
# National Child Protection Inspection Re-Inspection

Essex Police
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# Foreword

All children deserve to grow up in a safe environment, cared for and protected from harm. Most children thrive in loving families and grow to adulthood unharmed. Unfortunately, though, too many children are still abused or neglected by those responsible for their care; they sometimes need to be protected from other adults with whom they come into contact. Some of them occasionally go missing, or end up spending time in places, or with people, harmful to them.

While it is everyone's responsibility to look out for vulnerable children, police forces, working together and with other agencies, have a particular role in protecting children and making sure that, in relation to their safety, their needs are met.

Protecting children is one of the most important tasks the police undertake. Police officers investigate suspected crimes and arrest perpetrators, and they have a significant role in monitoring sex offenders. They have the powers to take a child in danger to a place of safety, and to seek restrictions on offenders' contact with children. The police service also has a significant role, working with other agencies, in ensuring children's protection and well-being in the longer term.

As they go about their daily tasks, police officers must be alert to, and identify, children who may be at risk. To protect children effectively, officers must talk to children, listen to them, and understand their fears and concerns. The police must also work well with other agencies to play their part in ensuring that, as far as possible, no child slips through the net, and to avoid both over-intrusiveness and duplication of effort.

Her Majesty's Inspectorate of Constabulary (HMIC) is inspecting the child protection work of every police force in England and Wales. The reports are intended to provide information for the police, police and crime commissioners (PCCs) and the public on how well children are protected and their needs met, in order to promote improvement in how the police protect children.

# Contents

# Summary

This report is a summary of the findings of a re-inspection of child protection services in Essex Police, which took place in September and October 2016.[1]

## HMIC's 2015 inspection

Our first inspection took place in September and October 2015, and was part of our rolling programme of child protection inspections.[2]

In March 2016, we published our findings[3], which concluded that, at the time of the inspection, the force was not adequately protecting all children who were at risk owing to widespread serious and systemic failings. The leadership and senior management oversight needed to improve to ensure the weaknesses in practice identified during that inspection were addressed.

We also made a number of recommendations aimed at improving practice in Essex Police (see Annex B).

## HMIC's 2016 re-inspection

Because of the serious concerns raised in the 2015 report, between September and October 2016 we conducted a full re-inspection of Essex Police's approach to child protection.

This examined the effectiveness of the police response at each stage of their interactions with or for children, from initial contact through to investigation of offences against them. It also included scrutiny of the treatment of children in custody, and an assessment of how the force is structured, led, and governed in relation to child protection services.

We also assessed the progress made by the force against the recommendations of our 2015 report.

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[1] 'Child' in the report refers to a person under the age of 18. See the glossary for this and other definitions.

[2] For more information on this programme, see www.justiceinspectorates.gov.uk/hmic/our-work/child-abuse-and-child-protection-issues/national-child-protection-inspection

[3] *National Child Protection Inspections: Essex Police*, HMIC, March 2016. Available at: www.justiceinspectorates.gov.uk/hmic/our-work/child-abuse-and-child-protection-issues/national-child-protection-inspection/

## Main findings from the 2016 re-inspection

We found clear evidence of strong leadership and oversight by the chief officer team and the senior officers responsible for managing the public protection command. They have acted decisively in response to the 2015 inspection, and have demonstrated a strong commitment to protecting children and improving practices.

The chief constable has made child protection a priority for Essex Police, and it is clear that there is now a force-wide focus on achieving good outcomes for children. This has translated into some major changes to the way child protection services are provided across the county. For instance, the force has made changes to the way it organises its child protection services (see pages12-15), and has provided new three-day public protection awareness training to almost 1,000 staff.

We found that this focus at the top of the force is leading to some positive results. For example:

- staff and officers we spoke with are clear that protecting children is a priority for the force, and that significant steps have been taken (and time invested) to improve practice since the 2015 inspection; and
- the concerted drive by the chief officer team to work more closely with other agencies (such as children's social care and health services) better to protect children in the county is recognised and appreciated by these agencies, who told us they saw the changes implemented in Essex Police as positive. They also spoke of a real change in the willingness of the force to engage with them, accept professional challenge and work together effectively.

This is a significantly improved picture. HMIC acknowledges the commitment at chief officer level to taking on board the 2015 findings and acting on them.

However, although some progress was apparent, we found that the overall dedication and energy invested at this top level has not yet translated into consistent improvements in policing practice across all areas of child protection work.

This is evidenced by the fact that we graded the majority of case files we audited as either 'inadequate' or 'requires improvement', with some of the weaknesses in practice identified in the 2015 inspection still evident. In particular:

- the force's response to child sexual exploitation remains an area for further improvement. We found officers were still failing to conduct timely and appropriate investigations (see pages 16-19) and to consider the wider risks to the victim or to other children; and
- the number of overdue visits by officers to registered sex offenders has significantly increased across the force since the last inspection (from 50 to 400, see page 40).

## Conclusion

Our 2015 inspection raised significant concerns about Essex Police's response to children in need of help and protection. This inspection found that the force has acted decisively on these findings, and is making improvements and addressing shortcomings.

However, some of the changes the force has made are still relatively recent, and may not have taken full effect. As a consequence, the force does not yet fully understand the effect the changes are having. We also found evidence that the priority placed on improving performance at the top of the force is not yet resulting in consistently better practice on the front line, and so in better outcomes for children across Essex.

The failures identified in 2015 were serious and systemic, and we therefore expect it to take some time to correct them. We are encouraged by the significant changes that are being introduced. The commitment and dedication to change displayed by the chief officer team in particular is evident, impressive, and widely recognised by the staff, officers and other agencies with whom we spoke as part of this inspection.

# 1. Introduction

## The police's responsibility to keep children safe

Under the Children Act 1989, a police constable is responsible for taking into police protection any child whom he has reasonable cause to believe would otherwise be likely to suffer significant harm, and the police have a duty to inquire into that child's case.[4] The police also have a duty under the Children Act 2004 to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children.[5]

Every officer and member of police staff should understand his or her duty to protect children as part of the day-to-day business of policing. It is essential that officers going into people's homes on any policing matter recognise the needs of the children they may encounter, and understand the steps they can and should take in relation to their protection. This is particularly important when they are dealing with domestic abuse or other incidents in which violence may be a factor.

The duty to protect children extends to children detained in police custody.

In 2015, the National Crime Agency's strategic assessment of serious and organised crime established that child sexual exploitation and abuse represents one of the highest serious and organised crime risks.[6] Child sexual exploitation is also an important feature in the *Strategic Policing Requirement*.[7]

[4] Children Act 1989, section 46.

[5] Children Act 2004, section 11.

[6] *National Strategic Assessment of Serious and Organised Crime*, National Crime Agency, June 2015. Available at: www.nationalcrimeagency.gov.uk

[7] The Strategic Policing Requirement was first issued in 2012 in execution of the Home Secretary's statutory duty (in accordance with section 37A of the Police Act 1996, as amended by section 77 of the Police Reform and Social Responsibility Act 2011) to set out the national threats at the time of writing, and the appropriate national policing capabilities needed to counter those threats. Five threats were identified: terrorism, civil emergencies, organised crime, threats to public order, and a national cyber security incident. In 2015, the Strategic Policing Requirement was reissued to include child sexual abuse as an additional national threat. See *The Strategic Policing Requirement*, Home Office, March 2015. Available at www.gov.uk

## Expectations set out in *Working Together*

The statutory guidance, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*[8], sets out the expectations of all partner agencies involved in child protection (such as the local authority, clinical commissioning groups, schools and the voluntary sector). The specific police roles set out in the guidance are:

- identification of children who might be at risk from abuse and neglect;
- investigation of alleged offences against children;
- inter-agency working and information-sharing to protect children; and
- use of emergency powers to protect children.

These areas of practice are the focus of our child protection inspections.[9]

[8] *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015 (latest update). Available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

[9] Details of how we conduct these inspections can be found at Annex A.

# 2. Context for the force

Essex Police has approximately 4,750 staff. The workforce includes:

- 2,806 police officers;
- 1,588 police staff; and
- 100 police community support officers.[10]

The Essex police force area is served by three local authorities: Essex County Council, Southend-on-Sea Borough Council and Thurrock Council. These local authorities are responsible for child protection within their boundaries.

There are three separate local safeguarding children boards (LSCBs)[11] in the force area, one in each local authority area.

The most recent Office for Standards in Education, Children's Services and Skills (Ofsted) judgments for each of the local authorities are set out below.

| **Local authority** | **Judgment** | **Date** |
|---|---|---|
| Essex | Good | January 2014 |
| Southend-on-Sea | Requires improvement | April 2016 |
| Thurrock | Requires improvement | February 2016 |

## Structures for child protection services

In Essex Police, public protection services are led by the deputy chief constable. He is supported by a detective chief superintendent and two detective superintendents (one for investigations and one for risk and safeguarding) from the crime and public protection command.

[10] *Police workforce, England and Wales*, *30 September 2016*, Home Office, January 2017. Available at: www.gov.uk/government/statistics/police-workforce-england-and-wales-30-september-2016

[11] LSCBs have a statutory duty, under the Children Act 2004, to co-ordinate how agencies work together to safeguard and promote the welfare of children and ensure that safeguarding arrangements are effective.

## Safeguarding hubs

The force and partner agencies have established a multi-agency safeguarding hub (MASH) in Thurrock, where agencies including the police, children's social care and health services share premises to work together and exchange information to protect vulnerable people. Those working in a MASH assess risks to individuals in a range of cases, including child abuse, domestic abuse and the abuse of vulnerable adults.

In the Essex and Southend local authority areas, the force and partner agencies have established multi-agency risk assessment teams (MARATs), which assess risks to individuals in domestic abuse cases.

The MASHs and MARATs co-ordinate engagement in each area with multi-agency risk assessment conferences (MARACs).

# 3. Leadership, management and governance

## Introduction: what is effective practice in this area?

Effective practice at all levels depends on ensuring that all officers and staff involved in child protection understand what they need to do, and what they can expect of other agencies, to safeguard children (as set out in the *Working Together* framework).

## Findings

During 2015, Essex Police conducted an extensive review of the crime and public protection command. This identified that demand (i.e. the number of crimes dealt with) continues to increase significantly in respect of certain types of crime (e.g. offences against vulnerable adults). In addition, the review identified additional pressures on the command, including:

- management of a growing number of sex offenders and potentially dangerous persons; and
- the increased need to target online sexual offences.

The public protection review undertook a detailed analysis of the workloads of the sexual offences investigation team, child abuse investigation team (CAIT) and domestic abuse investigation teams (Operation Juno) over a three-year period. This identified an average annual increase in demand of 29 per cent, and concluded that the current staffing allocation was insufficient to meet current and future projected demands.

