National Child Protection Inspection Re-inspection

Surrey Police
8 – 19 August 2016

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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, the police and crime commissioner (PCC) and the public on how well children are protected and their needs are met, and to secure improvements for the future.

Contents

Summary

In June 2015, HMIC inspected Surrey Police as part of its national child protection inspection programme[1], with the subsequent report published in December 2015.[2] This inspection found some serious failings in the force's response to child protection issues (which are summarised below). We therefore committed to re-inspecting the force six months later, to assess progress made.

This report sets out the findings of the August 2016 re-inspection.

What we found in 2015

Our 2015 inspection report concluded that:

> '...HMIC is concerned about the force's ability adequately to protect children who are at risk in Surrey because of the serious failings identified during this inspection: insufficient specialist (child protection trained) officers; the poor quality of many investigations examined by inspectors; the lack of intrusive supervisory oversight, and the paucity of management information and reviews to assess the quality of service. Leadership and senior management oversight needs to improve markedly to ensure the practice weaknesses found in this inspection are addressed with the urgency required.'

In January 2016, the force provided HMIC with an action plan setting out how it intended to respond to the recommendations in the inspection report.

What we found in 2016

Surrey Police demonstrates a strong commitment to improving the service it provides to protect vulnerable children. The chief constable has prioritised child protection and this is understood throughout the force. However, while this commitment has resulted in some good examples of children being protected, there remains more to be done to provide consistently improved outcomes for those at risk of harm.

There has been considerable investment in safeguarding through additional officers, staff and supervisors within the SIUs, POLIT and MASH.[3] It will take time, however, for some of the new staff to acquire the specialist capability that is required to deal

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

[2] *National Child Protection Inspections: Surrey Police*, HMIC, December 2015. Available at www.justiceinspectorates.gov.uk/hmic/publications/surrey-national-child-protection-inspection/

[3] Structures for child protection services in Surrey Police are set out in section 2 below.

effectively with complex and sensitive safeguarding issues and criminal investigations. Additional training has been provided across the force to help everyone understand that safeguarding is not just the role of specialist teams. The message that child protection is important is understood by officers and staff, but this has yet to manifest itself in consistent action and improved practice. There are some good examples of action taken to safeguard children at incidents and crimes but there is more to be done to ensure that every child in Surrey receives the same level of service.

There are better processes for auditing and reviewing cases, information from which is used to improve both the performance of individual officers and supervisors and to help identify common themes and address these to improve general practice.

The force needs to continue to work with partner agencies to understand better the risk posed by child sexual exploitation (CSE) in Surrey and how it can be addressed. There have been improvements in the information and data gathered from other agencies, but there is more that can be done. There is also a better understanding generally among officers and staff about identification of CSE and the links between CSE and children being reported as missing from home.

Relationships with partner agencies at a strategic level are improved since June 2015. This is echoed through the force with generally improved operational working relationships.

The use of experienced former police officers with a background in child protection and investigation to support officers and supervisors with their safeguarding work and lines of enquiry has contributed to some improved investigative practice. The force still has much to do before the standard of investigation across the force is consistently of a satisfactory level. However, there are clear signs that improvements have been made: we saw better recording on police systems of action taken and decision making in some investigations. Increased capacity, improved supervision and better management information all contribute to an improving service. Inspectors found that all staff from specialist teams spoken to are committed and dedicated to providing the best outcomes for children. There have been many changes in the way the force delivers service to the public over the past year and progress towards improvement has been slow in some areas. The force recognises this but believes that now the foundations for improvement have been laid there will be increased pace in achieving its ambition to provide a consistently good service to children.

Surrey Police’s continuous improvement plan for child protection is a comprehensive document which includes actions relating to many of the areas covered within this report. We have only recommended additional actions where they do not form part of the force’s own action plan or where further work is required beyond that identified by the force. This has resulted in very few recommendations added in this re-inspection, which is greatly to the force’s credit.

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 CSE and abuse represents one of the highest serious and organised crime risks.[6] CSE is also an important feature in the *Strategic Policing Requirement*.[7]

[4] Section 46 Children Act 1989.

[5] Section 11 Children Act 2004.

[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:

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 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

Surrey Police has approximately 3,650 staff. The workforce includes:

- 1,938 police officers;
- 1,417 police staff; and
- 119 police community support officers.[10]

The force serves a population of 1.1 million residents. Surrey is the most densely populated county in south-eastern England, with a growing population. Significant towns within the force area are Guildford, Woking and Reigate.

The Surrey police force area is served by one local authority, Surrey County Council, which is responsible for child protection within its boundary, and one local safeguarding children board (LSCB).[11]

The most recent Office for Standards in Education, Children's Services and Skills' judgment for the local authority is set out below.

Local authority	Judgment	Date
Surrey	Inadequate	June 2015

Structures for child protection services

Senior officer lead and central teams

In Surrey Police, services to protect vulnerable people are led by the assistant chief constable responsible for specialist crime, supported by a detective chief superintendent, two detective superintendents and three detective chief inspectors. They have responsibility for central public protection teams whose remits include:

- the paedophile online investigation team (POLIT);
- the complex abuse unit;
- the co-ordination of multi-agency public protection arrangements (MAPPA);

[10] *Police Workforce, England and Wales, 31 March 2016*, Home Office, July 2016. Available at www.gov.uk/government/statistics/police-workforce-england-and-wales-31-march-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.

- the sex and violent offender unit;
- the sexual offence investigation unit (SOIT);
- strategy and policy;
- the multi-agency safeguarding hub (MASH)[12], which was due to be expanded in November 2016;
- the co-ordination of the force's engagement with multi-agency risk assessment conferences (MARACs)[13]; and
- co-ordination and attendance at child protection case conferences.

Local teams

Surrey Police comprises three divisions, East, West and North. Each division has a commander who is responsible for day-to-day policing within it. In April 2015, Surrey Police devolved responsibility for safeguarding investigation units (SIUs), whose remit involves the investigation of child abuse, vulnerable adult abuse and domestic abuse, to these three geographical policing divisions.

Divisional commanders also have responsibility for 'missing from home' teams. These units and teams are each led by a detective superintendent, and a detective chief inspector is responsible for their day-to-day management.

The public protection executive board provides overarching accountability and governance to public protection as a whole. Divisional chief superintendents attend to represent their locally based SIUs.

Child protection action plan

Surrey Police is implementing an action plan to improve its services to protect children at risk of harm.

