Case 3 | Issue 37 – Young people

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LEARNING THE LESSONS

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Failure to investigate child sexual abuse allegations

Officers did not respond appropriately after a minor disclosed allegations of sexual abuse, raising issues about:

- *Accurate crime recording of sexual offences*
- *Proper management of caseloads, including those of subordinates, particularly in respect of case ownership*
- *Documenting rationale when a multi-agency investigation moves to a single agency one*
- *Honesty and integrity*

This case is relevant if you work in:

Investigation 	**Public protection** 

Overview of incident

Girl A is the 16-year-old daughter of Mrs E and stepdaughter of Mr D. At 8.15am, she alleged to a member of staff at her college that Mr D had behaved in a sexually inappropriate way towards her in the past, and had moved on to behaving in a sexually inappropriate way towards her five-year-old sister, Girl C. Girl A did not go into detail about his behaviour towards her but explained Mr D would touch Girl C inappropriately when changing her nappy. The college passed this information to social services and the force.

The staff member referred the matter to the Multi Agency Safeguarding Hub (MASH) at 9.03am. Shortly after, the MASH held a strategy meeting to discuss the allegation and safeguarding plans. Police officers and other professionals, such as the social worker and representatives from education, attended this meeting. The decision was made a 'section 47' joint investigation between police and social services should take place. Part of the reason for this decision was Girl A had indicated a criminal offence had taken place.

Section 47 investigations

A section 47 joint investigation is managed by the social services and may run concurrently to a police criminal investigation. When a joint enquiry takes place, the police have the lead for the criminal investigation, and children's social care have the lead for the section 47 enquiries

and the child's welfare. The police and local authority children's social care must co-ordinate their activities to make sure the parallel process of a section 47 enquiry and a criminal investigation is undertaken in the best interests of the child.

Find out more online:
https://www.legislation.gov.uk/ukpga/1989/41/section/47

Detective Sergeant B attended the MASH meeting. Her role was to add a summary of the meeting to the force's case management system (CMS) to make sure the agreed joint visit took place. This would include creating a 'task' on the system for a Serious Investigations Unit (SIU) sergeant to allocate. She noted Girl A had made a disclosure to her college about Mr D's behaviour towards her in the past, and more recently towards Girl C. However, she mistakenly assigned the task to a different force area, rather than the SIU. She also put the officer in charge (OIC) of the case as Detective Sergeant C on the CMS, an officer who was not responsible for allocating the case.

Detective Sergeant A was the duty sergeant in the serious investigations unit (SIU) at the time of the decision. He was responsible for allocating the case to an officer to lead the planned visit. Despite the errors of Detective Sergeant B, he was informed about the referral involving Girl A during a handover meeting at 2.10pm on the same day the disclosure was made. At 2.35pm, Detective Sergeant A held a meeting with his team, including Detective Constable A and Police Constable A. There is no record of who was the lead for the visit and subsequently OIC. However, evidence gathered as part of the IOPC independent investigation suggests it was Detective Constable A as Police Constable A was very inexperienced at the time, having only been with the SIU for two weeks.

Detective Constable A and Police Constable A conducted the visit with a social worker, Ms F, later that day. Mr D and Mrs E were compliant and allowed them to speak to Girl A alone. At some point during this interaction, they were joined by Female B, Girl A's cousin. She had recently lived at the same address with Girl A and Mr D. Female B joined them because Girl A found it difficult to talk. Police Constable A asked questions while Detective Constable A made notes.

Female B disclosed Mr D had touched her bum and her breasts on more than one occasion and would hug her too tightly. Girl A said he had done the same thing to her, and further stated "more things" had happened, but she was not comfortable discussing them.

The officers spoke to Mr D and Mrs E, with Detective Constable A taking the lead due to Police Constable A's limited experience. Mr D denied the allegations. He stated if he had touched the girls it was only a "stupid joke". Neither officer spoke to Girl C, despite the allegations made regarding her. Ms F recalled she did speak to Girl C but the officers were not present.

Section 9(1) *Sexual Offences Act 2003*

Section 9(1) *Sexual Offences Act 2003* states:
A person aged 18 or over (A) commits an offence if—
(a) he intentionally touches another person (B),
(b) the touching is sexual, and
(c) either—
(i) B is under 16 and A does not reasonably believe that B is 16 or over, or

(ii) B is under 13.