In response, the force changed its structures for providing public protection services and implemented a new model (described below) on 19 September 2016. This aims to provide consistency in the management of all cases across the command.

Staff across the force told us that the new structure being co-located and aligned to local policing areas provided greater clarity and a more joined-up approach to safeguarding and child protection.

**Essex Police's new model for providing public protection services**

The new model is built around four parts:

1. The operations centre. The purpose of the operations centre is to provide a consistent approach to research, risk assessment and allocation of incidents and referrals across all 14 strands[10] of public protection. Incorporated into this centre is an intelligence capability supporting both the tasking process for the command and the provision of information to assist the control room as well as officers attending and investigating incidents. The operations centre is also responsible for administering disclosure schemes, domestic violence protection orders, court orders and prison intelligence notifications.
2. The strategic centre. This team supports the strategic capacity and capability of the command. It develops policy and procedure, identifies national best practice and coordinates the command's response to national action plans, inspections and reports.
3. The investigation units. These are six local hubs responsible for the investigation of adult rape and child abuse offences. They are located in local police stations alongside Operation Juno teams.
4. Proactive operations. These include: the police online investigation team (POLIT); management of sex offenders and violent offenders (MOSOVO) teams; a proactive team providing operational support in the targeting and arrest of dangerous offenders; multi-agency public protection arrangements (MAPPA); and the disclosure and barring service. This allows a combined proactive response to prevention as well as targeting and arresting dangerous offenders.

The chief constable and his command team are committed to improving services for children. We found examples of visible leadership, such as a concerted drive to provide more focus around public protection, and efforts to work more closely with partner agencies better to protect children in Essex. The three directors of children's services are members of, and attend, the force's public protection programme board. Staff we spoke with were clear that protecting children is a priority for the force and that significant steps had been taken (and time invested) to improve since

[12] The 14 strands are child sexual exploitation, child abuse, domestic abuse, female genital mutilation, forced marriage, honour-based abuse, hate crime, human trafficking and modern slavery, missing persons, stalking and harassment, prostitution, management of sexual and violent offenders and adults at risk of harm and abuse.

the last child protection inspection. However, we identified some gaps between the clear strategic intent of Essex Police and frontline practice, which we will describe later in this report.

The chief constable has developed a 'Plan on a Page' to describe force objectives and priorities. These include tackling child abuse and exploitation, domestic abuse, urban street gangs and organised criminal groups linked to child sexual exploitation, underlining the force's commitment to improving the protection of children in Essex.

Senior officers described the frontline understanding of child protection and vulnerability matters as having significantly improved. They stated this was particularly apparent in evidence identification and recording, safeguarding, child welfare and an increased professional focus on vulnerability. This increase in understanding has been supported by a number of different approaches Essex Police has taken to improve its child protection response, including a series of vulnerability conferences for managers and supervisors and the proactive broadcasting of the 'Think Child Protection' message, which is intended to assist staff identify, assess and respond to vulnerability and decide when to make a referral to Children's Social Care. The force has also provided a three-day public protection awareness training course; at the time of the inspection (September 2016), 986 staff had attended this course and the aim is for all frontline staff to receive this training.

Professional relationships and engagement with partner agencies involved in safeguarding at a strategic level were described as positive and meaningful. These agencies viewed the changes being implemented by the force as positive and a real step change in its willingness to engage with them and in its receptiveness to professional challenge to improve its response for children. The leadership and commitment of the newly appointed deputy chief constable was particularly valued by partner agencies and seen as a clear commitment by the force at chief officer level to improve joint working.

Force governance arrangements for public protection are structured to provide scrutiny and delivery of performance at chief officer level, including progress against previous recommendations from HMIC inspections and serious case reviews as well as internal reviews. Oversight is provided through two boards, the public protection programme board and the force strategic oversight board (both chaired by the deputy chief constable). In addition the programme board is supported by two improvement boards, one for investigations and the other for vulnerable persons. Progress against actions is monitored and recorded on the force crime and public protection improvement plan.

Throughout the inspection it was clear that staff responsible for managing child abuse investigations were committed and dedicated to providing the best service for the child. Inspectors witnessed some good examples of child protection work by police officers, who displayed a mix of investigative and protective approaches. This ensured that protecting children remained central to their efforts while they were investigating cases.

# 4. Case file analysis

To determine how well Essex Police were dealing with specific cases, we asked the force to self-assess the effectiveness of their practice in 33 child protection cases. The force used criteria we provided[13] to grade the practice in each case as 'good', 'requires improvement' or 'inadequate':

> **good** – all the necessary steps have been taken to protect the child and improve the outcomes in the case, and there is clear demonstration that risks and wider threats have been understood and acted on;
>
> **requires improvement** – elements of good practice are missing, but there are no widespread or serious failures that leave children being harmed or at risk of harm; and
>
> **inadequate** – there are widespread or serious failures in practice that leave children being harmed or at risk.

HMIC inspectors then assessed these cases and compared their results with the force's results. In addition, during our inspection we assessed a further 42 child protection cases from across Essex Police.

A summary of the findings from both tranches of work is given below.

## Comparison of force self-assessment with HMIC's assessment

As Figure 1 shows, we identified considerably more weaknesses in practice than the force self-assessors: the force assessed 27 out of 33 cases as 'good', while we assessed 24 out of 33 to be 'requires improvement' or 'inadequate'.

**Figure 1: Cases assessed by both Essex Police and HMIC inspectors**

| | Good | Requires improvement | Inadequate |
|---|---|---|---|
| Force assessment | 27 | 6 | 0 |
| HMIC assessment | 9 | 10 | 14 |

[13] The assessment criteria for and indicators of effective practice used in this report are taken from *National Child Protection Inspection: Criteria Assessment*, HMIC, London, 2014. Available at: www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/ncpi-assessment-criteria.pdf

An example of contrasting assessments by Essex Police and HMIC is provided below.

**Use of police protection powers**

**Force assessment: good**

**HMIC assessment: inadequate**

This case involved a 16-year-old girl who reported that she was afraid of being assaulted if she returned home after her suspension from school. The police took her into police protection using their emergency powers (which enable any police officer to protect a child who is reasonably believed to be likely to suffer significant harm) [14], following which she then disclosed that she had shared an indecent image of herself via her phone. After discussions with children's social care (who advised the child should be returned to her parents), the police took the child home. The next day the girl reported to her school that she had been assaulted by both parents, which included her father pulling her tie and her mother grabbing her by the neck and pushing her into a pillow. The head teacher of the school confirmed that the child had marks on her neck and reported the matter to the police and children's social care.

**Explanation for HMIC's assessment**

This child was let down by agencies. The child disclosed to the police her concerns that she would be assaulted. The family's and child's histories, together with her fear of being injured and a previous assault by the mother, clearly indicate that a section 47 investigation[15] should have been undertaken. In spite of the clear signs of risk and concerns of the police, children's social care advised that the circumstances did not reach the threshold for the provision of alternative accommodation. There was no recorded challenge regarding this decision, and inspectors were unable to find evidence of a meaningful assessment of the risks. Despite there being no change in the circumstances, the designated officer[16] released the child from police protection back home where she was subsequently assaulted by both parents.

[14] Under section 46 of the Children Act 1989, the police may remove a child to suitable accommodation if they consider that the child is at risk of significant harm. A child in these circumstances is referred to as 'having been taken into police protection'.

[15] Under section 47 of the Children Act 1989, the police service, working with partner agencies such as local authority children's social care services, health services and education services, is responsible for making enquiries to safeguard and secure the welfare of any child within their area who is suffering (or is likely to suffer) significant harm.

[16] The designated officer is responsible for enquiring into cases in which the police take children into their protection. The designated officer should be at least of the rank of inspector.

The child's disclosure of sending an indecent image was recorded as a crime by the police, but there was no investigation and no recorded consideration of whether the recipient could have posed an ongoing risk to the girl or a wider risk to other children. There was no evidence of this information being shared with children's social care to inform their assessment of risk and development of protective plans.

## HMIC's assessment of 42 further cases

As Figure 2 shows, in this second tranche of case audits, we assessed 31 out of 42 cases as 'requires improvement' or 'inadequate'.

**Figure 2: Cases assessed by HMIC inspectors**

| | Good | Requires improvement | Inadequate |
|---|---|---|---|
| HMIC assessment | 11 | 6 | 25 |

HMIC referred 28 cases out of the 75 cases we audited back to the force because we considered they contained evidence of a serious issue of concern, for example, failure to follow child protection procedures and/or a child at immediate risk of significant harm. Some of these were cases among the 33 that had been self-assessed by Essex Police as either good or requiring improvement. We were concerned in particular that the force's assessors had failed to identify weaknesses in these cases and therefore had not taken action to address those deficiencies.

The force responded to the concerns raised by inspectors in these cases either by taking action or by providing further information.

Two examples of cases referred back to Essex Police follow.

**Use of police protection powers**

**Force assessment: requires improvement**

**HMIC assessment: inadequate**

This case involved a 16-year-old girl who was identified at initial response as being exposed to significant harm (because she was being subjected to emotional abuse within the home and there were concerns that she might self harm). She was taken into police protection after a dispute with her father. The force highlighted concerns about the girl returning to the family home, where the father was present. Despite these concerns and the wider risks faced by the girl, she was returned home by the police; there she was assaulted by her father. She was taken into police protection again the following day and placed into foster care. The girl also later disclosed that her father had sexually assaulted her in the past, but inspectors could find no evidence of the child being formally spoken to by the police about this in order to

support an investigation. This is of particular concern because force records show that when he was interviewed in relation to the physical assault, before the girl made her disclosure, the girl's father had informed the police of the potential allegation of a sexual assault on his daughter, but we could find no record of any action being taken as a result.

**Registered sex offender case**

**Force assessment: requires improvement**

**HMIC assessment: inadequate**

In this case no investigation had taken place into a registered sex offender who may have breached his notification requirements[17] and/or breached his sexual harm prevention order (SHPO).[18] Despite his moving into an address with children, there were delays both in speaking to the offender and in completing enquiries about other children he may have had access to. Inspectors were also unable to find any evidence of a referral being made (or considered) to children's social care about the other children he may have had access to.

## Breakdown of HMIC case file audit results by type of investigation

| Case type | Good | Requires improvement | Inadequate |
|---|---|---|---|
| Enquiries under section 47 of the Children Act 1989 | 9 | 0 | 2 |
| Referrals relating to domestic abuse incidents or crimes | 0 | 3 | 8 |
| Referrals arising from incidents other than domestic abuse | 0 | 3 | 2 |
| Children at risk from child sexual exploitation arising from the use of the internet | 4 | 1 | 6 |

[17] Sex offender notification requirements requires anyone who has become a subject of the Sex Offender Register to notify the police of certain details – current name, date of birth, home address. They must also notify the police of any changes, such as to name, address or intended foreign travel.

