

National child protection inspections

**Northamptonshire Police
27 January–7 February 2025**

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Overall summary

Our judgments

Our inspection assessed how good Northamptonshire Police is at [safeguarding children](#) who are at risk. Our graded judgments are as follows:

Outstanding	Good	Adequate	Requires improvement	Inadequate
	Working with safeguarding partners	Leadership of child protection arrangements	Responding to children at risk of harm	
		Risk assessment and referrals	Investigating child abuse, neglect and exploitation	

HM Inspector's summary

I am pleased with some aspects of the performance of Northamptonshire Police in safeguarding children at risk, but there are some areas in which it needs to improve.

We found [chief officers](#) and senior leaders make sure there are enough [officers](#) and [staff](#) to provide effective safeguarding services for children and their families.

The force has a range of measures to support the well-being of its officers and staff who work in child protection roles.

It contributes well to multi-agency child protection arrangements and works productively with its [statutory safeguarding partners](#). The force also collaborates well with partner agencies to carry out prompt and regular [risk assessments](#) of children at risk of, or harmed by, exploitation.

The force has detailed [problem profiles](#) to support its understanding of the risks to children.

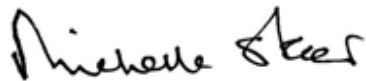
But there are some areas in which the force needs to improve. The force should make sure its strategies and policies prioritise the need to protect children, and that officers and staff understand their responsibility to safeguard children and promote their welfare.

This includes recording children's concerns and views and making sure this information is always shared quickly with safeguarding partners.

The force should improve how it assesses risks and responds to children reported [missing](#) from home and other incidents where children are at risk of significant harm. It should make sure officers recognise children as [victims](#) when they are exposed to [domestic abuse](#) and protect them accordingly.

The force needs to improve child protection investigations by making sure it carries out better joint working with its statutory safeguarding partners.

I was reassured that the force responded promptly and comprehensively to our feedback during this inspection. It has already put some plans in place to address the areas in which it needs to improve. I will continue to monitor its progress.



Michelle Skeer

HM Inspector of Constabulary

Introduction

About us

His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) independently assesses the effectiveness and efficiency of police forces and fire and rescue services, to make communities safer. In preparing our reports, we ask the questions that the public would ask, and publish the answers in an accessible form. We use our expertise to interpret the evidence and make recommendations for improvement.

Child protection and our inspections

Children are among the most [vulnerable](#) in society. Most children grow up in loving, caring families and reach adulthood unharmed. But some don't – they fall prey to people who coerce them into criminal enterprises or exploit them for sexual gratification. Children who don't grow up in loving, caring families face heightened risks, as do children who go missing from home.

These things are well known. Public services, including the police, have a shared responsibility to look for the warning signs, be alert to the risks and act quickly to protect children.

In February 2024, we introduced a new child protection rolling inspection programme. For each police force in England and Wales, we make five judgments on how effectively the force safeguards children at risk.

Our inspection findings are intended to provide information for the police, [police and crime commissioners](#) (and mayoral equivalents) and the public. The expectations of agencies to safeguard and promote the welfare of children are set out in statutory guidance: '[Working together to safeguard children 2023](#)' and '[Wales safeguarding procedures](#)'.

In each inspection, we focus on the experiences of children who come into contact with the police when there are concerns about their safety or well-being.

Terminology in this report

Our reports contain references to, among other things, 'national' definitions, priorities, policies, systems, responsibilities and processes.

In some instances, 'national' means applying to England and Wales. In others, it means applying to England, Wales and Scotland, or the whole of the United Kingdom.

Leadership of child protection arrangements

Adequate

Northamptonshire Police's leadership of its child protection arrangements is adequate.

Areas for improvement

The force should make sure its strategies, policies, guidance and toolkits are relevant to the risks affecting children, and it should clarify the responsibilities of officers and staff to safeguard children and promote their welfare

In December 2024, Northamptonshire Police introduced its strategic plan. The priority themes for its [officers](#) and [staff](#) are:

- neighbourhood crime;
- serious violence;
- [serious and organised crime](#);
- [vulnerability](#) and exploitation; and
- violence against women and girls.

However, we found the force couldn't demonstrate how it was prioritising the protection of [children](#).

The force's Vulnerability Strategy 2025 made no reference to providing a [child-centred](#) service or any references to child protection priorities.

Child [sexual abuse](#) is defined as a national threat in the [Strategic Policing Requirement](#). But the force's strategies and plans don't mention child sexual abuse.

[Section 3 of the Domestic Abuse Act 2021](#) requires forces to recognise children who are exposed to [domestic abuse](#) as [victims](#). The force couldn't demonstrate how it met this requirement.

It didn't follow the [College of Policing](#) approved professional practice '[Understanding risk and vulnerability in the context of domestic abuse](#)'.

For example, it didn't consider:

- that children are eligible to access services under [The Code of Practice for Victims of Crime \('the Victims' Code'\)](#);
- the use of appropriately trained officers to work with the child, and gather their evidence through [achieving best evidence](#); or
- keeping children updated on investigations.

We found that officers and staff weren't always clear whether child protection was a priority for the force.

