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Redesigning the response to reports of missing young persons. Can demand be prevented?

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Executive Summary

This report identifies improvements that can be made to help reduce demand and resource requirements to deal with young missing persons. The work is based on data from Hertfordshire Constabulary and other sources from agencies in the same area, including local authorities and associated charity providers of services. The scope of the work is based on a previous scoping study of the academic and grey literature (Bilsdon and Walley, 2023) about missing persons which directed us towards the study of hotspot locations for missing children and high-repeat missing incidents from individual children. Our report addresses three high level research questions:

1. What action can prevent children, who are at most risk, from going missing?
2. What activities can agencies undertake when a child goes missing that are most likely to ensure the return of a child to a safe environment?
3. What follow up activities to a missing episode in a child is most likely to prevent repeat missing episodes from occurring?

The work started with an analysis of all 9,184 records of missing incidents involving children that occurred in the Hertfordshire area between 2019 and 2022. This data is recorded in detail in the forces COMPACT database of missing reports. The work then looks at smaller samples of this data in greater depth, incorporating, where possible, information from other sources in this later analysis. We present 9 case studies of individual children who went missing in 2022 to highlight the factors associated with their motivation to go missing and the practices to deal with the missing child and prevent future missing incidents. Our final piece of analysis was to review the end-to-end process for missing incidents to identify fail points and recommend change.

Key findings

The research produced a wide range of findings including:

- Most missing incidents are of a short duration, with over 90% being resolved within the first 24 hours. Many last a short time, with most being found within 2 days of being reported missing.
- Incidents of missing by children in care are more likely to occur between 22:00 and 01:00, especially at weekends.
- 10% of children who went missing most frequently between 2019 and 2022 accounted for 54% of all missing incidents, showing that there is a small number of children responsible for most of the demand.
- Children who go missing frequently often do so in intense periods of missing events that can be reduced by addressing underlying causes and motivations.
- High repeat missing children are not just those placed in care homes. Children who are living in familial homes can demonstrate similar behaviour.
- Long-term and persistent missing young people often have flags associated with County Lines or gang-related activity.
- Out-of-county placements did not appear as significant a factor in demand, contrary to expectations.

- The processes associated with preventing missing incidents and managing missing incidents have not been formally designed as an end-to-end process. There is much work that can be done to improve these processes.
- The "Philomena protocol" to assist with missing incidents is potentially a valuable tool but has not been widely evaluated.

Key Recommendations

Although many of the recommendations are for Hertfordshire specifically, relevant agencies in other regions should consider similar actions where these have not been taken already.

- Police should become an interested party in the matching and placement process for a child in care and partake in information sharing.
- There should be full adoption of the Philomena Protocol with a training package for all agencies involved and an evaluation tool to assess its effectiveness.
- Where possible there should be information sharing practices established between partner agencies with IT systems designed to do this without excessive workload placed on individuals.
- The interface between COMPACT and police intelligence databases should be assessed to see how much integration is possible.
- Missing person intelligence needs to be shared between police forces.
- Ofsted and police should review their feedback mechanisms in relation to care home performance around missing children, particularly in light of recent changes to inspection of un-regulated care homes
- The working hours and remit of the Missing Person team within Hertfordshire Constabulary should be expanded to provide support at the appropriate times of day.
- Return home interviews need to be consistently compliant with statutory guidance, so that full information is obtained and can be shared.
- In the long term there are significant opportunities for ambitious (big) data sharing between agencies so that underlying factors associated with missing incidents (and other child welfare issues) can be established.

Introduction

The Open University and Hertfordshire Constabulary have been working jointly on an "Open Society Challenge" initiative to reduce the demand from young people going missing. The general approach is to sustainably reduce demand for public services by eliminating avoidable demand such as unnecessary repeat demand or demand created by internal process issues, referred to as *failure demand*. The work fits with Hertfordshire Constabulary's overarching strategy of *Prevention First* which seeks to tackle the root drivers of crime and demand with a focus on primary, tertiary and secondary prevention. In the context of this research, primary prevention seeks to prevent the missing episode before it occurs. Secondary prevention seeks to reduce the impact of harm and risk during a missing episode, while tertiary prevention seeks to tackle the root causes of repeat demand. The chosen topic of missing persons offers a good fit with the strategy due to the potential for repeat demand and the underlying factors associated with that.

Our first report presented a scoping review of the issue of demand for police and other public services that is generated by people going missing (Bilsdon and Walley, 2023). This work identified that, at a national level, this demand is significant. Over 400,000 reports of missing people across the country each year. These incidents often occur because those going missing are vulnerable and there are underlying factors that lead to a missing report. Hence, there is significant value in being able to reduce the underlying causes of missing incidents. In particular, there is significant demand from children, especially those in care, where many children go missing on more than one occasion.

This report summarises the findings of the second phase of our work, which analyses new data taken from Hertfordshire Constabulary and public and voluntary sector partners, to assess the underlying reasons why the demand occurs and what actions can be taken to reduce this demand while maintaining or improving the service to young people.

Briefly we summarise the findings of our scoping review. In the next section we detail our methodology for this report, which does include information from over 9,000 missing incidents that have occurred in the Hertfordshire area since 2019. Our findings are contained within three distinct sections. First, we look at the aggregated statistics for missing young people over the period 2019-2022. Second, we study in more depth a sample of those going missing in 2022 to establish the factors that may have contributed to their missing incidents. We place particular attention on those who go missing on a regular basis and establish the "hotspot" locations from where many missing incidents are reported. We also present nine narrative case studies of missing incidents that capture the full stories of how and why missing incidents involving young people may occur. At the heart of this work is the intention to reinforce the notion that this demand reduction is centred around improving the welfare of vulnerable young people and these accounts provide illustration of the issues and complexities. Our third findings section studies the missing persons multi-agency process with the aim of establishing both what these processes are like in practice and where they can be improved. These findings are discussed with recommendations for future action and change within the relevant public services.

Research Questions

The research questions we have set for this work are consistent with the principles of demand reduction that we have articulated. Above all, the aim of the work is to maintain and improve the service offered to potentially vulnerable people who need the support of public services. As such demand reduction must be sustainable, i.e., it does not compromise the quality or availability of services needed, nor does it involve restricting access or rationing services to control demand. Instead, it addresses how demand might be prevented by solving problems at an earlier stage or preventing unnecessary repeated service requests. The research questions we are asking over the course of this work are as follows:

1 What action can prevent children, who are at most risk, from going missing? (Primary Prevention)

Aim: to understand why children in care go missing and to prevent demand on public services.

Objectives:

- To identify patterns of behaviours and characteristics of missing episodes for children in care.
- To identify the current multi-agency arrangements in relation to measures taken to manage the risk of going missing presented by children in care.
- To identify any further activities that can reduce this risk.

2 What activities can agencies undertake when a child goes missing that are most likely to ensure the return of a child to a safe environment? (Secondary Prevention)

Aim: to ensure missing children are located as quickly as possible.

Objectives:

- To identify patterns of behaviours and characteristics of children while missing.
- To identify the current multi-agency arrangements and activities undertaken during a missing episode and to conduct a value analysis of those activities.
- To identify potential improvements to existing processes.

3 What follow up activities to a missing episode in a child is most likely to prevent repeat missing episodes from occurring? (Tertiary Prevention)

Aim: to protect children from the long-term harms of going missing and prevent repeat demand on public agencies.

Objectives:

- To identify patterns of behaviours of children who repeatedly go missing.
- To identify the current multi-agency arrangements and activities undertaken after a missing episode and to conduct a value analysis of those activities.
- To identify any potential improvements to existing processes.

Scoping Review Summary

We conducted our scoping review of the literature into missing young persons between January and March 2023 (Bilsdon and Walley 2023). The report can be accessed at this link. The review identified 75 articles of relevance to our study, and these were categorised into themes. The following key issues are summarised below.

Patterns of disappearance and statistical analysis

The patterns of disappearances has been studied relatively well over the last decade. Welfare cases (including missing persons) accounts for 19% of all police demand (Boulton et al., 2017). For cases involving missing children two key observations are made:

a) There are "hotspot" locations from which people go missing on a regular basis. These include care homes and supported living residences, which can experience multiple missing persons cases each year. In one study these locations were the source of 57% of incidents (Shalev-Green and Hayden, 2014).
b) Some young people go missing on a repeated basis. In one study 15% of the missing children accounted for nearly two-thirds of all missing person reports. (Babuta and Sidebottom, 2018).

For young people there has also been identification of the motivations for going missing. these factors include:

- Being unhappy with being in care
- Finding a placement too strange
- Changes in the people in charge of where you live
- Not liking your placement
- Running away to escape police
- Feeling you don't get what you want or need in your placement
- Being affected by family issues
- Curfews
- Problems at school
- Not being allowed to go home from care
- Not settling in a new place
- To escape from violence
- Wanting to stay out

Source: Ofsted, 2012

Repeat Missing persons

There have been several reports about repeat missing children. In addition to the study by Babuta and Sidebottom (2018), others have similar findings. Sidebottom et al. (2020) found that 75% of missing reports of children were repeats, with only 4% of the group being responsible for 28% of reported incidents. Bezeczky and Wilkins (2022), Galiano López et al. (2021) and Tansil (2021) also found a small number of children were the subject of most missing episodes.

Issues of risk assessment

Forces have different approaches to risk assessment of missing children despite attempts to standardise. Vo (2015) reviewed risk assessments in one UK police force and found that whilst 16% of cases were graded high risk and 68% graded medium risk, 99% of those reported missing did not suffer any harm whilst they were missing, leading him to also question the effectiveness of current

risk definitions. Classifications of "missing" and "absent" have been generated but not all forces use these.

Improvement of the system

One of the main attempts to address missing young persons is the use of "Return Home Interviews" (RHIs) which go beyond the original police action of a "safe and well" check (now known as a Prevention Interview). Ideally these uncover the underlying factors that have led to a missing incident and provide a mechanism to prevent future incidents. Boulton et al. (2023) found that the quality of them varied in numerous ways, limiting their effectiveness in reducing the number of repeat missing episodes. Similarly, Ofsted (2013) reported limited RHI effectiveness as they were rarely used to determine patterns of behaviour for children who ran away frequently.

Our scoping review concluded:

> *"There are many calls for multi-agency or coordinated working both during and after missing incidents but there appears to be little follow-up evidence of solutions being trialled. The literature strongly indicates a relative lack of combined action."*

This report uses the findings of our scoping study to guide the research objectives and methodologies of this research phase of our work.

Research Methodology

In this section we explain the methodologies that we have employed in this study within the domain of Hertfordshire Constabulary.

Our data source is primarily the COMPACT missing persons database. The COMPACT system records all of the stages of a missing persons incident, from initial reporting to closure of the incident. It is widely used in UK policing and can provide accurate and timely information on missing people. We extracted COMPACT data at three levels of granularity:

1. All COMPACT records from 2019-2022 were anonymised and extracted into a data file to establish the patterns of demand over the last four years. This file contained 9254 separate missing incidents recorded in the Hertfordshire Constabulary area during this time. This data was used to establish the descriptive statistics about missing young people in Hertfordshire and to establish some key patterns in the data concerning the seasonality and demographics. The main source contained 78 separate items of data for each missing incident, including:

- The age and gender of the missing person
- The date and time of the missing report
- The time they were missing
- Where they went missing from
- Assessment and classification of risk
- How and where they were found, including distances travelled
- Explanatory details of how they went missing
- Detail of any harm while missing
- Details of who cares for the child: care home/family
- The types of vulnerability indicated, where appropriate, including drugs/addiction, county lines, mental health, gang risks, modern slavery and trafficking risk
- Contextual details of underlying reasons for missing
- Any criminal incidents associated with the missing child

The data contains two ID numbers – the "PID" which is an identity number associated with the missing person and the "RID" identifies each missing incident. From this we can easily identify repeat missing incidents from any individual.

2. Out of all the children and young people who went missing in 2022, a sample of 82 of the young persons was systematically derived. The entire list of those who went missing that year was ranked in decreasing order of how many incidents were on their records and every 9th young person on that list was selected for further analysis. This was intended to create a sample of children who went missing for in-depth analysis but where the same still contained a mix of those who went missing more frequently and those who were involved in only one incident in that year. This totalled 249 reports. Additional details from police records were added and some text-based records were coded for this additional analysis.

3. A sample of nine case studies were developed out of the sample of 82. These were split by demographic and contextual factors to illustrate the underlying contextual factors and to build a richer picture of the actions across the whole public system of what actions have taken place to prevent repeat demand and the full outcomes of the incidents.

A series of three workshops were held, both in-person and online, to process map the missing young person process. We started by looking at the groups with the highest probability of going missing repeatedly – those in the care system – and looking at what preventive activities were taking place on placement etc. We then process mapped the missing person incident process with a range of stakeholders from the public and voluntary sectors (including police and local government departments). The aim of this step was to identify how different agencies interact in the journey and to identify "fail points" where improvements can be made. The process mapping started with the existing generated process maps (created in Visio software in force). Participants were placed into multi-disciplinary groups to compare this process map with actual practice and to identify issues. The exercise encouraged them to identify "fail" points where the system introduces errors, "wait" points where there are avoidable delays and issues of sequencing or timing of specific actions. A "3C" table was produced from this analysis, which identifies the concerns expressed, suggests an underlying root cause of the problem and suggests a countermeasure that would reduce or eliminate the problem. The 3C diagram acts as a main driver for the report's recommendations.

Results

The following four sections contain the results derived from each of the methodologies described in the previous section.

Missing Young Persons' Data 2019-2021

This first section of the results contains the aggregate descriptive statistics for the patterns of missing incidents over the period 2019-2022. Inevitably due to Covid and the associated lockdown periods the patterns of missing incidents are likely to have been affected over the time period. This limits the validity of assessing any changes in demand patterns and seasonality.

Annual Demand Patterns and Trend

Table 1 shows the overall statistics for missing incidents in Hertfordshire, collated in the same manner as the national statistics presented by Reilly (2020) in our earlier scoping report.

Table 1: Missing persons statistics in Hertfordshire 2019-2022

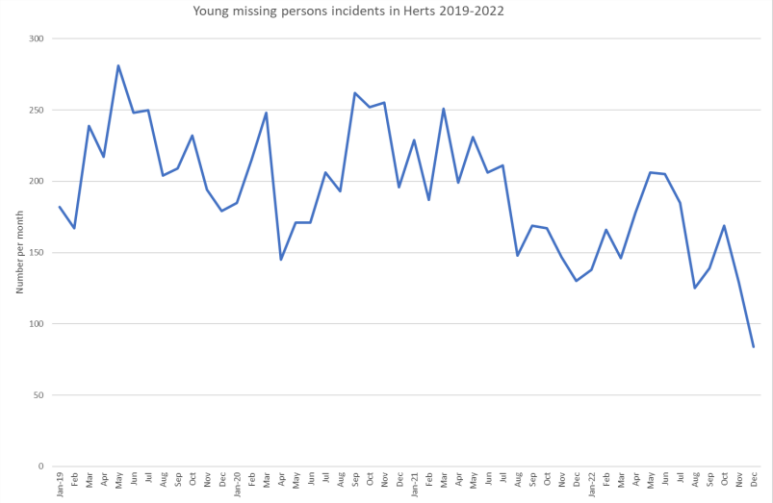
	Total no of recorded calls	Missing incidents	Average per day	Missing reports total	Missing reports U18	Ave reports per day	Missing Individuals Total	Missing Individuals U18	Average per day
2019	461,722	5,634	15.46	4,515	2,604	12.37	2,580	989	7.04
2020	433,355	5,238	14.31	4,087	2,497	11.17	2,136	883	5.83
2021	483,930	5,879	16.10	3,930	2,275	10.77	2,272	909	6.22
2022	563,673	5,945	16.3	3,015	1,863	8.26	1,705	769	4.67

The table shows that missing incidents represent a significant load within the Control System. However, although the number of missing incidents increased slightly in 2022, the number of incidents converted into reports fell considerably. For missing persons under the age of 18 the number of reports is 30% lower in 2022 than 2019. Children in care have seen a reduction of up to 60% from 2019 to 2022. This pattern of falling demand is also seen in the monthly statistics presented in figure 1.

A new Force Control Room process was introduced whereby a Delay, Defer or Deploy policy changes the initial classification of incidents. This new policy was introduced in 2021 which is within our data set period. This change will have reduced the number of missing incidents being recorded by police, for example instances where a child is late home, but their whereabouts are known. This could therefore be a

contributing factor to the drop in demand, however the new policy has not been evaluated.

Figure 1: Monthly Breakdown of Missing Young Persons Incidents 2019-2022



The above data was assessed for monthly seasonality, but no practice-relevant seasonal patterns were detected in the data. December was the month in each year when missing reports were lowest. Table 2 shows where a child went missing from. We can see that missing from home provides the largest total, with missing from care the second largest.