[18] Sexual harm prevention orders issued by the courts prohibit an individual from doing anything described in the order. These prohibitions are to protect the public from sexual harm. Any breach of the order is a criminal offence.

| | | | |
|---|---|---|---|
| Children at risk from child sexual exploitation arising out of local contact and not from the internet | 3 | 1 | 3 |
| Children missing | 3 | 2 | 4 |
| Children taken to a place of safety by police officers using section 46 Children Act 1989 powers | 1 | 4 | 3 |
| Sex offender management where children have been assessed as at risk from the person being managed | 0 | 2 | 4 |
| Children detained in police custody | 0 | 0 | 7 |

## Conclusion

Our audit shows that the force did not achieve good results for children in Essex in almost three-quarters of the cases we reviewed. This is a similar position to that identified in the case audits conducted at the time of the 2015 inspection, and indicates that the clear leadership and commitment to improving child protection services is not yet resulting in consistent improvements in decision-making on the front line. The force's response to enquiries under section 47, in contrast, were mostly found to be good, and in some of the other cases examined the initial response to safeguarding was also found to be good.

# 5. Initial contact

## Recommendations from the 2015 inspection report

The 2015 inspection report recommended that Essex Police immediately puts in place an action plan to ensure that, as a minimum:

- control room staff assess risks to children, paying particular attention to drawing all relevant information together at an early stage as part of that assessment, and ensure frontline staff are alerted to relevant information;
- incidents are not downgraded or the response delayed without proper justification and without appropriate checks having been made on the welfare of any children involved;
- any concerns about an incident involving children at risk are escalated if police have been delayed in attending; and
- relevant intelligence to assess risk is routinely updated on police systems in a timely manner.

It also recommended that, within three months, Essex Police ensured that officers always check on the welfare of children and record their observations of a child's behaviour and demeanour in domestic abuse incident records, so that a better assessment of a child's needs can be made.

## Re-inspection findings

Our inspection considered the extent to which, from the first point of contact, officers and staff are alert to and can identify children and young people at risk of harm – and act to protect them from harm.

Overall, inspectors found that the frontline response to child protection had improved since our 2015 inspection.

In January 2016, the force introduced a single form for referring cases of concern to children's social care. The form (called a PP57) sets out the thresholds under sections 17 and 47 of the Children Act 1989[19] for intervention referral to children's social care. This provides an effective and efficient way for officers and staff to make referrals to children's social care across the three local authority areas. Between March and September 2016, 2,640 PP57 forms had been submitted by officers for

[19] Section 17 of the Children Act 1989 identifies that a child may be in need of support if without it, the child may come to harm. Section 47 refers to a child suffering or likely to suffer significant harm and places a duty on the local authority in whose area the child resides to make enquiries into the circumstances.

referral to children's social care. However, staff in the family operations hub informed inspectors that staff are not consistently ensuring that, before the form is submitted the required consent is obtained from a parent/carer (for cases where a child may be in need of support) so that children's social care can work with that family. This leads to delays in progressing the referral (further details are provided on page 26).

In February 2016, the force supplemented the awareness training they had delivered (see page 14) with a booklet called *Officers Guide to Vulnerability*. This contains information about all areas of public protection and safeguarding work and advice on the responsibilities of staff who encounter vulnerable adults and children. Staff inspectors spoken with were extremely positive about the content and usefulness of this booklet.

Initial contact with Essex Police is made via the switchboard, for 101 calls, or the force control room, for 999 calls.[20] Switchboard operators now automatically route calls linked to child abuse and other public protection strands to the force control room as a call for service, which is reflected in the Essex child protection procedures. Previously such referrals were directly reported into the local CAIT hubs by children's social care. This change now ensures that all reported crimes and incidents are initially directed to and recorded within the control room, ensuring the calls are managed and assessed in relation to the National Crime Recording Standards (NCRS) and National Standard for Incident Recording (NSIR) for compliance – a positive step.

Force control room staff are trained in the use of the decision model known as 'THRIVE'. The model – Threat, Harm, Risk, Investigation, Vulnerability and Engagement – was implemented in June 2016 and is used to assess the initial police response to some incidents (including child protection concerns). However, domestic abuse incidents are not subject to a THRIVE risk assessment and this makes it more difficult for control room staff consistently and appropriately to assess and prioritise the risks related to these incidents. The force has made some changes to its command and control systems to enable operators to indicate if a child is involved in the incident and (separately) if there is any vulnerability. Although a positive step, these markers are not visible to staff on the summary page of outstanding incidents and can only be viewed by opening individual incidents. The process would be improved by showing a 'marker flag' on the summary page.

The public protection operations centre assessment team (which went live on 19 September 2016 and is an extension of the previous domestic abuse investigation team) provides centralised intelligence research about children involved in incidents to assist the force control room and frontline staff to make informed threat, harm and

[20] 101 is the police non-emergency number used for enquiries, advice on police matters and to report crimes that have already happened. 999 is the emergency number to contact the police when there is a danger to life or if a crime is in progress.

risk decisions. As part of this function, the assessment team will in future conduct background checks on all STORM[21] logs opened by the control room in relation to any incident involving the 14 strands of vulnerability. The team currently only conducts this work in relation to domestic abuse. From October 2016, this process will also include similar checks on all missing people and, as more trained staff become available, additional vulnerability strands will be adopted.

The force also have daily pacesetter briefings (at both local and force level), which we observed and found to provide good oversight of daily business and significant cases. These briefings provide senior leaders with information about critical risk, threat and harm, together with any resourcing issues, and ensure that staff deployments are efficient and sufficient to meet demand on a daily basis.

The *Officers Guide to Vulnerability* booklet issued to all frontline staff specifically instructs officers to check the welfare and speak with all children when attending incidents of domestic abuse and other child protection scenarios. Officers are given clear instruction that if there are children at domestic incidents they must see the children to check on their welfare, even if it is late at night and it means waking them. If the children are not present when the police attend, the police cannot finalise the incident until they have revisited and checked on their welfare. When officers contact the crime bureau to record a crime, they are asked specifically if they checked on the welfare of the children. However, in 8 of the 11 domestic abuse cases we examined there was no record of the children being spoken with. This is of concern: a child's demeanour, especially in those cases where a child is too young to speak to officers, or where speaking to them in the presence of a parent might present a risk, provides important information about the impact of the incident on the child. It should inform both the initial assessment of need and any referral to children's social care services.

We also found delays in the initial response to some domestic abuse incidents. For example, in one case the victim attended the police station to report concerns about her ex-partner. She told the police that her ex-partner was not supposed to have access to their daughter while a court case to determine custody was ongoing. The victim's ex-partner had sent her a text message saying he would come to her home to get their daughter. She also described him as having been threatening and angry in the past, and stated he had also tried to obtain the passport for their daughter. The victim returned home after being given some advice by the police about securing her premises. Later that evening, the victim contacted the police again to say her ex-partner was outside her home, constantly ringing the doorbell. Despite the

[21] STORM is the System for Tasking and Operational Resource Management used by the force to create and manage incidents reported by members of the public, but also to manage the deployment of operational resources.

circumstances and evidence of increasing risk, the police did not send an officer to the house and the domestic abuse intervention team did not review the incident until almost eight hours had passed

This case should have been progressed more quickly, at the time when the ex-partner was present at the address. The response provided failed to recognise the safeguarding issues present in this case and the factors indicating increasing risk.

# 6. Assessment and help

## Recommendations from the 2015 inspection report

The 2015 inspection report recommended that Essex Police immediately undertook a review, together with children's social care services and other relevant agencies, to ensure that the police are fulfilling their responsibilities as set out in *Working Together to Safeguard Children*. As a minimum, this should cover:

- attendance at and contribution to strategy discussions[22] and initial child protection conferences;
- recording and communicating decisions reached at meetings; and
- how partner agencies refer child protection matters to the police, with a view to reducing delays and improving the timeliness of assessments.

It also recommended that, within three months, Essex Police took steps to improve practice in cases of children who go missing from home. As a minimum, this should include:

- improving staff awareness of their responsibilities for protecting children who are reported missing from home, in particular in those cases where absences are a regular occurrence;
- improving staff awareness of the significance of drawing together all available information from police systems, including information about those who pose a risk to children, to inform risk assessments better;
- ensuring that staff are aware of the need to pass this information on to other agencies;
- providing guidance to staff that identifies the range of responses and actions that the police can contribute to multi-agency plans for protecting children in these cases.

[22] Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm there should be a strategy discussion involving local authority children's social care services, the police, health services and other bodies such as the referring agency. This might take the form of a multi-agency meeting or phone calls and more than one discussion may be necessary. A strategy discussion can take place following a referral or at any other time, including during the assessment process. *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015 (latest update), available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

## Re-inspection findings

The three local authorities – Southend, Essex and Thurrock (SET) – have worked with Essex Police to produce the SET safeguarding and child protection procedures,[23] which provide instruction and guidance for frontline officers on all aspects of child protection. The procedures cover making referrals, taking children into police protection, and safeguarding advice and evidential considerations.

Essex does not currently have a county-wide multi-agency safeguarding hub (MASH), which means that there are three different referral processes across the county. The force has therefore adapted its processes to work alongside the requirements of each local authority.

We were concerned to find in some of the case audits, where there was no evidence of a referral to children's social care, that there was no record of a strategy discussion or meeting taking place, and no detail of what information had been shared. This was very evident in the domestic abuse referral cases we audited. We also found inconsistent recording of whether children who were present at an incident (such as a domestic abuse incident) had been spoken with (see page 23).

In Essex there is a family operations hub, which includes staff from children's social care and six police officers. The officers' role is to receive child referrals and forward them on to children's social care. These officers check the quality of the referrals, provide feedback to other officers to improve learning, and review domestic abuse linked to children. We were told by staff within the hub that nearly 40 per cent of PP57 forms submitted by police to children's social care were returned because they did not meet the required standards (e.g. because they did not show that the necessary consent had been obtained from victims/carers – see page 22).

The officers within the hub have responded by compiling a spreadsheet which shows when submitting officers have returned amended forms when requested to do so; this shows that very few have in fact been returned. It was unclear which of the PP57 forms requiring amendment had been acted on by social care, meaning a potential ongoing risk to children and young people in Essex identified by the police as being in need of support. We examined a case at random from those not accepted and found delays in activity to safeguard. The example was a domestic abuse case in which the mother and father had gone through an acrimonious divorce but were still living in the same house. In June 2016 the police correctly made a referral to children's social care, but because the form did not have the victim's consent to enable children's social care to work with the family, no action was taken. The referral was returned to the police in July 2016, 40 days after the initial referral. Although the delay in activity is a matter for social care, this vulnerable child identified by the police did not receive any safeguarding engagement for over a

[23] Available at: www.escb.co.uk

month. This has been exacerbated by a failure to update police systems and ensure that quality assurance activity and effective professional challenge and escalation is taking place within the hub.