Where we considered that the implementation of this plan will address the concerns set out in this report, we have made no further recommendations for improvement. However, where we consider that more work is required, we have made recommendations for the additional action that the force now needs to put in place to ensure that children in Surrey are adequately protected.

[12] The police, children's social care services and mental health services work together in the MASH to protect vulnerable people. Acting on reports from officers, the MASH assesses risk to individuals in a range of cases (child abuse, domestic abuse and vulnerable adult abuse) and shares information with other agencies.

[13] There are plans to move the co-ordination of MARAC and the co-ordination and attendance at child protection case conferences to the SIUs in divisions in the near future.

3. Leadership, management and governance

The PCC in his police and crime plan for Surrey[14] clearly makes a commitment to ensure that victims of child abuse receive proper support and care. The chief constable's vision of making Surrey 'the safest county it can be' and his aspiration to make it a leader in public protection demonstrate the force's commitment to making improvements in the way it delivers safeguarding. This has been visibly supported by the significant increases in staffing for those teams that specialise in the protection of the most vulnerable.

The chief constable and his command team are providing visible strategic leadership to the force. There is no doubt, at all levels and in all departments, that protecting children from harm is a priority. Inspectors were pleased to find an increased awareness among staff and officers across the force about their responsibility to safeguard children and how they should do this.

The management of SIUs is devolved to divisions. There is a daily management meeting held by the public protection command where critical matters and staffing are discussed. SIUs are also represented at each of the divisional daily management meetings. Information and details from these meetings then feed into the force-level management meeting which enables the command team to understand better the level of risk each division faces. However, there is little movement of specialist officers between divisions when extraordinary demand outweighs capacity. Instead, officers are supplemented from local non-specialist teams. Senior managers recognise this to be a problem and understand the need to address the culture that causes a lack of agility in moving resources to where they are most needed.

There has been considerable investment in staffing numbers within the SIUs, POLIT and sex offender management teams. Officers and staff in these teams are generally passionate and dedicated about the work they do to help protect children. There is a demand review in process which will soon report and is likely to result in further staff being allocated to vulnerability-related roles within the force. However, some staff currently report high levels of stress and an unmanageable level of work, which means they are often unable to expedite important investigations. This contributes to uneven standards of safeguarding and investigation across the force area. Divisional commanders and chief officers are aware of these pressures and the issue of unacceptable delays in completing actions which has arisen with some investigations, in particular those that are more complex. The welfare needs of some staff are also a matter of concern as there is no mandatory counselling and we received reports of delays in referral to occupational health professionals.

[14] The police and crime plan for Surrey, published in September 2016, is available at www.surrey-pcc.gov.uk/plan/

There were no backlogs in cases being reviewed within the MASH at the time of our inspection. This is an improvement on the inspection in June 2015 in which significant backlogs were found. There is to be further investment in the MASH from both police and children's social care. This is an opportunity for the MASH to grow and become an important part of the way in which Surrey Police protects and safeguards children.

Governance arrangements for public protection have become embedded and there is now a much clearer understanding by chief and senior officers about current public protection performance and activity at both an operational and strategic level. There is better performance information available which is more focused on areas of risk and harm. The performance framework, while still developing, is beginning to make possible the scrutiny of both qualitative and quantitative information, and allowing recognition of the need to focus on outcomes for children. This allows for better scrutiny of the work of the SIUs and also a better understanding of workloads carried by each officer and team. Again, this is an improvement when compared with our inspection in June 2015.

There are still delays in the analysis of computers and mobile telephones, although the backlog is smaller than that found in June 2015. These delays, coupled with the continuing delays in decision making about charging by the CPS, are significantly reducing the speed with which cases are dealt with in the criminal justice system. This can lead to victims, particularly when they are vulnerable young people, losing faith in the police.

Senior leaders in Surrey Police are involved in partnership working and are building stronger and more effective joint working at a strategic level. The chair of the Surrey safeguarding children's board and a representative from children's services described a significant improvement in their working relationship with the police at a senior level over the past year. It is essential that these relationships continue to develop and enable appropriate professional challenge between agencies. Partnership relationships are generally good throughout the force at all levels.

The way in which policing is delivered under the PiYN model has created additional difficulties for the force in the short and medium term, with officers and staff having to gain or enhance investigation and interviewing skills in order to be able to fulfil the demands of their omni-competent role. There has been a great deal of financial investment in agency staff to form the PPST employed to review and provide advice on cases, safeguarding and investigations. Agency staff are also employed to work alongside frontline teams to support officers as they develop their skills of investigation and understanding of safeguarding under this model of working. This is a temporary measure designed to mitigate some of the skill and experience gaps that exist in specialist teams, supervision and frontline teams. The force is working towards a level of skill within its own teams where such support is no longer

required. There is recognition that this remains some way in the future; however, the force is building a public protection standards unit which, alongside other public protection roles, will carry out some of the checking and reviewing processes currently performed by the PPST.

4. Case file analysis

During the course of this inspection, Surrey Police audited 33 cases in accordance with criteria provided by HMIC. The force was asked to rate its handling of each of the 33 self-assessed cases. The force assessors rated practice as good in 22 of the cases, as requiring improvement in 6 and as inadequate in 5. HMIC assessment found 11 to be good, 8 requiring improvement and 14 inadequate. Inspectors selected and examined a further 42 cases where children were identified as being at risk. Of these, 12 were assessed as good, 11 as requiring improvement and a further 19 as inadequate.

Figure 1: Cases assessed by both Surrey Police and HMIC inspectors

	Good	Requiring improvement	Inadequate
Force assessment	22	6	5
HMIC assessment	11	8	14

Figure 2: Additional cases assessed only by HMIC inspectors

	Good	Requiring improvement	Inadequate
HMIC assessment	12	11	19

An example of where the force graded the handling of a case as requiring improvement and HMIC graded it as inadequate was where a 22-year-old man exchanged explicit communications through chat rooms with a child believed to be a 13-year-old girl. A risk assessment was not completed until three weeks later, when he was assessed as posing a medium risk. Enquiries with a hospital where he was thought to work did not take place until April 2016 – four months after the police were first made aware of the communications. Also in April 2016, a supervisor identified that the suspect had previously been spoken to by police about the exchange of indecent images with another 13-year-old in 2011. The suspect was arrested later that month and admitted several offences. There was little more progress in the case until it was reviewed by the force on behalf of HMIC at the end of May 2016 and further action instigated. From June 2016 onwards, more victims were identified, within the United Kingdom and abroad. The case is continuing.