Table 2: Locations children went missing from

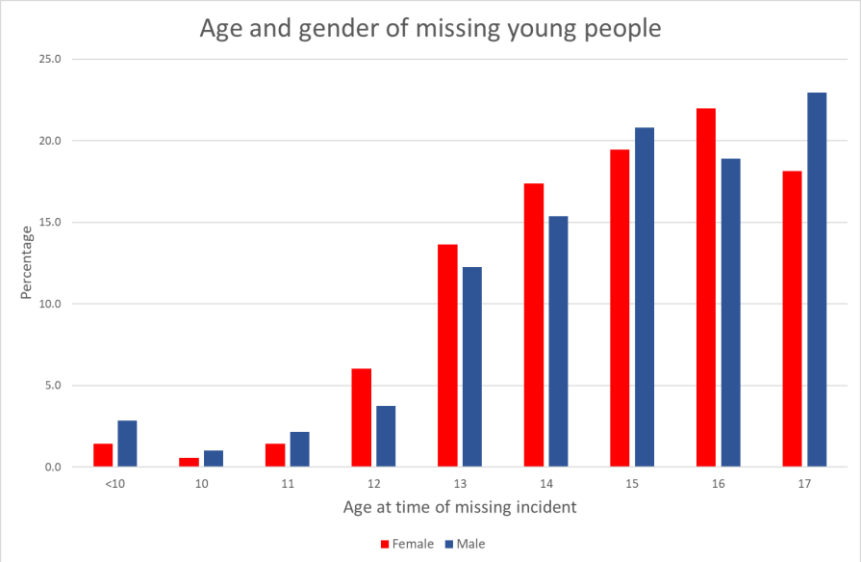
Place missing from	Total
Home/Neighbourhood	5925
Childrens Home and Supported Living	3014
Place of Education	178
Hospital	48
Street	36
Town Centre	18
Leisure Facilities	13
MHA Patient (Sectioned)	11
Detention	2
Licensed Premises	2
MHA Patient (Voluntary)	2
Youth Custody	2
Public Transport	1
Special Event Category	1
Total	9253

Other Demographics

We assessed the age of each child at the time of the missing incident. Figure 2 shows the difference in age when missing between genders for the sample as a whole. Although there are only small differences between genders, girls tend to go missing proportionately more often in the 12-13 year

age band than boys.

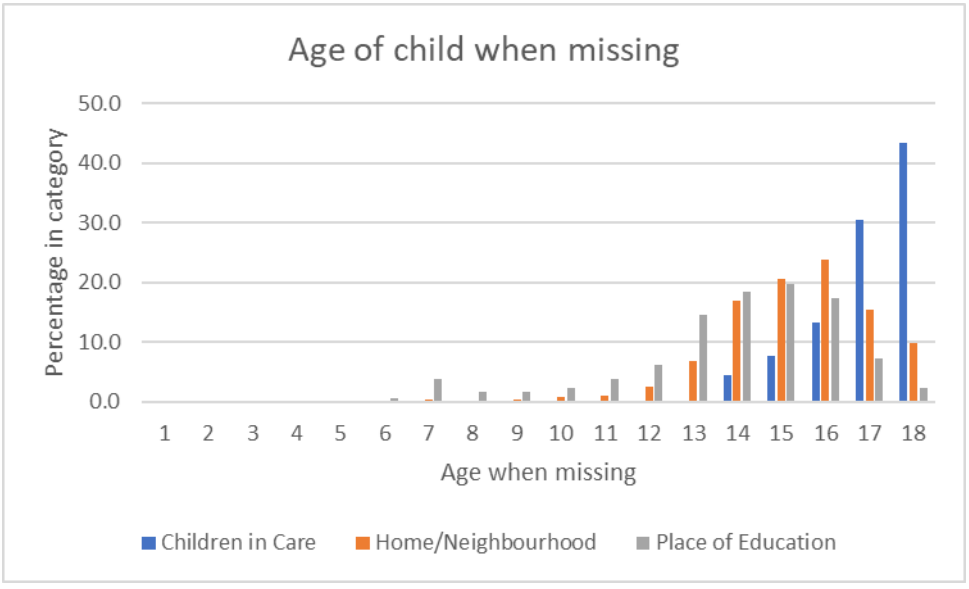
Figure 2: Age and gender of missing young persons.



Note: 0.35% of the sample were recorded as transgender.

However, the age when children go missing varies widely based on where they go missing from. Figure 3 shows that the spread of age is much greater in children missing from home than children in care. We have also added data to illustrate the age range from school missing incidents, although the numbers missing from school are much smaller.

Figure 3: The age of child when missing related to missing location



Ethnicity

Ethnicity is not recorded in the COMPACT database, but ethnic appearance is recorded as part of the activity to find the missing person. The data shows that 64% are recorded as British with another 8% where ethnic appearance is not recorded. Rows marked with * identify ethnic groups that are over-represented when compared to the population of Hertfordshire as a whole.

Table 3: Ethnic appearance reported in the COMPACT database

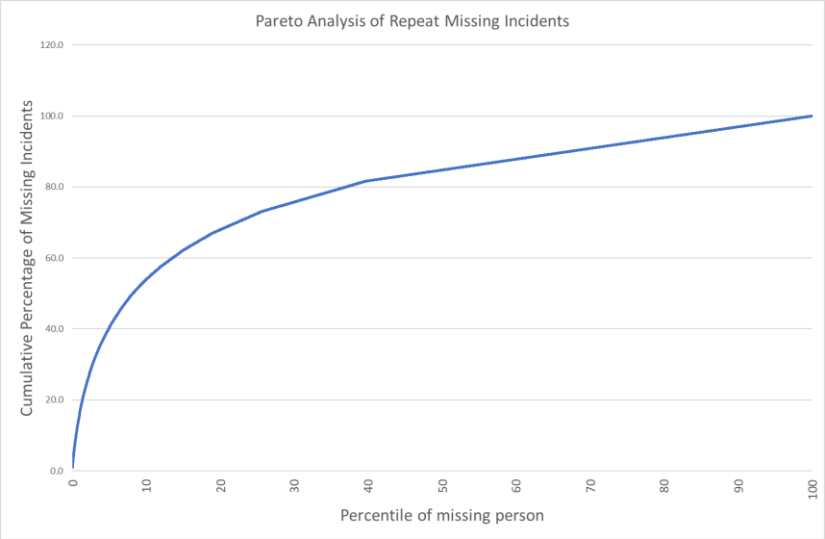
Ethnic description	Frequency
British	5969
Not Stated	775
African	483*
Any Other Black Background	418*
Any Other White Background	368
Any Other Mixed	344*
Any Other Asian Background	203*
Caribbean	167*
Irish	84
White And Black Caribbean	75
White And Black African	74
White And Asian	73
Any Other Ethnic Group	52*
Pakistani	34
Bangladeshi	30
Indian	17
Arab	9
Gypsy Or Irish Traveller	5
CHINESE	4
Total	**9184**

African and other black background groups are over-represented significantly by a factor of two or more. Given the relatively high proportion of instances where ethnicity is not reported there is scope for some error in the statistics. For instance, we suggest that many instances of British missing children, the ethnicity could be assumed and hence not recorded. If this is a significant factor, the number of British children in the sample will be under-reported.

Repeat Missing Reports

One of the features of our scoping review was the high proportion of children who repeatedly go missing. Figure 4 presents the pareto analysis of the missing incidents ranked with the child with the highest number of missing incidents first.

Figure 4: Pareto Analysis of Repeat Missing Incidents

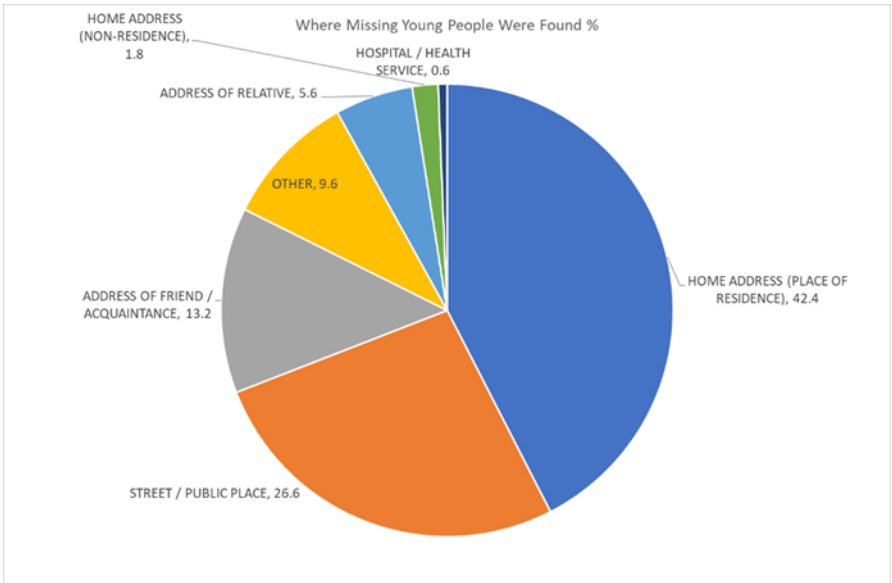


The 10% of young people with the highest number of missing incidents accounted for 54% of all missing incidents between 2019 and 2022. Most of those reported missing more than 25 times were reported as missing from more than one location in separate incidents. 72% of the 50 most frequently missing children were reported missing from care more often than a family home. 28% were more likely to have gone missing most often from home.

Return/Found data

Just over half of all missing young people (52%) returned of their own accord, usually to their home address. In about a third of missing incidents, there is police involvement in the resolution of the missing incident. However, in at least half the cases the police are being used as a first point of contact for someone intending to be returned to their home. COMPACT records two types of data here, “found by” and “found how”. The “found by” data reports that police are involved in 32% of missing incidents. The “found how" data presents a different picture of 2.6% which suggests that police involvement in proactive searches for children do not appear as frequently as the resolution for the incident. The difference arises because directed activity by the police to locate the child through police led actions can be nuanced. This could include routine police actions like patrols or stop and search to activity by police to influence the return of the child indirectly through others involved with the child like friends or family members.

Figure 5: Proportions of “found” locations



Distance Travelled

Although it is possible that a child travels a long distance during a missing incident, children are usually found close to where they went missing. The table below shows the distances between missing and found locations for the sample of incidents.

Table 4: Distance between Missing and Found locations

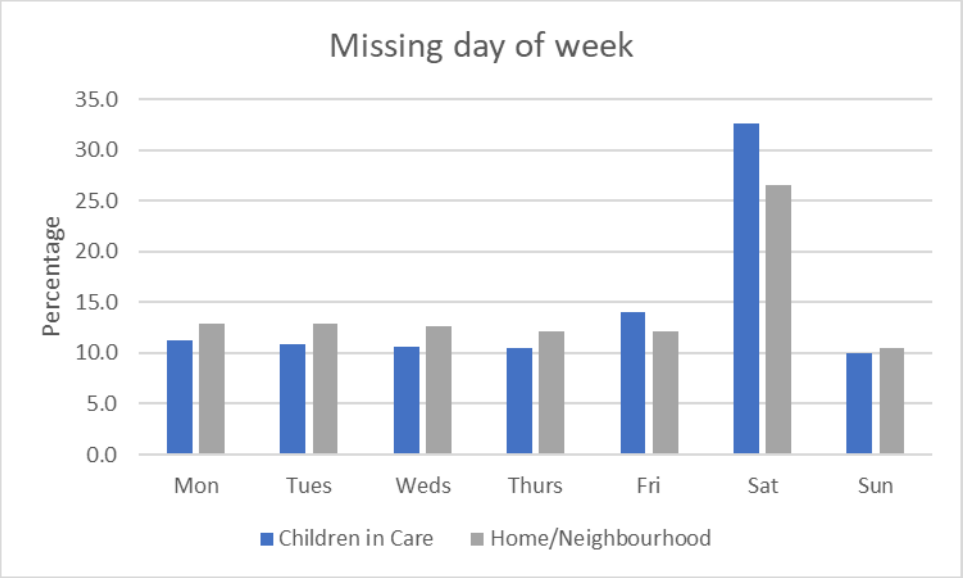
Distance travelled	Percentage of missing incidents
0-5 miles	72.1
6-10 miles	10.7
11-20 miles	8.5
21-40 miles	5.6
41-80 miles	1.6
>80 miles (in UK)	1.4
Out of UK	0.1

Timing of Missing Incidents

We have already assessed the monthly patterns of demand, concluding that there are few annual seasonalities other than a drop in missing incidents in December. We have also assessed any weekly patterns in demand and the timing and durations of missing incidents. These are detailed in the charts below.

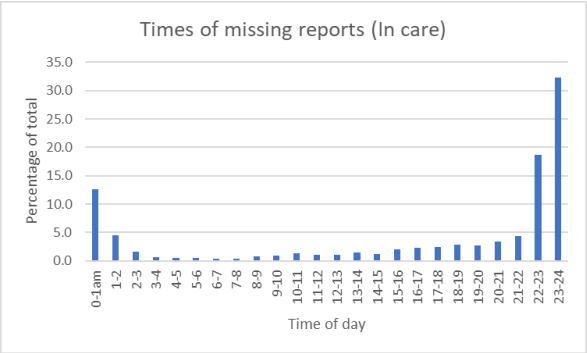
The data suggests that Saturdays are significantly busier than other days of the week for missing incidents as a whole. There is very little difference between care and home locations with the daily pattern of incidents.

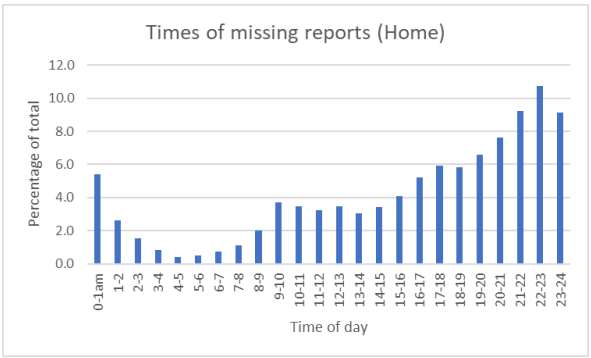
Figure 6: Day of Week Patterns in Missing Young Persons Incidents



A key difference between source of demand is the timing of the reports. Care homes and supported living residences report the majority of missing incidents between 22:00 and 01:00 whereas those missing from home are reported over a much wider span of time during each day. There is still a peak in missing reports late at night in both cases. Missing incidents from other sources have different patterns due to the obvious nature of the context. For example, those missing from school are reported during school hours only and almost entirely during Monday to Friday.

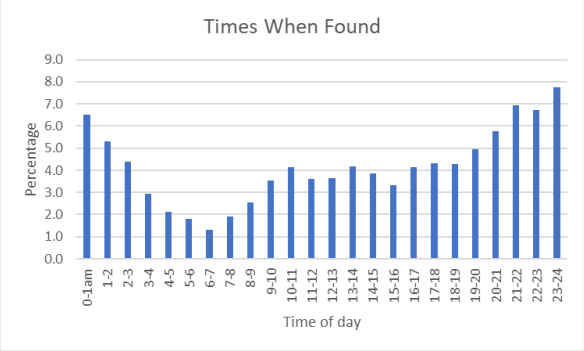
Figure 7: Hour-of-day Timing of Missing Incidents





The data shows that almost all missing children are found within 2 days of being reported missing, but this does not give the full picture. Figure 8 shows the times of day when missing children are found and the number of days they are missing for.

Figure 8: Time-of-day found and missing incident duration



In practice there two likely scenarios for many incidents:

1. A child is reported missing after a curfew is breached, usually between 10pm and midnight (although curfews are not enforceable for children in care). They are found within a few hours as they return late.
2. A child is reported missing late at night, but they are found/return the following day, having stayed overnight with friends.

Hence even when missing and found reports are a day apart, they have often only been missing for a very short period of time. Appendix 1 presents a cross-tabulation of missing and found times for those missing for 1 day or less, showing the high prevalence of 10pm-3am missing episodes.

Child Vulnerability

The data set was analysed to establish the levels of vulnerability associated with going missing and the causes of going missing. The table shows the frequency of vulnerability issues recorded as reasons for going missing in the entire data set of 9,184 incidents.

Table 5: Stated Reasons for going missing linked to vulnerability (Sample 9184 incidents)

Reason	Count
County lines	324
Gang related	318
Criminality	180
Modern slavery	11
FGM	3

It is likely that the role played by County Lines is under-reported in these figures as other data within the data set suggests a more significant role for the motivations to go missing. The recording of some vulnerabilities is also lacking standardisation. For example, we identified regular text-based recording of conditions such as ADHD as relevant to missing incidents, but these are often labelled in a "marker" column that also includes issues such as the person carrying a knife, so it is difficult to separate these out. Such issues will be analysed further in our case study section.

Perhaps of greater relevance are the markers for vulnerability that are listed in the records that are not necessarily the reason for going missing, but there is an associated risk to the person. The table below shows the listed risks and vulnerabilities associated with the full sample.

Table 6: Risks and Vulnerabilities listed in missing person records 2019-2022

Risk/Vulnerability	Percentage of mentions in incident reports
Gang risk	14.2
Criminal activity	13.2
CSE risk	13.1
County lines	11.3
Suicide risk	10.5
"Other" risk	7.5
Domestic abuse risk	1.6
Vulnerable	2.0
Trafficking	0.5
HBA	0.3
Modern slavery	0.3
Terrorist Offences risk	0.3

The use of flags to signify vulnerabilities should be relative to both the individual at the time and the circumstances of the incident. Gang involvement, county lines and criminal activity have overlap and therefore feature highly. The data appears to be auto-correlated in that when reports are compiled it is quite usual to see all of the above criminality-related markers appearing at the same time.