In Thurrock there is a single MASH that receives and assesses all child referrals, including those involving domestic abuse cases linked to children from the unitary authority area. It was established in April 2014 and involves 17 agencies, including children's social care, police, independent domestic violence advisers, early help, 'troubled families', housing and schools. Officers based in the MASH receive the PP57 forms from frontline response officers. These forms are checked for quality before they are assessed, researched and shared with partner agencies in the MASH. All incidents involving cases where social care are already involved with the child or family are passed direct to allocated social workers. Staff reported that the quality of referrals had improved since the single referral form had been introduced. If the form is not of sufficient quality, it is sent back to the originating officer to address any issues highlighted, such as a gap in information required to support an assessment, before it is submitted to partner agencies. Inspectors found that police staff in the MASH process information quickly and efficiently and make timely referrals to children's social care. There were no assessment backlogs within the MASH.

The dedicated police decision-maker in the Thurrock MASH has not received any specialist training to undertake the role (e.g. the specialist child abuse investigator's development programme) and does not have any previous experience working in child protection. Training and experience are vital for those involved at the assessment stage, to ensure decisions and risk assessments lead to the correct response being implemented at the earliest opportunity.

In Southend, referrals are made direct to children's social care.

There are also two multi-agency risk assessment teams (MARATs), one in Essex and the other in Southend, which receive domestic abuse referrals, including those linked to children, from referring agencies such as the police. The Southend MARAT receives daily information, which has been collated from police systems, from the Essex MARAT police representative on all high-risk incidents across the force. There is a process where referrals into the Southend MARAT are discussed after three days. This provides an early safeguarding review, allowing a multi-agency discussion and consideration of whether additional safeguarding measures are needed before the case is heard at a full multi-agency risk assessment conference (MARAC) on day 14. Cases are not closed at this stage unless the perpetrator has died or has received a custodial sentence, or the family lives outside the Southend area (in these cases, a MARAC-to-MARAC referral is made to the area where the family live).

Both MARATs only deal with high-risk abuse cases, which are heard at the local MARAC. In Southend, the MARAC is held weekly; in Essex there is a daily MARAC.

Thurrock MARAC meetings are heard at the MASH once a week. We found that MARACs across the county were well-attended and involved a range of partner agencies, with good evidence of joint working, intelligence sharing and risk management planning.

A central referral unit within Essex Police deals with the safeguarding elements for all high-risk domestic abuse, providing safety planning, support and signposting to external support services. In addition, each officer within the unit is supporting at least one of a cohort of acute victims who require longer-term safeguarding support.

The force has Juno teams across all three local policing areas, which are responsible for investigating all domestic abuse cases where the victim has been assessed as being at a high risk and a crime has been committed. They also investigate medium-risk cases where a crime has been committed, depending on capacity. Standard-risk cases remain the responsibility of the local policing teams. Juno team detective sergeants conduct supervisory reviews of Athena[24] domestic abuse, stalking and honour-based violence (DASH) risk-assessment forms where a criminal allegation has been made and the case is high, medium or standard risk. However, the south local policing area does not currently have capacity to review standard risk cases where a crime is alleged. Where there is no crime alleged, this function remains with the local policing teams, and includes the supervisory reviews of risk assessments.

Essex Police's policy is that staff (investigation support officers) from the child abuse investigation team will attend all child protection conferences where there has been involvement with the family or information to share that is relevant to child protection; if police do not attend, a report will be sent. There has been a drive to attend all initial child protection conferences, but this is not always achieved. Attendance at initial and review child protection conferences varied: between January and September 2016 there were 581 initial child protection conferences, of which the force attended 529 (91 per cent), and 1,113 reviews, of which they attended 194 (17 per cent). The force is trialling video and telephone conferencing to improve this, which should also reduce travelling time and associated costs. Twenty meetings have already used this facility.

Initial child protection conferences are convened when the outcome of a section 47 enquiry confirms that the child is suffering, or is likely to suffer, significant harm. A review conference is intended to consider explicitly whether the child is suffering, or is likely to suffer, significant harm and therefore continues to require safeguarding from harm through a formal child protection plan. While the provision of a report may be appropriate in some cases, significant value is lost when the police are not

[24] Athena is a police system used to manage police investigations, intelligence, custody and case preparation.

present to respond to or challenge discussions regarding how to manage a child's welfare.

In June 2016, the force hosted a multi-agency missing persons' conference, which was opened by the chief constable. Presentations and workshops covered missing persons, child sexual exploitation, sexual trauma, mental health and children's social care response. The force missing persons co-ordinators are also working with children's home providers and have agreed a memorandum of understanding with the 37 under-16 children's homes in Essex, setting out steps the carers should take when a child goes missing from their care. Within this memorandum is a 'planning for missing' form, which carers agree to complete and return to police when a child is placed in their home from another county and is known by them to carry a missing or other risk. This helps to ensure police are aware of the most at-risk children living in children's homes in Essex and have as much information as possible if one of these children goes missing.

The force has removed the use of the 'absent' category for children reported as missing, and therefore all reported incidents for children receive an active response and investigation – a positive change. We did find that repeat incidents were not always considered as a continuum of risk, which has led to some poor practice when cases have been viewed in isolation.

Police complete a 'vulnerability' check when missing children are located, and return-to-home interviews are undertaken by the relevant local authority. However, when return interviews have been conducted, feedback has not consistently been given to the police to help understanding and risk planning for future episodes. This is a lost opportunity to inform the development of protective plans.

We also found overall an inconsistent approach to the way in which the force responds to children who go missing. While some cases were thorough and well documented, others showed delays in supervision or contained reviews that did not appear to take into account key intelligence or information that should have informed the assessment of risk.

A 15-year-old boy living in foster care was reported missing by his carer. There was early intervention by the duty inspector who directed an appropriate initial response. The officer in the case was thorough in the enquiries and, during the search of the child's room, found a school book on which was written a mobile phone number, which was established to be linked to a 52-year-old registered sex offender. There was no evidence of enquiries being carried out to locate this individual, and when the first inspector review was added to COMPACT[25], nearly 12 hours after the child was reported as missing, no mention was made of the link to the phone number of the registered sex offender. There was no record of this information being shared with

[25] The COMPACT system is a police database that records the detail and history of missing people.

social care or of the relevant force managing this individual. The child returned home of his own accord.

Another missing episode case concerned a 14-year-old boy who had been missing 23 times and was at risk of child sexual exploitation. At the time of this missing episode he was the victim of grooming by a 40 year old male which was being investigated by the police, and two child abduction warning notices in relation to this child had been issued to the 40 year old and a further male. There was early supervisory oversight of this missing report and the force policy was adhered to, with the night supervisor reviewing the case as well as the duty inspector. However, neither of them mentioned the ongoing grooming offence or child abduction warning notices and no action raised around the address of the males. In the case file, there is no record of a strategy discussion with social services or of any involvement of the missing person liaison officer, despite the marker on COMPACT which stated that the case should be highlighted to them. The wider picture was not considered and the potential risk posed to the child from the known males was not considered nor acted on. The child was missing overnight and he had been potentially vulnerable as a result.

# 7. Investigation

## Recommendations from the 2015 inspection report

The 2015 inspection report recommended that Essex Police took immediate steps to ensure that all relevant information is properly recorded and readily accessible in all cases where there are concerns about the welfare of children .

We also recommended that Essex Police acted to improve child abuse and child sexual exploitation investigations with particular attention to:

- staff awareness, knowledge and skills;
- responding promptly to concerns raised;
- risk assessments that consider the totality of a child's circumstances and risks to other children;
- how the force identifies, disrupts and prosecutes perpetrators involved in child sexual exploitation;
- the capacity of investigators;
- the audit, supervision and management of cases;
- improving governance in the POLIT; and
- the 2013 protocol and good practice model to secure third-party material in a timely manner.

## Re-inspection findings

Our inspection considered the extent to which Essex Police child protection investigations are thorough, timely and demonstrated that the needs of children are central.

The introduction of the Athena database, which holds all investigation, custody and case file data in a single location, has improved the ability of officers and staff to access all relevant information. However, officers currently have to input information into several places for it to appear in the investigation summaries. For example, information on strategy meetings needs to be duplicated in the investigation summary or it can be difficult to find. There are also a number of older systems that have to be searched. A significant number of paper records held in the family files have not been converted. Chief officers are still to decide if converting these records will be cost effective.

We found that information relating to child protection matters (such as minutes from missing and child exploitation meetings and strategy discussions held with partner agencies) was not routinely provided to the police or recorded within Athena. In addition, inspectors were also concerned about the standard of recording on police systems across the force, also seen in case audits, where the record of actions/activity was not always evident. The use of flagging was also inconsistent in some of the cases viewed. Accurate and timely recording of information is essential for good decision-making in child protection matters.

The standard and progress of child sexual exploitation investigations was mixed. Inspectors examined 18 cases and assessed 11 to be inadequate or require improvement. However, some cases demonstrated a good response, such as in the following case.

A 19-year-old male met a 14-year-old girl and had sexual intercourse with her against her will. There was a prompt response and action by the police to the report, with appropriate safeguarding of the child considered. The child did not wish to engage, but she was dealt with very sensitively by the officer and lines of enquiry were pursued regardless of her uncertainty about the matter. She also received ongoing support from children's social care and the care home where she resided.

However, most of the cases assessed as inadequate involved a failure by police to take appropriate action when a concern was raised. Examples include the following case.

A 15-year-old girl was coerced into sending indecent images of herself to a man via the internet after he threatened her. The girl sent the images of herself, which the suspect then uploaded to the internet. The initial response to the incident was poor. There were significant delays and little evidence of appropriate action being taken to safeguard the girl or locate the suspect. The girl's mother first contacted the police on 12 January 2016, but the incident was not recorded as a crime until 29 January. It was not until May 2016, following a supervisor's review, that the investigating officer was instructed to make a referral to children's social care. Inspectors were also concerned that, despite the girl's mother providing the identity of the suspect, no action had been taken at the time of the inspection to locate and arrest the suspect.

