2.12 However, the audit highlighted aspects of the responses which fell short of what was required. There was no particular pattern to this, with issues not repeated across cases. These included:

- a lack of clarity regarding the viewpoint of the LSU Decision Maker, for example of what they intended to achieve through the strategy discussion
- risks presented by the father's parenting capacity were not fully reflected, and no evidence that safeguarding checks were conducted of the family members with whom the children were to stay
- aspects of multi-agency working, such as a case where no responsibility was taken to ensure that action agreed through the multi-agency plan was completed, with the outcome left unknown
- a lack of follow-up to check what was done with sensitive information entrusted to another agency to share with the mother of the children

2.13 The audit examined 10 cases where a **child was identified as being at risk of CSE**. The audit found in the 8 cases managed by Topaz that the model had tangible benefits in safeguarding highly vulnerable children and in protecting them from harm:

- good information sharing and joint working with partner agencies
- a level of victim engagement and bespoke support which ensured that the best service possible was given to the child and wider family
- suspect disruption opportunities were taken in a timely manner which enabled safeguarding and the prevention of future offences
- good quality investigations
- the child remained the centre of the investigation throughout and was fully supported through the Criminal Justice process

2.14 However, the audit did identify a rape investigation involving a 17 year old child supported by a BASE worker which was held in the LSU with the Detective Sergeant decision-maker conducting desktop enquiries with no victim contact. It was 15 weeks before the case was allocated a Topaz Engagement Officer and Disruption Officer due to a lack of capacity at that time to support an additional child. Given that this was a rape investigation, it should have been allocated at an early stage to an OIC for investigation and victim contact, and subject to supervision.

2.15 6 of the 8 audited cases where a **child suspect was linked to County Lines** raised cause for concern about the way in which the potential vulnerabilities of children identified as suspects were not adequately considered:

- in 2 cases there was a failure to recognise the suspect as a child
- in several cases the police focus was clearly upon the offences and not upon safeguarding issues
- in several cases there was evidence of incidents appearing to have been dealt with in isolation without attempts made to search for the signs of vulnerability and exploitation
- 2 cases highlighted a lack of understanding of the Section 45 defence, one of which also showed a lack of understanding of the Modern Slavery and Human Trafficking aspects of the case