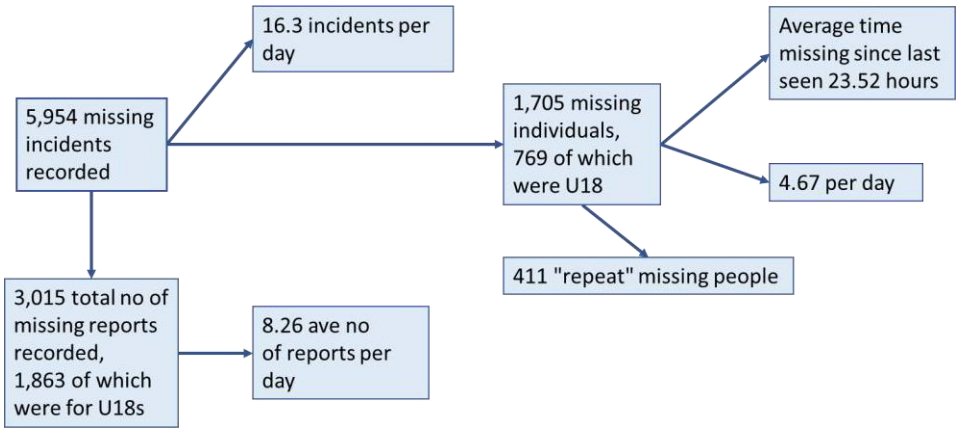
We note the relatively high number of incidents where child sexual exploitation (CSE) is listed as a potential vulnerability associated with the incident. This observation directed our later analysis of case studies, to establish why there may be CSE factors included in the reports. If CSE is prevalent in missing incidents it further establishes the importance of reducing the occurrence of this type of missing incident.

The percentage of reports listing suicide as a risk is worthy of further comment as qualitative analysis of the reports suggest that self-harm and suicide are aggregated into this flag, albeit they have quite different causal factors. There is a lack of supporting information within the COMPACT data provided to explain why this flag has been selected in many cases is not always apparent and the text explaining why they went missing and where they were found does not always contain detail relating to risk of self-harm or suicide, though this may be recorded within other fields in COMPACT, not examined as part of this report. Attention to the proper assessment of these vulnerabilities and subsequent use of the flag is recommended as it portrays a far greater risk than the data suggests is present. Out of 9,184 missing records, 2 children died whilst missing recorded as suspected suicide.

Detailed Sample Analysis 2022

Missing incidents for the calendar year of 2022 have been assessed in greater detail, adding further information about missing incidents from other data sources. Where descriptive statistics follow the same pattern as the aggregated statistics for 2019-2022, we have not presented repeated information. We have only added to this section new information that provides a richer picture of the patterns of missing incidents and the underlying characteristics. The overall picture of the missing incidents in 2022 is shown in figure 9.

Figure 9: Summary of Missing Incidents in Hertfordshire.



Children in Care (CLA)

Nationally, in 2022 the number of children in care, termed 'children looked after' (CLA) rose to 82,170 which is 70 per 10,000 children or 0.7% (Gov.UK 2022). Hertfordshire Children's Services CLA and Safeguarding Commissioning (2022) estimate that 272,588 children and young people reside in the county of Hertfordshire as of 31st March 2022. The number of children looked after was 1030. This equates to 0.4% of the total U18 population of Hertfordshire, which indicates a rate of placing children in care at almost half that of the national average.

The overall number of missing reports for children recorded in 2022 in Hertfordshire, was 1,863. These were generated by 769 children, of which 133 were children in care. A small number are for children under the care of another county council but placed in a Hertfordshire care home. There are only 24 reports listed below that do not relate to children under the charge of Hertfordshire County Council. It is worth noting the anomalies of other county councils listed as the responsible authority for a total of ten incidents in Hertfordshire where the child is recorded as not in care. This is believed to be human error on the part of the officer completing the COMPACT report, however the number is so small it does not influence the overall pattern.

If we compare the missing incident rates of children living in a home environment and those in a care environment, the differences are considerable:

- 12.9% of children in care in Hertfordshire had at least one missing incident in 2022. This compares with 0.23% of children in the main population.
- The children in care were involved in 499 missing incidents, almost a quarter of all missing incidents for under 18s. Due the high level of repeat incidents, this rate equates to 1 missing incident for every two children in care per year.

Table 7: Missing Incidents from Children in Care and their responsible council

IN CARE				
RESPONSIBLE_AUTHORITY	**Yes - Full Care**	**Yes - Accommodated**	**No**	**Grand Total**
Buckinghamshire County Council		1		1
Cambridgeshire County Council			1	1
Derbyshire County Council	1			1
Enfield London Borough Council	1		1	2
Essex County Council	1	1		2
Hampshire County Council	1			1
Hertfordshire County Council	305	166	1368	1839
Lancashire County Council	1			1
Non-Local			1	1
Northamptonshire County Council			1	1
Unknown	1		6	7
Wiltshire County Council	6			6
Grand Total	**317**	**168**	**1378**	**1863**

The data continues to demonstrate that most of the demand in terms of repeat missing children in care is generated by those who are the responsibility of Hertfordshire County Council, with only one child in the top ten most frequently reported missing showing any connection to another county council. Four of the ten children were in care, five lived in familial homes and one had a mix of semi-independent living and living at home.

Table 8: The ten most frequently missing children and their care characteristics

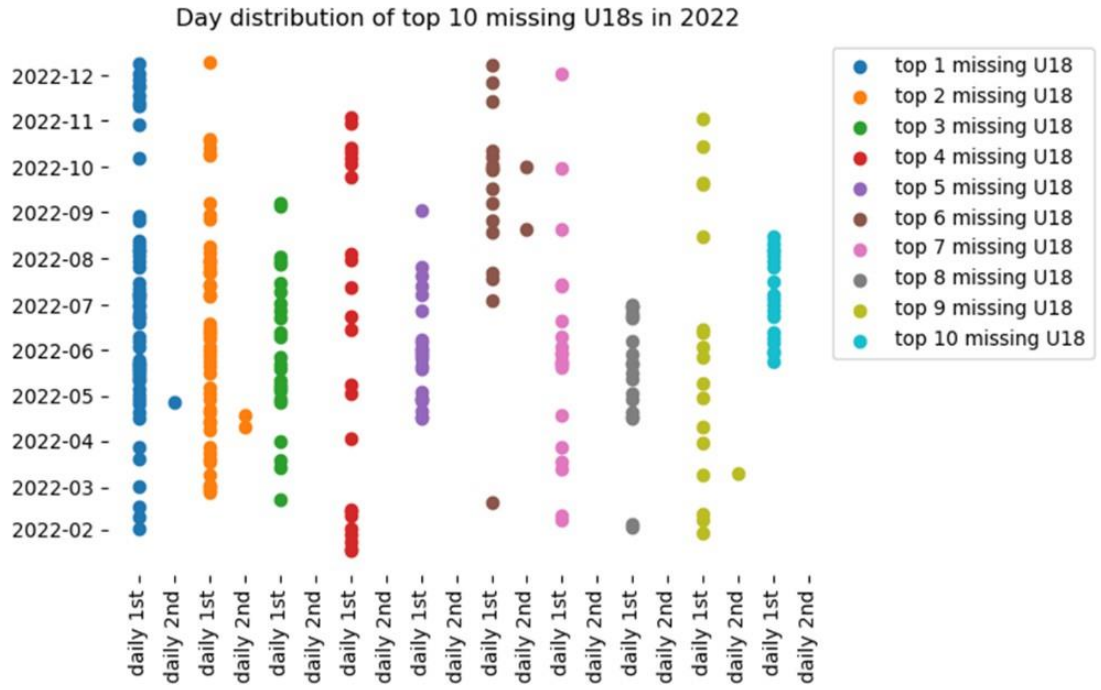
10 Most Frequent Repeat Missing Children PID in 2022	No. of Times Reported Missing in 2022	Child in Care	Social Worker Allocated	Out of County Placement
1st	58	No	Yes	No
2nd	52	Yes	Yes	No
3rd	25	No	Yes	No
4th	23	Yes	Yes	No
5th	22	Yes	Yes	No
6th	20	Yes	Yes	Mix
7th	20	Mix	Yes	No
8th	19	No	Yes	No
9th	19	No	Yes	No
10th	19	No	Yes	No
10	**277**	**5**	**10**	**1**

The patterns of missing incidents for 2022 for high repeat missing children.

We assessed the timing of every missing incident for these ten children to establish any patterns in repeat missing episodes. The figure below only shows missing incidents for 2022 when a number of these children would have had missing incidents in preceding years. There are twenty columns to

the diagram as some children went missing twice within a 24-hour period. These missing incidents are shown in a separate column for each child.

Figure 10 Repeat missing patterns for the ten most frequently missing children in 2022



The diagram suggests that five out of the ten children had missing incidents spread throughout 2022 and five had their missing incidents compressed into shorter spans of time. The top three all demonstrated intense periods of missing incidents where they would go missing every few days.

Four of the children appear to have ceased their missing activity and another two appear to have reduced the frequency of their missing incidents towards the end of 2022. This provides some indication that repeat missing incidents can reduce either where circumstances change or where interventions make a difference.

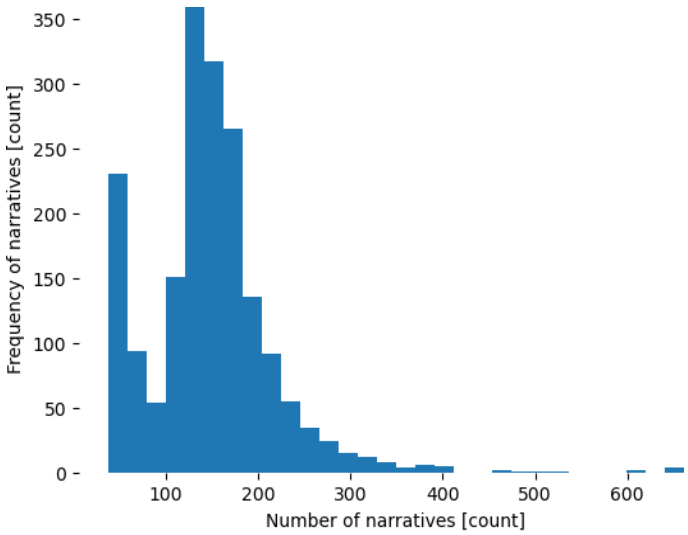
Two of the children had single missing incidents early in 2022, followed by a period of time without going missing, before an intense period of missing incidents. We question whether such early missing incidents are worth understanding to establish if there are indicating factors for future repeat missing activity.

Police Workload

We used the 2022 data to assess the police workload in dealing with missing incidents. There are two indications of workload in the COMPACT data base:

1. Narratives: this is an indication of the number of comments recorded about a missing incident. It reflects the workload in recording the incident and is a good indication of the complexity.
2. Tasks: Once a child is reported missing and risk level signed off, COMPACT generates a list of generic tasks relative to the risk level. This set of tasks is listed in appendix 2.

Figure 11: Frequency distribution of the narrative workload per incident



For 2022 there was a mean number of 148 narratives generated by each missing persons incident. The risk level of incidents did not change the number of narratives for incidents with any statistical significance. The number of narratives did not change with any significance if the missing person was found by police, but there was a 25% increase in the number of narratives generated when a missing person was reported as found by social services.

Table 9: The number of tasks associated with each incident based on risk classification

Risk level	Mean No. of Tasks
High risk	26.1
Medium Risk	18.2
Combined	19.2

The higher risk category contains an average of 6 more tasks (30% more) than medium risk. It is worth noting that the number of tasks generated in 2022 per high-risk incident is half that of the workload in 2019. In July 2021 a review and removal of the least effective automatically generated tasks was carried out by the Missing Persons team to reduce unnecessary demand on officers. The data shows this has been effective.

When we assessed the tasks and narratives there was no statistically significant difference in the police workload when they find missing children.

Hotspot analysis

Appendix 3 contains a map showing the locations of all missing incidents for U18 in 2022 that were reported to Hertfordshire Constabulary. It shows the correlation between location and centres of population, which is to be expected. Full hotspot analysis can only be conducted using postcode or similar analysis. To maintain confidentiality, full postcodes of home addresses have not been presented in this report.

There are 7 Local Authority, 15 private and 4 voluntary/charity children's homes within the county.

Table 7 shows that not all children's care homes generate missing demand, with several postcode areas covering addresses including care home locations not having any missing activity recorded throughout 2022. This can be explained in part by the nature of the care home, with some being for short break stays only or for children with additional needs who are incapable of going missing on their own. Demand generated by children living in care homes can therefore be expressed as intermittent, in that it is not the concentration of children living in one address, or the fact that it is a care home, but the presence of one or two children who are repeatedly reported missing whilst they reside in the care home, then move on that generate these results.

Table 10: Missing incidents by Postcode.

Postcode Area	No. of Missing Reports against postcode 2022
AL1 2**	8
AL10 0**	0
AL4 0**	0
AL7 2**	0
AL7 3**	0
AL8 6**	7
CM21 9**	4
CM23 3**	6
HP2 7**	26
HP4 1**	54
SG1 1**	1
SG1 4**	0
SG10 6**	0
SG13 7**	16
SG13 7**	0
SG2 0**	17
SG2 8**	25
SG5 1**	10
SG6 4**	10
SG6 4**	0
SG7 6**	0
SG9 0**	0
WD18 0**	0
WD23 2**	14
WD25 7**	19
WD3 9**	0

Vulnerability

Detailed analysis of the vulnerability of children who went missing in 2022 identified two factors of relevance.

1. Eight out of the 20 most frequently missing children were marked as being involved in county lines activity. The data was auto-correlated for other crime-related markers, so there was little other analysis that could be meaningfully conducted. These children were

at risk of exploitation and were likely to have addiction or substance abuse records as well as criminality.

2. Eleven out of the top 20 most frequently missing children had warning markers on their records. There were split between two completely separate types of characteristics. Firstly, those involved in county lines activity would have markers for knife possession or violence, to act as a warning to officers. Second, however, were markers for mental health or behavioural issues such as ADHD. Such markers reflected on the vulnerability of the childrather than the danger they posed to police or public. There was insufficient systematisation of recording of such vulnerabilities, with a variety of text-based comments on records that all identified similar conditions. We also noted the use of the term "undiagnosed" for behavioural issues, perhaps suggesting lack of access to diagnosis and appropriate support.

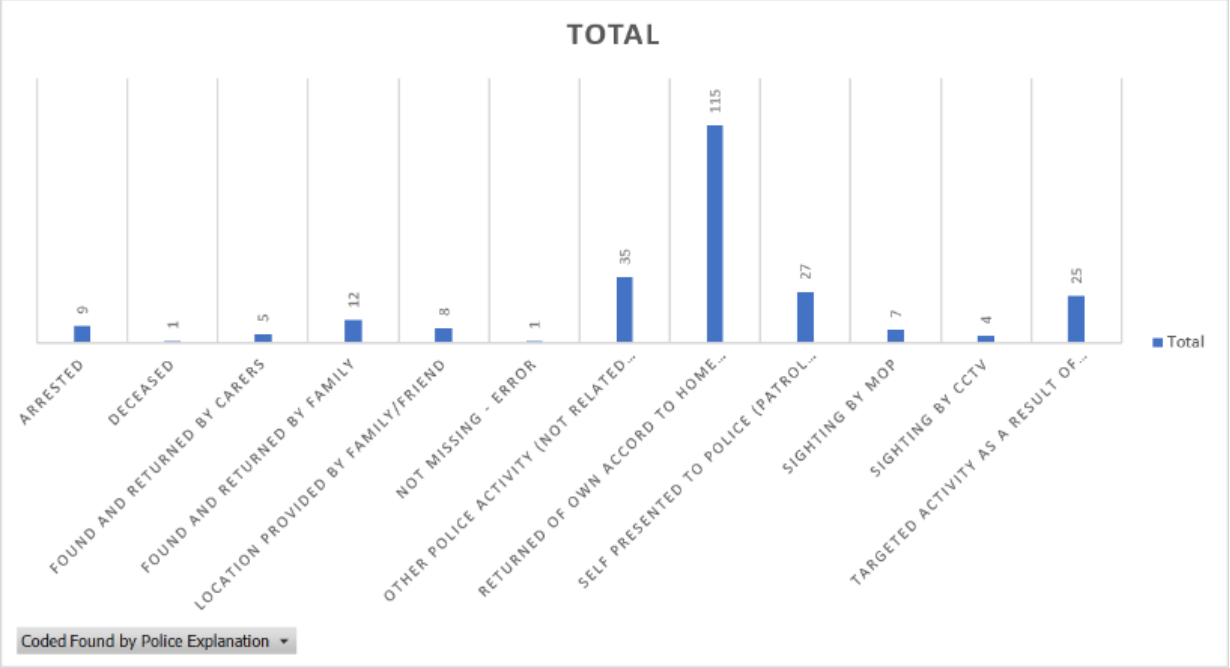
Sample of 82 cases

The next two tables contain data relating to reasons for going missing and how the missing child was found. The data is a combination of information from several fields within COMPACT including the circumstances of going missing, detail from the prevention interview and pre-coded fields of how found and found by who (excluding return home interview information as this was not provided in time for the reports) and codified. This category therefore is our best effort at looking at all the relevant fields and coding them appropriately for analysis.