The handling of this case was graded as inadequate by inspectors as prior to the case being reviewed by the force for HMIC there was little investigative action to identify other potential victims who may have still been at risk. Had HMIC not requested the review of certain cases, this investigation may not have progressed and more children may have been at risk.

5. Initial contact

What we found in 2015

The 2015 inspection found inconsistencies in the way in which child protection matters were identified and dealt with by the control room. The way in which children who were missing from home were dealt with was found to be poor and the use of police databases to help staff fully understand the level of risk a child faced was inconsistent , for example the way in which children at risk of CSE were ‘flagged’ on the systems.

Recommendations from the December 2015 inspection report

We recommend that Surrey Police immediately takes steps 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 to form part of that assessment;
- incidents are not downgraded without proper justification and without appropriate checks having been made as to the welfare of the child; and
- any concerns about an incident involving children at risk are escalated if police have been delayed in attending the incident or alleged crime.
- We recommend that, within three months, Surrey 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.

What we found in 2016

In our re-inspection, inspectors found that the force has provided training for contact centre (CTC) and control room staff, which includes the use of risk assessment tools known as SNAPPER[15] and the National Decision Model (NDM)[16]. Additional training has also been provided to help staff better understand vulnerability and signs of CSE.

We found that staff within the control room and CTC have an improved understanding of vulnerability and how to identify risk to children. The demand reduction team in the control room carries out additional supervision and checking processes. This means there is a greater likelihood that where potential risk to a child has not been identified this will be picked up and remedial action taken at an early stage to ensure that children are safeguarded. The checking processes are applied before an incident is closed to ensure that all aspects of risk to children have been checked, as the example below shows.

A youth worker requested that a welfare check be carried out on a family. The mother had been missing for two weeks (believed to be in a youth hostel) and the house in which she was bringing up her autistic daughters was unsuitable, flea-ridden and lacking food. Even though SNAPPER was used to assist in identifying risk, it was thought not to be 'relevant' as the children were under the care of a youth support worker. The demand reduction team reviewed the report and correctly identified concerns about the mother and her children. Officers were deployed quickly, to see both the daughters (who were staying with their father) and the mother. Officers submitted detailed child notification reports (39/24s)[17] having assessed the family's circumstances. They identified no immediate concerns but requested additional support from children's social care.

[15] The SNAPPER risk assessment is a mnemonic template which prompts the call taker to identify risk to any child where a call is not likely to need an officer to attend.

[16] The NDM is suitable for all decisions and should be used by everyone in policing. It can be applied to spontaneous incidents or planned operations, by an individual or team of people, and to both operational and non-operational situations. The NDM has six key elements. Each component provides the user with an area for focus and consideration. The element that binds the model together is the Code of Ethics at the centre.

[17] Locally, police officers must make a referral to children's social care services on an agreed form, providing information about their concerns. This referral must be made as soon as possible when any concern of significant harm becomes apparent.

The SNAPPER risk assessment takes time to complete and has resulted in extended call times, on occasion up to 45 minutes to complete the assessment and call. This has had an impact on the force's ability to answer calls to the control room, with calls to 101 not being answered within the target time and some remaining unanswered as callers hang up. The force is closely monitoring this situation and is aware of the potential issues it creates.

Inspectors sampled ten cases from the contact centre and found them generally to be dealt with adequately, with appropriate risk assessments and decision making.

The control room now has a 24/7 intelligence research capability. This means that when officers attend incidents involving children more thorough checks of police systems can take place, making subsequent risk assessments and safeguarding more informed.

Since the previous inspection, work has taken place to improve the use of child protection warning signs and other markers held on police IT systems to help identify children at risk. More still needs to be done to ensure that the markers and warning signs are visible and accurately applied.

The police response to children missing from home has improved. Where cases are uncomplicated and quickly resolved, investigations are completed and generally well recorded, as the example below shows.

A 15-year-old boy was reported missing by his mother at 11.19pm. She had last seen him at 6.30pm. It was believed that he was with a friend and officers made diligent enquiries and found him at the friend's address safe and well; accordingly, he was not recorded as missing. He was returned to his home address and a 39/24 form (which outlines the incident, the risks to the child and any action taken) was shared with social services and an appropriate risk assessment made. The risk assessment included reference to his having autism and having previously taken ecstasy.

Sometimes, however, where cases are more complicated or where specific children are frequently reported missing, inquiries are not treated as urgent and actions to find children are not prioritised because of other calls on police resources, as the example below shows:

There was a delay in attending the home address of a missing boy while enquiries were made at his father's address in another police area (the Metropolitan Police area). The inspector in charge of the case mentioned at the time that a 25-year-old female had been issued with a child abduction warning notice[18] as she had previously encouraged the boy to stay with her and she was believed to have posed a risk to him. She had recently been arrested for breaching the notice but there was no evidence that the risk she posed to the missing boy was taken seriously or formed a significant part of the investigation strategy. There was some good supervisory oversight, but because of workload and staffing levels a conscious decision was made to stop actively looking for the boy, despite the recognised risk to him.

In spite of this occasional lack of urgency and failure to prioritise, inspectors found that the use of trigger plans (a plan to locate a child quickly when he or she goes missing frequently), although still inconsistent, had improved. There is also clear evidence of more comprehensive recording of actions taken to find children, and of intelligence or information which might inform any searches for children if there are future missing episodes.

The force has invested considerably in training for officers and staff on the front line to help them identify and recognise CSE and risk to children. The force aspires to have a workforce that believes that safeguarding children is 'everyone's business' and not just the responsibility of child abuse investigation teams. Inspectors found that throughout Surrey Police there is now a greater understanding of the need to safeguard children: although many staff could not recall specific training on this, they know they have a duty to check on the welfare of children at incidents they attend, and that they should ensure that other agencies are notified through the submission of the child notification form 39/24.

Officers understand the need to check on the welfare of children at domestic abuse incidents and, as we found in our last inspection, most officers do make these checks; however, the demeanour and views of children are not always recorded. This information is important in assessing risk to children and what impact the domestic abuse they are witnessing is having on them.

[18] 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.

6. Assessment and help

What we found in 2015

In our 2015 inspection, inspectors were concerned about the lack of local out-of-hours service for children who require a medical examination or support after suspected sexual assault.

We also found considerable delays within the MASH, with large backlogs of notification forms requiring risk assessment. We were also concerned to find that not all notification forms went to the MASH – some were sent direct to children's social care services and were not risk assessed against police information.

Domestic abuse cases assessed as standard risk (lower risk) were not being reviewed by specialists before closure. This meant that children who were repeatedly witnessing domestic abuse were not being identified and any cumulative risk was not being referred on to the MARAC.