In October 2015, a referral was received from the Child Exploitation and Online Protection Centre (CEOP) of a suspect downloading an indecent video of a child. The video was of indecent activity between an adult and a child aged about ten. In November, a review by an inspector stated that the investigation would be delayed

because of the workload of the police online investigation team (POLIT) and availability of staff. There was then a delay of over six months (since the CEOP referral) before the warrant was executed on the suspect's address. There were then further delays in the examination of seized items, which subsequently identified further indecent videos of children and numerous visits to child abuse websites.

The force has recognised there is more to do to understand the extent and nature of child sexual exploitation across Essex. Analysis of child sexual exploitation was undertaken in March 2015. Inspectors saw evidence of individual and local profiling and knowledge of both victims and perpetrators of child sexual exploitation, but a wider joint partnership profile would support more proactive analysis of networks (both victims and perpetrator) and enable the development of protective and disruptive plans. This assessment now needs real impetus to ensure the force and partner agencies have the necessary information to respond effectively to child sexual exploitation.

The previous child sexual exploitation triage team function has now been incorporated into the operations centre child triage team. Their functions include:

- identifying those victims who have suffered, are suffering or are at risk of suffering child sexual exploitation and implementing measures to safeguard them from harm;
- identifying those who are involved in the perpetration of child sexual exploitation and supporting operational staff to intervene, disrupt and collect evidence against them; and
- improving information-sharing across agencies in Essex in the best interests of victims of child sexual exploitation.

The child triage team is responsible for initial risk assessment, identifying and recording crimes, developing non-crime child sexual exploitation intelligence, and information-sharing with partner agencies. Cases are then forwarded to the local policing area, POLIT or CAIT. The force reported that, between January and September 2016, they had 390 non-crime child sexual exploitation cases and 40 child sexual exploitation crimes recorded.

The response to child sexual exploitation is inconsistent. In particular, officers fail to conduct appropriate and timely investigations and to consider the wider risks to the victim or other children.

However, inspectors were pleased to see that cases undertaken by the POLIT showed clear direction from supervisors on investigations with a clear investigation plan.

In May 2016, the force decided to trial including a digital forensic analyst within the POLIT to improve its response to investigating child abuse and exploitation. The

analyst provides specialist advice to the teams about investigating electronic devices at the scene of an incident (known as triage[26]). The trial aims to reduce the number of devices retained by police unnecessarily and produce better evidence at the earliest opportunity. Although the trial is ongoing and has not been evaluated fully, early benefits identified by the force include fewer seizures of exhibits and the provision of early evidence for interviews.

In some of the cases reviewed, inspectors were concerned about the use of police protection powers and the poor standard of record-keeping. We identified cases of children being returned to the same environment with little evidence of any action been taken to mitigate clear risk factors, in some cases resulting in assaults on children.

Inspectors were also concerned that in the cases reviewed there were differences between the assessment of risk by police and children's social care. Officers and staff spoken to by inspectors were able to provide additional examples and stated that they felt there was no mechanism for referring concerns to senior leaders when differences occurred. Officers spoke of what they saw as frustrating delays in the timeliness of the response of children's social care when emergency powers had been used and of a general lack of appropriate alternative accommodation leading to officers paying for hotel accommodation for vulnerable children.

However, inspectors also found good examples of investigations arising from section 47 referrals undertaken by the child abuse specialist investigators. Officers considered the best approach for interviewing children, gathered evidence from a range of sources, arranged timely medical examinations and made effective plans to pursue and apprehend suspects. In the 11 cases which we examined, we assessed 9 as good.

As an example, a four-year-old boy had been physically assaulted by his mother. The case was initially subject to a THRIVE assessment in the control room, and appropriately prioritised. Officers attended the home and arrested the mother. The child was spoken to sensitively and contact was made with children's social care and the child taken to hospital for examination. A strategy discussion was held, after which a joint section 47 investigation was agreed and undertaken, and the child was placed with foster carers. The child's interests in this case were at the centre of all decisions taken.

In another case, a four-month-old boy was admitted to hospital with fractured ribs that were believed to be non-accidental injuries. Specialist officers from the child abuse team arrested the parents and contacted children's social care to develop an appropriate protective plan for the boy and his three siblings (aged six, five and two).

[26] Triage allows the police to quickly investigate and extract evidence from computers and other digital devices.

A strategy meeting was held and a joint investigation agreed. There is evidence of a detailed investigation with good supervisory oversight. All appropriate lines of enquiry were followed, with decisions being made in the best interests of the child. Inspectors saw evidence of continuing effective joint working between police, children's social care and health practitioners. The child is now subject of an interim care order within the family court.

Essex Police state that they have a good relationship with the Crown Prosecution Service (CPS), which attends the force investigation improvement board. The force reported that the number of rape and serious sexual offences lawyers available to them had increased recently. However, despite this, child abuse investigation supervisors reported delays in CPS appointments of up to three months and charging decisions delays of up to eight months. The force is aware of this and is working with colleagues from the CPS to make further improvements. A regional bid for further rape and serious sexual offences lawyers has been developed and submitted.

# 8. Decision-making

## Recommendations from the 2015 inspection report

The 2015 inspection report recommended that Essex Police immediately acted to improve child abuse and child sexual exploitation investigations, with particular attention to ensuring that all relevant information is properly recorded and readily accessible in all cases where there are concerns about the welfare of children and, as a minimum, provides guidance to staff on:

- what information (and in what form) should be recorded on systems to enable good-quality decisions;
- the value and relevance of ensuring that records are made promptly and kept up to date; and
- carrying out quality assurance checks on records and providing feedback to police officers and staff.

## Re-inspection findings

Our inspection considered the extent to which decisions taken by Essex Police in child protection cases are child-centred, prioritise their needs and are based on good-quality evidence. These decisions may include those to remove a child from his or her home, to work jointly with other agencies or organisations to protect a child, to find and increase the number of sources of evidence that an offence may be taking place, and to conclude a case (for instance, through a charge, or through no further action being taken).

We found some good examples of effective decision-making during the initial response by frontline staff to protect children. For example, two children aged nine and five years were found with their mother, who was drunk. The police attended and removed them, working with children's social care which placed the children into foster care while family court proceedings were undertaken.

In another case, a 14-year-old boy, who had been reported missing, told frontline officers when they located him that he had been physically assaulted by his father. This was recorded by the officers on their body-worn video cameras. The boy was taken into police protection and the officers contacted children's social care, which undertook an assessment and provided the necessary ongoing support to the family.

However, inspectors also found in some of these cases that, as the investigation progressed, the police did not make good decisions. In the eight cases we assessed, seven were either inadequate or required improvement and one was good.

The force has also introduced an investigation advisory team within the crime and public protection command. This team undertake reviews of investigations, including child abuse investigations, to identify good practice or areas for development. Although this is a positive step, the review document used for such assessments is a general template that is not specifically tailored to child protection investigations. It therefore does not specifically identify if investigations are child-centred, and currently contains references to victim management, rather than the views of the child or the effect on a child and the outcome of an investigation, and may benefit from further development for use within child protection reviews.

# 9. Trusted adult

## Recommendations from the 2015 inspection report

The 2015 inspection report recommended that within six months action was taken by Essex Police to ensure that:

- it records the views and concerns of children;
- it records any available outcomes at the end of police involvement in a case;
- it informs children, as appropriate, of decisions made about them;
- information about children's needs and views is regularly made available for consideration by the police and crime commissioner, and to service managers, to inform future practice.

## Re-inspection findings

Inspectors found evidence that, when the concern was serious and immediately recognised as a child protection matter, there was good engagement with partner agencies, family members and other individuals to better protect a child. The approach to the child or parents (even when the parent was a suspect) was carefully considered, and the best ways to engage with the child were explored. This sensitive approach resulted in effective safeguarding outcomes for those children involved, as the following examples show.

There was a good police response when they went to an address where the mother of five children (aged between 2 and 16 years) was taken by ambulance to hospital after a drugs overdose. The police found the house to be in a poor condition. The children were taken into police protection and arrangements made for them to be suitably accommodated elsewhere. Joint visits between the police and children's social care to the children took place, during which the children said that they enjoyed living with their mother when she was well and taking her medication. A strategy discussion was held and a safeguarding and support plan was agreed that clearly took account of the wishes and best interests of the children. No prosecution was undertaken and significant support was put in place for the children, who remained in foster care with the agreement of the mother, while she received medical care for her mental health

Police were called following a report of a mother being seen physically assaulting her four-year-old son by slapping his face and head. The police went to the home of the mother and arrested her for assault. The boy was spoken with and there was engagement with children's social care and healthcare services throughout the case, with the child's interests at the centre of all decisions. Longer-term safeguarding was provided through a child protection plan.

However, in most of the cases assessed, inspectors found very little information about the views of the child, the effect of an offender's behaviour on the child and the outcomes of a case.

The force has prioritised more effective engagement with young people, and has invested in the development of a children and young people strategic co-ordinator and introduced children and young people officers into the community partnership hubs. These officers replace the previous schools and youth offending team roles and their priorities have changed to working with the most vulnerable children and engaging with the wider younger community.

Missing person liaison officers are also working with the fire service and police volunteer cadets to help prevent children from placing themselves at risk and from regularly going missing.

# 10. Managing those posing a risk to children

## Recommendations from the 2015 inspection report

The 2015 inspection report recommended immediate action in relation to the management of those who pose a risk to children:

- to reduce the delays in visiting sex offenders and to improve the management and response to other offenders who are subject to restrictions under a sexual offence prevention order
- to undertake a review with partner agencies to ensure attendance at MAPPA is at a suitable level to support the creation of effective action plans to protect vulnerable children from those who pose the most risk of harm.

## Re-inspection findings

Our inspection considered the extent to which officers and staff in Essex Police identify those who pose a risk to children and young people, and work with staff from partner agencies to protect children from them.

The force has a team dedicated to multi-agency public protection arrangements, aimed at managing known registered sex offenders and other dangerous individuals. These are known as the MOSOVO teams.

Following the restructuring of public protection, the MOSOVO teams have moved to the main police stations in each local policing area. This means that there are now stronger links between these specialist teams, local officers and staff. All registered sex offenders are flagged on the Athena system and their address is flagged in STORM, which means that local officers will be aware of any registered sex offenders who may be present when they attend incidents. In addition, MOSOVO officers are notified via a flagging system when the record of a registered sex offender has been accessed or updated, or if the police have attended an incident at their registered address.

Although the force uses proactive tactics to monitor registered sex offenders, such as covert monitoring, policing conditions of a sexual harm prevention orders (SHPO) issued against an offender, or using remote monitoring software, we were concerned to find that across the force 400 visits to sex offenders were overdue, 38 of which were to high-risk offenders (the most overdue high-risk visit should have been carried out in July 2016). At the time of our previous inspection of the force in 2015, there were 50 visits that were overdue. In September 2016 the force decided to

diverge from national guidance on visits to registered sex offenders[27] and to focus on those who posed the greatest risk. This means that all outstanding visits to low-risk offenders have been cancelled, and they may now not receive a police visit for up to two years. Visits to medium-risk offenders that were more than three months overdue have been cancelled and incorporated into the next scheduled visit, and now the offenders may not be seen by police for a year.