Figure 12: Reasons for going missing

This data suggests that in most cases the reasons for going missing are pull factors that do not directly cause harm. Wanting to see friends/partner, cooling off after an argument with family and staying out past curfew being the largest drivers of reporting.

Figure 13: How missing U18 children were found (2022 sample of 249 incidents)



When evaluating the 249 reports from the sample group to understand how these children were found, it became clear that only a small number of them (25 occasions) were located as a direct result of officers' activity targeted at locating them, with almost half of the group either returning themselves or presenting themselves to a police officer to be returned. Interestingly, the number of children who were found as a result of other police activity was higher than the targeted activity at 35 occasions. This included instances of a report of anti-social behaviour where a missing child was identified and a call from ambulance concerned for a patient they had been dispatched to, who turned out to be a missing child. On nine occasions a child was identified as missing following their arrest, suggesting some criminal activity took place whilst they were missing. The offences reported include drugs possession, shoplifting, attempted robbery, criminal damage and breaching court bail conditions. This supports the opinions discussed in the literary review that offences such as shoplifting are committed whilst missing to sustain themselves, as well as being part of the reason for going missing, such as selling drugs for county lines.

Narrative case studies

In this section we present 9 narrative case studies that introduce more contextual detail about the nature of missing incidents and the actions that have taken place prior to the child going missing and the subsequent attempts, if any, to prevent future missing incidents. These cases have been selected to illustrate the factors that lead to missing incidents and the challenges associated with prevention. They are not representative of the sample as a whole, but were selected to provide different combinations of age, gender, in care or home living, vulnerabilities and prevention activity. The table below summarises the cases.

Table 11: Summary of the Narrative Case Studies.

Case	Age	Gender	Freq.	Location	Context	Actions
A	9	Male	1	Home	Non-verbal ADHD. Difficult home situation.	Child in Need Plan. Bonding with carers reduced risk of repeat.
B	12	Male	1	Care	ADHD. Out-of area placement. 9 siblings.	No contact with relevant council before or after missing incident
C	15	Female	1	Home	Autism, Aspergers's and classified "at risk". Mental health issues.	Mental health Care plan has addressed issues
D	15	Female	5	Home	Difficulties with home environment.	Complex case in terms of addressing which Council has responsibilities. Lack of coordination of support or prevention activities.
E	13	Female	4	Care	Out of area placement. At risk of CSE. Multiple missing incidents.	Local council eventually acted as voluntary surrogate for responsible council to protect the child.
F	13	Male	58	Home	Criminal record with referral order/tag. At risk of County Lines and Child Criminal exploitation.	Considerable multi-agency work has not yet reduced the extensive repeat missing incidents or addressed the criminal activity.
G	13	Male	19	Home	Victim of domestic violence. Substance abuser with criminal record and vulnerable to exploitation. Involvement in County Lines.	Support often refused by child. Eventually taken into care and moved away from local area.
H	16	Female	42	Care	Multiple vulnerabilities and health issues. Suicide risk. Taken into care due to neglect.	Has had 10 different foster/care placements. At least 13 identified support processes in place.
I	17	Male	3	Home	Moved to avoid exposure to County Lines and CCE. Involved in serious criminal offences. Kidnapped for 4 days.	Poor record availability missed opportunities to safeguard.

Child A: Single Missing incident

Child A is a 9-year-old male living in a familial home. He has a diagnosis of severe ADHD, Autism and is nonverbal leading to him lashing out in frustration on occasion and presents challenging behaviour. He lives with his mother and sister in temporary accommodation due to domestic abuse and two days before the missing incident his mother had reported a domestic incident involving herself and her ex-husband to the police. His father is currently living some considerable distance away. He is registered as a child with disabilities and has a Child in Need (CIN) plan with Hertfordshire County Council (HCC). The 0-25years Team within HCC have been involved with him since 2022. He attends school in Hertfordshire where he is reported to be settled and doing well.

Child A has fixations, at the time of being reported missing he was fixated on hiding from his mother. He has an underdeveloped sense of danger/risk and needs constant supervision. Their accommodation has shared facilities and gardens which the mother cannot fully control access to. His mother described how he had gotten out before but was always found quickly and not come to harm. There are no other COMPACT reports for him, suggesting police were not called on those

occasions and his mother took actions to find him herself. Assessment of his accommodation was that this was likely to happen again due to the nature of the property and that it housed multiple families.

The missing incident

In July 2022, Police were called approximately 20 minutes after his mother reported Child A could not be located. He was graded as high risk due to diagnosed vulnerabilities and young age. Officers carrying out an area search in the vicinity of his accommodation located him approximately 40 minutes later as he was climbing out of a tree a couple of streets away. It is believed that Child A saw police from the tree and came down as a result, but due to being nonverbal it cannot be confirmed. His mother reported he was missing for around 1 hour. He did not come to any harm whilst missing.

Actions

Police officers completed a Child Safeguarding referral. Hertfordshire County Council (HCC) did not offer a Return Home Interview as being nonverbal. Support was put in place via HCC through an agency which appears to have reduced his fixation to wander. HCC report he has bonded with carers. Support workers are present at the accommodation 4-7pm on weekdays and 11-5pm on weekends for all occupants and a support worker from school also provides support for the whole family. There have not been any further missing reports to police for Child A.

Child B: Out-of-area placement in care

Child B is a 12-year-old boy under an Interim Care Order who was placed into a care home in Hertfordshire by another local authority 5 days prior to the missing episode. Very limited information is known about the history of Child B due to a lack of information sharing from that local authority at the point of placement into Hertfordshire. HCC became aware of his placement in the county because of being notified of this missing episode. As a result, we are unable to say if there were any previous missing episodes or what support provisions, if any, had been put in place by the placing local authority.

Child B is a triplet and has 9 siblings in total, of which 2 are also in care. He is living apart from all his siblings which is presenting challenges of separation.

The missing incident

Whilst in attendance and taking the missing report, police identified that Child B suffers from ADHD for which he takes medication and is described as not being able to communicate effectively with the public. He has an Education, Health and Care Plan (EHCP) for special educational needs support but does not attend school at present due to suitable provision not being available. He does not know the area and has no known local connections.

The circumstances of this missing incident are that care home staff removed access to his mobile phone for an unknown reason, causing him to run away. As soon as Child B left the care home, Police were called who attended the location immediately. He was graded as medium risk. Child B self-presented to police, having hidden in a tree a short distance from the care home and was returned approximately 10 minutes after the call to report him missing was made.

Actions

A return home interview (RHI) was not offered by Hertfordshire Children's Services (HCS) as he is an out of area looked after child and the statutory guidance places this responsibility onto the placing authority. The matter was therefore passed to them to complete. HCS have not received any update

from the responsible local authority and as such we are unable to state if the RHI was completed or any safeguarding or diversion support was provided.

The COMPACT report for this episode shows that the safeguarding referral task is still outstanding and the RHI is marked as not completed (report was made in April 2022). No further missing reports have been made in respect of this child and it is unknown if he is still within Hertfordshire.

A lack of communication and information sharing between agencies in these circumstances highlights the problems faced when a child goes missing in being able to assess the risks and vulnerabilities surrounding them. Neither police nor Hertfordshire Children's Services establish what, if any, actions have been undertaken to prevent any future missing episodes in relation to this child because the information sharing process is not clearly defined and adhered to.

Child C: At risk with 2 recent incidents

Child C is a 15-year-old girl who lives with her parents and siblings in Hertfordshire. She is identified as a risk of suicide and self-harm, and she also has a diagnosis of autistic spectrum disorder.

Child C has been reported missing three times in total, the most recent 2 missing reports were 8 days apart and had similar circumstances. Prior to that she had a missing report that was a year and a half earlier. This shows an escalation over a short period of time.

Child C has been suffering with her mental health and at the time of going missing she was diagnosed with depression which she takes medication for. In the immediate hours before going missing, she did not show any outward signs of a decline in her mental health, although the missing episode 8 days before was recent enough to be a concern. She was also suspended from school at the time of the most recent missing reports. These are all factors that contribute to her vulnerability.

The latest incident

On the last missing occasion parents woke up to find that Child C had left the house, whilst her family slept, her father called police immediately and she was classified as a high-risk missing person. Her school uniform was missing, as was alcohol and medication from the house. Her father called police and due to Child C being located at her school in the previous missing episodes, her mother attended there as soon as it was discovered she was missing and found her. She had self-harmed by cutting herself with glass and taking an overdose of paracetamol.

Child C was believed to be missing for approximately 5 hours and was located 30 minutes after it was realised that she was missing. Child C was taken to hospital for physical assessment and agreed to a mental health assessment, she attended as an informal patient but was subsequently detained under s.3 of the Mental Health Act so she could receive support with her mental health and attempts of suicide, due to the escalation over such a short time.

Actions

A return home interview was offered and taken up, mental health support provisions were put in place because of the section imposed. Her case was taken to a multi-agency meeting where it was decided that it would not be in her best interests for her to attend a face-to-face assessment. The focus was identified as her mental health for which she was receiving support via the hospital. Due to being accommodated in a mental health hospital with no plans for discharge in the immediate future, her case with Children's Services was put on hold pending discharge. HCC report whilst she is in hospital, she falls out of the scope of other HCC services and agencies to support her.

Due to proactive steps being made by parents, heavy police involvement in the missing episode was negated. Child C engaged with support services including the return home interview which provided support to treat the root cause, which was her mental health at the time. There have not been any further missing reports for Child C.

Child D: Difficult home circumstances

Child D is a 15-year-old girl. Her mother and sibling live in Hertfordshire and her stepfather lives in another county with a new partner and child. She lived with her stepfather for 18 months (about 1 and a half years) before moving back to her mother's address. Since then, she has flit between the two addresses and as a result is not currently attending school.

Child D has 4 previous missing person reports recorded in Hertfordshire between 2019-2020 (before she went to stay with her stepfather). The reason for these missing episodes all relate to arguments between mother and Child D, where there appears to be a relationship breakdown. Her mother reports she has gone missing several times more, but she did not report these to police.

The safeguarding lead at her previous school in the county where she lived with her stepfather reported that she was doing well and was very involved, but since contact with her mother was restarted her behaviour changed. Child D raised concerns that her mother had a male living at her address that she did not feel safe around.

There was a social worker allocated to Child D by the other county's Children's Services, but not in Hertfordshire. Their details are not known to the mother or Hertfordshire County Council. Another example of a break in information sharing between County Councils in respect of children they are supporting. HCC had previously been involved with Child D 2020-2022, but at the time of writing, her case was closed. It has not been determined whether Child D was reported missing to the responsible police force during the time that she lived with her stepdad, as COMPACT remains force-specific in terms of data access.

The most recent incident

On the last occasion of being missing, her mother was arrested on 15th October. During interview she disclosed that she had a 15-year-old daughter who was home alone and so a welfare check on her was requested. Hertfordshire Constabulary did not carry this out. When her mother returned home from custody on the 16th of October, Child D was not there, and her mother reported her missing. Addresses in both Hertfordshire and the county where her father lives were checked, and she was located at a friend's house in the other county on 17th October. She remained there overnight, and her biological father collected her the following day and took her to his address. On this occasion she was missing for 2 days and 4 hours.

Actions

Hertfordshire Children's Services did not complete a return home interview as Child D was not physically in Hertfordshire and it posed logistical difficulties for the social worker to conduct an RHI for a child who is currently out of area. At the time of writing this report, COMPACT still shows an outstanding task for a safeguarding referral which is graded high.

On 20th October HCC received a referral from the Accident and Emergency Dept stating that Child D's mother had driven whilst intoxicated with her son in the car and had a crash. This event was resulted as Information and Advice. On 31st October the Children's Services covering the area where her father lived, and where she was now staying contacted HCC requesting information to complete

their risk assessment following a referral to themselves for Child D as she had removed herself from her mother's care. They asked if Hertfordshire Childrens Services were completing a strategy discussion on this basis as well as asking for the history with regards to her younger brother. HCC finalised this case as Information and Advice. This suggests that when requested, HCC do share information in the best interest of the child.

The instability of Child D's living situation and suitability of her mother to care for her are highlighted in this case. Had a return home interview been offered and taken up, social workers may have been able to better understand the risks and vulnerabilities posed to Child D by her living arrangements and the risk Child D was exposing herself to in order to escape this environment. This risk could then have been mitigated and support provided at a much earlier stage.

Child E: Out-of-area placement without local knowledge

Child E is a 13-year-old girl. She was placed into a care home in Hertfordshire in April by another county council. Hertfordshire Children's Services were not aware of Child E being placed in Hertfordshire and only became aware of her when her missing episodes were reported to them via her care placement. A further example of gaps in information sharing posing a risk when a child is reported missing.

Police ascertained from taking the missing person report that Child E had been sending indecent images of herself to others using Snapchat on her mobile phone. It was removed from her by care staff and as a result she could only use the internet under supervision. She was also not allowed to leave the care home without supervision for more than 30 minutes or have physical possession of any of her money. She was assessed as at risk of child sexual exploitation (CSE).

Four missing incidents

Child E was reported missing 4 times in total during 2022. The first occasion was in June, she did not provide a reason for why she left the care home, but another child who was reported missing from the care home at the same time, stated that they went together to London and walked around. She was missing for around 12 hours and was graded as high risk due to the CSE risks.

The second occasion was in August; however she was not actually missing and was hiding in the care home. The address was not searched before police created the report on COMPACT. This highlights the importance of carers carrying out some initial actions before reporting a person missing to police.

The third occasion was in September. Child E stated she wanted a break from the care home. She went to a local car park with another child from the care home and was located by staff there. She was missing for around 2 hours, again graded high risk, but downgraded to medium through the course of the investigation as the context of this episode was reassessed.

The last occasion, Child E left the care home using her 30 minutes of allowed time unsupervised to attend local shops, however another child from the care home told staff she was travelling to London with a 15-year-old boy and whilst missing contacted a friend to say she was in Camden. Care home staff travelled there to look for her.

Actions

She was graded as High risk due to the risks presented by the boy she was in company with. Phone location work commenced. Child E was in text contact with a friend from the care home and told

them who she was with. The information she provided along with the result of phone work led the local police to an address where she was finally located. She was missing for 13 hours approximately. Also found at the address was another girl who had been reported missing from another care home in a different local authority area. There are no further details about this girl due to the delineation of council responsibilities and lack of consistent information sharing between councils regarding children placed out of county.

The police officers that found her recorded that she appeared under the influence of alcohol but was able to communicate clearly. She stated she had not been the victim of any crime or subject of harm but would not talk further with officers when they carried out a safe and well interview.

HCC records state that the placing county council have responsibility for this child. They do not hold any information about Child E's history or any precursor behaviour. Hertfordshire Children's Services forwarded all information about these missing episodes to the placing Children's Services team for them to review.

Unusually, in February 2023 Hertfordshire Services for Young People met with Child E to discuss her needs and interests. She was invited to join some local projects to provide social interactions and further 1:1 meetings were arranged to support her emotional & mental wellbeing and safeguard against CSE risks. HCC are not obligated to provide this, but the benefits to the child, police and ultimately HCC to support children living in their area should ultimately reduce demand placed on them when they go missing.

Child F: Extreme frequency of missing incidents from home

Child F is a 13 year old boy living with his mother in a familial home in Hertfordshire. Child F has identified vulnerabilities around county lines and child criminal exploitation. He has no formal diagnoses but demonstrates traits of ADHD and potentially oppositional defiant disorder. Child F intermittently attends school. He was assessed as not fitting the threshold for a secure unit or further support by HCC. Child F is also a known cannabis user. He currently resides with his mother; his father does not reside in the familial home and Child F has previously made allegations of assault against his father.

Missing incidents

Child F was reported missing 58 times during 2022, the vast majority of which he was missing for under 10 hours. Most reports were received by police around 9pm when Child F had failed to return home after being out in the evening. In the main he either returns home himself or presents himself to police to be taken home. He general returns between 10pm and 8am. He was arrested ten times when found for offences ranging from drugs, theft and robbery, many of which were committed whilst being missing. On most occasions Child F goes missing with friends who are also reported missing or following arguments with his mother.

In his most recent missing episode in November 2022, Child F was collected by his mother following him being out for the day. Child F remained for 15 minutes before suddenly leaving the house stating he was staying at a girl's house. This was a breach of his curfew imposed by a Youth Referral Order (YRO). His mother gave Child F two hours to return before she notified police. He was missing for 12 hours in total on this occasion and returned of his own accord. When asked, Child F stated he was bored at home and didn't want to follow his YRO. He refused to provide details as to where he went during the missing episode. He was graded as medium risk on this occurrence.

