Inspecting policing in the public interest

National Child Protection Inspection Post-Inspection Visit

Norfolk Constabulary
28 April 2015

October 2015

ISBN: 978-1-78246-920-9

www.justiceinspectorates.gov.uk/hmic

Contents

1. Background

HMIC carried out a child protection inspection in Norfolk Constabulary in April 2014 and the report of this inspection was published in August 2014. In September 2014 the constabulary provided HMIC with an action plan setting out how it intended to respond to the recommendations in the inspection report. Inspectors carried out a post-inspection visit in April 2015 specifically to assess progress with the implementation of the recommendations. We report on progress in section 2. During the course of our visit we were made aware of a number of developments that have a bearing on Norfolk Police's approach to child protection. We summarise these below.

The visit included:

- an interview with the head of safeguarding and harm reduction.

Summary

HMIC recognises that Norfolk Constabulary is committed to improving the protection of children. Child protection has been prioritised and there is a strong desire to improve outcomes for children who are at risk of harm. There is visible leadership and much work underway to improve the protection of children. Force and multi-agency plans are in place and some important steps have been taken to implement the majority of the recommendations from HMIC's inspection in April 2014.

At the time of our visit in April 2015, improvements were evident. Substantial investment has been made to improve services: an online safeguarding team has been created and further investment made in the force's safer schools partnerships. Governance arrangements had been refreshed to improve consistency and reflect the importance the force attaches to protecting the vulnerable. The safeguarding and investigation command team is now well established and tasking processes and analysis of child sexual exploitation (CSE) have also been enhanced.

The force will want to be confident that this body of work translates into consistently improved practice at the frontline which results in good outcomes for children.

2. Post-inspection visit findings

Investigation

Recommendations from initial inspection report

> We recommend that, Norfolk Constabulary takes **immediate** action to improve the effectiveness of action plans for identifying, disrupting and prosecuting perpetrators involved in child sexual exploitation.
>
> We recommend that, Norfolk Constabulary takes **immediate** steps to reduce the timescales for analysis in the high-tech crime unit.
>
> We recommend that, **within three months**, Norfolk Constabulary monitors compliance with the recently introduced information-sharing protocol to address the delays in the exchange of information between the constabulary and Norfolk County Council.
>
> We recommend that, **within three months**, Norfolk Constabulary identifies and reviews all child abuse investigation cases that have taken more than three months to investigate from the first report, ensures that each child is supported and safeguarded, and puts in place appropriate measures to manage the risk posed by suspects.

Summary of post-inspection visit findings

Norfolk Constabulary had made progress in disrupting and prosecuting perpetrators involved in child sexual exploitation (CSE). However, there is still some way to go to join up and co-ordinate activity between teams. Work is continuing to ensure the timescale for analysis in the high tech crime unit are reduced. Good progress had been made to reduce delays in information-sharing with Norfolk County Council. Inspectors were concerned that non-specialist staff were investigating some child protection cases, including online sexual exploitation.

Detailed post-inspection visit findings

Norfolk Constabulary reported progress in disrupting and prosecuting offenders for CSE. The constabulary had delivered awareness training to the frontline and had made good use of some disruption tactics, for example, better use of child abduction warning notices[1] to deter offenders. However, inspectors were told that work to identify and disrupt offenders was limited. A CSE team provides support to children

[1] A non-statutory notice issued when the police become aware of a child spending time with an adult who they believe could be harmful to them. A notice is used to disrupt the adult's association with the child or young person, as well as warning the adult that the association could result in arrest and prosecution.

at risk. The team's remit did not extend to disruption as this responsibility sat with other policing units. Inspectors were also told that a lack of engagement by children's social care services staff based within the CSE team constrained disruption activity. This was being actively addressed by the constabulary. Concerns had been raised formally with both Norfolk Safeguarding Children's Board and Norfolk County Council's children's social care services and plans were in place to expand the remit of the CSE team to include proactive work in the future.

A post to develop intelligence had been created by the constabulary. However, due to demands in responding effectively to CSE incidents, the officer had not yet started intelligence development work.

Norfolk Constabulary has a well-established and extensive programme of collaborative work with Suffolk Constabulary. This includes collaboration on the work to analyse computers and other media devices. Also, the constabulary had invested in advanced technology in an effort to reduce delays within the high-tech crime unit (HTCU). These developments were due to take effect at the time of our visit. A governance and performance management process had been established with a focus on risk assessment. Work is continuing to ensure that the timescales for analysis in the HTCU are reduced. At the time of the review there were approximately 50 cases waiting for analysis. The oldest case awaiting examination was from January 2015.

Norfolk Constabulary had created an online investigation team which we were told predominantly investigated cases received from CEOP (the National Crime Agency's Child Exploitation Online Protection command) and other forces but which also dealt with internally-generated online enquiries. At the time of our visit, additional staff were being recruited to increase further the constabulary's capacity and capability to target proactively online perpetrators. However, inspectors were told that there was limited capacity within the existing Safeguarding Children Online Investigation Team (SCOIT) to investigate the volume of offences in the constabulary area. As a result, some cases were allocated to other teams, including neighbourhood officers, who lacked the specialist skills necessary to undertake the work.