As a result, officers and staff didn't always focus on the child when making decisions about their lives. For example, the force took seven days to respond when they received a report that a child had been assaulted by his mother. Officers spoke with the child, but they didn't share any information with children's social care services or make sure the child was safe.

The force needs to make sure that its officers and staff consistently record the voice of the child (including the child's behaviour and demeanour) and effectively share this with its safeguarding partners

The force has encouraged its [officers](#) and [staff](#) to speak with the [children](#) they meet and record their views, concerns, and experiences. But we found [personnel](#) didn't always speak to the children. And, in 17 of the 49 cases we reviewed, they didn't record the [voice of the child](#).

These included cases where children were [victims](#) of crime, but the force made no effort to see or speak to them.

Speaking with children, observing them, and noting their demeanour and behaviours helps everyone protecting and supporting the child to better assess their needs.

In addition, we found the voice of the child wasn't consistently recorded on [public protection notices](#), which the forces uses to share information. This means its [safeguarding partners](#) may not have all of the information they need to make decisions in children's best interests.

Main findings

In this section we set out our main findings that relate to the force's leadership of its child protection arrangements.

The force has child protection governance arrangements, but senior leaders don't use performance information to improve outcomes for children

An assistant chief constable has responsibility for the force's leadership of vulnerability, which includes child protection. This makes sure that there is leadership at chief officer level.

In December 2024, the assistant chief constable chaired the first child vulnerability board. Prior to this the force vulnerability board focused on adults and children. The decision to separate the meetings reflects the chair's recognition of the force's need for a greater focus on child protection performance.

The assistant chief constable reports to the force executive meeting. The deputy chief constable chairs the meeting.

The force child protection working group and the domestic abuse working group oversee operational activities. Senior leaders who have safeguarding experience chair both meetings. They report to the vulnerability boards.

Force performance relating to child protection is available through the force's [protecting vulnerable people \(PVP\)](#) dashboard. We found this had detailed records that included who is responsible for child protection investigations, the investigation length and information identifying children most at risk of harm.

All relevant senior leaders, officers and staff can access the dashboard. Analysts also use it to provide performance information to governance meetings. However, PVP senior leaders didn't share this performance pack across the leadership team, and it wasn't used in meetings to hold leaders to account.

We found that the PVP senior leaders used leadership meetings to discuss the workloads and welfare of staff members in their teams. They didn't discuss either qualitative or quantitative performance information. This means they can't be sure their expectations are being met and can't hold officers and staff to account for their performance. Without using the performance information, chief officers don't have good oversight of how effective their child protection services are.

This finding remains consistent with [our PEEL 2023–2025 inspection of Northamptonshire Police](#) in respect of leadership and force management.

Senior leaders told us they had recognised the gaps in performance management and were introducing new performance meetings within the PVP command.

The force is mostly good at recording children's ethnicity, but issues with force systems means it can't effectively use this information

We know that the recording of ethnicity of victims and suspects is a challenge for forces nationally. Following our PEEL 2023–2025 inspection, the force had taken steps to improve this. It set up a working group to check on the quality of its data recording, to oversee additional training for officers and staff and to explore ways of improving its IT system.

We were pleased to find that in most of the cases we reviewed, the force's records included information about the child's ethnicity. This helps officers and staff more accurately assess the risks to children. It also makes it easier for the force to analyse how risks differ for certain groups of children, based on their cultural heritage.

However, we found that officers and staff often recorded ethnicity on one part of a record and not on another. For example, some personnel recorded the victim's ethnicity on the person's record, but not on the record of a crime they have reported. This means that analysis of types of crime and their victims may be flawed.

At the time of our inspection, chief officers were aware of these recording and reporting practices and were working to resolve them.

Chief officers and senior leaders make sure there are enough officers and staff to provide effective safeguarding services for children and their families

In 2024, the force recognised that the demands on specialist resources dealing with crimes committed against vulnerable people were too high. Consequently, it reviewed and increased the number of officers and staff working on those cases. It also increased the number of managers and senior leaders overseeing that work.

We found that the child abuse investigation unit had enough officers and staff to carry out effective investigations. This was also the case in the specialist child exploitation hub, which is a multi-agency team that identifies and supports children at the highest risk of [criminal](#) or [sexual exploitation](#).

Officers and staff in both these teams deal with the most complex and serious offences against children and require specialist training and skills to get the best outcomes for children.

The force had identified that detective constables and detective sergeants in those teams should have [specialist child abuse investigation development programme](#) accreditation. We found the force had a good understanding of which officers were accredited and which were working towards it.

We were reassured that the force provided additional support to newer or inexperienced officers. It allocated them less complex investigations as they worked towards their accreditation.

The force provides good training for its officers and staff, but we found isolated cases of officers and staff using victim-blaming language

The force has made sure the curriculum for new recruits covers matters which may affect how they deal with children. This includes an understanding of [adverse childhood experiences](#), [victim-blaming](#) language, voice of the child and the importance of submitting public protection notices (PPNs).

The force also provides further training on domestic abuse and understanding [controlling or coercive behaviour](#). Officers and staff take part in an immersive training event dealing with a domestic abuse incident when a child is present at the home.

The force supplements this training with [continuing professional development \(CPD\)](#) events. The events cover subjects such as using the AWARE mnemonic (appearance, words, activity and behaviour, relationships and dynamics and environment) to help officers better record the voice of the child. The events also explain the effect of victim-blaming language.