Actions

In August 2022 a S.20 care order was pursued and Hertfordshire County County liaised with police to target those adults exploiting Child F. The details of this are held by HCC and not shared on COMPACT or Athena at a level that frontline officers can access. This highlights another instance where better sharing of information would improve safeguarding and hopefully prevent further missing episodes, crimes and harm to Child F. During 2022, HCC assessed Child F and classified him as a Child in Need, which triggered additional support for him, the exact details of this could not be established for this report unfortunately, so we are unable to analyse their effectiveness.

In September 2022 Child F was sentenced to 9 month Youth Referral Order and a 3 month electronic tag with a curfew of 8pm-7am due to his criminal behaviour. Child F was also referred to the Missing Person Charity in 2022 for diversion and was open to both Specialist Adolescent Service Hertfordshire and Youth Offending Teams, which are part of the county council. He was discharged from the Multi-Agency Criminal Exploitation group in October 2022, but preceded to go missing a further 7 times that year. HCC did consider removing him from the family home, however when he was convicted of offences, the court imposed a referral Order and subsequently a Youth Rehabilitation Order based on him living with his mother, so it was decided not to consider Child F for placement, and he remained living with his mother.

HCC tentatively closed his case in October 2022 at his final Child in Need meeting. He was worked with via his Youth Rehabilitation Order and formally closed on system in November but went missing again soon after.

In January 2023 the Police opened a non-crime investigation into criminal exploitation. He has been the subject of several multi-agency meetings, two of which were since his most recent missing episode. He has previously been the subject of a Child in Need plan and has allocated social workers. He has also been referred to the Schools and Gangs team within the police as well as mentors and other specialist services.

In this child's case, the sheer volume and frequency of missing episodes is noteworthy. Whilst he has received attention and support from Children's Services and multi-agency meetings have been held, they have not been successful in reducing the pattern of missing shown throughout 2022.

Child G: Longer missing episodes

Child G is a 13-year-old male living with his mother. He is a previous domestic abuse victim from his father, who no longer lives at the family address, but with whom he has regular contact. He is vulnerable to exploitation, specifically county lines, and is a habitual substance abuser. He has poor school attendance having been excluded from his initial school for behavioural issues and does not attend his new placement. He has been involved in crime and arrested for offences of criminal damage and assault. He is associated with other local children who are also reported missing regularly.

Child G moves between his parents' addresses based upon their capacity to manage his behaviour. He is open to Specialist Adolescent Services Hertfordshire and is under a Child in Need plan with HCC. He has been missing 19 times in 2022, on several of these occasions he was missing for over 48 hours.

Recent missing incident

His most recent missing episode of 2022 in Hertfordshire was in July. Child G went missing for 14 hours. He was found by police with another missing child, sleeping in the garden of a property and returned to his father's address in the early hours by the police. He left the house whilst his father was at work and was subsequently reported missing a further time. His father spoke to him via telephone, but Child G refused to say where he was. Approximately 8 hours later Child G returned of his own accord to his mother's house. He was spoken to by Police but refused details as to where he had been. It is unknown if HCC conducted a RHI for this episode.

Actions

He was subsequently taken into the care of the local authority and moved into residential care, initially to London however he continued to return to his hometown in Hertfordshire and was subsequently placed in Scotland to put greater distance between him and the people he was at most risk from and deal with his cannabis use. He often declines RHI's and has varied recorded reasons for going missing although most featured is involvement with drugs and county lines.

This case demonstrates that even when offered, an RHI does not need to be taken up by the child, which closes one avenue of offering support and ultimately prevention.

Child H: Many repeat incidents and extensive support network.

Child H is a 16 year old female in a care home under full time 2:1 care. She has multiple vulnerabilities including autism, foetal alcohol syndrome, oppositional defiant disorder and has a deprivation of liberty order in place due to a lack of capacity. She is a suicide risk and has self-harmed on several occasions which has resulted in hospital admission and surgery. She has sustained permanent damage as a result of the ingestion of batteries. She is prescribed a variety of medications which she does not always take, leading to impulsive and erratic behaviours which is described as presenting as blind rage and aggression towards others.

Child H comes from a family with complex needs. In 2010 she was subject of a Child Protection Plan due to neglect. Child H and her 5 siblings were taken into care in June 2012, which was unopposed by their parents, and she has been a CLA since then. She has been in approximately 10 placements from foster care to secure accommodation. Child H's mother died in 2014.

Missing Incidents

Child H has been missing 42 times total, 10 times during 2022. Generally, her missing episodes are because of a negative interaction with care home staff and discontent around limitations imposed due to her care status. On her most recent episode Child H ran away from the staff in anger at not being allowed to go on a field trip due to recent poor behaviour. On hearing this she lashed out at staff members before running away and being reported as missing. She was graded as high risk due to the vulnerabilities mentioned above. Officers commenced a search; however, she was located by ambulance (who notified police) following a call she made to them after having taken an overdose of paracetamol. She was found approximately three and a half hours after being reported missing.

Actions

Child H was offered an RHI in person, which she refused. Police have little details about agencies working with Child H. HCC have a working professional group that meet to discuss Child H including representatives from CLA to Social Care, Children & Adolescent Mental Health Services, Care Coordinator, Safeguarding Nurse from local hospital, Virtual Schools, Police Missing Person Team,

Education provider, Transitions Team, Care Home Staff, Transforming Care Worker, Independent Reviewing Officer, 0-25 adult social worker and a tutor, however it is unknown what the results of these meetings were. Since then, there have been multiple calls to the police about Child H, both as a victim and offender in offences. She has also been in hospital due to a suicide attempt.

Child I: Child at risk with complex support needs

Child I is a 17 year old male living in a familial home with his mother. He is vulnerable to county lines and CCE (Child Criminal Exploitation). He moved to Hertfordshire in June 2021 in an attempt to remove him from these affiliations where he was living, he was open to a London-based Childrens Service in 2021 under a CIN plan due to gang affiliations and repeat missing episodes. He has been missing 3 times in 2022 whilst residing in Hertfordshire, all three have been for periods ranging between 17-35 days.

Child I originates from Eastern Europe and his father still resides there. There is a history of domestic abuse within the household. When Child I lived in London he became entrenched in gang culture which he glorified and he has a criminal history of drugs and violence, including having previously stabbed someone in early 2021 which resulted in a 12-month Referral Order, which means he is obliged to work with the Youth Offending Team.

Recent missing incident.

On his most recent missing episode of 2022 Child I was reported missing by his mother in early September. On this occasion he had in fact left the home address on the 15th of August (24 days prior) stating he had unfinished business with someone and was going to see his friends. His mother did not report him missing at this point. Between the 15th of August and the 1st of September his whereabouts are unknown, and he was not shown as a missing child on the Police National Computer. On the 1st of September Child I was arrested by the Metropolitan Police for multiple offences including offensive weapons, theft from person and threats to kill. Child I's mother was contacted to attend Custody as an appropriate adult but was unable to do so. Police records show that Child I was charged and released on police bail on the 8th of September. It is unclear what happened when Child I was released however it appears it was not into the care of an appropriate adult, as on the 7th of September he was reported missing by his mother who confirmed that she had not seen him since the 15th of August. Child I returned of his own accord on the 8th of September to his home address.

Actions

When police conducted the Safe and Well interview he disclosed that he had been kidnapped whilst missing and assaulted by unknown persons. These unknown persons released him after four days, which is when he returned home.

Child I was offered and took part in the RHI; however he was not fully cooperative and little information was gleaned from it.

On 23rd September he reported concerns for his safety as his kidnappers had paperwork relating to his arrest which contained his home address details. He and his family were subsequently relocated in October to another county.

There are issues with a delay in being reported missing by his mother on this occasion, which meant that when he was arrested by police he was not shown as missing on police systems.

The Multi-Agency Missing Persons Process

Childrens' care home provision is the responsibility of Hertfordshire County Council. Ofsted are the regulatory body for children's care homes and as of April 2023 they were given additional responsibility for overseeing standards of care provided for 16–17-year-old children placed into semi-independent, mainly private provisions. Until this time, these provisions were unregulated.

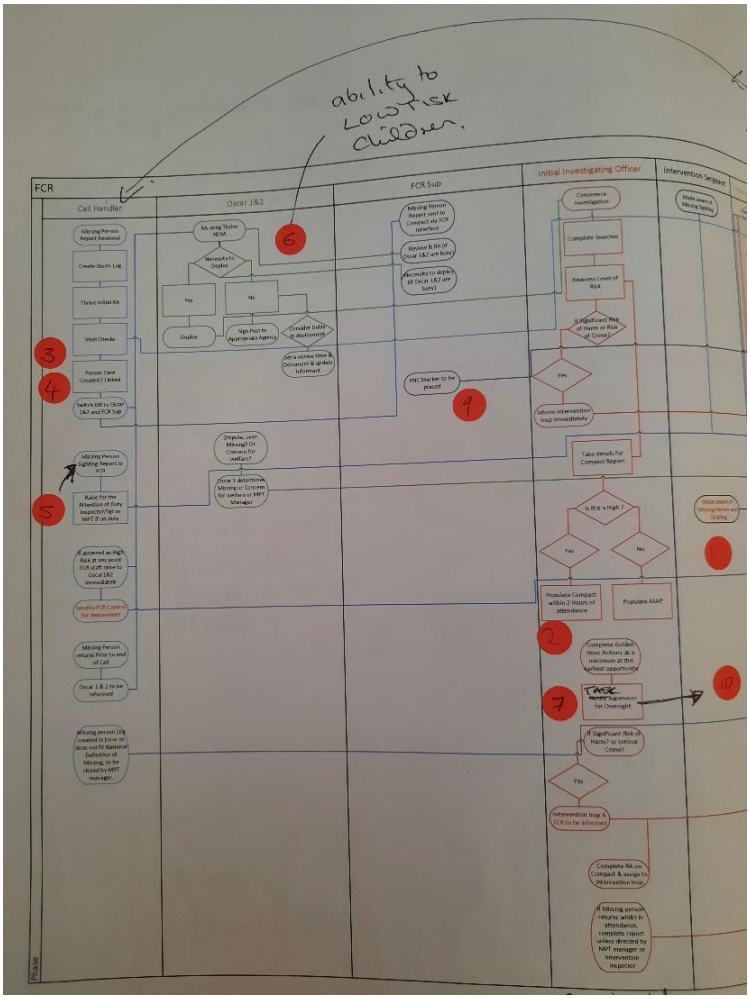
A workshop was held at Hertfordshire Constabulary Headquarters, in Welwyn Garden City and a follow-up online using MS Teams. The purpose of the workshops was to understand the current processes followed by each stakeholder in respect of preventing children in care from going missing and acting when they do. The following stakeholders attended at least one meeting:

HCC Children's Services	Specialist Adolescent Service Hertfordshire (SASH) Children Looked After team (CLA1)
Missing Persons Charity	Return Home Interview team
Hertfordshire Constabulary	Control Room Frontline Response team Missing Person team Prevention First team

Ofsted were invited but unable to attend.

The following excerpt from the workshop shows a section of the police standard operating procedure mapped out according to role. Attendees worked through the procedure marking where there were points of failure, digressions from the policy and what activity happens that is not documented. The dots in the picture represent team members highlighting where a failure or concern is noted.

Figure 14: Example of the Process Map Failure Point Identification



The results of these workshops for both HCC and Police processes were collated into a 3Cs table (concern, cause, countermeasure). Evidence of failure demand was identified at several points along the missing person journey. Some of which are discussed in detail here. A summary of the concerns is listed in table 12. Further detail, with the complete 3C tables is provided as appendix 5.

Table 12: Summary of the 3C "concerns"

Stage in the process	Concern
Pre-missing	Police involvement in pre-missing planning is not formalised Placement selection compromised by lack of availability Limited ability to address the suitability of placement location Failure of Out-of-area notifications process COMPACT system not a national system No engagement between care homes and local police Contact form not consistent with the Philomena Protocol
During missing	"Late" returns are reported as missing incidents Missing incidents reported before checks are complete Lack of use of "low" risk assessment category Lack of use of "Absent" category Errors in the Intelligence reporting Misuse of "Concern for welfare" incident categorisation Lack of use of the NPCC levels of intervention model Duplication of effort/reporting delays Data errors on COMPACT Auto-generation of tasks creates failure demand Response Sergeants not given a formal role in incidents Delays with PNC markers being placed Sightings reports might not be picked up Limited hours of operation of the Missing Persons team Missing Person team office-based Lack of reporting structure for the missing person's process
After missing	Prevention interview not always effectively conducted Officers not submitting intelligence into the system Return Home Interview (RHI) misses opportunities for prevention Out-of-County RHI not always conducted RHI conducted at inappropriate time Delays or errors in reporting RHI information by third parties

Before going missing

It became clear that at the start of a child's experience of the care system police are not routinely asked to share information that would assist in identifying risks and potential harms, specifically in the commissioning, matching and placement process. It is the statutory responsibility of the local authority to decide whether it is in the child's best interest to be removed from their parent's care, with police only having such powers in emergency situations. However, where time is being taken to make these decisions, police information and intelligence could prove useful. In addition, police and in particular local officers having knowledge at the earliest opportunity that a vulnerable child is being placed into a care home in their area provides opportunities for engagement and safeguarding that is currently absent in the process.

What specific actions care homes take to identify the likelihood of a child going missing in advance of the episode could not be clarified during the workshop, however it was determined that the form designed to extract key information required to conduct an efficient investigation is not well known

to officers or provided by care home staff to officers. Scope for development, including digitalising and automatic sending of this form became apparent. The police Missing Persons team commented that HCC have their own version of the Philomena Protocol form which was co-designed. There was little academic research into the effectiveness of using the Philomena Protocol found during the literary review, hence it was not included. As part of this report however, we have established that it is considered national best practice, so is covered here.

The Philomena Protocol

The Philomena Protocol is a national scheme, devised and piloted by Durham Constabulary in 2017/18, which focuses on the multi-agency response to children who are reported missing by carers. Following its success in Durham, it was adopted by several forces to keep young people safe by driving down the number of missing episodes. During the workshop it was established that Hertfordshire have not fully adopted it, as they continue to use a form devised prior to the Philomena Protocol known as the HCC Key Contacts form. The use of this form is written into HCC contracts with care home providers that this form must be used. Following the workshop, the HCC Key Contacts form was compared against eight other police forces (Avon & Somerset, Cleveland, Cheshire, Greater Manchester, Hampshire, Nottinghamshire, Northumbria and Staffordshire) who have adopted the Philomena Protocol and used the template with minor adaptations, to create their own forms for care homes to complete. Also in existence are an information leaflet for care home staff and a flowchart for them to follow. The role of these are to act as prompts to assess whether the child is firstly, missing or somewhere where they are not supposed to be and secondly, whether they ought to deal with locating and returning the child back to the home themselves, or whether they need police assistance due to the vulnerabilities of the child and the risk of harm posed to them as a result of being missing. This goes some way to reduce the over reporting of children in care as missing and ensure that those who are genuinely missing and at risk have necessary information about them prepared in advance to streamline the reporting section of the process.

The HCC Key Contacts form is a council form which has been mandated for use by care homes and supported living residences. However, it does not provide the same level of detail or provide contextual information to help assess the potential risk to the child whilst they are missing, whereas Philomena is police-led. It contains a good list of specific actions for care home staff to carry out, which is more generic on the Philomena template, but these are at the back of the form and are not stated as explicitly as it is on the Philomena flowchart, leaflet and form. Adopting Philomena by embedding the most useful sections of the HCC Key Contacts form, along with supporting leaflet and flowchart is recommended. Appendix 6 is an example of the Philomena Protocol flowchart template, branded by Northumbria Police.

Care Home Actions

The care home staff's response to children who are late home or are not where they are expected to be must consider when it is appropriate to contact the police. Calling too early can lead to the unnecessary involvement of police in the child's life, have a negative impact on their relationship with carers, and in some cases lead to the unnecessary criminalisation of children in care, all of which are adverse experiences made evident in the literary review. Further consequences include unnecessary demand being placed on police, local authorities and other agencies. Calling too late can have the opposite effect of children not being adequately safeguarded. Staff training has been completed; however, care home staff turnover and low staffing levels were cited as reasons why this is not always adhered to and over-reporting occurs. Where the level of risk sits at parent/carer level, insufficient staffing is not reason alone to call police and care homes must be encouraged and supported to make contingency plans. Again this is an area where collaborative working with Ofsted, HCC and neighbourhood/local policing teams to have more robust training and enforcement could have significant

impact. In particular for cases where data shows that the child was reported missing due to breaching curfew or seeing friends/family and returns of their own accord within a couple of hours of being reported missing, having suffered no harm.

Police Actions

The role of the Control Room Inspector in the reporting and early investigative stage is to act as a gatekeeper to inappropriate reporting and recording of missing children in line with the National Police Chief's Council position that, not every missing reports warrants a police response. This is echoed by the College of Policing APP (2016) which states "The police are entitled to expect parents and carers, including staff acting in a parenting role in care homes, to accept normal parenting responsibilities and undertake reasonable actions to try and establish the whereabouts of the individual. Children who are breaching parental discipline should not be dealt with by police unless there are other risks." Breach of curfew alone is not a reason to report and the assessment of whether there is risk posed to the child should be made based on their precursor behaviour, any trigger events, behaviour that is known to be out of character and their behaviour when returned from their last missing episode if they have been missing before. The option to pause before deploying an officer to decide whether to commence an investigation, therefore, is a valid one. One of the hoped outcomes of this report is to provide guidance from the data, how long that pause should be. We acknowledge that changes to the Standard Operating Procedure were made at the beginning of 2023, this has not been analysed as it was outside of our data window.