Find out more online:
https://www.legislation.gov.uk/ukpga/2003/42/section/9

Appendix C of the *Sexual Offences Act 2003* states when an allegation of abuse amounts to a criminal offence, the police always have primacy over the criminal investigation. Based on this legislation, the disclosures made to the officers by Girl A and Female B amounted to two allegations under Section 9(1) *Sexual Offences Act 2003* and, accordingly, required investigation by the police.

Further, the force's child protection policy states all police officers and staff, regardless of role, have a statutory responsibility to safeguard and promote the welfare of children, and a duty to make sure concerns about child abuse, suspected or actual, are properly investigated.

Despite this, both officers told Ms F while still at the address that the police would have no further involvement, and that the investigation would continue as a single agency investigation, conducted by social services.

The officers updated Detective Sergeant A back at the station. He recalled being informed the matter would be dealt with as a single agency investigation as there had been no clear disclosure and there were no immediate safeguarding concerns. He did not document a conversation with either officer in his pocket notebook (PNB) or complete a supervision entry on the CMS.

Ms F detailed the allegations made in her section 47 report and carried out her own investigation, implementing a 'no personal contact plan' for Mr D and the children for the period it took her to complete her enquiries. This meant Mr D could not assist in the personal care of the children and was not allowed to change Girl C's nappy.

Girl A disclosed further information about the allegations to Ms F a few days after the joint visit. Ms F did not share this with the police because she had been told they would not be dealing with the case. Neither Police Constable A nor Detective Constable A tried to contact Ms F for an update after the initial joint visit, despite Police Constable A reporting that in most cases officers would seek an update from the relevant social worker to find out the outcome of their enquiries.

All the evidence suggests after the initial joint visit was completed and recorded on the case log by Detective Constable A, no further police investigation was conducted. There is no evidence either Police Constable A or Detective Constable A completed any further checks or enquires and the case log remained a 'non-validated crime'. Neither Detective Constable A, Police Constable A, or Detective Sergeant A accessed the case for the next 13 months.

Less than a week after the decision was taken there would be no further police involvement, the case was reviewed by the force's crime management unit (CMU). A member of the unit made an entry on the case log stating the case should be listed as a crime, one report for each girl and each allegation against Mr D. She was not certain a crime had been committed, however, and so she left the decision to the OIC. She did not create a task to make sure the OIC saw the advice because it was not policy to do so - it was assumed within the force that OIC's would regularly review their cases.

Home Office counting rules

The Home Office counting rules state that:

"An incident will be recorded as a crime for offences against an identified victim if, on the balance of probability the circumstances as reported amount to a crime defined by law and there is no credible evidence to the contrary."

Find out more online:
https://www.gov.uk/government/publications/counting-rules-for-recorded-crime

During this time, the CMS still listed Detective Sergeant C as the OIC. She made notes on the day the force was initially informed of the allegations, but handed the case to Detective Sergeant A for action. Detective Sergeant C was in a supporting role at the time that involved allocating work to other sergeants' officers, but not investigating or reviewing cases. However, it does not appear there was any proper process in place to make sure cases were removed from her name once allocated. She did not notice the case was in her name as she could have up to 60 cases due to the nature of the role. The system did not notify officers when cases were put into their name. Accordingly, she did not see the entry made by the CMU.

As referred to above, the only task that was created was the one created by Detective Sergeant B. This task was allocated to the wrong force area rather than the SIU. A member of the team for that area, Ms G, marked the task complete despite it not being for her or her unit. She explained she did so because there was no action for her or her team to take.

Thirteen months passed before the case was checked by the OIC, Detective Sergeant C. She assumed, based on the information added to the case by Detective Constable A, that Detective Constable A had updated Detective Sergeant A. She further assumed Detective Sergeant A had subsequently forgotten to record his review of the case.

Detective Sergeant C contacted Detective Constable A, explaining she did not know why the case was in her name and asking the officer to 'update and close' the case as she had attended the joint visit. Detective Sergeant C assumed the case was due to be closed because no action had been taken on it for 13 months and, as Detective Constable A was an experienced detective constable, she would already have taken the necessary actions (such as having the case reviewed by her supervisor).

Nine days later, Detective Constable A closed the case, stating: "no clear disclosure has been given to PC Hayes when asking questions of the girls. No further police action." She claimed she had spoken to Police Constable A on the phone, and Police Constable A had informed her there was no clear disclosure. Police Constable A refuted this, stating they spoke on the phone on a different date and she told Detective Constable A she could not recall the outcome. Phone records supported Police Constable A's account over Detective Constable As.