Although we saw some evidence of officers using such language, these were isolated cases. In one case, we saw a supervisor challenge an officer's use of victim-blaming language in a crime report.

The force has a range of measures to support the well-being of officers and staff who work in child protection roles

The force provides good well-being support services for its officers and staff. It has recognised all roles in the PVP command as high-risk roles. This means it schedules counselling appointments for officers and staff every two months. These appointments allow them to discuss the effect of their work on their well-being. If the counselling identifies that officers and staff have increased needs, the force offers additional support services.

Most of the officers and staff we spoke with told us that they also discussed their welfare during regular meetings with supervisors.

We found the PVP senior leadership team meetings included detailed discussions about the well-being of individual officers and staff. Human resource advisors were present to provide advice and guidance.

In addition, the force also has a peer support and employee assistance programme.

Following significant or traumatic incidents, such as the sudden or unexpected death of a child, the force supports its officers and staff by using the [trauma risk management](#) process.

Most of the officers and staff we spoke to who work in PVP roles told us they were aware of, and happy with, the well-being support offered to them.

Working with safeguarding partners

Good

Northamptonshire Police is good at working with safeguarding partners.

The expectations of agencies to safeguard children are set out in statutory guidance: 'Working together to safeguard children 2023' and 'Wales safeguarding procedures'.

The framework for how forces and statutory safeguarding partners should effectively protect children is set out in the following primary legislation:

- [Children Act 1989](#)
- [Children Act 2004](#)
- [Social Services and Well-being \(Wales\) Act 2014](#)
- [Children and Social Work Act 2017.](#)

Statutory safeguarding partners have a legal duty to work together, and with other local partners, to safeguard and promote the welfare of all children in their area.

Northamptonshire Police is a member of Northamptonshire's [safeguarding children partnership](#).

Within this partnership the force is an equal partner with the two local authorities and Northamptonshire integrated care board.

Promising practice

A partnership team uses data from community safety and other partner organisations to support early intervention work with children who may be at risk of harm or exploitation

The Observatory is a partnership team which gives the force access to data from community safety and other partner organisations. It has analysed 350 police records for under 25-year-olds to identify events throughout their lives that have resulted in contact with the police and other partner agencies. This includes school attendance levels and exclusion, involvement with children's social care services, [antisocial behaviour](#), gang and drug-related activity and serious violence.

The data analysis identified links between these events and the possibility the [children](#) may be exploited, harmed by or involved in criminal offences.

The Observatory uses the information to add [flags](#) to the police systems which monitor children's records. Analysts at the Observatory use multi-agency data to recognise events that may lead to criminality for children. This then helps the identification of children at risk at an early stage so they can be referred for partnership support.

When an [officer](#) is alerted that the child they are in contact with may be at risk of further harm, they talk to the child and their family about a referral to the [Youth Justice Services](#) 'Turnaround' programme. This could give the child support to prevent future harm.

Force data suggests this approach has been successful in protecting children from harmful behaviour that may have taken place without the early identification and support.

The force's Operation Satin helps to prevent children from going missing from home

Operation Satin aims to build trust with [children](#) who have been [missing](#) and their families, identify their support needs and any risks they may be exposed to. This helps [officers](#) to develop plans to reduce the risk of the child going missing from home again.

The force employs a specialist early intervention worker to work alongside its missing people team.

They can advise children and families about where to get help. They also carry out work with them, where relevant, about:

- knife crime;
- child exploitation;
- managing and understanding emotions;
- healthy and unhealthy relationships;
- [adverse childhood experiences](#); and
- parenting support.

Between November 2023 and November 2024, statistics provided by the local authority showed that when compared against the force data, a child visited by an early intervention worker at an early stage was more than 5 times less likely to have a further missing episode.

Main findings

In this section we set out our main findings that relate to how well the force works with safeguarding partners to help safeguard, protect and promote the welfare of children.

The force understands its statutory responsibilities to safeguard children

Four times a year, the chief constable meets with lead safeguarding partners from the Northamptonshire children's safeguarding partnership. This gives them a shared understanding of local needs and how the services work together to safeguard and promote the welfare of children. It demonstrates the chief constable's understanding of his obligations as set out in '[Working together to safeguard children 2023](#).'

An assistant chief constable is the delegated safeguarding lead and represents the force at the delegated safeguarding partners group.

We found that officers and staff who represented the force in the various partnership arrangements were sufficiently senior and knowledgeable to contribute to discussions and make decisions.

During this inspection, we spoke to senior leaders from the statutory safeguarding partnership. They all spoke positively about the force's commitment to working in partnership to achieve better outcomes for children in their communities. They also described strong working relationships and the positive role the force had in helping develop the partnership over several years.

All of the senior leaders knew, and had regular contact with, senior police leaders in their area. They described being able to easily contact the force to resolve issues, if necessary.

The force works with local and national partner organisations to identify learning but doesn't do enough to make sure it improves practice.

The force has a team of dedicated review officers. These officers represent the force and contribute to joint practice reviews, such as those about adult safeguarding, domestic homicide or child safeguarding.