Furthermore, inspectors were told that a governance process had been introduced for the management of child abuse investigations and those arrangements were well embedded within specialist teams. However, this degree of scrutiny was not extended to those cases being investigated by non-specialist teams.

Inspectors were concerned that on occasions this resulted in the investigation of some more complex child protection cases by officers who lacked the knowledge, experience and training to effectively safeguard children (for example, to understand when a strategy discussion needed to take place) or investigate offences to a good standard. However, we were pleased that changes were being made to the IT

system to ensure that all CSE investigations were reviewed and allocated to appropriately-trained officers.

Norfolk Constabulary had successfully reduced delays in reviewing third party material, following the introduction of an information sharing protocol with Norfolk County Council. Cases were reviewed during a joint governance meeting and any concerns about information-sharing resolved. These arrangements now fulfil the requirements of the relevant national protocol.[2]

Assessment and help

Recommendations from initial inspection report

We recommend that, **within six months,** Norfolk Constabulary ensures that all officers and staff dealing with any concern about children know whether a child protection plan is in place, and that this information informs their risk assessment

We recommend that, **within six months,** Norfolk Constabulary takes steps to improve practice in cases of domestic abuse involving children. As a minimum these should include:

- improving staff awareness of the severe adverse effects of chronic domestic abuse on children;
- improving the information (history of abuse and assessments of risk and needs) passed to other agencies;
- improving the oversight of assessments and the provision of information to children's social care and other services;
- identifying the range of responses and action that the police can take;
- ensuring that multi-agency risk assessment conferences record what safeguarding action has been taken and the actions planned for the future; and
- ensuring that when police officers and staff recognise a risk and consider that other agencies are failing to play their parts, they raise that issue with managers to ensure that the risk is properly addressed. Staff should know how to escalate their concerns.

We recommend that, **within three months,** Norfolk Constabulary:

[2] The 2013 Protocol and Good Practice Model, on the disclosure of information in cases of alleged child abuse and linked criminal and care directions hearings, is a joint agreement which describes the timescales and process for agencies to disclose information in these cases.

- improves staff awareness of the importance of recording information when a child is removed using police protection powers;
- issues guidance to officers and staff on the management and retention of police protection documentation; and
- introduces a periodic monitoring and auditing process to make sure that police powers are being used correctly, and in the best interests of the child.

We recommend that, Norfolk Constabulary takes steps to ensure that officers attending incidents have access to relevant information about registered sex offenders and families 'at risk' including information on safeguarding and risk management plans.

Summary of post-inspection visit findings

Norfolk Constabulary had developed a robust governance process to ensure that officers correctly recorded information on the use of police protection powers.[3] Overall, the constabulary had made good progress with safeguarding children involved in domestic abuse – an action plan on domestic abuse was in place and being actively implemented. However, problems remained in the multi-agency safeguarding hub (MASH) [4] with the lack of assessment for cases considered as standard risk.

Detailed post-inspection visit findings

The constabulary had made good progress in monitoring the use of police protection powers. Guidance had been issued to all staff on the management and retention of documentation. In addition, a member of staff in the MASH had responsibility for reviewing all documentation relating to officers' use of police protection powers, to ensure that the information therein was clear and accurate, and appropriate action had been taken.

[3] Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, (a) remove the child to suitable accommodation and keep him/her there or (b) take such steps as are reasonable to ensure that the child's removal from any hospital, or other place, in which the child is then being accommodated, is prevented.

[4] This is an entity in which public sector organisations with common or aligned responsibilities in relation to the safety of vulnerable people work. The hubs comprise 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.

Inspectors were pleased that information relating to high risk sex offenders living locally was now visible to officers through the crime and intelligence system, and routinely communicated at internal tasking meetings. Inspectors were also made aware that information about children who were subject to a protection plan was visible within the constabulary's command and control system. This enabled officers to be alerted when attending incidents. However, the full details, such as the names of children and the nature of the risk, were held on other systems. When all relevant information is not readily accessible to officers, decisions may be taken without awareness of the risks to the child.

Norfolk Constabulary has made progress in improving practices for children affected by domestic abuse: an action plan is in place and is being actively implemented. Training had been delivered and staff were now far more aware of the impact of domestic abuse on children.

Domestic abuse cases considered high and medium risk were routinely reviewed by officers within the MASH. Inspectors were concerned to be told that research was not yet conducted for the children of those victims assessed as standard risk. All referrals involving children were sent to children's social care services. Police staff in the MASH took no further action, the perception being that children's social care services were responsible for assessment. The constabulary relied on examination of a sample of a small number of standard risk referrals to monitor the effectiveness of the system. This approach can result in failure to recognise cumulative risk arising from a child's exposure to repeat low level domestic abuse incidents and missed opportunities to intervene at an earlier stage to protect the child. Plans were in place for additional staff to be deployed (by July 2015) to ensure that incidents assessed as presenting a "standard" risk could be reviewed.

Norfolk Constabulary continued to refer every incident involving contact with a child to children's social care services (by completing a child notification form) without any form of filter. This resulted in a very high volume of cases being referred which did not require the attention of children's social care services. We were concerned that this practice had not changed since the inspection in April 2014. Recognising the risk that this creates, the constabulary planned a new multi-agency triage function in the MASH but timescales for implementation were not in place at the time of the visit.