We found that strategy meetings to discuss information relating to children, and to make decisions on safeguarding and how to progress a case, were either not held or not recorded. This meant that it was unclear if agencies had worked together to safeguard children. The lack of records also meant that the cumulative risk to children may not have been understood by those making decisions.

We were also concerned about the lack of independent return interviews[19] for children who go missing from home.

The minutes and actions from multi-agency missing and exploited children conferences (MAECCs) to discuss children who were at high risk of sexual exploitation were inconsistent across the divisions with some children not being adequately supported.

Recommendation from the December 2015 inspection report

We recommend that, within six months, Surrey Police works with partner agencies to ensure that timely forensic medical examinations are conducted in sexual abuse cases involving children.

[19] When a child is found, he or she must be offered a return interview by the local authority. Independent return interviews provide an opportunity to uncover information that can help protect children from the risk of going missing again, from risks they may have been exposed to while missing or from risk factors in their home.

What we found in 2016

Medical examination

The sexual assault referral clinic (SARC) in Surrey provides a service for children who have been sexually abused. Even where a medical examination does not take place, children are referred to this clinic in order to provide them with access to the necessary support and counselling services they may need. This remains very effective during the SARC operating hours, but outside these times children are required to attend a similar facility in the Metropolitan Police area. This is not in the best interests of vulnerable children. The force has not been able to address this recommendation with partners and the issue remains. However, children do not often have to be sent to the more distant facility – it is recorded as happening on three occasions in 2015.

Each case where a child requires a medical examination is reviewed by the SARC governance board to ensure that what happened was in the best interest of the child involved.

The MASH

Inspectors were pleased to find that the backlogs are no longer present and notifications are dealt with within 24 hours of their arrival in the MASH. All notifications are now sent to the MASH, providing a more consistent referral process. This is important as it means that risk assessments are completed more quickly, which will result in the identification of risk at an earlier stage, so that measures to protect children can be put in place sooner. Inspectors found good working relationships between partner agencies.

The MASH comprises police and children's social care services co-located within police premises. Both organisations have committed to a significant increase in staff in November this year. There are currently no other agencies consistently involved in the risk assessment process. The MASH does not undertake any strategy meetings; instead, these are delegated to divisions for SIU staff to progress.

Inspectors are concerned that full advantage is not taken of the co-location of police and children's social care services, as we were told that the two agencies still tend to work in isolation, sharing information by email rather than discussing specific cases and researching jointly to understand the risk to children in a more immediate and effective way. In several of the cases we reviewed, inspectors considered that a more immediate discussion between agencies could have resulted in children being protected sooner. With the increase in staffing levels within the MASH, the force has an opportunity to develop the current function of the MASH and to improve the consistency of safeguarding in the county.

Domestic abuse cases

These cases are now reviewed within the MASH, and we saw evidence that repeat incidents of domestic abuse involving children are now being referred to the MARAC for longer-term safeguarding plans to be put in place.

Strategy meetings

Strategy meetings are attended by SIU detective sergeants from each division. These scheduled meetings take place twice a week, although if necessary more urgent cases may be discussed through strategy meetings on the telephone. While there is no reported delay, inspectors noted that some minutes from MARAC meetings included action points which called for strategy meetings. In several of these cases, there was no representative from children's social care services at the MARAC and this led to delays in the convening of the meeting and thus unnecessary delays before a safeguarding plan for children was put in place. There are too many occasions where single-agency investigations are being conducted where instead a strategy meeting and joint investigation should take place.

Inspectors found there has been an improvement in the recording and availability of the minutes of meetings, including strategy meetings and conferences, although these were still not always readily accessible. Minutes were found in several different filing systems within the force IT systems, which can make researching a child or family difficult and time-consuming for officers and staff. This can result in an incomplete understanding of the level of risk to a child and a failure to adequately protect them.

Return interviews

This is a local authority responsibility and the force has used its influence as a partner to encourage increased capacity for this service. This is currently being developed, and further capacity has been commissioned from a charity which will be providing more comprehensive face-to-face interviews for all children who go missing from home.

Multi-agency missing and exploited children conferences

Cases of children who are considered to be at risk of sexual exploitation are discussed at the MAECCs, which take place every four weeks in each division. While there were some examples where action was taken and plans put in place to safeguard children, in its current form the MAECC process is not working effectively to reduce risk to children. Minutes examined by inspectors show actions not being completed by agencies and cases being allowed to 'drift' without any effective intervention being pursued. The force has identified this as an issue and has

allocated detective chief inspectors to chair these meetings in an effort to improve the rigour of the process and ensure that the MAECCs help to safeguard these very vulnerable children. It is too early to assess if this measure will make these meetings more effective.

7. Investigation

What we found in 2015

In 2015, HMIC identified a high level of voluntary attendance interviews being used as an alternative to arrest in cases of child abuse, particularly where these involved family members. Although voluntary interviews can be a useful way of dealing with suspects, their use should be carefully considered. Offenders, alerted to the need to attend the police station, could dispose of evidence. If an arrest has not been made, suspects cannot be made subject to bail conditions while the investigation proceeds. Inspectors found that appropriate use of bail conditions to control the alleged behaviour of the suspect had not been used to protect the child. This can, understandably, undermine victims' confidence in the police.

Recommendation from the December 2015 inspection report

We recommend that, within three months, Surrey Police provides clear guidance to staff in the use of voluntary attendance[20] for suspects in child abuse cases to ensure that:

- no opportunity is lost for the seizure of evidence;
- protective measures are put in place to reduce the risk to the child; and
- cases are dealt with expeditiously through the criminal justice system.

What we found in 2016

Voluntary attendance interviews

In 2016, it is clear from cases reviewed that this method of dealing with suspects is still being used frequently and inappropriately. Inspectors found that this recommendation requires further action to ensure that officers fully understand when and where voluntary attendance at a police station is an acceptable alternative to arrest.

In April 2016, Surrey Police moved to a new model of service delivery. This is called 'Policing in Your Neighbourhood (PiYN)'. The new way of operating, described by the force as 'omni-competence', aims to ensure that the same frontline uniformed officers investigate crime and deal with victims, witnesses and suspects throughout the criminal justice process. Previously, frontline uniformed officers would rarely be

[20] Section 29 of the Police and Criminal Evidence Act 1984 recognises that a person may voluntarily attend a police station or any other place where a constable is present, or accompany a constable to a police station or any such other place, without having been arrested and for the purpose of assisting with an investigation.

involved in the investigation of crime and therefore had not been given the necessary training. Once arrested, suspects would be dealt with by other teams within the organisation. The move to PiYN means that some officers have now received the required training and coaching to ensure that they have the skills to investigate. The force has invested time and funding to help improve the standard of investigation. It has provided training, agency staff who are retired investigators to support officers and staff with investigations, and mentoring by more experienced staff and officers. However, many officers on the front line do not yet have the capability to investigate some crimes they are allocated.