The team monitors for incidents and investigations which may require the local authority to make a referral to the [Child Safeguarding Practice Review Panel](#). When they see cases which fit the criteria, they formally report them to the relevant local authority. The team is then responsible for contributing to the partnership decision to make a referral, carry out a rapid review and jointly analyse the findings. Leaders in the partnerships spoke favourably about the team's contribution.

The review officers record learning for the force on an action plan. The deputy chief constable is responsible for making sure that learning improves the force's performance.

Strategic leads for specific areas of work, such as domestic abuse or child exploitation, are responsible for making sure that learning is included in training, guidance and CPD events.

The force has carried out some quality assurance analysis with its safeguarding partners. This includes joint audits of practice and an examination of the force's use of [police protection](#) powers.

But the force couldn't demonstrate whether learning from reviews had led to improved practice. It doesn't carry out specific quality assurance or audit activity after training, CPD or when it makes changes to its policies and guidance.

The force should, with the support of its safeguarding partners, make sure that the learning identified in these reviews becomes part of future practice.

The force works with care providers to better safeguard children who are reported missing from children's homes

The force has analysed which care providers children are most likely to be reported missing from.

Officers and staff in the missing person investigation unit work more closely with these care providers to better understand why the children go missing. They then agree working practices, similar to the [Philomena protocol](#), to make sure the force and care providers understand each other's responsibilities. This means the care staff provide a suitable response before reporting the child missing to the police.

When children go missing regularly, the force and the care providers agree joint plans to try to reduce the number of times this happens. They also work together to develop [trigger plans](#) for children so they can be found more quickly.

In all four of the cases we reviewed when a care provider reported a child missing, the carers had already carried out the agreed activities. The force told us this approach has reduced the number of missing child incidents reported to the police for children living at these homes.

The force, with safeguarding partners, has invested in a specialist role to better support families when their child has died

Positively, the force has supported the funding of the safeguarding children's partnership child death co-ordinator role. This means a trained clinician can provide care and support to bereaved families who have experienced a child death. The clinician also supports officers in working with families at such a traumatic time.

The force shares information promptly with schools to help children get support

When school-aged children are exposed to domestic abuse, the force shares information with the child's school through [Operation Encompass](#). The force uses an automated process which means this information is shared with the school before the next school day begins. This should help to make sure children receive support when they most need it.

The force told us it is working with its safeguarding partners to improve the process further. Together they intend to make sure that the information has enough detail to help the school understand the best way to support the child.

The force has broadened this information sharing scheme to include children who are, or have been, reported missing from home.

Responding to children at risk of harm

Requires
improvement

Northamptonshire Police requires improvement at responding to children at risk of harm.

Areas for improvement

The force should improve how it assesses risks and responds when children are reported as missing from home or at risk of significant harm

We found that when the force correctly identifies that [children](#) who are reported [missing](#) are at high risk of harm, it takes prompt and effective action to find them quickly. However, it doesn't always grade the risk correctly. This means the force can't always act quickly enough to find missing children.

We examined six cases when children were reported missing. In three of these cases, the force had information which indicated the children were at high risk of harm. But the [force control room](#) supervisor incorrectly graded the children as medium risk. While the children remained missing, other supervisors reviewed the cases, but they didn't challenge or correct the grade.

In 4 of the 6 cases, the force took between 4 and 12 hours to deploy [officers](#) to start the investigation to find the children.

We also reviewed six cases where children were at risk of significant harm. In two of these cases, although force control room [personnel](#) had recognised the risk was high, there were delays sending officers to check the children were safe.

In one of these cases, it took the force ten days to see a child after the initial report. When officers did attend, they correctly used their protective powers to remove the child from harm.

The force needs to make sure officers and staff responding to domestic abuse recognise children as victims and protect them from further harm

We found the force's response to [domestic abuse](#) wasn't sufficiently [child centred](#).

[Section 3 of the Domestic Abuse Act 2021](#) requires [children](#) to be treated as [victims](#) of domestic abuse when they see, hear or experience the effects of domestic abuse, and they are related to the [abuser](#) or the abused person.

The [College of Policing approved professional practice](#) sets out what this means for police forces and how they should act. For example, the police need to consider the full range of existing legislation (including relevant offences) and [safeguarding](#) procedures to protect children.

We found [officers](#) didn't routinely see and speak with children who were present when they attended domestic abuse incidents. Therefore, they didn't record the [voice of the child](#). And they were unlikely to fully understand the children's experiences. This means the force couldn't share this information with its [safeguarding partners](#).

We also found officers didn't always consider if there were children in an extended family. This could leave them at risk from an offender. We are aware the force has been doing work to support officers to identify children in extended families and this should continue.

Officers and [staff](#) didn't routinely consider using protective powers such as [bail](#) conditions, [domestic violence protection notices](#) and the [domestic violence disclosure scheme](#) to protect adult and child victims.

This makes it more difficult for the force and its safeguarding partners to make decisions and take action to protect children.

Main findings

In this section we set out our main findings that relate to how well the force responds to help safeguard children at risk.

Children, and people acting on their behalf, can easily contact the force

The force's website explains how people can make reports to the police, including crimes, or concerns affecting children. It has a web page about child abuse which provides specific advice for children to help them report matters to the police. It also has guidance about how children can get help from other services.