There are currently 1,297 offenders being managed in the community by the force, and the ratio of offender managers to offenders is also a cause of concern. We found that the number of offenders that officers were responsible for managing varied across the force: one officer had 215 offenders to manage, a part-time officer had responsibility for 120 offenders and another officer was managing 203 offenders.

### Overdue visits and breach of notification requirements

A registered sex offender on the register for life, with convictions for inciting a child to engage in sexual activity, was also subject to a sexual offences prevention order (SOPO) preventing access to the internet and children. At the time of our case audit, he had not been seen by the police for 18 months.

Within that intervening period, he had moved address and had breached his notification requirements (two days late), having previously made late notifications on three occasions. This new address had not been visited to assess any risk he poses within the new surroundings.

The reasons for the overdue visit were recorded as heavy workloads and the offender being assessed as low risk.

[27] Management of offenders is outlined in the multi-agency public protection arrangements (MAPPA) guidance and is based on a risk-assessment outcome. Very high-risk offenders receive monthly visits, high risk every 3 months, standard risk every 6 months and low risk annually.

At the time of the case audit, a registered sex offender who had a SOPO preventing access to the internet and to children aged under 16 years had not been visited for nearly 12 months.

During that time he had moved address and purchased three separate devices capable of accessing the internet. Despite compliance with his SOPO prohibitions in notifying the police regarding the purchase of the devices, his use of them had not been checked.

His father also rang the police in February 2016 to raise concerns about his son's relationship with his 13-year-old step-sister and his general demeanour, which was becoming reclusive.

At the time of the HMIC audit, despite several supervisory reviews, the obvious safeguarding issues such as engagement with children's social care and probation had not been addressed.

At the time of the case audit, a high-risk registered sex offender's visit was overdue by nearly three months.

He is employed as an odd job man, which on occasions brings him into contact with children, but he had only been seen once by the police in December 2015, shortly after his release from custody.

A SOPO was issued restricting his access to the internet, but we found no activity to suggest how this is being managed effectively. His registered address was also not flagged on STORM.

Missed or overdue visits to the addresses of registered sex offenders prevents officers from gathering the type of intelligence only obtainable from a home visit to help assess their risk assessments.

As more offenders are registered, managing them, collecting intelligence and disseminating it appropriately becomes increasingly demanding. This presents ongoing resourcing challenges for the force to ensure the risk the offenders pose is managed effectively. The number of offenders being managed by individual officers, coupled with the overdue visits, presents a real risk for the force.

The force is planning to enhance these teams with a further eight investigative support officers, but at the time of the inspection they were not in place.

Essex Police routinely searches for evidence of children being abused or exploited online and has a dedicated unit for overseeing these investigations. To ensure its resources are used in the most effective way the force takes a risk based approach utilising the Fighting International Internet Paedophilia (FIIP) assessment model[28] to identify and prioritise those suspected of being offenders who use the internet to meet and abuse children.

The force also reported that between January and September 2016 they had received 107 referrals from the National Crime Agency's Child Exploitation and Online Protection (CEOP) centre about suspected online perpetrators. These go to the force operations centre in the first instance, where initial background checks and a KIRAT[29] risk assessment takes place. They are then sent to the police online investigation team (POLIT), who investigate all those cases assessed as medium or high-risk. Those assessed as presenting a lower risk are dealt with by the local policing CID officers, who have received additional training and receive support from the POLIT team.

MAPPA[30] include regular meetings aimed at sharing information to support multi-agency risk assessments and formulating effective risk management plans to manage the risk of serious harm posed by dangerous offenders, including registered sex offenders.

Our review of MAPPA minutes showed that the majority of meetings were well attended by partner agencies. They reflected that the meetings were structured, following MAPPA guidance relating to information-sharing, risk, diversity and disclosure, leading to the formation of risk management plans and supporting actions to be undertaken, such as the completion of the Active Risk Management System (ARMS). ARMS is a structured assessment process to assess risk factors known to be associated with sexual re-offending, and factors known to be associated with reduced offending. It is intended to provide police and probation services with information to enable them to plan the management of convicted sex offenders in the community. The force reported that over 80 per cent of offenders had been ARMS assessed.

MAPPA guidance currently states that the police should attend all level 2 and 3 meetings, with the rank of officer required for level 2 meetings being inspector and,

[28] The Fighting International Internet Paedophilia (FIIP) assessment model is a European risk assessment tool to assist in identification, prioritisation and targeting of contact offenders who use the internet.

[29] The Kent Internet Risk Assessment Tool (KIRAT) is used to assess the level of risk posed by a suspect who possesses and views indecent images of children on the internet, and likelihood of that person becoming a contact offender – someone who commits sexual offences against children.

[30] Multi-agency public protection arrangements. See the glossary for a further explanation of these arrangements.

for level 3 meetings, superintendent. We found that on some occasions the representative for level 2 was a sergeant and for level 3 an inspector. It is vital that such attendees are appropriately briefed and knowledgeable and have the ability to make decisions and where necessary commit resources on behalf of the force.

# 11. Police detention

## Recommendations from the 2015 inspection report

The 2015 inspection report made five recommendations about managing the detention of children. The force was told to:

- improve awareness on the part of custody staff of child protection, the standard of risk assessment required to reflect the needs of children and the support they require at the time of detention and on release;
- assess at an early stage the likely need for secure or other accommodation and work with children's social care services to achieve the best option for the child;
- ensure that custody staff comply with statutory duties and complete detention certificates to the required standard if children are detained in police custody for any reason;
- ensure that custody staff make a record of all actions and decisions on the relevant documentation; and
- ensure adequate appropriate adult provision.

## Re-inspection findings

Our inspection considered the extent to which children and young people are detained in police custody only when absolutely necessary. We sought evidence that children in custody are protected from harm and every effort is made to release them or to transfer them to more appropriate accommodation.

We found that all custody staff have received additional training on vulnerability, with a further day specifically for supervisors, since the 2015 inspection. The force has also ensured that when girls are brought into police custody there is a female member of staff to look after their welfare while they are detained.

Responsibility for referrals being made to children's social care regarding those children detained in custody is not clear. Custody staff stated that there is no expectation for them to make referrals because this would be the investigating officer's responsibility, and that referrals should be recorded on the custody record. The force custody policy introduced in June 2016 is too vague in relation to the requirement for making referrals, and does not specify who is responsible for undertaking this activity. We found in the case audits that referrals in some cases had not been made and there are no quality assurance checks in place to ensure compliance.

We examined seven cases of children in detention (four boys and three girls) and assessed them all as inadequate. The youngest child was 14 years old and the oldest 17. They had been detained on suspicion of offences which included common assault, theft, and causing grievous bodily harm.

The force conducts quarterly audits of 30 custody records. Against each record 23 areas of custody practice are examined, but only four of these areas relate specifically to children and young people. The selection of cases is chosen at random with no minimum number required to relate to children, and no clear record of how many cases examined involved a child. It is therefore impossible to tell from the force audits whether custody practice in this area is good or requires improvement.

Our audits identified a number of areas of poor practice that applied in all of the cases we examined. Some of the areas of weakness are:

- a departure from the Police and Criminal Evidence Act 1984 codes of practice and force guidelines;
- no requests or delayed requests for appropriate adults; and
- healthcare practitioners were either not requested or there was a delay in the request.

Examples of some cases assessed as inadequate are outlined below.

**Significant period of detention for a minor offence**

This case involved a period of detention of over 27 hours in police custody for this 16-year-old, which was not proportionate to the minor nature of the offence being investigated – theft of a ball. There were opportunities to expedite this investigation, thereby reducing the period of detention at the police station.

A 16-year-old boy was arrested for theft of a ball.

During his detention a decision was made not to bail overnight in case he collaborated with another male involved in the theft. Although the child seemed to be a persistent criminal, the decision could have been averted with an early interview and bail to the next morning (there was no indication that the child ever failed to appear). The interview, which took place the following day, lasted 11 minutes.

This child remained in custody for over 27 hours, during which his detention was reviewed on two occasions by an inspector. However, there was no record to indicate that he was informed of these reviews and the reasons for his continued detention.

He was subsequently charged, refused bail and transferred into non-secure accommodation with the local authority.

**Poor provision of support and welfare during detention**

This case involved a girl with an injury and a history of self-harming who was detained in custody. No healthcare practitioner was requested to attend and assess if the child had any medical needs. During her period of detention, her welfare requirements were also not met appropriately.

A 14-year-old girl was arrested for a minor assault causing no injuries.

At the initial risk assessment, the girl disclosed that she suffered from depression, had an injury and had previously self-harmed when in custody. Despite this, no healthcare practitioner was called; there was no record of why this did not take place.

During her detention, the child asked for a female hygiene pack, but there was no record to indicate that this was provided. There was also no record of provision of the Essex juvenile information leaflet, no nominated welfare officer provided and no referral to children's social care.

This child was detained for over 13 hours.

**Poor practice and unnecessary post-charge detention**

In this case, although some basic tasks were completed correctly, overall there were significant departures from both force guidelines and the codes of practice. Reviews were poorly recorded, failed to identify relevant actions such as the attendance of an appropriate adult and were often undertaken in the absence of the child. The continued detention of an extremely vulnerable child with mental health needs in police custody because of a lack of transport and officer availability, despite alternative accommodation being available, is concerning.

A vulnerable 16-year-old girl was arrested for causing actual bodily harm to her sister and mother, after they tried to intervene to stop her from self-harming. The assessment at the time of detention identified the risks as self-harm, overdose and also her mental health needs.

During her detention, reviews were conducted; the first took place while she was asleep, and failed to identify that no appropriate adult had been called or parent informed. During the second review, the child was not reminded of all her rights, and again it was not identified that no appropriate adult had been called.

The child was in custody for more than 17 hours before an appropriate adult was contacted.

There was no consideration of finding the child accommodation overnight (prior to charge) that would be a more suitable place for her to stay.

During an assessment of the child by the mental health team, it became clear that she was often left to look after her siblings (aged three and six years). However, there is no record of a referral being made to children' social care about the risk she may present to her siblings.

The child was subsequently charged without an appropriate adult or solicitor being present, and bail was refused. The grounds for refusing bail were that it was for her own protection, to prevent further offences, that her siblings could be put in danger as a result of her behaviour, and that she was a serious risk to herself and others.