The force has several ways of mitigating this risk, including the use of experienced former detectives allocated to teams to coach and advise officers. However, HMIC remains concerned that some crimes involving children are allocated to inexperienced officers, which may mean the children are not being properly safeguarded, as the following example shows.

A woman and her daughter aged four and son aged seven were approached by a registered sex offender (RSO). He indecently exposed himself to the woman and grabbed at her, witnessed by her two young children. The gravity of the offence was not properly considered and the case was allocated to an officer without the necessary skills or experience to deal with it. While there is evidence of supervisory oversight, clear risk factors were not recognised, there was a two-week delay before any further action was taken and an arrest was unnecessarily delayed.

The force has increased staffing levels within the SIUs, which deal with cases involving children, vulnerable adults and domestic abuse. The force reacted quickly to HMIC's concerns about staffing levels and posted officers into these teams. However, some have not yet had the necessary training and do not yet have the experience they need in this area of safeguarding and investigation.

Inspectors therefore found that there are some officers within specialist teams who have not yet received the necessary training for them to feel confident in their roles, or who do not have the required skills and understanding to give the best service to children. This, coupled with high workloads in some offices (most notably East division) has resulted in officers saying that they feel highly stressed and speaking of colleagues who are on sick leave as a result of the volume and type of work they are doing.

There is an inconsistent approach to welfare support for officers in specialist teams and delays are reported in referring for support those officers who have requested it. However, most SIU officers recognised that more staff and a greater focus across the force on the work they do had much improved their situation compared with a

year ago. A further review of staffing and demand is currently taking place. The force told us that this was likely to result in further increases in staff for teams who protect vulnerable people in Surrey.

While inspectors once again found some investigations to be inadequate, there are clear signs that since our last inspection there have been some improvements in the standard of investigation. There remains concern, however, that cases are sometimes unnecessarily prolonged, with actions not carried out, interviews with victims delayed and suspects not pursued expeditiously. These factors combined result in a failure to safeguard children, as the following example shows.

In early April 2016, a mother reported that a 62-year-old male had sent sexual comments to her 16-year-old daughter via social media. A week later, the SIU was still awaiting an update from the area policing team following the team's visit to the home. Over two weeks later, children's social care services contacted the MASH asking for further details of the case. The same day, a child notification form 39/24 was submitted, but it lacked detail. There was no evidence of proactive joint work to support and protect the child. Safeguarding advice was limited and stated that the child should stop using certain social media. In early May, a supervisor asked for the officer investigating the case to review some exhibits. At the end of May, the child's mother called the police as her daughter had been contacted again by the man. The family were not visited and no further details were taken. Two months later, a request was made to establish the identity of the man through his internet account address. The request was rejected as 'the network doesn't provide the service'. The child's mother was updated and the case closed the same day.

This case also highlights the lack of proper supervision apparent in some investigations.

The level of supervision in cases has, however, generally improved since our last inspection, particularly within the SIUs, where there has been an increase in supervisor numbers. This has been enhanced by the introduction of the public protection standards team (PPST), a team of retired investigators and child protection specialists working in each SIU who actively review cases in divisions, providing officers and supervisors with recommendations and reviews of active cases.

Where there are cases categorised as 'complex' (as defined by the 2006 version of *Working Together*)[21] they are generally dealt with by the complex abuse team. This team is staffed with very experienced and capable officers. However, they currently have some cases which, while progressing well, are being managed on a standalone system rather than on the Home Office Large Major Enquiry System (HOLMES)[22] (or a similar database for such complex cases with numerous victims, witnesses and suspects). As a consequence, cross-checking of names with other HOLMES inquiries is not carried out. Such cross-checking can identify connections between victims, witnesses and suspects, children who may still be at risk, and further offences and offending. HMIC has been informed that the force has bought the Altear system, designed for complex case management, which is ready to be installed and for staff to be trained in its use. Once it is in place, all complex cases will be managed on this system.

The guidance for complex case investigation contained in *Working Together* advocates joint working and a joint approach to investigation. However, in Surrey, there are no partner agencies working as part of the complex case team, which detracts from its ability to have immediate access to partner information and to address additional wider safeguarding issues. There have also been significant delays in other agencies responding to requests for information. In one case involving alleged abuse in a children's home, a full response to requests for disclosure made in October 2015 had not been received at the time of the inspection some ten months later. This matter should have been escalated to a senior level far sooner; however, inspectors are reassured to know that this has now been escalated to the chief constable, who is resolving this issue with partner agencies.

The paedophile online investigation team (POLIT) investigates all cases referred by the National Crime Agency's Child Exploitation and Online Protection Command (CEOP)[23], by other forces, and through proactive work by searching the peer-to-peer

[21] Complex (organised or multiple) abuse refers to abuse involving one or more abusers and a number of related or non-related abused children. The abusers concerned may be acting in concert to abuse children, sometimes acting in isolation, or may be using an institutional framework or position of authority to recruit children for abuse. *Working Together to Safeguard Children*, HM Government, 2006, available at http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/WT2006%20Working_together.pdf

[22] HOLMES (Home Office Large Major Enquiry System) is a computer system used by the police to manage serious and complex crime investigations.

[23] The National Crime Agency's CEOP Command (formerly the Child Exploitation and Online Protection Centre) works with child protection partners across the UK and overseas to identify the main threats to children and co-ordinates activity against these threats to bring offenders to account. It works to protect children from harm online and offline, directly through NCA-led operations and in partnership with local and international agencies.

network[24]. During the last inspection, HMIC was concerned about significant delays in investigations, and a lack of understanding within the team about safeguarding and wider child protection. This had already been identified by the force and a plan put in place to change practice and increase staffing levels. Inspectors found during the re-inspection that there had been an increase in staffing, the team had no backlogs of cases and most were up to date. Officers had manageable workloads and an improved understanding of safeguarding with the additional benefit of a supervisor with a background in child protection. This is a much improved situation and represents a significant achievement.

In July 2015, inspectors were concerned about the delays in the examination of digital equipment (phones and computers) seized in the course of investigations. There were delays of six months for computer examination and five months for telephone examination.