When it comes to a report being received, one of the first actions police undertake is to assess the initial risk of harm and continue to reassess during the progress of the investigation. What became apparent in the workshop was that the risk assessment was often generic and did not always include contextual factors that could increase or decrease the risk of harm, sometimes due to not being provided that information but also due to the definition of "harm" applied. The College of Policing APP (2016), quote the Home Office definition of serious risk of harm to compliment the high-risk level as "a risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible", but no definition of harm for medium risk which simply states that the risk of harm to the subject or the public is "likely but not serious" and as a result is applied very broadly.

Section 31 of the Childrens Act 1989 defines harm as "ill-treatment or the impairment of health or development including, for example, impairment suffered from seeing or hearing the ill-treatment of another". 'Development' means physical, intellectual, emotional, social or behavioural development, 'health' means physical or mental health and 'ill-treatment' includes sexual abuse and forms of ill-treatment which are not physical. Discussions were had whether this is a more fitting definition of harm to apply to cases of children reported missing.

Hertfordshire Constabulary's decision to restrict U18 missing reports to be either medium or high risk, could be interpreted as removing decision making ability from the risk owner (the Response Inspector), in effect tying their hands to follow a course of action that includes activity we have shown, is unlikely to contribute to the safe return of the child in many cases. Because they are forced into following a greater series of actions than would be necessary if they were able to assess as low/standard risk or absent. At the time of writing, the Missing Persons Team had recently introduced reporting via Single Online Home and a review by the Control Room Inspector to decide whether to defer, delay or deploy to a missing person report, which replaces the use of absent risk.

Multi-Agency Meetings

The point at which multi-agency meetings takes place varies depending on the severity of the missing incidents it can be suggested from the case studies, that the risk of physical harm is more

quickly identified and prioritised for action. The timeliness of meetings and implementation of agreed measures when reviewing the reasons why a child has been reported missing is an area for further exploration, to see whether they could reduce frequency at an earlier stage. In addition, who attends from the police and how active their role is was not clear. There were anecdotal conversations of local officers attending some meetings, but how much input they give or actions they are tasked with could not be substantiated. The HCC Missing Persons Coordinator and PC from the Police Missing Persons Team have a weekly meeting, this is to share information and update respective computer systems. They also discuss whether to refer children to the Missing Persons Charity as an emerging frequent missing child, but restrictions on the number of children that can be referred means not all potential children can be referred and limited budgets also means the most beneficial interventions might not be available to them.

Data on the completion of return home interviews was unable to be provided by HCC, but it was agreed and has been evidenced in the case study analysis that the offering of a return home interview is inconsistent, as is meeting the 72 hour window to conduct one where accepted. Another variable was the time taken by social workers to update computer systems once the interview was completed. Budget constraints have led to HCC using social workers to conduct the majority of interviews, rather than an independent third party which is recommended in statutory guidance. The impact of this on the quantity and quality of return home interviews is an area that could be further studied.

Discussion of Findings

The research conducted between February and May 2022 highlighted one item that was missed from our scoping review, namely the Philomena Protocol. At the time of our review none of the academic papers we found assessed or evaluated this protocol in any way. It is also interesting that our search for grey literature did not uncover this development at the time, perhaps indicating that there has been very little discussion of the development. We question whether this points towards a comparative lack of awareness of the protocol in policing or whether its implementation is currently not a priority for forces. It is important that the protocol develops an evidence base that establishes its levels of effectiveness and highlights any implementation issues associated with it. Looking at our own process assessment the force in this study has an existing prevention approach in place that has elements of the protocol embedded, but not all the features are currently adopted.

Comments on the Data Set

The 2019-2022 data set derived from COMPACT shows a steady decline in the number of children reported missing each year. We have been unable to separate out the underlying reasons for this, but there are two potential explanations. It is possible that reporting protocols, especially for children in care, have been more established and some incidents of lateness or absence do not reach the police system. This would suggest an improvement to the system rather than a reduction in the number of absences and ties in with the time that the Missing Persons Team was established and worked to reduce unnecessary reports and improve the Constabulary's response to missing person reports. The impact of their work can be seen in the reductions mentioned at the beginning of this report. It is also possible that some demand is filtered within the police reporting system, reducing the number of incidents that are classified as missing using the new risk-based defer, delay, deploy model.

The other demographics uncovered by the data suggest that Hertfordshire's experiences of missing children are consistent with the national picture in most respects. The age distribution of children who go missing is very typical with the peak in missing activity in the teenage years, with slight

variations between boys and girls. We found no significant issues associated with ethnicity. An unexpected finding was that the children in care who went missing were far more likely to be local to the area whereas the expectation was that out-of-area placement could be a driving factor.

Our scoping review had guided us towards two specific issues:

1. Hotspot analysis

The literature points towards hotspot locations where children go missing, chiefly care home and supported living locations. In our own study we inevitably found that most missing incidents were in areas of high population density and there were some postcodes where there were unusually high numbers of missing incidents. Given that postcodes represent more than one address we cannot say for certain that all incidents in one post code area are from a single address, but we can identify that some care and supported living settings do seem to have a concentration of missing incidents. However, there are some care homes that experienced no missing incidents. This could be due to factors associated with who gets placed at these locations and type of care home, but it is worth further assessment to see why some care homes may have different practices or features that help prevent missing incidents.

In comparison to the national average, Hertfordshire has fewer children in care than many other council areas. Of these children, 87% have not been reported missing suggesting that the support and diversions that Hertfordshire Children's Services deploy are effective in most cases.

Failings to follow the current processes, however, have led to missed opportunities to address the root cause of that child's reason for going missing, allowing for patterns of missing to develop.

2. Repeat Missing incidents

The data set did show that a small proportion of children who go missing can account for a large proportion of missing incidents. We repeat that in our study 10% of the children who went missing in 2022 accounted for 54% of all the missing incidents. There were some unanticipated findings when looking at the repeat demand. Firstly, not all high repeat children were in care. We have presented a number of case studies where the children who go missing are residing at a familial home location but there are overriding factors that encourage missing activity, such as behavioural or mental health issues. In such cases access to support would be a vital component of demand reduction activity.

Secondly, there are often issues associated with drugs or county lines activity as a factor in repeat missing individuals. Our analysis of the highest frequency children showed that some children will go missing on an exceptionally regular basis when there are county lines or gang-related motivations. This contrasts with the longitudinal assessment of others where there are acute motivations to go missing but where intervention and support can bring this activity to a complete stop.

Risk and harm

One of the features of the data set is that missing incidents tend to last a relatively short period of time, with over 90% returning or being found within a day of going missing. There were few instances of children being harmed while missing and the number who went missing for reasons that put them at immediate risk,.e.g., forced marriage, is very low

Uncertainty around what risk and what harm should be included in decision-making by both those who report children missing and by the police officer assessing is apparent. Occasions where breaches of curfew have been unnecessarily reported, recorded and investigated, and other occasions where police have graded a missing child as high risk due to generalised concerns, generating demand and not taking into account the details surrounding this occasion such as antecedent behaviour and/or trigger event which could well suggest that on this occasion the risk is

medium.

Of greater concern to us is the number of incidents that have a tag of child sexual exploitation. A subtle feature of the case study analysis is the involvement of third parties in missing incidents. In many of the cases the missing child either went missing with someone else or there was someone else who motivated or facilitated the missing incident. This is important in the context of CSE and CCE. The systems link together repeat missing incidents from individual children, but they do not link together incidents where more than one child goes missing, or where someone else repeatedly motivates the missing incidents. We identify a risk that the opportunity for police to act against adults who exploit vulnerable children is missed. This intervening activity is one that is most appropriate for police to execute within a multi-agency partnership and is critical to the sustainable prevention of missing episodes to these vulnerable children.

The "problem analysis triangle"

The application of the problem analysis triangle in figure 15 provides a good way to establish some alternative actions that may address issues of risk and vulnerability.

Figure 15: The police "Problem Analysis Triangle"

When considering the location of care homes and supported living residences, an holistic approach that assesses the risks of vulnerable children drawing one another into missing episodes should be taken. Considering the prevalence of links to child sexual and criminal exploitation with the data, a move away from individual missing person focus to a collective analysis could also help identify specific adults with a footprint in exploitation. Police activity can then be targeted on these drivers to prevent missing episodes.

The triangle also highlights the guardianship role that public services and others need to play in this type of incident. All the evidence points towards drivers for missing incidents that are outside of the child's control and often as a result of compromised guardianship. The effectiveness of the guardianship, especially in circumstances where there are third parties attempting to exploit children, is key to the protection of each child.

We would propose further work to develop community guardianship, with a wider range of stakeholders. There could be formalised inclusion of more voluntary agencies. While the missing persons charity featured in data, other charities such as Crimestoppers or Childline were noticeably absent. Such agencies could support confidential reporting to agencies during the missing investigation process. Additionally, although there is already considerable activity to involve children in care in activities that allow them to settle into locations, thus reducing temptations to go

missing, these activities appear to be ad hoc and supply driven. There is a wide range of voluntary organisations that could be more formally engaged in such work.

Use of policing resources

An important observation was made when comparing police workload involved in investigating missing persons under 18 with how children were found (Figure 13). Our data suggests that police were involved in 30% of all missing incidents, but a third or less of those were proactive responses by frontline officers. Most incidents were actually resolved either by the child returning home or reporting to a place of safety, which could include police locations.

Another key factor is the concentration of demand created by children in care between the ages of 16 and 17 (Figure 3). Unless there is some immediate risk of serious harm to the child, police have no powers to force the child to return to a care placement, meaning the return of thechild to a safe environment relies on the co-operation of the child, underpinning the importance of developing positive relationships between police and missing children.

As a result of this analysis, we suggest that the best focus of effort, and therefore use of police time is in preventing demand from occurring and on preventing the repeat episodes as there is limited impact achieved by police through the effort to locate individuals or deal with demand they have no influence over.

Lessons from the Process review

Our general observation following the process review is that the missing persons process has not been formally designed as an end-to-end process across the stakeholders involved. This is not an unexpected finding but it is important in that it presents an opportunity to re-design the process to become more effective. No one single stakeholder or agency can be responsible for the entire process and so there needs to be significant collaborative work to integrate processes as much as necessary. All stakeholders will need to review their internal processes to identify internal changes that can be made to improve the process as a whole. This improvement would include:

1. More formalisation and standardisation of current practices so that all stakeholders can anticipate what should happen at each stage. The rationale for each step in the process needs to be understood.
2. Some parts of the process are over-complex with multiple groups taking responsibility for niche activities without cross-coordination with other parties.
3. There are many fail points at the intersection between different service providers. Eventually these hand-over points need to be optimised.
4. Information needs to be shared with the right people. In particular, where information is being gathered, it may benefit other stakeholders to receive this. This places an extra requirement on all parties to ensure their own information reporting is thorough, timely and accurate.

The collection and recording of information appears to be done in isolation by agencies throughout the process and the sharing process is limited. Initial investigating police officers in particular fail to appreciate that the information they gather is of value to and used by others, post-missing to implement interventions, and not just for themselves for the duration of the missing episode. From an academic perspective, higher quality data would allow for greater analysis and confidence in findings.

Very little multi-agency work is done when a child is first placed in care. Focusing on supportive

preventive activity at this early stage by all partners is worth further investigation as it could lead to a large-scale reduction in demand for several agencies in the short and long term.

Police actions in relation to missing children are not as effective as you might expect. Physical resources are limited and the use of tools such as urgent live cell site location of mobile phones is restricted to cases where the risk is assessed as high. Police rely therefore on traditional methods of search and investigation which, without specific search parameters such as address of friends or places they are known to frequent is largely ineffective and costly when compared to other types of police investigation.

What happens at multi-agency meetings, post missing could not been obtained for this report. It is an area for further exploration, paying particular attention to the most frequent missing children to identify at what point was support put in place and what impact it had to see if it could be replicated for other similar cases.

Conclusions

In these conclusions we will address, in turn, each of the research questions that we presented at the start of the report:

1 What action can prevent children, who are at most risk, from going missing? (Primary Prevention).

Behaviours and characteristics of missing episodes for children in care

The report has presented detailed information about the patterns of missing activity for children in care and elsewhere. 63% of missing incidents of children in supported living occur between the 22:00 to 1:00 night-time period. This corresponds to children failing to return to a curfew time, although we stress that such curfews are not strictly enforceable. The peak on a Saturday night also highlights the social activity pressures that may encourage missing incidents. There are several factors at play when children go missing and case studies reflect high levels of support provided, but achieving cessation in missing episodes is elusive because the drivers are complex. Repeat missing incidents for children in care are likely to be compounded by two types of additional factors:

1. County Lines activity, often associated with substance abuse/addiction or exploitation.
2. Behavioural issues such as ADHD or struggles with mental health.

Current multi-agency arrangements.

During the period before a child is missing, multi-agency processes are not clearly defined. Departments within HCC may work closely together, but there is a gap in working with police and with other councils placing children in Hertfordshire. The data suggests that most children in care who are reported missing are the responsibility of Hertfordshire County Council and not other county councils. Therefore, most benefit would be gained from Hertfordshire Constabulary and Hertfordshire County Council working in closer partnership at the time a child is placed in care.

Activities that can reduce this risk.

The Philomena Protocol requires care homes to gather information and form an opinion whether a child is likely to go missing prior to a missing incident. That knowledge creates opportunities for care homes to put in interventions as soon as they become aware that a child is likely to go missing. It also requires them to record vulnerabilities and risks to a child prior to them going missing, which makes the reporting process more efficient and allows police officers to assess risk more thoroughly. For cases where the missing child is placed in Hertfordshire by another local authority, if completed

by care homes and supported living placements, the Philomena Protocol becomes the conduit for accessing the information that we have shown is frequently missing in these cases.

The rise in numbers of children with mental ill-health and neurodiversity placed into care has been recognised by Hertfordshire Children's Services and is commented on in their Sufficiency Statement Summary (2022) and they have secured funding to increase support provisions for children to meet this need with the creation of a specialist children's home staffed by a multi-disciplinary team. Studying the impact of this new care home on patterns of missing behaviour is something that could be explored at a later stage.

Our analysis has revealed that third parties may be involved in many missing incidents creating enhanced risks e.g. of CSE. One action would be to focus on third party involvement of adults in missing incidents and better identification of adults who may be involved in repeat missing incidents (possibly targeting more than one child or targeting specific locations).

Our data analysis provides little evidence of community guardianship in keeping children in care safe. The role of community guardianship is not adequately appreciated either as a means of prevention or as assistance within the investigation process once a missing incident occurs.

2 What activities can agencies undertake when a child goes missing that are most likely to ensure the return of a child to a safe environment? (Secondary Prevention)

Patterns of behaviours and characteristics of children while missing.

The patterns of behaviour while missing are usually very predictable and, in most cases relatively benign. Most missing incidents are of a short duration with 90% of missing children being found or returned within a day of the missing incident being reported. 77% of children are found within 10 miles of where they went missing and only 3% travel more than 40 miles. Over half of the children return of their own accord, usually to their home or place of care. Only 2.6% are found by police activity, which highlights the limited role police have in proactive searching. Care does have to be taken to correctly identify when there is vulnerability. We have identified situations where aspects of vulnerability have been missing but also systematic overstatement of factors such as suicide risk while missing.

Current multi-agency arrangements and activities undertaken during a missing episode.

Partnership working between care homes/support living placements and police during a missing episode is inconsistent. Where this is not done, extra demand is placed on police. The time of day which most children in care are reported missing and return is outside of standard office hours, meaning that in these cases multi- agency activities are limited. From the sample set, certain actions such as police social media appeals do not appear to have a high success rate as they were not listed in the activity leading to the child being found.

Potential improvements to existing processes.

Working with Ofsted as the regulatory body for care homes and HCC to ensure the implementation and adherence to the Philomena Protocol by both police and care homes would shift the imbalance of demand on police created by over reporting and over recording missing children as well as ensuring that those actions reasonably expected to be conducted by a parent/guardian were conducted by care homes and not police. Utilising technology available to digitalise and automate the sharing of this information would streamline the process further, potentially designing out the need to double key information into separate computer systems.

Ofsted do not formally consult police when assessing a care home's performance in the prevention

and management of missing episodes. This presents further opportunity to solidify working practises between these three stakeholders by including police data and feedback in the regulatory assessment process with the aim of increasing that joint work ethic to locate and return a missing child.

When police are contacted, taking a more risk-informed approach, using the findings within this report as the evidence base, in conjunction with the child's vulnerabilities and contextual information to rationalise when to act and if not immediately, how long to wait before commencing an investigation could result in vast savings of police time. Currently initial investigating officers are following a process without thinking why, resulting in poor data quality and missed opportunities for prevention.An end-to-end redesign of the overall process by all stakeholders including all the above reflections with the aim of designing out areas of duplication and inclusion of automated sharing of appropriate data to reduce the need for manual data handling.