The custody officer took the decision not to transfer the child to alternative accommodation which had been offered by children's social care. The reasons recorded were that no transport or escort was available and the child was asleep. A detention certificate was also completed, stating that it was impractical to transfer the child as no officer was available.

The child was detained for 40 hours.

Poor record-keeping is a significant concern, particularly in the context of important information, such as legal grounds for the serious step of detaining children, the rationale for refusing bail and explanations for not transferring children to local authority accommodation. In the case audits, we found examples where reviews of detention were poorly recorded, details of the outcome of an examination of a detainee by a healthcare practitioner had not been documented, no reason given for placing a child into a cell and errors in custody procedures.

There are three appropriate adult schemes within Essex (aligned to each local authority), which have different hours of operation. The contractual arrangements end in March 2017, and a proposal is being negotiated with the three authorities for the provision of one service across the county. This would be a five-year contract for services operating between 6.00am and midnight, with only a telephone service provided overnight. We are concerned that the current proposal (from midnight to 6.00am) may not sufficiently meet the needs of children detained in police custody or provide the necessary welfare support during their detention.

Staff told us that because the appropriate adult scheme operating in Essex has operating hours of between 7.30 am and 11.30 pm, it is difficult to ensure that appropriate adults attend police stations after 10.00 pm. This is not just an issue for children, but also those vulnerable adults in custody who need access to some form of appropriate adult provision. This provision of service (whilst not the responsibility of the police) is not satisfactory for those children detained outside of these operating hours.

The case audits also found delays for children presented to custody having access to an appropriate adult to look after their welfare. In one case there was no record of an appropriate adult being in attendance at any stage during the child's detention, and in two cases there was no appropriate adult present when the children were charged. Charging is a serious step, especially for vulnerable children. For this reason the codes of practice make it clear that forces should take reasonable steps to give an appropriate adult sufficient notice to attend.

An appropriate adult is responsible for protecting (or safeguarding) the rights and welfare of a child or mentally vulnerable adult who is detained by police. Responsibilities are:

- to support, advise and assist the child or young person while in detention, including during any interview;
- to ensure that the child or young person understands his or her rights and that the appropriate adult has a role in protecting those rights;

- to observe whether the police are acting properly, fairly and with respect for the rights of the child or young person and to tell them if they are not; and
- to assist with communication between the child or young person and the police.

We also had concerns about officers' failure to keep children informed about the progress of an investigation while they were detained in police custody. Some custody PACE reviews[31] (which examine the need for continued detention) had been conducted when children were asleep, and they were not made aware of the outcome of the review regarding their continued detention. In one case the child's detention was subject to two reviews by an inspector, but neither identified that the child had not been provided with access to an appropriate adult.

The force has a specific children and young person policy, which determines how persons under the age of 18 who come into custody are treated. It states that safeguarding is at the heart of the care afforded to persons under 18, and if a custody officer does not seek guidance from a healthcare practitioner, that custody officer must justify the decision in writing on the custody record. A custody sergeant told inspectors that there is no expectation that all children will be seen by a healthcare practitioner and that it would only happen if the risk assessment revealed a need.

In most cases we examined, we found a deficiency in requesting the attendance of a healthcare practitioner.

For those children charged, refused bail and detained in custody, there is a joint protocol between Essex Police and the three local authorities for the provision of accommodation (one foster care place). This protocol covers both secure and alternative placements; however, there is no facility to place children into accommodation overnight before they are charged.

Detention officers have not been provided with guidance about what type of accommodation to request when making contact with children's social care. As a result, secure accommodation is being requested when it is inappropriate.

The force provided information showing 1,635 children had been brought into police custody between January and September 2016. Since June 2016, there had been 26 occasions when accommodation should have been provided, but it was only provided eight times. On only two occasions was the accommodation not available because it was in use by another detainee. There is also no secure accommodation in the county − the nearest is in Peterborough. The time that would be involved in taking the child to Peterborough is prohibitive and so this accommodation is not

[31] Police and Criminal Evidence Act 1984 (PACE) Code C, *Revised code of practice for the detention, treatment and questioning of persons by police officers*.

used. The force reported that secure accommodation had been required on six occasions since June 2016. Reports of children kept in custody overnight are dealt with at the daily force pacesetter meeting, where issues can be escalated.

In the cases we audited, no child had been detained under section 136 of the Mental Health Act 1983. The force has a policy that states that young people should not be brought into police custody as a place of safety and should be accommodated at the two specialist units within Essex. Over a 12-month period to April 2016, there had been only three incidents of young people aged under 18 detained under section 136 being brought into custody as a place of safety. The force explained that the circumstances for these cases were that they were exhibiting extreme violence.

# 12. Conclusion: the overall effectiveness of the force and its response to children who need help and protection

Essex Police has made some significant changes to the delivery of services for children and to improve its response to children who need help and protection. However, many of these changes are recent and consequently the force does not yet have a full understanding about the nature and extent of the improvements to the outcomes for vulnerable children.

The force has demonstrated a strong commitment to protecting children and to the development of a culture of continual improvement. This is particularly evident among the chief officer team and senior officers responsible for managing the public protection command. The chief constable has prioritised child protection since the last inspection, and it is clear that there is a force-wide focus on delivering good outcomes for children. The force is also engaging with senior representatives from partner agencies enabling them to scrutinise and challenge where appropriate, but as importantly to work co-operatively to assist the police in its response to child protection.

The recent public protection review, structural changes, engagement with partner agencies and training for staff provide a real opportunity for the force to reassure itself it has the capacity, capability and consistently good standards of practice required to improve outcomes for children. However, these improvements are not yet providing all their potential benefits. Given the scale of the challenge that faced the force in 2015, this is to be expected; it will take time for the strategy to translate fully into frontline practice.

The majority of cases we examined were assessed as 'inadequate' or 'requires improvement', with weaknesses in practice identified in the previous inspection still requiring further improvement. There were still poor responses by some officers, often missing the wider risk posed, together with a lack of robust supervisory management or recognition of these deficiencies, which is worrying.

The current position in relation to overdue visits to sex offenders and the numbers individual officers are managing presents a significant risk for the force.

The improvement processes implemented by the force are developing and in progress. If the force is to be confident that it is consistently delivering improved outcomes for the children of Essex, then its current focus and momentum must be maintained.

The force has effective processes in place to monitor the implementation of previous HMIC recommendations. However, these processes do not place sufficient focus on

the quality of frontline practice. A performance framework that focuses on outcomes for children who need protection (rather than the number of cases processed), the recognition of risk and the quality of decision-making, would help the force to make improvements with greater consistency.

Officers and staff reported some frustrations with the way some agencies responsible for child protection responded to concerns raised by the police, and also about their ability to draw these perceived issues to the attention of more senior personnel when they arise. If the force has concerns over how organisations are working together to safeguard and promote the welfare of children, *Working Together* allows for these to be taken forward and examined by the local safeguarding children board (LSCB). Although not required by statute, these LSCB reviews are important for highlighting good practice as well as identifying improvements which need to be made to local services.

In summary: the force has addressed the widespread serious and systemic failings identified during the 2015 inspection with clarity of leadership and senior management oversight. The force must now focus on translating the overall commitment and energy it has invested in response to the earlier HMIC findings into consistent improvements in police practice across all areas of child protection work.

# Glossary

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| Association of Chief Police Officers | professional association of police officers of assistant chief constable rank and above, and their police staff equivalents, in England, Wales and Northern Ireland; leads and coordinates operational policing nationally; a company limited by guarantee and a statutory consultee; its president was a full-time post created by the Police Reform Act 2002; replaced by the National Police Chiefs' Council (NPCC) on 1 April 2015 |
| Authorised Professional Practice | official source of professional practice on policing, developed and approved by the College of Policing, to which police officers and staff are expected to have regard in the discharge of their duties |
| CEOP | the Child Exploitation and Online Protection command within the UK National Crime Agency (NCA), working with child protection partners across the UK and overseas to identify the main threats to children and to co-ordinate activity against these threats to bring offenders to account |
| child abuse investigation team (CAIT) | responsible for investigating allegations of abuse relating to children |
| child | person under the age of 18 |
| child in need | defined under the Children Act 1989 as a child who is unlikely to reach, or maintain a satisfactory level of health or development, or whose health and development will be significantly impaired without the provision of services, or the child is disabled |
| child sexual exploitation | the nationally-agreed NPCC definition of child sexual exploitation is: sexual exploitation of children and young people under 18 which involves exploitative situations, contexts and relationships where the young person (or third person/s) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or others performing on them, sexual activities. |

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| | child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post images on the internet/mobile phones without immediate payment or gain |
| College of Policing | professional body for policing; established to set standards in professional development, including codes of practice and regulations, to ensure consistency across the 43 forces in England and Wales; also has a remit to set standards for the police service on training, development, skills and qualifications |
| control room | police control and communications room which manages emergency (999) and non-emergency (101) calls, and sends police officers to these calls |
| emergency powers | given by section 46 of the Children Act 1989 to enter premises and remove a child to ensure their immediate protection |
| flags | markers on IT systems which highlight particular characteristics or needs, and which enable police officers to assess risks effectively |
| (independent) return interviews | carried out by non-statutory agencies with children who go missing when they return. The purpose of the interview is to try and establish why the child went missing and what might need to be done to prevent reoccurrence or to keep the child safe in the future |
| LSCB (local safeguarding children board) | required by section 13 of the Children Act 2004 to be set up in each local authority; the Act specifies the organisations and individuals that should be represented; the LSCB has a range of statutory functions with the aim of ensuring that children are safeguarded |
| MAPPA (multi-agency public protection arrangements) | mechanism through which local criminal justice agencies (police, prison and probation trusts) and other bodies dealing with offenders work together in partnership to protect the public from serious harm by managing sexual and violent offenders; established in each of the 42 criminal justice areas in England and Wales by sections 325 to 327B of the Criminal Justice Act 2003 |

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| MARAC (multi-agency risk assessment conference) | locally-held meeting where statutory and voluntary agency representatives come together and share information about high-risk victims of domestic abuse; any agency can refer an adult or child whom they believe to be at high risk of harm; the aim of the meeting is to produce a co-ordinated action plan to increase an adult or child's safety, health and wellbeing; agencies that attend vary, but are likely to include the police, probation, children's, health and housing services; there are over 250 currently in operation across England and Wales |
| MASH (multi-agency safeguarding hub) | hub in which public sector organisations with responsibilities for the safety of vulnerable people work; it has staff from organisations such as the police and local authority social services, who work alongside one another, sharing information and co-ordinating activities to help protect the most vulnerable children and adults from harm, neglect and abuse |
| missing and absent | the definitions used by the police are currently:<br><br>missing – 'anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be subject of crime or at risk of harm to themselves or another'<br><br>absent – 'a person not at a place where they are expected or required to be and there is no apparent risk. 'Absent' cases should not be ignored, and must be monitored over periods of time with consideration given to escalating to 'missing' if there is a change to the circumstances that has increased the level of risk' |
| missing persons coordinator | collates information on all instances of absence and missing people in order to inform interventions to prevent repeat episodes |
| National Centre for Applied Learning Techniques | produces e-learning programmes to meet the training needs of the police service |