The force control room (FCR) has an online reporting portal and live chat service. This is positive because we believe children may be more likely to communicate with the force in this way. However, the service is only monitored between 7am and 8pm.

The force has worked with the local safeguarding children's partnership to produce promotional material for use in a campaign which helps professionals and parents to identify when children may be at risk from exploitation. The campaign includes details of the force's website and how to report concerns to the force or its safeguarding partners. This helps people understand what to look out for and how to report their concerns quickly.

The force's initial risk assessments don't always result in an appropriate response

Officers and staff in the FCR carry out [threat, harm, risk, investigation, vulnerability and engagement \(THRIVE\)](#) risk assessments to prioritise the force's response to incidents.

An [intelligence](#) development team supports officers and staff in the FCR. The team carries out research to help the force have a detailed understanding of risks when it responds to incidents. This team can be assigned incidents, such as when a child at high risk of harm is reported missing. The team also monitors incidents to identify cases it can help with.

We saw several examples when the research provided extra information which helped to prioritise the force's response when children were at risk.

However, when the force received reports that children were missing, it didn't always recognise the level of risk the child faced.

Specialist officers and staff support risk assessments when children are reported missing, but they don't see all cases

Officers and staff in the specialist missing person investigation unit completed comprehensive and accurate risk assessments for reports of missing children.

We saw they corrected risk grading decisions which staff in the FCR had got wrong. They also directed or carried out prompt activity to find children. They worked closely with other teams, such as CID, to support the investigation.

Case study: Specialist missing person supervisor quickly and correctly identifies risk to children and supports a focused investigation to find them

On a summer afternoon, a member of staff at a children's home reported to the police that a 17-year-old girl who lived at the home was [missing](#). The staff member told the [force control room](#) staff that the last time the [child](#) was missing she had been found in a man's flat and had been there for four days. The caller also said that she thought this child might be with another 14-year-old girl who was also missing, but she wasn't sure.

The [intelligence](#) development team searched police systems and identified that 6 months earlier the 17-year-old child had been a [victim](#) of stranger rape and she remained at high risk of harm from [sexual exploitation](#). An earlier record on the police missing person system also identified the child as being at high risk of harm.

A force control room supervisor reviewed the incident and graded the 17-year-old girl as being at medium risk of harm, recording that this was due to the time of day and that the child was believed to be with another young girl. During the same incident, the 14-year-old child was also graded as being at medium risk of harm.

Several hours later, another supervisor reviewed the incident and supported the grading of both children as medium risk. There was a delay of several hours before [officers](#) began to look for both children. They didn't find them.

The following morning, the inspector from the specialist missing person team quickly identified the children as at high risk of harm, referencing the information on police systems previously identified by the intelligence staff.

The inspector completed an investigation plan, setting actions for officers to complete to locate the children quickly.

Later the same day, the police found the children and established that, while missing, they had been given drugs and alcohol.

When the specialist missing person team is off duty, the force has a poorer response to reports of children who are missing. The team doesn't work overnight. This means that when children are missing and found during the night, the risk grading is more likely to be inaccurate.

The inaccuracies in risk grading mean the force can't rely on its data to help it understand which children are most at risk.

Officers and staff carefully consider when to use their protective powers to safeguard children, but this needs better oversight

The force recognises that it is a very serious step for a police force to use its emergency power to take a child into police protection. Senior leaders told us they have done a great deal of work to make sure officers use police protection powers appropriately.

Having assessed the need to take immediate action, attending officers used their powers appropriately to remove children from harm's way. In the six cases we examined, officers made well-considered decisions to take a child to a place of safety. They did this in the best interests of the child.

Officers also quickly contacted children's social care services to begin joint planning which helps better joint decision-making, again in the best interests of the child.

This power should be overseen by the [designated officer](#), who should be at inspector level or above. The designated officer should do what is reasonable for the purpose of safeguarding or promoting the child's welfare. This includes considering the length of the time the child is under police protection.

It also includes making sure they are aware of the child's wishes and feelings. The designated officer should consider and allow contact between the child and their parents or carers when it is reasonable and in the best interests of the child.

We found designated officers' records weren't always good enough. Important details were missing or incomplete, such as when the police protection had ended or been rescinded. In some records, there were no details of who the designated officer was. The force was aware of this and had worked to improve its practices by providing guidance to those fulfilling the role of designated offer. Consequently, we did see an improvement in the more recent cases we examined.

Assessing risk to children and making appropriate referrals

Adequate

Northamptonshire Police is adequate at assessing risk to children and making appropriate referrals.

Area for improvement

The force should remove unnecessary delays in sharing information with safeguarding partners

[Officers](#) and [staff](#) in the [multi-agency safeguarding hub \(MASH\)](#) are responsible for reviewing all [public protection notices \(PPNs\)](#) that officers and staff submit when [children](#) are at risk of harm.

If the person completing the form has missed information, MASH personnel return it to them to complete properly.

If the child is at high risk of harm, MASH personnel share the information they have with children's social care services so prompt action can be taken to protect the child.

If the child isn't identified by MASH as being high risk, they don't share the PPN with partners and it is sent back to the officer for more information. MASH personnel told us they found it could take up to two weeks for officers to respond to the request.