In 2016, inspectors found that delays had reduced to three and a half months for computers and four months for telephones. The POLIT is undergoing a restructure and until the team is fully staffed and equipped to deal with the volume of work within the county, cases will continue to be outsourced to external companies for analysis. Consequently, there remains unnecessary delay in some investigations due to the time being taken to review digital media evidence forensically.

There also remain considerable delays within the Crown Prosecution Service (CPS) as it reviews cases sent to it and decides on whether to bring charges. The force has asked the Home Office to seek a solution.

In summary, while there have been some improvements in the standard of investigation particularly in terms of specialist teams, there is still work to be done. It is likely to be some time before the workforce achieves omni-competence and until this happens there are risks that officers will not be able to safeguard children properly and investigate cases appropriately. The use of the PPST and additional supervision are helpful but there remain concerns relating to the general standard of investigation across the force.

[24] Peer-to-peer networks are computer systems which are connected to one another by the internet without the need for a central server. They have many legitimate uses but can be used by people to share indecent images and digital files of children.

Further recommendation

We recommend again that, within three months, Surrey Police provides clear guidance to staff on the use of voluntary attendance for suspects in child abuse cases to ensure that:

- no opportunity is lost for the early seizure of evidence;
- protective measures are in put in place to reduce the risk to the child; and
- cases are dealt with expeditiously through the criminal justice system.

8. Decision making

What we found in 2015

In 2015, inspectors were concerned about the standard of decision making throughout Surrey Police, the subsequent recording of these decisions and the rationale for making them. Because the force was already taking action to address the issues identified by inspectors, no specific recommendations were made in the December 2015 inspection report.

There were no specific recommendations in the December 2015 inspection report

What we found in 2016

During the August 2016 re-inspection, inspectors found that the officers and staff spoken to had a better understanding than previously about safeguarding children and their responsibilities when attending incidents where children may be at risk. Inspectors found that throughout the organisation there was a clear emphasis on protecting vulnerable people and that this was a force priority. This does not always translate into action, and although officers do not always check on the welfare of children at incidents of domestic abuse as they are expected to do, they now do so more often.

There were some examples of sound decision making by frontline staff that clearly prioritised the best interests of the child, as the following example shows.

A five-year-old child wandered away from outside his home address where he was playing with a friend and walked to the local shops to buy sweets. He was found by security guards before his mother had realised he was missing. Officers attended promptly and returned him to his parents. They paid attention to the child's living conditions and considered longer-term safeguarding issues. They gave advice to the boy's parents. A 39/24 child notification form was appropriately shared with children's social care.

Inspectors found that there had been some improvement in the recording of information including decisions and their rationales, although there were still cases found where poor recording practices persisted, as the following example shows.

A child who had been reported missing was taken into police protection[25]. Initial action by officers to find the child and take her into police protection was good, and took place in difficult circumstances as she became abusive and violent. However, recording practices for use of police protection powers were poor, and it is not clear what happened to the girl while in protection. There was an early referral to children's social care services but a great deal of information was missing from the record keeping, such as in relation to the handover between officers who were in charge of the case, trigger plans and essential intelligence about risks posed to the child from a specific adult male.

Such poor recording results in much information being unavailable, thus making it more difficult to take soundly based decisions about the level of risk to children and impairing the ability of agencies to protect them.

When officers attend an incident in Surrey where there is a concern for a child, as well as taking any necessary action to protect the child, they should complete a child notification form 39/24. An incident may in itself be minor and require no further police action, but the record is important because it enables patterns of abuse to be identified. The force has put in place a process to ensure that before cases are closed a notification form is completed and submitted so that the necessary referrals can be made. The MASH also now receives all these forms, giving a far more complete picture of incidents involving children.

Learning from specific cases or incidents is collated and used to inform both training for individuals who may have been found lacking in the way they dealt with a child protection matter and, particularly where a theme emerges, wider training. The PPST takes on some of this work, particularly where it has identified training or learning issues for specific members of staff or supervisors. The team will provide additional support and mentoring where required in an effort to improve the understanding and skills of individual officers or staff.

The force recognises that there is still work to be done to ensure consistent good decision making and record keeping relating to safeguarding children. There are relevant actions within the force action plan which are still being progressed and it is essential that its implementation continues to achieve these standards.

[25] 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'.

9. Trusted adult

What we found in 2015

There were no specific recommendations in the December 2015 inspection report

What we found in 2016

As in our inspection of 2015, inspectors found some good examples of cases where children have been heard and listened to, child protection issues have been identified and actions have been taken to safeguard children, as the following example shows.

> A responding officer's knowledge of a family when a child was reported missing ensured an appropriate response and that information was shared in a timely way. The 'safe and well check', when the child was found, included multi-agency consultation to provide immediate safeguarding activity. This case also demonstrated significant recognition and understanding of potential CSE risk.

However, in some cases, police action would not have gained the trust of the child, as the following example shows.

> A 16-year-old girl with learning difficulties was identified as being at risk of CSE, and reported being pestered by a 35-year-old local man for sex. Although the initial response was timely and the suspect arrested within 24 hours, no investigation plan was set until five days later. The subsequent investigation lacked drive, and many of the actions set in the plan were not progressed. Wider enquiries to trace witnesses, CCTV material and other possible victims were not completed. A statement was not taken from the victim for three weeks and there was no consideration of an achieving best evidence (ABE)[26] interview as an alternative. A decision was subsequently made to take no further action. Although this case was reviewed by the PPST and the investigation has now been re-opened, the victim, a vulnerable young woman, was not adequately protected by the police.

[26] The way in which the evidence of children is obtained and recorded, which will ensure that the best evidence is secured in the best interests of the child. Available at www.cps.gov.uk/publications/docs/best_evidence_in_criminal_proceedings.pdf

Inspectors also viewed several cases where a child has not initially been believed and this has influenced the ensuing investigation. While there is now a better understanding among officers and staff about young people with complex and troubled lifestyles, particularly those in adolescence, there is still more work to do to ensure that every police approach works towards gaining the trust of children.

Again, the Surrey Police action plan to improve its services to children addresses these issues and there are no specific recommendations.

10. Managing those posing a risk to children

What we found in 2015

There were no specific recommendations in the December 2015 inspection report

What we found in 2016

Multi-agency public protection arrangements (MAPPA) for RSOs remain generally good, with meetings well attended by police and partner agencies. Minutes from these meetings are clear and well recorded. Local officers are generally made aware of sex offenders living in their area where this is appropriate. In these cases, consideration is given to safeguarding children and, where necessary, plans are put in place to protect children.