3 What follow up activities to a missing episode in a child is most likely to prevent repeat missing episodes from occurring? (Tertiary Prevention)

Patterns of behaviours of children who repeatedly go missing.

We noted two aspects of repeat missing episodes that inform future actions:

1. Repeat missing activity is not entirely confined to children in care. Our detailed case analysis shows that children who repeatedly go missing from home feature regularly and are a significant source of demand for police. This is partly driven by County Lines activity or child behavioural issues that need to be addressed. Post-missing activity needs to focus on the separate needs of these groups and tackle the underlying problems.
2. The case studies show two different patterns of repeat missing activity. Half of our detailed cases of the frequently missing have incidents on an almost continuous basis for long periods often up to or exceeding a year. There are some children whose repeat missing incidents are confined to shorter periods of regular, repeat activity that does end. For this group, it is likely there are sustainable solutions to bring the repeat missing activity to a stop by addressing the underlying motivations for missing incident. These pressures should be uncovered ideally after a first missing incident.

We noted that a small number of children demonstrated one missing incident weeks or months prior to the start of repeat missing activity. This should be investigated further to establish whether future repeat missing activity could have been anticipated and prevented.

Current multi-agency arrangements and activities

Multi-agency meetings focusing on managing the risk of missing behaviour of children (MARM) are convened by Hertfordshire Children's Services when a child is missing, identified as likely to repeat going missing, is subject of exploitation or vulnerable to it. These meetings are the first stage of the escalation process, their focus to strengthen the plans in place to manage the risk, thereby reducing the likelihood of repeat missing episodes. Should those plans be ineffective, the child is escalated for discussion at MACE meetings.

Multi-agency meetings focusing on child exploitation (MACE), including missing episodes and other vulnerabilities take place in a diarised fashion on a monthly basis. They are chaired by Hertfordshire County Council's Childrens Services with attendees from HCC, police, mental health services, drugs and alcohol support and charities. There is a governance and reporting structure, a child will remain on the agenda until the risk is reduced to an acceptable level or the child moves out of the area.

Potential improvements to existing processes.

There are clear structures in place to support the most vulnerable children when the risk has become known at a strategic level. On a more localised level, there is a gap in partnership working between local police officers and care homes that should be explored. We do recommend further engagement of additional stakeholders as community guardians as part of the processes to prevent missing incidents.

Furthermore, we have identified that significant demand comes from children who go missing to see friends and family and who go missing due to issues with family members, who are not vulnerable toexploitation of this nature. Working together to address the cause of these missing episodes, could have a great impact on the overall volume of missing investigations.

Recommendations

Throughout the conclusions sections recommendations have been made to improve the existing processes at each stage of a missing episode. In this section we list the suggested actions in order achieve these improvements which involve the entire community of agencies that are involved with missing children.

Immediate Actions

- With regards to children in care, co-create a preventive information sharing process for the matching and placement stage by HCC and Hertfordshire Constabulary. To include discussions about the availability of suitable placements within the county and establish firm protocols for sharing information between local authority areas.

Already in place is the MASH and information ISA with HCC.

Placements of children are influenced by the MPT as we are able to do so.

- Hertfordshire Constabulary to work with HCC and care home staff to implement the Philomena Protocol fully, utilising existing flow chart and leaflet templates and merge HCC Key Contacts form into the template form. As above in narrative
- Utilise existing capability within IT systems to automate information sharing between HCC and police.
- Ofsted to ensure care homes to review their staffing profile to ensure they are able to meet their responsibilities under the Philomena Protocol. – Policing cannot direct reviews of ofsted. It might something if raised the HMICFRS would do in a joint inspection.

Hertfordshire Constabulary to revise the police process document for the following –

- To explicitly highlight when it might be appropriate to utilise the option of wait, before deploying, using the analysed data in this report to determine the appropriate length of time. At the time of writing the Missing Person Team work on this was underway and it is recognised that new guidance will soon become available from the NPCC in relation to Right Care Right Person, which should be used in conjunction with the NPCC's Children Missing from Care Framework.
- to review the usefulness of the risk assessment points in decision making or accurately predicting the potential for harm both in the short term from the missing episode and in the long term to the individual.
- to instruct officers to enter information directly onto COMPACT from the scene

Other immediate actions could include:

- A collaboratively created advice pack which can be physically given or digitally sent to the

parents/guardians of children who go missing from familial homes to empower them to safeguard their child. Include relevant signposting to support services, signs of criminal and sexual exploitation for them to look out for, what to do if they are concerned, and parenting advice how to deal with the most frequently cited reasons for going missing that have been established in this report, namely to see family/friends and issues with family members.

- Missing Persons Team within Hertfordshire Constabulary to review existing feedback mechanism embedding performance measures with care homes and Ofsted where inappropriate reporting is identified.
- Create and deliver a combined training package for frontline officers, control room staff, care home staff and HCS staff who work with children on the revised process and reasons for it.
- Review the remit and responsibilities of the police Missing Person Team, including the Missing Persons Team with a view to extending their working hours to cover key reporting times from care homes and potential benefits of them become gatekeepers for all missing reports through embedding into the Control Room.
- Develop a tool to evaluate the effectiveness of the immediate recommendations.

Later Actions

Not all actions can be completed at once. We recommend other actions that can take place at later point include:

- HCC and Hertfordshire Constabulary to jointly review the return home interview process, ensuring process documentation is relevant, accurate, understood and information sharing process to be actively managed. Include a feedback mechanism to encourage compliance. Arrange for this training to be delivered jointly.
- Further evaluation and comparison of the cost benefit of both HCC and Missing Persons Charity processes for conducting return home interviews and their impact on reducing/preventing missing episodes.
- Senior leaders within the entire community of people who deal with missing children to discuss opportunities for big data sharing to enable changes in the trends and patterns of missing incidents to be identified early on and processes adapted to keep up with them.
- Approach the COMPACT working group to understand planned developments of the system and possibility of increased automated information sharing between forces, whether they use COMPACT or another system with a view to writing a business case to develop this functionality if not already planned for.
- Hertfordshire Constabulary to investigate the feasibility of an interface and other alternative solutions between COMPACT and Athena to automate intelligence submissions from one system to the other.

Implementation Issues

This project has evidenced that to achieve sustainable reductions collaborative working is critical. Creating process improvements will only be possible if consensus to dedicate resources to it is obtained at executive level from all organisations involved. It will require the creation of a multi-agency project team with an agreed aim and objectives to avoid mission creep. Clarity of the roles and expectations of each team member need to be established so that actions are achieved.

Without a set governance and reporting structure, oversight as to the progress of the project is difficult. This needs to be established as a priority. To ensure communication is maintained, the

project keeps momentum and deadlines are met will require project members to attend regular meetings and the use of shared project management software (MS Project). Clear record keeping of actions and updates and key milestones for both project team members and project sponsors can be recorded and reported on.

There are likely to be cost implications to some of the recommendations. Alternative sources of funding such as the Office of Police & Crime Commissioner or Home Office for joint funding bids are suggested as an option to secure a budget if money is not sourced internally.

Support Requirements

The set up of a project team to include representatives from HCC Children's Services (Specialist Adolescent Services Hertfordshire, Children Looked After team, Social Worker), Hertfordshire Constabulary Missing Person team, Force Communications Room, Prevention First team, Neighbourhood team and Response team, care homes in Hertfordshire who experience the most missing episodes, Ofsted, Children and Adolescent Mental Health Services.

In order to achieve the greatest impact, it is recommended that this be an intensive working group, set to run over a period of twelve months with deliverable outcomes timetabled at regular periods to maintain momentum. Following the initial set-up, a period of three months is suggested for organisations to deal with internal process issues. These will be presented to the project team. The following months will then be focused on working jointly to make efficiencies.

Future Research

Two further pieces of research are recommended as a consequence of these findings. Firstly, the Philomena Protocol has the potential to be an important tool to ensure that police forces have quick access to vital information about children who are being reported as missing from care. The value of this new protocol needs to be established with a good evidence base. Secondly, the results were slightly surprising in that many of the high-frequency missing children were not in the care of the Local Authority, but instead were living at a home address. There were two clear factors that pointed to missing activity. The involvement in County Lines is a key problem and a major factor in missing incidents in these circumstances. Vulnerable children with behavioural difficulties were also very likely to feature in this group. This shows more effort should be put into understanding how to protect children from County Lines activity. There should be other research to establish what preventive measures and/or support can be effectively put in place to protect children with behavioural difficulties and to limit their repeat missing incidents.

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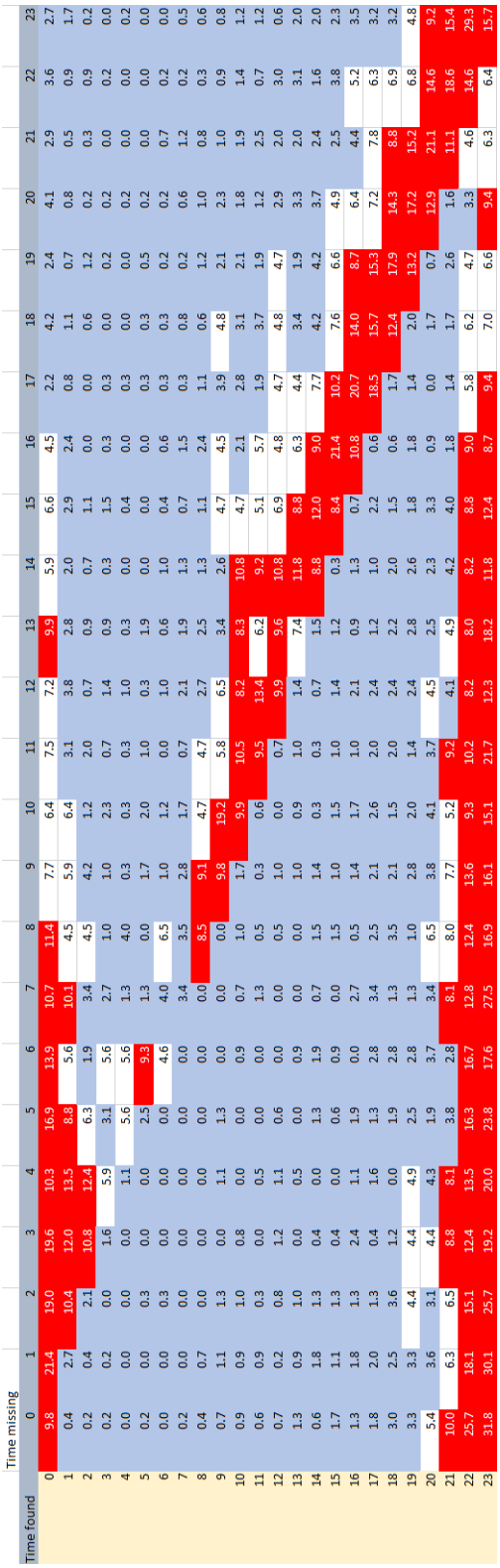
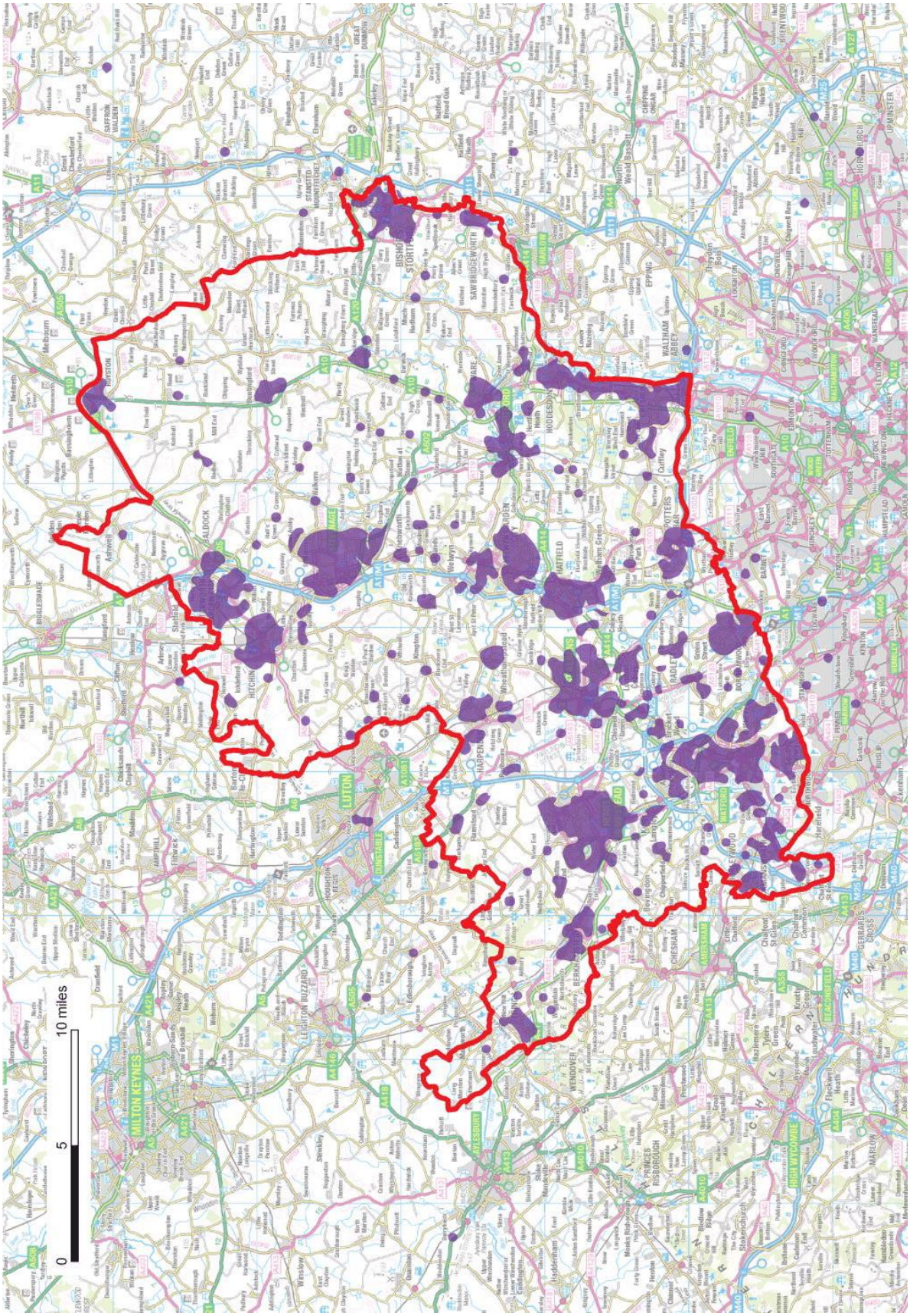
Appendix 1 Time missing and found