We sampled eight PPNs which the MASH team hadn't yet shared with the force's [safeguarding partners](#). The PPNs had been returned to the submitting officer to add further details. In these cases, we found that the child was at high risk of harm and the force should have shared the information without delay.

The force didn't have scrutiny or oversight of the reasons for decisions to delay information sharing.

Main findings

In this section we set out our main findings that relate to how well the force assesses risk to children, and makes appropriate referrals.

The force provides training, guidance and tools to assess risk and manage responses to children

The force provides information and guidance about risks to children in its initial training for FCR officers and staff. A senior officer from the PVP command also provides training at CPD events. This includes information about child protection topics.

The force has also published guidance about risks to children on its intranet. This is easy to access and contains useful information and links about [child sexual exploitation](#), neglect and child death. This helps officers respond more effectively when dealing with child safeguarding matters.

To support non-specialist investigators, the force has set up weekly 'detective surgeries'. A detective sergeant attends a police station each Wednesday to review cases, answer questions and provide support to frontline colleagues. Some of the investigations are cases that involve children, such as online child sexual exploitation.

All neighbourhood, response officers and supervisors we spoke to talked positively about these sessions and told us how the detective sergeants had provided them with advice and guidance on their investigations and case files. The officers used the surgeries when they needed help or had questions in cases they, or their supervisor, may not have dealt with before.

Officers told us that, in addition to these surgeries, they found specialist officers were helpful in supporting them with advice about investigations.

The force's multi-agency safeguarding hub has enough officers and staff to help it share child protection referrals promptly

At the time of our inspection, we found the force had allocated enough resources to its MASH. Officers and staff in the MASH told us they prioritise PPNs relating to children. However we did find delays in some children's cases and we have highlighted this as an [area for improvement](#).

In most cases, senior leaders have good oversight of the MASH. They use the PVP dashboard to understand demand and the timeliness of processing PPNs. But the force needs to do more to better recognise the risk to children in cases where PPNs aren't shared with partners promptly. This will make sure it has oversight of how all MASH processes are operating.

We found that officers and staff working in the MASH had a good understanding of what information to share. They knew what services were available for children and families. This helped them to make sure children receive the right support at the right time.

However, the force doesn't provide the officers and staff working in the MASH with specific training for their role. They are expected to contribute to [strategy discussions](#). These meetings take place to decide how to investigate allegations of child abuse and whether a [joint investigation](#) is needed. This is an area for improvement for the force we discuss in more detail in the section [Investigating reports of abuse, neglect and exploitation of children](#).

The force has detailed problem profiles to support its understanding of the risks to children

The force has commissioned several problem profiles to make sure it understands the nature and scale of crimes and issues affecting children. These include missing children, domestic abuse and child criminal and sexual exploitation. We were encouraged to see that the force asked for and used information from its safeguarding partners and shared the completed profiles with them. This helps to create a better joint understanding of risk to children in Northamptonshire.

Notwithstanding the data quality problem we reported earlier (see section on [Leadership of child protection arrangements](#)), having these problem profiles means the force can better understand which children or groups of children are at most risk. This includes where exploitation most often takes place and the different types of child exploitation happening in local areas. This has had a positive effect on how the force tackles child exploitation. For example, the child exploitation problem profile informed the force's decision to create its specialist child exploitation hub.

However, the force didn't use the perpetrator flagging function in its IT system. This could help the force identify known or suspected child exploitation offenders. This meant officers and staff attending incidents may not have known essential information when assessing risks to children.

We highlighted this to the force during our inspection. It responded quickly and began work to make sure suspects and offenders could be easily identified on the force's IT systems.

The force collaborates well with partner agencies to carry out prompt and regular risk assessments of children at risk of, or harmed by, exploitation

The child exploitation hub has specialist officers who carry out criminal investigations. A disruption team also carries out prevention and disruption activity to better protect children at risk of, or harmed by, exploitation. This team uses intelligence to identify suspects and make arrests when victims don't recognise they are being exploited.

Similar to the approach of [Operation Makesafe](#), force personnel work with local hotels to make sure their staff can spot signs of exploitation and report it. They also carry out patrols in high-risk areas to prevent children from being harmed or exploited.

The child exploitation hub holds a weekly multi-agency triage meeting. In this meeting, professionals review cases of children who are at risk of being exploited. Prior to the meeting the professional who knows the child best completes a risk assessment called a child exploitation risk assessment form (CERAF). The attendees discuss the form's content and together decide the level of risk and how to minimise it.

When all partners have a joint understanding of the exploitation risks faced by the child, professionals make a joint grading decision which relates to both the level and imminence of that risk. The child exploitation hub is responsible for children at the highest level of risk, and neighbourhood teams are responsible for those children considered less at risk.

Officers in the hub chair a daily risk management meeting about children at risk of, or harmed by, exploitation. Representatives from children's social care services and the youth offending service attend this meeting. They discuss children who are currently in custody, incidents reported in the last 24 hours which involve children, and the cases of children reported missing from home.

We found there was good information sharing in the meeting. Safeguarding partners held each other to account to make sure agreed activity was carried out.