There are no delays in conducting visits within national timescales[27], an improvement on our inspection findings last year. The sex and violent offender unit staff describe their workload as manageable. Most officers in the team have had appropriate training and have a good awareness of the need to safeguard children. There is also sufficient capacity to mount proactive operations where these are required, and sex offender managers attend the daily management meeting each day to highlight any issues which might require additional police action.

While most cases are managed competently, there were a few which were very worrying, as the following example shows.

> An RSO had taken a child overseas with the child's mother. While out of the country he subjected the child to a sexual assault. There was little evidence of enquiries or intelligence gathering about this RSO, despite warning signs and a history of breaching his conditions, which should have made the manager concerned and prompted further enquiries.

A full understanding of the nature and extent of CSE within Surrey is still being developed. The introduction of the new role of analyst into the MASH is a positive move and, properly used, could help the force and partner agencies better understand CSE within the county. At present the role is being used simply to gather data, but its usefulness will be increased if and when the data are used to inform intervention and disruption activities. While there remain issues with police and partnership data, the force is actively trying to establish improved ways of collecting

[27] National guidance on MAPPA is published by the Ministry of Justice and is available at www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2

and analysing all available data to build a more complete picture of CSE in the county. The office of the police and crime commissioner and local authority have jointly funded two 'What is sexual exploitation?' (WiSE) workers for a year who are based within the MASH. These outreach workers work with children at risk of sexual exploitation and offer support and safeguarding opportunities.

There are small, dedicated single-agency CSE and missing people teams in each division. Inspectors saw some good examples of multi-agency disruptive and preventative work instigated by these teams, for example training for Uber taxi drivers to help them recognise potential CSE. However, inspectors were told of capacity issues within the CSE teams which are currently preventing them from undertaking more proactive and disruptive operations.

Inspectors found some good examples of investigations where CSE has been recognised and children safeguarded. However, inspectors were concerned that there were still cases where clear risks of CSE to children were apparent but opportunities to investigate were not pursued expeditiously in order to protect children, as the following example shows.

A missing child was found naked at an adult's house. Underwear was seized but not medically examined. There was no evidence of the CSE risk and potential sexual offences being considered, despite the circumstances of the incident. There was no formal ABE interview of the child, neither was there an appropriate medical examination. The adult suspect was identified as a sports coach and proper notification procedures were not followed in relation to his potentially having contact with other children who might be at risk and in need of safeguarding. The child is currently safeguarded in secure accommodation and is also allocated to a CSE single point of contact within Surrey Police, who is working to build trust regarding previous disclosures of historic sexual offences.

Suspected CSE perpetrators and children at risk of sexual exploitation are regularly discussed at the force daily management meetings, and inspectors found that this information was sometimes disseminated to response teams. Many frontline officers and staff displayed a good understanding of those who were considered at risk or a threat in their division. This level of knowledge was, however, inconsistent across the force area.

Again, the Surrey Police action plan to improve its services to children addresses these issues so there are no specific recommendations.

11. Police detention

What we found in 2015

There were no specific recommendations in the December 2015 inspection report

What we found in 2016

Since our last inspection, Surrey Police has sought to reduce the number of children being brought into custody. This has resulted in 300 fewer children and young people being brought into custody compared with the previous 12 months. While this can be seen as positive, inspectors were concerned that an unintended consequence of the campaign has resulted in officers reporting that they are not arresting young people when this may be the best and most appropriate course of action.

The force has also significantly reduced the number of children remanded overnight in police custody.

The daily management meetings on each area discuss the cases where children are in custody, whether overnight or during the daytime, and officers are encouraged to ensure that the time in police detention is kept to a minimum.

Each child or young person who is brought into custody is seen by a health care professional (HCP). The HCP discusses any concern the child or young person might have about their home and personal lives with them and, where information is forthcoming which indicates a level of risk, a 39/24 child notification form is completed and submitted. The HCP also has access to medical and mental health records and this can help to safeguard children during their time in police custody.

In the case of those young people detained in custody between 7.00am and 7.00pm, a criminal justice liaison and diversion officer (CJLDO) will also speak to them. The CJLDO will refer young people to the youth support service and also to children's social care. Outside these hours, referrals will still be made to appropriate services, but without the face-to-face meeting with the CJLDO.

The force is well served by the Surrey Appropriate Adult Volunteer Scheme (SAAVS) which provides 24-hour access for children and young people to support and advice from an appropriate adult[28]. The scheme generally provides an appropriate adult in a timely way when contacted by custody staff.

[28] Under section 63B of the Police and Criminal Evidence Act 1084, an appropriate adult is a parent, guardian, social worker or any responsible person over 18 years old who is not a police officer or a person employed by the police

In June 2015, Surrey Police and Surrey County Council Youth Support Service agreed a joint Surrey protocol for the provision of local authority accommodation. The protocol aims to safeguard children and young people through avoiding, as far as is practicable, their detention in police custody following charge and the denial of bail. This protocol was reviewed and updated in May 2016. However, officers and custody staff report that there is seldom any local authority secure accommodation[29] available, and that the reduction in the numbers of children detained overnight in police stations is partly due to fewer being arrested and detained in custody and partly to others being bailed to parents' addresses without an attempt to obtain secure accommodation. Also contributing to the reduction in numbers is the training which has been delivered to custody staff covering the circumstances in which it is appropriate for secure accommodation to be sought from the local authority, as a result of which staff have a better understanding of when they should request it.

Inspectors examined seven cases of children in detention and judged two cases to be good, two cases to require improvement and three to be inadequate.

During our last inspection, there was some concern about the standard of record keeping in some cases, where important information setting out the legal grounds for detaining children, the rationale for refusing bail, the reasons for delaying contact with others, and an explanation as to why they were not transferred to local authority accommodation when required was not recorded. Inspectors found that in some cases this was still a concern, as the following example shows.

A child was arrested along with others, believed to be his family, for illegally entering the UK. He was taken into custody and detention authorised. Early contact was made with children's social care services and then the UK Border Agency (UKBA) was notified. The child was seen by the HCP in custody. Although he was identified from the outset as a child, there was no attempt until the following day, 19 hours after detention was first authorised, to contact an appropriate adult to explain to him his rights and entitlements while in custody. In addition, he was not offered the option of speaking to his Embassy until shortly before being handed over to the escorting agency after a prolonged period in custody.

[29] Under section 38(6) of the Police and Criminal Evidence Act 1984, a custody officer must secure the move of a child to local authority accommodation unless he certifies that it is impracticable to do so or, for those aged 12 or over, no secure accommodation is available and local authority accommodation would not be adequate to protect the public from serious harm from him.