Time found \ Time missing	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
0	9.8	21.4	19.0	19.6	10.3	16.9	13.9	10.7	11.4	7.7	6.4	7.5	7.2	9.9	5.9	6.6	4.5	2.2	4.2	2.4	4.1	2.9	3.6	2.7
1	0.4	2.7	10.4	12.0	13.5	8.8	5.6	10.1	4.5	5.9	6.4	3.1	3.8	2.8	2.0	2.9	2.4	0.8	1.1	0.7	0.8	0.5	0.9	1.7
2	0.2	0.4	2.1	10.8	12.4	6.3	1.9	3.4	4.5	4.2	1.2	2.0	0.7	0.9	0.7	1.1	0.0	0.0	0.6	1.2	0.2	0.3	0.9	0.2
3	0.2	0.2	0.0	1.6	5.9	3.1	5.6	2.7	1.0	1.0	2.3	0.7	1.4	0.9	0.3	1.5	0.3	0.3	0.0	0.2	0.2	0.0	0.2	0.0
4	0.0	0.0	0.0	0.0	1.1	5.6	5.6	1.3	4.0	0.3	0.3	0.3	1.0	0.3	0.0	0.4	0.0	0.3	0.0	0.0	0.2	0.0	0.0	0.2
5	0.2	0.0	0.3	0.0	0.0	2.5	9.3	1.3	0.0	1.7	2.0	1.0	0.3	1.9	0.0	0.0	0.0	0.3	0.3	0.5	0.2	0.0	0.0	0.0
6	0.0	0.0	0.3	0.0	0.0	0.0	4.6	4.0	6.5	1.0	1.2	0.0	1.0	0.6	1.0	0.4	0.6	0.3	0.3	0.2	0.2	0.7	0.2	0.0
7	0.2	0.0	0.0	0.0	0.0	0.0	0.0	3.4	3.5	2.8	1.7	0.7	2.1	1.9	1.3	0.7	1.5	0.3	0.8	0.2	0.6	1.2	0.2	0.5
8	0.4	0.7	0.0	0.0	0.0	0.0	0.0	0.0	8.5	9.1	4.7	4.7	2.7	2.5	1.3	1.1	2.4	1.1	0.6	1.2	1.0	0.8	0.3	0.6
9	0.7	1.1	1.3	0.0	1.1	1.3	0.0	0.0	0.0	9.8	19.2	5.8	6.5	3.4	2.6	4.7	4.5	3.9	4.8	2.1	2.3	1.0	0.9	0.8
10	0.9	0.9	1.0	0.8	0.0	0.0	0.9	0.7	1.0	1.7	9.9	10.5	8.2	8.3	10.8	4.7	2.1	2.8	3.1	2.1	1.8	1.9	1.4	1.2
11	0.6	0.9	0.3	0.0	0.5	0.0	0.0	1.3	0.5	0.3	0.6	9.5	13.4	6.2	9.2	5.1	5.7	1.9	3.7	1.9	1.2	2.5	0.7	1.2
12	0.7	0.2	0.8	1.2	1.1	0.6	0.0	0.0	0.5	1.0	0.0	0.7	9.9	9.6	10.8	6.9	4.8	4.7	4.8	4.7	2.9	2.0	3.0	0.6
13	1.3	0.9	1.0	0.0	0.5	0.0	0.9	0.0	0.0	1.0	0.9	1.0	1.4	7.4	11.8	8.8	6.3	4.4	3.4	1.9	3.3	2.0	3.1	2.0
14	0.6	1.8	1.3	0.4	0.0	1.3	1.9	0.7	1.5	1.4	0.3	0.3	0.7	1.5	8.8	12.0	9.0	7.7	4.2	4.2	3.7	2.4	1.6	2.0
15	1.7	1.1	1.3	0.4	0.0	0.6	0.9	0.0	1.5	1.0	1.5	1.0	1.4	1.2	0.3	8.4	21.4	10.2	7.6	6.6	4.9	2.5	3.8	2.3
16	1.3	1.8	1.3	2.4	1.1	1.9	0.0	2.7	0.5	1.4	1.7	1.0	2.1	0.9	1.3	0.7	10.8	20.7	14.0	8.7	6.4	4.4	5.2	3.5
17	1.8	2.0	1.3	0.4	1.6	1.3	2.8	3.4	2.5	2.1	2.6	2.0	2.4	1.2	1.0	2.2	0.6	18.5	15.7	15.3	7.2	7.8	6.3	3.2
18	3.0	2.5	3.6	1.2	0.0	1.9	2.8	1.3	3.5	2.1	1.5	2.0	2.4	2.2	2.0	1.5	0.6	1.7	12.4	17.9	14.3	8.8	6.9	3.2
19	3.3	3.3	4.4	4.4	4.9	2.5	2.8	1.3	1.0	2.8	2.0	1.4	2.4	2.8	2.6	1.8	1.8	1.4	2.0	13.2	17.2	15.2	6.8	4.8
20	5.4	3.6	3.1	4.4	4.3	1.9	3.7	3.4	6.5	3.8	4.1	3.7	4.5	2.5	2.3	3.3	0.9	0.0	1.7	0.7	12.9	21.1	14.6	9.2
21	10.0	6.3	6.5	8.8	8.1	3.8	2.8	8.1	8.0	7.7	5.2	9.2	4.1	4.9	4.2	4.0	1.8	1.4	1.7	2.6	1.6	11.1	18.6	15.4
22	25.7	18.1	15.1	12.4	13.5	16.3	16.7	12.8	12.4	13.6	9.3	10.2	8.2	8.0	8.2	8.8	9.0	5.8	6.2	4.7	3.3	4.6	14.6	29.3
23	31.8	30.1	25.7	19.2	20.0	23.8	17.6	27.5	16.9	16.1	15.1	21.7	12.3	18.2	11.8	12.4	8.7	9.4	7.0	6.6	9.4	6.3	6.4	15.7

High correlations between missing and found times are shown in red (more than twice the number expected). Blue shows low correlations.

Appendix 2 Heat Map of Missing Incidents 2022



Appendix 3 Tasks for different risk levels

Task	**Risk**		
	Low	Medium	High
Check Custody	✓	✓	✓
Check access to mobile phones	✓	✓	✓
Check hospitals	✓	✓	✓
Insp. Review and handover	✓	✓	✓
House to house	✓	✓	✓
Inform CCTV	✓	✓	✓
Liase with MH triage team	✓	✓	✓
Missing person team manager	✓	✓	✓
Obtain photograph	✓	✓	✓
Obtain DNA (Within 7 days of report)	✓	✓	
Obtain social network account information	✓	✓	✓
PNC / PND / Intel checks	✓	✓	✓
Search address / location missing from	✓	✓	✓
Search home address	✓	✓	✓
Establish items missing person has in their possession	✓	✓	✓
Enquiries with place of work / school / college		✓	✓
Enquiries with key professionals working with or supporting the missing person		✓	✓
Check of places frequented by the missing person		✓	✓
Cell data analysis			✓
Check with ambulance control			✓
Checks with banks / credit card companies			✓
Consider services of missing people charity			✓
Consideration of pub watch & OWL notification			✓
Liase with partner agencies (LA, housing, charities, probation, EMS, passport office etc)			✓
Obtain DNA (within 24 hours)			✓
POLSA review			✓
Press appeal			✓
Public transport enquiry			✓
Cell site analysis of mobile phone			✓

Appendix 4 Vulnerabilities or markers for top 40 missing children in 2022

Rank	No. times missing in 2022	County lines	Warnings, e.g. knives or MH condition
1	58	Yes	Yes
2	53	Yes	Yes
3	25	Yes	Yes
4	23		Yes
5	22		Yes
6	20		
7	20		
8	19		Yes
9	19	Yes	Yes
10	19	Yes	
11	18	Yes	Yes
12	15		Yes
13	13		Yes
14	13		
15	12		
16	12		
17	11	Yes	Yes
18	11		
19	10		
20	10	Yes	
21	10		
22	10		
23	10		Yes
24	10		
25	10		
26	9		
27	9		
28	9		Yes
29	9		Yes
30	9		Yes
31	9		
32	9	Yes	
33	8		
34	8		
35	8	Yes	
36	8	Yes	
37	8		Yes
38	8		
39	7	Yes	
40	7		Yes

Appendix 5 3Cs Table from Process Map Workshops

Before the missing incident

Concern	**Cause**	**Countermeasure**
Specific discussion and support to prevent missing episodes is not formalised by HCC in their initial planning and meetings with every child. Unknown if it is part of placement's settling in process.	HCC deal with meeting each child's needs and outcomes based on Contact Orders agreed by the courts. They will not discuss the issue of being reported missing with every child unless they deem it likely and necessary to do so.	Work with HCC and placements to ensure appropriate levels of parental-style support is available and known to child specifically to reduce the likelihood of breaching curfew, testing boundaries as well as going missing as part of settling in at placement.
Placement selection; HCC have sometimes had to place children who should be in full care into semi-independent care homes due to lack of available places in their regulated care homes.	Lack of suitable placements available to HCC.	Increase provision of suitable residential placements in line with HCC Residential Strategy.
Placement suitability; As an example, two children from rival gangs could be housed in the same placement unknowingly exposing each to risk of harm.	Police are not involved in the matching process, therefore their intel is not used in the assessment. The known risks & intel of other residents held by police are not part of the matching process as standard.	Involve/request info from police to be shared for the purposes of matching child with suitable placement.
Failure of OOC notification; HCC not informed of placements into Hertfordshire made by the placing LA or the placement themselves:	Statutory guidance recommends communication takes place between placing and host Local Authorities, but it is not always done.	Enforce adherence to the Care Planning, Placement and Case Review statutory guidance and the associated regulations (2013), which outline duties on local authorities to notify other local authorities if they place a child in care within their area. It also requires children's homes to notify their host local authority when a child is placed with them by another authority. Consider M365 automation to streamline this activity. The College of Policing and NPCC (2022) request that LA are encouraged to also notify

		the relevant police force when a child is being placed out of area, based on the needs/risk of the child, this should include the risk of the child going missing.
COMPACT not a national system. Sharing of missing person information between forces is manual and time-consuming.	Cases can be exported to other forces for them to own going forwards, but there is no way for police to access COMPACT to see what previous missing history a child has with police in another area.	Development of COMPACT to allow for forces to "share access" to COMPACT data for individuals who go missing in their area on a case-by-case basis. Like M365 sharing functionality. Through the user group.
No engagement and rapport with care homes by local officers as standard.	Local officers have no role in the current SOP. Engagement is inconsistent across the county. Knowledge who the vulnerable children in their area is therefore limited and often discovered after they have been reported missing.	SNT local officer/PCSO role to be part of the SOP in a preventive capacity, building relations rather than criminalising their contact with police.
Key Contacts Form content and use; The form is substantially different to the Philomena template (the national term). The form is not being completed and provided to officers as expected. Where used, the form is inconsistent in content and quality due to lack of information being provided to placement.	Bad practise has developed whereby officers and placements either have forgotten or do not see the value of the form.	Redesign and relaunch the form following national best practise templates. Adopt the term Philomena to align with national terminology. Digitalise and automate where possible to streamline the submission process and futureproof for inclusion in online reporting portal (SOH). Add field on STORM record whether Philomena Protocol was applied to reinforce compliance by police and placement.

During the missing incident

Concern	Cause	Countermeasure
Care homes overreporting CLA missing when they are actually just late home.	Bad practice, risk aversion amongst staff, failure to undertake responsibilities reasonably expected by a parent/guardian.	Joint training with placements staff, HCC and police.
Care homes fail to conduct minimum expected enquiries before reporting to police.	Low ratio of staff to children in placements means they are not always able to conduct the minimum expected enquiries.	Police enforce adherence to Philomena Protocol and NPCC levels of intervention.
Risk assessments (RA) not being completed within timescales set in SOP.	There appear to be too many RA conducted by numerous Police roles, Call handler, Oscars, IIO, Intervention Insp, SIO.	Review of the points at which a RA is required, clarify the risk being assessed is whilst missing episode, not risks to the child in general.
Hertfordshire Constabulary's policy is not to use Absent or Standard (low) risk categories for U18s.	Risk averse culture. Fear that a vulnerable child will be misclassified and come to harm whilst missing.	Review the definition of risk being applied for appropriateness. Take evidence-based approach to the harms experienced previously and known risks of this missing episode.
Force policy not to use Absent & Standard risk means other classifications potentially being misused as a countermeasure instead of applying the national APP properly.	Officers are forced to conduct additional tasks that are automated for Medium & High risk investigations, often unnecessarily.	Understand and apply the national policy properly, with detailed risk assessments evidencing understanding of individual's vulnerabilities and context-specific risk of harm.
Intelligence on Athena not always found due to errors with Person Cards.	Call-takers creating new Person Cards on Storm, which then fails to spot previous history relating to that person.	Review/refresh training to call-takers, directed effort to reduce number of inappropriate new Person Cards created. Make this a rolling training to keep it in organisational memory.
Concern for Welfare classification used in place of Missing.	Lack of understanding force wide that Missing does not require a full COMPACT report and investigation every time.	Understand and apply the national policy properly, with RA evidencing understanding, both NPCC levels of intervention and of child's contextual vulnerabilities and therefore risk.
Failure to follow NPCC levels of intervention model. Initial Investigating Officer often is "going through the motions"	Lack of understanding as to what their role is or the NPCC levels of intervention.	Refresh training and officer awareness to include the need to conduct initial investigation before deciding whether

of recording on COMPACT and commencing tasks without evaluating against the NPCC levels of intervention model.		creating a COMPACT report is necessary.
Initial recording of information issue; Officers often record on paper and enter onto COMPACT afterwards resulting in duplication of work for themselves, delays in entering onto the system and ability of Inspector to sign off the RA.	Bad practice of recording basic details in pocket notebook. All frontline officers are equipped with laptop and mobile phone. Possible lack of knowledge how to connect laptop to the network whilst mobile.	Enforce IIOs enter information directly onto COMPACT at the location (using laptop and tether to mobile phone for connectivity). Provide technical training and evidence of the improvements this makes to the process.
Quality of data entered onto COMPACT is variable throughout the investigation, gaps or wrong classifications used.	Lack of understanding of COMPACT fields, how data quality impacts its subsequent use.	Ensure officers enter directly onto COMPACT from the scene and duration of investigation. Provide awareness of the requirement to complete fields correctly and completely through feedback mechanism.
Tasks autogenerated by COMPACT result in unnecessary demand on officers and do not contribute to the safe return of the child	Using only Medium and High risk categories generates tasks for officers to complete which they do without questioning. These tasks rarely result in the misper being located yet take considerable resource.	Review the auto generated tasks against the COMPACT data for "how found" to review what tasks were most effective & worthwhile.
The Response Sgt does not have any responsibility within the SOP; however the Sgt is the best placed role to manage local resources compared with the Inspector who has responsibility for multiple areas areas and multiple risk incidents.	The SOP outlines that the Inspector owns the risk of the missing person investigation but overlooks the management of resources by the Sgt and Control Room dispatcher.	Review SOP and roles to include management of local resources rests with Response Sgt and Control Room dispatcher, who may be tasked by the Inspector.
Delay in PNC markers being placed for medium risk reports, meaning potential missed opportunities for child to be found by police who stop and conduct a PNC check during the intervening period,	PNC marker is generated after the RA has been signed off for medium risk cases. Compared with a high-risk case which is generated immediately by the FCR controller before RA has been signed off.	Investigate whether technological advancements allow for auto generation of PNC marker for medium and high-risk cases to remove this delay.
Notification for reporting sightings received into the Control Room suggests various people to inform allowing for	Wording of the SOP is unclear. Separation of actions for if still in sight or if reported after the fact.	Review and reword the SOP making it very clear and consistent who should be notified to maximise opportunities to locate child.

failure in it being picked up in a timely manner.		
Hours of operation for the Locate Team; currently 0800 – 2300 hours, 7 days a week.	Data shows majority of missing reports for CLA are made 2200 – 0100hrs after they have finished work for the day.	Expand the hours of the Locate Team, so that they can act as gatekeepers for all missing person reporting, investigation, and prevention. Consider embedding into the Control Room so they can be involved at earliest opportunity.
Role of Locate team; they are office based and do not complete any physical enquiries, which results in frontline officers being tasked with these time-consuming tasks. No DS/DI in the current structure.	Locate team capability is limited by staffing constraints.	Conduct a cost benefit analysis of an enhanced Locate team to work with HCC on reducing demand in missing, as well as driving down the over reporting, over recording and improving risk assessments and prevention interview quality as specialists in missing investigations.
No formal structure for Police as to who should liaise with other professionals whilst child is missing, it could be Locate team or frontline officers tasked with the investigation.	Not clear in the SOP who is responsible for this during an investigation.	Review to see if this task can be assigned to a role and clarify in the SOP.

After Missing Incident

Concern	**Cause**	**Countermeasure**
Prevention Interview (safe & well) quality; Level of detail is varied as officers are inconsistent in the quality of what they write regardless of the detail they obtain from the child.	Officers not fully appreciative of the value of this activity going forward and complete it as a necessary task on COMPACT. Missed opportunity to give some initial signposting to additional support. Officers viewed as adversaries rather than allies by the child who don't feel comfortable talking with them.	Consider using PCSOs who may have more time and the child might open up to. Schools PCSOs could be used under Op Encompass if the child is in education. Only available during PCSO working hours, however. Re-train those who complete the discussions as to the need to build rapport and trust, not just go through the motions
Officers not submitting Intelligence gleaned from RHI onto Athena from COMPACT	COMPACT does not talk to Athena therefore an intel submission requires double keying in of information. Unclear whether officers think placing intel onto COMPACT is sufficient, or if they are deliberately choosing not to enter onto Athena also.	Explore whether Athena/COMPACT interface can be developed to automate the process. If not add a tick box to COMPACT to prompt officers to enter onto Athena and refresh training package to include this. MPT to quality assure before COMPACT record closed and provide feedback where not complied with.
Return Home Interviews (RHI); The form does not maximise the opportunity to identify risk and opportunities to prevent future missing episodes.	Current form has too many questions, many of which are not answered by the child. There are not enough questions to explore the causes of going missing and	Redesign the form with multi-agency and child input.
Return Home Interviews; Out of County placements in Hertfordshire	Current policy is for the placing authority to arrange and complete the RHI. Due to geography this often isn't possible. There is no agreement for both LA's to work together to ensure RHI is completed in the best interests of the child rather than by statutory responsibility.	Statutory guidance recommends an independent third party is used to complete RHI. If adhered to, opportunities exist to include cross-charging to other LAs for their services. Explore the feasibility of this being pursued.
Return Home Interviews; Hertfordshire children placed out of county	As above	As above

Return Home Interviews; timescales and completion rates often outside of the 72hrs recommended timescale and also not always completed by allocated social workers. Relevant details of RHI should also be shared with police, but this does not consistently happen.	Bad practice is most likely caused by high workloads and competing demands.	Investigate the option of contracting out all RHI as per statutory guidance to remove this from social workers workloads, increasing adherence to statutory guidance duties and reduce failure demand.
Submission of intelligence gleaned from RHI by HCC to Hertfordshire Constabulary; HCC complete a proforma Word doc and email into the Intelligence dept of police who evaluate and upload to Athena. Dip sample of 6 submissions revealed delays in submitting the intel by HCC which led to delays in adding to Athena, minor errors in dates recorded by HCC in comparison to COMPACT record were also found.	Manual process with scope for human error. Stretched capacity of HCC staff completing submission means not always done in a timely manner.	Refresh and automate the form to streamline the submission process and enhance data quality.

Appendix 6 Philomena Protocol Templated Flowchart, personalised by Northumbria Police