Case study: Child exploitation meeting supports better multi-agency understanding of risk to children

We observed a daily risk management meeting chaired by a representative from the child exploitation hub. During this meeting, a [police officer](#) challenged children's social care services in the best interests of a [child](#). The children's services representative had previously agreed to complete a child exploitation risk assessment form (CERAF) for a child but hadn't done so. The child's case had since been closed.

The officer raised their concern that the multi-agency group didn't understand the risk the child faced until the CERAF was completed and the multi-agency meeting had reviewed it. They asked for the child's case to be reopened.

Children's social care services agreed to complete the CERAF so the risks faced by the child could be discussed and understood by all partnership organisations, and the child supported appropriately.

Officers usually speak with children who have been missing from home to understand what has happened to them

When a child returns after being missing the force should carry out a [prevention interview](#) to find out where the children went, who they were with and what had happened to them during the time they were missing. This interview helps police forces understand the child's circumstances, whether there are ongoing risks and whether they may have been a victim of crime. This information is important to help the force and its safeguarding partners to prevent the child going missing again, find them more quickly when they do and minimise the risks they face.

We found the force was good at making sure its officers and staff completed these interviews. In the cases we reviewed, we found those officers and staff recorded detailed information about what the child told them. They added this information to the PPN so they could share it with their safeguarding partners.

The force has good representation at multi-agency risk assessment conferences, but it needs better oversight of activity to manage the risk

A commissioned service, [Voice for Victims & Witnesses](#), is responsible for co-ordinating [multi-agency risk assessment conferences \(MARACs\)](#) in Northamptonshire. The force provides a chairperson for some of the meetings. We found the force contributes well to discussions about adult victims. It agrees to carry out activity aimed at reducing risks to them. However, we found these meetings predominantly focus on adult victims and they don't always take account of children being victims.

Also, the force doesn't receive a copy of the MARAC meetings' minutes. It only receives a list of agreed actions. Therefore, the force can't check whether the minutes are accurate about police involvement, the information shared, or safety plans made to protect adult and child victims of domestic abuse. This means senior leaders can't be assured that the force's agreed activity is completed.

The force told us it plans to make sure it receives these minutes.

Investigating reports of abuse, neglect and exploitation of children

Requires improvement

Northamptonshire Police requires improvement at investigating reports of abuse, neglect and exploitation of children.

Areas for improvement

The force should improve its arrangements for responding to sudden and unexpected child deaths at night

When a [child](#) dies, it is usually because of illness or accidental injury. A small proportion of child deaths are due to abuse. Therefore, when the police respond they must find a balance between compassion and [professional curiosity](#). This relies heavily on the knowledge and skill of the lead investigator.

The lead investigator must work closely with health professionals, children's social care services, the local coroner and other partner organisations to quickly understand the circumstances leading to the death and decide together how to proceed. How services respond in the early stages can have a substantial effect on the resulting investigation.

We assessed the force's preparations for, and initial response to, these incidents.

The force told us it has provided training to some, but not all, detectives who may attend sudden or unexpected deaths of infants and children.

We found that when the death of a child is reported to the force during the day specialist detective inspectors from the child abuse investigation unit lead these investigations. The force has provided specific training for this important role.

However, during the night the most senior detective on duty is a sergeant. The night shift can be covered by investigators from various departments. Many have limited experience of child protection. The force has provided very few of these [officers](#) with training about the investigation of sudden or unexpected deaths of infants and children.

During our inspection, many detectives we spoke to told us they were concerned about dealing with these incidents. They said they didn't receive enough support from specialist or senior officers.

The force should make sure all officers and staff responsible for making decisions and investigating child abuse, and their supervisors, have appropriate knowledge and skills

During our inspection we reviewed cases where [children](#) were at risk of, or had suffered, significant harm and other incidents of concern for children. We also [dip sampled](#) some crime reports with child [victims](#) that required a [joint investigation](#).

We found poor decision-making in five of the six [strategy discussions](#) attended by [multi-agency safeguarding hub \(MASH\)](#) officers. Criminal offences against children were left for children's social care services to investigate as a single agency. These included cases of assault on children by family members and child neglect.

Officers in cases relating to both [criminal](#) and online [child sexual exploitation](#) didn't always complete [public protection notices \(PPNs\)](#) for the children. We saw some [officers](#) recorded that a PPN wasn't needed as the child's parents told them they didn't require support. This means officers don't understand the requirements to share information with children's social care.

Even when PPNs were completed, MASH officers and [staff](#) didn't routinely share them with children's social care and other [safeguarding](#) partners.

In addition, we found little evidence of any joint working when [frontline officers](#) were the investigator.

Specialist child abuse investigation unit officers didn't always carry out joint investigations when needed. When joint investigations were agreed, there wasn't always joint planning or visits to the child with children's social care services.

The force needs to make sure its officers and staff can recognise when children are being criminally exploited, act to protect them and carry out effective investigations

We reviewed six cases where [children](#) had been the [victim](#) of [criminal exploitation](#). In five of those cases the force didn't recognise children had been exploited.

Most of the investigations where children were linked to drugs, focused on drug supply. The force didn't carry out any investigation into the exploitation. Instead, it focused on the offences committed by the children and not who had exploited them.

The force did make referrals to the [national referral mechanism](#). This should help to make sure children receive the right support within existing child protection procedures. However, the language used by the submitting officers made clear they didn't believe the child should be regarded as a victim for the purpose of a defence under the [Modern Slavery Act 2015](#).