Nonetheless, inspectors found other cases where the standard of record keeping was higher, as the following example shows.

The treatment of a child who was arrested for the attempted murder of another child was well documented; details of the explanation of the child's rights and entitlements, the attendance of appropriate adults, the details of the referrals made to children's social care services and requests for alternative accommodation were all fully recorded.

Inspectors were pleased to find that in the past year no children were detained in police custody under section 136 of the Mental Health Act.

Surrey Police has improved the service it provides to children detained in police custody, but there remain inconsistencies and poor practice. The force has identified these issues within its action plan and is working towards addressing them.

Further recommendation

We recommend that, within three months, Surrey Police provides clear guidance to staff on when arrest is appropriate for children and young people who have committed crimes. This will ensure that children who need to be dealt with through the criminal justice system are given the appropriate rights and access to advice and support that custody provides.

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

We found some improvements in the way Surrey Police responds to child protection issues, with a clear commitment to making this better. However, there is still work to do to ensure that this translates into consistently good practice on the ground.

For instance, Surrey Police has delivered a great deal of training to help educate its workforce to recognise CSE and how to safeguard children. While this is widely understood across the force, inspectors found this understanding does not always translate into safeguarding activity. This is particularly the case where children have troubled and chaotic lifestyles. These children are still labelled as 'streetwise' on occasion, whereas they are often those who are at most risk. This sometimes affects the speed of response when they are reported missing and results in other enquiries and police work taking priority over finding them.

The arrangements for managing high-risk sex offenders are well developed, with thorough information-sharing and sound inter-agency planning to manage risk. Officers of appropriate seniority regularly attend multi-agency meetings where offenders are discussed. Local officers were generally aware of those high-risk offenders who live in their area, and any issues requiring immediate action are discussed at daily management meetings.

Children detained under section 136 of the Mental Health Act are taken directly to hospital; this is good practice. Compared with last year, fewer children are detained unnecessarily overnight in police custody after charge. This is predominantly due to children being appropriately bailed rather than being accommodated by the local authority. The force's use of the Surrey Appropriate Adult Volunteer Scheme to provide 24-hour access for all children to the support and advice of an appropriate adult is working well, with no significant delays in the attendance of an appropriate adult when requested. This process is generally trusted and used by custody staff. Every child or young person entering a custody suite is spoken to by an HCP to assess their well-being.

The force has begun to profile the nature and extent of CSE risk (both perpetrators and victims) within Surrey. However, there are issues with the quality of data held and collected by police and partner agencies, as each agency collects different data and the sources and quality of this information vary from agency to agency. The expected improved service from return visits for those who are missing from home will increase the number of children who are seen by an independent agency. This may help to provide more qualitative information which could help agencies in Surrey to better understand the extent of CSE within the county and how best this can be tackled.

While there is still work to be done, inspectors saw some improved recording of information on police IT systems, for example what safeguarding measures have been taken in respect of a particular child. Inspectors also found an improvement in the way in which ‘markers’ indicating specific risks to children or families are held on police systems. While these processes require further development, they are factors which contribute to an improved approach to the way in which Surrey Police, together with its partner agencies, is able to understand CSE and other risks to children within the county. Nonetheless, more work is required to target more effectively those who pose the greatest risk of harm to children.

Therefore, while inspectors found evidence of definite improvements in child protection practice across the force, there remains inconsistency; and, in some areas, there is still much to do to deliver a service that adequately protects children.

Surrey Police has a comprehensive action plan in place which addresses many of the areas for improvement outlined in this report. Inspectors reviewed this and found there to be a great deal of work being carried out. There is now a far better grasp within the force of the amount of work yet to be completed and where more is required to achieve the desired outcomes. While there is much still to be done, the force’s own understanding of this is much more in line with the findings of this inspection, and the force’s commitment to achieve high standards in safeguarding children is evident.

13. Further recommendations and next steps

We recommend that Surrey Police continues to work to implement the recommendations made by HMIC following the child protection inspection report in December 2015 and ensures that the recommendations are implemented in full.

We also make the following further recommendations in light of our re-inspection in August 2016.

Recommendations

- We recommend again that, within three months, Surrey Police provides clear guidance to staff on the use of voluntary attendance for suspects in child abuse cases to ensure that:
  - no opportunity is lost for the early seizure of evidence;
  - protective measures are in put in place to reduce the risk to the child; and
  - cases are dealt with expeditiously through the criminal justice system.
- We recommend that, within three months, Surrey Police provides clear guidance to staff on when arrest is appropriate for children and young people who have committed crimes. This will ensure that children who need to be dealt with through the criminal justice system are given the appropriate rights and access to advice and support that custody provides.

Within six weeks of the publication of this report, HMIC will require an update of the action being taken to specify how the force intends to respond to the recommendations made in this report, and an updated version of the force action plan to improve child protection.

Glossary

child	person under the age of 18
multi-agency risk assessment conference (MARAC)	locally held meeting of statutory and voluntary agency representatives to 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 well-being; agencies that attend vary, but are likely to include the police, probation, children's, health and housing services; over 250 currently in operation across England and Wales
multi-agency safeguarding hub (MASH)	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
Office for Standards in Education, Children's Services and Skills (Ofsted)	a non-ministerial department, independent of government, that regulates and inspects schools, colleges, work-based learning and skills training, adult and community learning, education and training in prisons and other secure establishments, and the Children and Family Court Advisory Support Service; assesses children's services in local areas, and inspects services for looked-after children, safeguarding and child protection; reports directly to Parliament

multi-agency public protection arrangements (MAPPA)	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
police and crime commissioner (PCC)	elected entity for a police area, established under section 1, Police Reform and Social Responsibility Act 2011, responsible for securing the maintenance of the police force for that area and securing that the police force is efficient and effective; holds the relevant chief constable to account for the policing of the area; establishes the budget and police and crime plan for the police force; appoints and may, after due process, remove the chief constable from office
registered sex offender (RSO)	a 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

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 drive improvements in forces' 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 outcomes 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; and
- 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 exercising 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;
- CSE; and
- the detention of children in police custody.

Below is a breakdown of the type of self-assessed cases we examined in Surrey Police.

Type of case	Number of cases
Child protection enquiry (s. 47)	5
Domestic abuse	5
General concerns with a child where a referral to children's social care services was made	4
Sex offender enquiry	3
Missing children	3
Police protection	3
At risk of sexual exploitation	3
Online sexual abuse	4
Child in custody	3