to locate the suspect. At the time of our inspection there were 110 outstanding domestic abuse perpetrators, 13 of whom were assessed as high risk. This is an improvement on our initial inspection, but is still of concern and unlikely to improve given the continuing staffing problems.

The emerald team includes five victim engagement officers who bring additional professional knowledge and experience from other safeguarding backgrounds. These officers complete safeguarding visits, maintain contact with victims and other support workers, make referrals and attend some strategy meetings and case conferences. This releases some time so that other officers can concentrate on investigations.

In addition to police training, all officers also complete a local authority domestic abuse course and some attended a specialist course on the effect of domestic abuse on children.

We were told that following the 2017 inspection Bedfordshire Police promoted the use of both domestic violence prevention notices (DVPNs) and the domestic violence disclosure scheme (DVDS) or Clare's Law. The result was that the daily management meetings discussed all suspects who were in custody for domestic abuse offences, and considered if DVPNs should be issued. We noted that there has been a significant rise in DVDS 'right to know'[12] applications. This is positive. However, the force could not demonstrate a similar increase in the number of DVPNs, which means that further work is needed.

Type of notice	2017/18	2018/19 (7 months)
DVPN	37	20
DVDS	39	67
Right to know	5	31

[12] The domestic violence disclosure scheme (Clare's Law) has two functions. The 'right to ask' enables someone to ask the police about a partner's previous history of domestic violence or violent acts and the 'right to know' allows police to proactively disclose information in prescribed circumstances.

Bedfordshire Police understands the importance of passing information to schools and educational establishments about children who have been affected by domestic abuse. This allows school staff to support and meet the needs of these children in a timely way.

Police detention

Recommendation from the report of the 2017 inspection

> HMICFRS recommends that, within six months, Bedfordshire Police should, in conjunction with children's social care services, review how it manages the detention of children. As a minimum it should:
>
> - ensure that all children are only detained when absolutely necessary and for the absolute minimum amount of time;
> - ensure that officers and staff in the custody suite assess at an early stage a child's need for alternative accommodation (secure or otherwise) and work with children's social care services to achieve the most appropriate option for the child;
> - ensure that custody staff comply with their statutory duties to complete detention certificates if a child is detained for any reason in police custody following charge;
> - ensure that custody staff make a record of all actions taken and decisions made on the relevant documentation; and
> - improve the timeliness of adequate appropriate adult support for children who are arrested.

Summary of post-inspection review findings

In July 2017 we found that some children were detained unnecessarily in police custody when the Police and Criminal Evidence Act 1984 (PACE) required that alternative accommodation[13] should have been found.

Bedfordshire Police's chief constable has written to each local authority chief executive to highlight the critical gap in the provision of alternative accommodation for these children. The chief executives said that there was some confusion in the force about the different types of accommodation available for detained children, and the circumstances in which police officers should ask for it. Two local authorities

[13] Police and Criminal Evidence Act 1984 (PACE) Code C (Detention, treatment and questioning of persons by police officers).

have now made provision for accommodation for detained children, but this resource has not yet been used.

Despite work to improve understanding, such as additional training and the recirculation of 'the concordat'[14] to all members of the workforce, custody officers are still uncertain in some cases about when they should ask for alternative and secure accommodation, and the threshold required for each. In two of the cases we assessed, custody officers had authorised the detention of a child without sufficient grounds to meet either the requirements of PACE codes of practice or the concordat guidance.

Detailed post-inspection review findings

We saw some good practice. During office hours staff members from the youth offending team visit detained children to provide intervention and support.

All custody officers and custody staff now receive continuing professional development training. This training includes child protection and the workforce's responsibility to be more focused on the best interests of the child while carrying out their duties.

Bedfordshire Police reviews the circumstances of all children who have been detained overnight. They are reviewed each morning by a chief inspector with responsibility for custody and notified to the assistant chief constable who has responsibility for custody throughout the three-force collaboration of Bedfordshire, Cambridgeshire and Hertfordshire. In the daily evening management meeting, the duty superintendent also reviews any detained children.

If, when charged with an offence, a child is to be denied bail and detained, the local authority is responsible for providing appropriate accommodation. Only in exceptional circumstances (such as during extreme weather) would the transfer of the child to alternative accommodation not be in the child's best interests. In rare cases – for example, if a child presented a high risk of serious harm to others – secure accommodation might be needed. The law does not recognise or allow for a situation where a child remains in police cells despite secure accommodation not being required.

Custody officers routinely contact the local authority social work emergency duty team at an early stage to establish the availability of alternative accommodation for children who may potentially be kept in custody. But it is still the case that very few children are transferred to such accommodation. In some cases, this is because foster carers may refuse to take a child because of the nature of the offences for

[14] *The concordat on children in custody. Guidance for police forces and local authorities in England on their responsibilities towards children in custody* (last updated June 2018).

which the child is in custody, or any potential risks the child may pose to the carers and their households. In cases where alternative accommodation is not provided by the local authority, the force does not review its decision to deny bail and as a consequence children continue to be unnecessarily detained in police custody.

Work is continuing in the multi-agency partnership to increase the availability of suitable accommodation on these occasions. The force gives the local authorities the details of cases where the force has made requests that have been refused, or where no accommodation was available, so that the local authorities can better understand the demand.

Officers completed juvenile detention certificates[15] as required in all the cases we saw where a child had been charged with a criminal offence and detained in custody overnight to await the next available court session.

We saw cases in which the inspectors' reviews had been made while the detained child was either asleep or in interview. Our review of the detention logs in these cases showed no records of officers having spoken to the child to tell them about the review. Custody staff told us that it was routine practice for a healthcare professional to see all detained children, but we did not see these events recorded on any of the custody records we audited. Bedfordshire Police has not yet sufficiently addressed our recommendation that custody staff should record on the relevant documents all actions they have taken and the decisions they have made.

We had previously seen long delays in appropriate adults attending in order to support children in custody, and this has contributed to the length of time children spend in detention. We again found long delays in appropriate adults attending, and this was generally timed to facilitate the child's interview. In only two of the eleven custody cases we audited did the appropriate adults attend within reasonable timescales for the needs of the child. In most of the cases there was insufficient explanation on the custody record to explain the delays.

[15] Section 38(6) of the Police and Criminal Evidence Act 1984.