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| National Crime Agency | non-ministerial department established under the Crime and Courts Act 2013 as an operational crime-fighting agency to work at a national level to tackle organised crime, strengthen national borders, fight fraud and cyber-crime, and protect children and young people from sexual abuse and exploitation; provides leadership in these areas through its organised crime, border policing, economic crime and Child Exploitation and Online Protection commands, the National Cyber Crime Unit and specialist capability teams |
| NPCC (National Police Chiefs' Council) | organisation which brings together 43 operationally independent and locally accountable chief constables and their chief officer teams to co-ordinate national operational policing; works closely with the College of Policing, which is responsible for developing professional standards, to develop national approaches on issues such as finance, technology and human resources; replaced the Association of Chief Police Officers on 1 April 2015 |
| national policing lead | senior police officer with responsibility in England and Wales for maintaining and developing standards and guidance for all police forces in respect of a particular area of policing |
| place of safety | under the Children Act 1989, police officers can use their powers to remove a missing child and place them somewhere safe |
| PEEL | annual assessment of police forces in England and Wales, carried out by HMIC; forces are assessed on their effectiveness, efficiency and legitimacy; they are judged as outstanding, good, requires improvement or inadequate on these categories (or pillars) based on inspection findings, analysis and Her Majesty's Inspectors' (HMIs) professional judgment across the year |
| perpetrator | someone who has committed a crime |
| PCSOs (police community support officers) | uniformed staff whose role is to support the work of the police officers within the community |

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| police officer | an individual with warranted powers of arrest, search and detention who, under the direction of his chief constable, is deployed to uphold the law, protect life and property, maintain and restore the Queen's peace, and pursue and bring offenders to justice |
| police protection powers | powers exercisable by a police officer under section 46 of the Children Act 1989 to remove a child to a place of safety if the child is considered to be at risk of significant harm |
| professional lead | nominated senior organisational lead for a particular discipline |
| protecting vulnerable people lead | person who maintains responsibility for the oversight of all public protection matters |
| registered sex offender | person required to provide his details to the police because he has been convicted or cautioned for a sexual offence as set out in Schedule 3 to the Sexual Offences Act 2003, or because he has otherwise triggered the notification requirements (for example, by being made subject to a sexual offences prevention order); as well as personal details, a registered individual must provide the police with details about his movements, for example he must tell the police if he is going abroad and, if homeless, where he can be found; registered details may be accessed by the police, probation and prison service |
| risk assessment | assessment intended to assist officers in deciding appropriate levels of intervention for victims |
| safe and well check | interview carried out by police officer with a missing person when they are found or return to ensure that he is safe and well |
| safeguarding | broader than 'child protection'; relates to the action taken to promote the welfare of children and protect them from harm. It is defined in statutory guidance as:<br>• protecting children from maltreatment<br>• preventing impairment of children's health and development<br>• ensuring that children grow up in circumstances consistent with the provision of safe and effective |

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| | care<br>• taking action to enable all children to have best outcomes |
| sexual violence | any act, attempt, or threat of a sexual nature that results, or is likely to result in, physical, psychological and emotional harm |
| trigger plan | plan to locate a child quickly when he or she goes missing |
| vulnerable person | a person who is in need of special care, support, or protection because of age, disability, or risk of abuse or neglect, or is a ward of court child or young person for whom a guardian has been appointed by the court or who has become directly subject to the authority of that court |

# Annex A – Child protection inspection methodology

## Objectives

The objectives of the inspection are:

- to assess how effectively police forces safeguard children at risk;
- to make recommendations to police forces for improving child protection practice;
- to highlight effective practice in child protection work; and
- to assist forces in improving their child protection practices.

The expectations of agencies are set out in the statutory guidance *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, the latest update to which was published in March 2015. The specific police roles set out in the guidance are:

- the identification of children who might be at risk from abuse and neglect;
- investigation of alleged offences against children;
- inter-agency working and information-sharing to protect children; and
- the exercise of emergency powers to protect children.

These areas of practice are the focus of the inspection.

## Inspection approach

Inspections focus on the experience of and the results for children, following their journey through the child protection and criminal investigation processes. They assess how well the service has helped and protected children and investigated alleged criminal acts, taking account of, but not measuring, compliance with policies and guidance. The inspections consider how the arrangements for protecting children, and the leadership and management of the police service, contribute to and support effective practice on the ground. The team considers how well management responsibilities for child protection, as set out in the statutory guidance, have been met.

## Methods

- Self-assessment – practice, and management and leadership.
- Case inspections.

- Discussions with staff from within the police and from other agencies.
- Examination of reports on significant case reviews or other serious cases.
- Examination of service statistics, reports, policies and other relevant written materials.

The purpose of the self-assessment is to:

- raise awareness in the service about the strengths and weaknesses of current practice (this forms the basis for discussions with HMIC); and
- initiate future service improvements and establish a baseline against which to measure progress.

## Self-assessment and case inspection

In consultation with police services. the following areas of practice have been identified for scrutiny:

- domestic abuse;
- incidents where police officers and staff identify children in need of help and protection, e.g. children being neglected;
- information-sharing and discussions about children potentially at risk of harm;
- the exercise of powers of police protection under section 46 of the Children Act 1989 (taking children into a ‘place of safety’);
- the completion of section 47 Children Act 1989 enquiries, including both those of a criminal nature and those of a non-criminal nature (section 47 enquiries are those relating to a child ‘in need’ rather than ‘at risk’);
- sex offender management;
- the management of missing children;
- child sexual exploitation; and
- the detention of children in police custody.

# Annex B – 2015 National Child Protection recommendations for Essex Police

## Immediately

We recommend that Essex Police immediately puts in place an action plan to ensure as a minimum:

- control room staff assess risks to children, paying particular attention to drawing all relevant information together at an early stage as part of that assessment, and ensure frontline staff are alerted to relevant information;
- incidents are not downgraded or the response delayed without proper justification and without appropriate checks having been made on the welfare of any children involved;
- any concerns about an incident involving children at risk are escalated if police have been delayed in attending; and
- relevant intelligence to assess risk is routinely updated on police systems in a timely manner and is readily available to frontline officers when attending incidents.

We recommend that Essex Police immediately undertakes a review, together with children's social care services and other relevant agencies, to ensure that the police are fulfilling their responsibilities as set out in Working Together to Safeguard Children. As a minimum, this should cover:

- attendance at and contribution to strategy discussions and initial child protection conferences;
- recording and communicating decisions reached at meetings; and how partner agencies refer child protection matters to the police, with a view to reducing delays and improving the timeliness of assessments.

We recommend that Essex Police immediately acts to improve child abuse and child sexual exploitation investigations with particular attention to:

- staff awareness, knowledge and skills;
- responding promptly to concerns raised;
- risk assessments that consider the totality of a child's circumstances and risks to other children;
- how the force identifies, disrupts and prosecutes perpetrators involved in child sexual exploitation;

- the capacity of investigators;
- the audit, supervision and management of cases;
- improving governance in the POLIT; and
- the 2013 protocol and good practice model to secure third party material in a timely manner.

We recommend that Essex Police takes immediate steps to ensure that all relevant information is properly recorded and readily accessible in all cases where there are concerns about the welfare of children and, as a minimum, provides guidance to staff on:

- what information (and in what form) should be recorded on systems to enable good-quality decisions;
- the value and relevance of ensuring that records are made promptly and kept up to date; and
- carrying out quality assurance checks on records and providing feedback to police officers and staff.

We recommend that Essex Police takes immediate action to:

- to reduce the delays in visiting registered sex offenders and to improve the management and response to other offenders who are subject to restrictions under a sexual offence prevention order; and
- to undertake a review with partners to ensure attendance at MAPPA is at a suitable level to support the creation of effective action plans to protect vulnerable children from those who pose the most risk of harm.

## Within three months

We recommend that, within three months, Essex Police ensures that officers always check on the welfare of children and record their observations of a child's behaviour and demeanour in domestic abuse incident records, so that a better assessment of a child's needs can be made.

We recommend that, within three months, Essex Police takes steps to improve practice in cases of children who go missing from home. As a minimum, this should include:

- improving staff awareness of their responsibilities for protecting children who are reported missing from home, in particular in those cases where absences are a regular occurrence;

- improving staff awareness of the significance of drawing together all available information from police systems, including information about those who pose a risk to children, to better inform risk assessments;
- ensuring that staff are aware of the need to pass this information on to other agencies; and
- providing guidance to staff that identifies the range of responses and actions that the police can contribute to multi-agency plans for protecting children in these cases.

We recommend that, within three months, Essex Police reviews how it manages the detention of children. Essex Police should request the assistance of children's social care services and other relevant agencies in this review. The review should include, as a minimum, how best to:

- improve awareness on the part of custody staff of child protection, the standard of risk assessment required to reflect the needs of children, and the support they require at the time of detention and on release;
- assess at an early stage the likely need for secure or other accommodation and work with children's social care services to achieve the best option for the child;
- ensure that custody staff comply with statutory duties and complete detention certificates to the required standard if children are detained in police custody for any reason;
- ensure that custody staff make a record of all actions and decisions on the relevant documentation; and
- secure adequate appropriate adult provision in the force.

## Within six months

We recommend that, within six months, Essex Police:

- takes steps with partners to ensure timely forensic medical examinations are conducted in sexual abuse cases involving children;
- undertakes a review of the initial risk assessment process in domestic abuse cases to understand whether processes are consistently applied by staff and to ensure cumulative risk to children living with domestic abuse is identified and addressed; and
- takes steps with partner agencies to evaluate its current MARAC arrangements, including preliminary meetings to filter cases, to ensure

that vulnerable people including victims and children are protected at an early stage.

We recommend that Essex Police continues its discussions at a senior level with the CPS to address delays in advice and charging decisions.

We recommend that Essex Police immediately acts to improve child abuse and child sexual exploitation investigations with particular attention to:

- staff awareness, knowledge and skills;
- responding promptly to concerns raised;
- risk assessments that consider the totality of a child's circumstances and risks to other children;
- how the force identifies, disrupts and prosecutes perpetrators involved in child sexual exploitation;
- the capacity of investigators;
- the audit, supervision and management of cases;
- improving governance in the POLIT; and
- the 2013 protocol and good practice model to secure third party material in a timely manner.