On the same day, Detective Constable A made her inaccurate entry, she assigned a task to the CMU for the case to be closed. Detective Constable A mistakenly believed the CMU could have chosen not to close the case if they believed it should not have been closed. An admin clerk filed the case away without any further checks. It is not the part of the admin clerk's role to review the cases they are filing.

The failure to investigate this matter only came to light because, 14 months later, Girl C alleged to staff at her primary school Mr D had behaved in a sexually inappropriate way towards her. While investigating this matter, the force discovered the investigation into Girl A's allegation and, due to the apparent lack of police action, referred this matter to the IOPC.

Type of investigation

IOPC independent investigation

Findings and recommendations

Local recommendations

Finding 1

1. The force's case management system allows an investigation to be assigned to an area in the force, meaning no individual officer has responsibility for or ownership of the case. An IOPC investigator identified a child sex abuse case [not related to this investigation] had been assigned to a force area, with no investigating officer attached, for a number of months.

Local recommendation 1

2. The force should review this process to make sure child sex abuse cases are always assigned and have an owner within an appropriate timeframe.

Finding 2

3. The force does not have a routine method for informing officers when cases have been allocated to them, or for recording the allocation decision.

Local recommendation 2

4. When an officer is assigned a case involving child abuse, they should be notified they are the officer responsible for the investigation in whatever way the force deems appropriate. Their acknowledgement of this notification should be recordable.

Finding 3

5. The force does not have a specific policy governing what should be recorded and reported following joint visits with social services.

Local recommendation 3

6. When officers conduct joint visits with the social services, a supervisor should be updated afterwards and a note made of what happened at the joint visit by the attending officers and the supervisor.

Finding 4

7. No record was made by Detective Constable A, Police Constable A, or their supervisor Detective Sergeant A of why the decision was taken to re-determine the joint agency investigation as a single agency investigation.

Local recommendation 4

8. Where a child abuse investigation is re-determined from a joint agency investigation to a single agency investigation, the officer responsible for this decision should make a note of their decision and their rationale.

Outcomes for officers and staff

Detective Constable A

1. Detective Constable A, the officer in charge of the joint visit who decided the matter needed no further force involvement and documented inaccurate rationale as to why that was the case, was found to have a case to answer for gross misconduct. It was decided she should attend a misconduct hearing, which took place in her absence due to her retirement. She was found to have breached the Standards of Professional Behaviour in respect of 'duties and responsibilities' and 'honesty and integrity'. She would have been dismissed had she still been a serving officer. The panel also decided concerns about her integrity and capabilities warranted her inclusion on the barring list.

Police Constable A

2. No case to answer or other learning necessary.

Police Staff Ms G

3. Ms G, the police staff member who marked the task mistakenly allocated to her team as 'complete' without checking whether any action had been taken, was reminded she should make sure she only actions tasks assigned to herself or her department.

Detective Sergeant A

4. Detective Sergeant A, Detective Constable A's line manager who did not review the case before its closure or document any of his decision making, was found to have a case to answer for misconduct for breaching the Standards of Professional Behaviour in respect of 'duties and responsibilities'. A misconduct meeting was considered unnecessary and he was given management action to remind him of the importance of conducting initial reviews for cases allocated to his staff, and to seek clarity from his staff following joint visits to make sure any decisions are appropriately challenged where required.

Detective Sergeant C

5. Detective Sergeant C, the officer who was mistakenly allocated the case on the CMS, was not found to have a case to answer for misconduct. She was required to attend a first stage Unsatisfactory Performance Procedures (UPP) meeting in order to remind her to regularly review all cases allocated to her. This is to make sure her assigned case load

is accurate and correct and there are no outstanding high-risk matters mistakenly assigned to her.

Questions to consider

Questions for policy makers and managers

1. How do you make sure officers are told which cases are part of their case load?

2. What do you do to make sure serious investigations do not ‘fall off the radar’?

3. How do you make sure you are kept up-to-date with any significant developments when control of an investigation has passed to another agency?

Questions for police officers and police staff

4. What do you do to make sure your caseload is accurately reflected on force systems and vice versa?

5. What steps do you take to avoid incorrect assumptions about the roles and responsibilities of your colleagues?