In four of the six cases, the force didn't hold a [strategy discussion](#) with children's social care services. This missed important opportunities to work together to prevent the children coming to further harm.

Main findings

In this section we set out our main findings that relate to how well the force investigates reports of abuse, neglect and exploitation of children.

Specialist investigators carry out good investigations into child sexual exploitation

When children are victims of sexual exploitation, the force usually allocates the case to specialist investigators. Those investigators demonstrated a good level of understanding about their obligations to work jointly with their safeguarding partners. We saw several examples of the force and its safeguarding partners holding prompt strategy discussions. They agreed what they should do together to safeguard the child and pursue the suspect.

The Victims' Code requires forces to carry out a victim needs assessment at an early stage to determine whether victims need additional support. We were pleased to see investigators carried out needs assessments with children at the start of investigations. They also kept in contact with the children and made sure they knew what was happening with their case.

Case study: specialist officers recognise risk to children and work jointly to protect children

A social worker reported to the police they were concerned two 15-year-old boys may have been sexually exploited by a 30-year-old woman. The woman worked with [children](#) and had a 10-year-old son.

A detective inspector in the child exploitation hub reviewed the information and a specialist [officer](#) was assigned to investigate the case. In a [strategy meeting](#), the police and social worker agreed a [joint investigation](#). The following day the police arrested the female suspect.

There was good supervision of the investigation, and the detective sergeant recorded an early investigation plan to support the officer. All lines of enquiry were followed. For example, the force examined the [victims'](#) digital devices. And the officers considered the victims' needs throughout the investigation.

The suspect was quickly arrested, interviewed and then [bailed](#) with conditions designed to protect the victims, her son and other children. To further protect the victims, the force served a [child abduction warning notice](#) on the suspect.

Children's social care services supported the suspect's son to live with relatives for his protection during the investigation.

Officers completed and shared [public protection notices](#) for all the children involved. They included good detail about the thoughts and concerns of those children. This helped to keep other services informed of the progress of the investigation and the effect it was having on the children.

At the time of our inspection the investigation was ongoing.

We found the force made good use of its powers to help protect children, such as bail conditions, child abduction warning notices and [sexual risk orders](#).

In most cases where officers dealt with children who were suspected of having committed a crime, they gave consideration to not arresting them. Where the arrest of the child was the most appropriate option, we saw bail conditions imposed which could help minimise the risk of further harm.

In one case, officers had arrested a 17-year-old boy for robbery, and possession of drugs and an offensive weapon. We found officers considered there was a likelihood of a high risk of harm to the child if he was bailed. As a result, the force remanded him in custody for his own protection prior to his court appearance the following day.

Frontline officers don't always follow specialist advice to support online child exploitation investigations

We found many online child sexual exploitation investigations allocated to frontline officers who didn't have suitable training or experience.

The force did have a victim identification investigator. When police investigate digital material that shows children being abused this role can help frontline officers establish the identity of the child victims.

In the cases we reviewed we found missed opportunities to recover digital material (including images), record intelligence, carry out victim identification processes and upload information to the [child abuse image database](#).

We saw the force's victim identification investigator had tried to support online investigations by recording suitable actions to be completed, but we didn't always see these actions done.

In speaking with frontline officers across the force, we found only a small number had heard of or understood the role of the victim identification investigator. This meant they didn't always understand the value of their advice.

The force needs to do more work to promote the role of the victim identification investigator to improve outcomes for children who are victims of cyber-enabled child abuse.

The force is sometimes missing opportunities to arrest suspects by failing to consider all relevant evidence

We were disappointed to see that in several cases the force didn't start, or continue, an investigation where the child victim didn't wish to support the prosecution. In most of these cases, especially offences committed online, there were other sources of evidence which could be used to identify and hold the suspect to account.

By not identifying and arresting the suspect, the force isn't assessing or managing the risk they pose to children. At worst this means the suspect can continue to offend against the same child or other children.

Case study: the force failed to investigate an online child sexual exploitation crime, leaving the victim and other children at risk of harm

A mother reported to police that her 14-year-old son had been extorted online to send [indecent images](#) of himself, followed by demands for money.

Frontline [officers](#) visited the [child](#) and his mother. The child said someone he didn't know, but who appeared to be female, had contacted him through different social media accounts. They demanded a picture of his penis and made threats against him if he didn't send it. He told the officers he did send a picture of a penis he found on the internet. The child's mother said that, after her son had received more threats, she sent the unknown offender two separate payments of £30. She used an online money transfer service linked to email addresses the offender had provided.

Both the [victim](#) and his mother told the officer that they didn't want to make a statement as they didn't think the police would find the offenders.

In the records we reviewed, we found no mention of whether the officers had viewed any of the evidence on the child's phone.

The force didn't follow up any lines of enquiry to identify the offender, such as those relating to the social media accounts, email addresses or banking details. The force closed the investigation.

We raised our concerns regarding this case with the force. In response, it reopened the investigation.

Next steps

Within eight weeks of this report's publication, Northamptonshire Police should tell us in writing how it has addressed or intends to address the areas for improvement we have specified. It would be helpful for this information to be contained in an action plan.

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