Promoting improvements in policing to make everyone safer

PEEL: Police effectiveness 2015 (vulnerability)

A revisit inspection of Surrey Police

July 2016

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Introduction

This report sets out Her Majesty's Inspectorate of Constabulary's (HMIC's) findings following our inspection revisit to Surrey Police on 12-13 April 2016. This revisit assessed progress made against the two causes of concern and four areas for improvement in the *PEEL: Police effectiveness 2015 (vulnerability) – An inspection of Surrey Police*, which HMIC published on 15 December 2015. The report is available on HMIC's website: www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/police-effectiveness-vulnerability-2015-surrey.pdf

PEEL: Police effectiveness 2015 (vulnerability)

In summer 2015, as part of our annual inspections into police effectiveness, efficiency and legitimacy (PEEL), HMIC's effectiveness programme inspected how well forces keep people safe and reduce crime. This included an assessment of how effectively forces protect vulnerable people from harm, and support victims, based on findings against four questions:

- How well does the force identify those who are vulnerable and assess their level of risk and need?
- How well does the force respond to vulnerable victims?
- How well does the subsequent police action and work with partners keep victims safe?
- How well does the force respond to and safeguard specific vulnerable groups (missing and absent children & victims of domestic abuse); and how well prepared is it to tackle child sexual exploitation?

What we found in Surrey Police in 2015

HMIC had significant concerns about the capability and capacity of Surrey Police to safeguard vulnerable people and investigate crimes committed against these vulnerable people. We found serious weaknesses in the force's arrangements for protecting vulnerable people from harm and in supporting victims.

The force had prioritised protecting vulnerable people and recognised the importance of identifying vulnerable victims as early as possible and properly assessing the risks they face. However, the force's current systems and practices were unreliable and ineffective. We found inconsistencies in the way it assessed risks and carried out investigations which meant that vulnerable people might not

always get the response from the police that was needed to keep them safe. The force needed to take urgent action, particularly where children are at risk, to ensure it improved and supervised properly its services.

The force had made some promising progress in beginning to tackle child sexual exploitation and needed to continue this work to ensure it could identify proactively offenders and protect children at risk.

The way the force dealt with reports of missing children was poor. We found evidence of an inconsistent and poor approach to decision-making which resulted in high-risk cases often being graded lower than they should have been. This meant they were not being dealt with by the right people with the right skills or with sufficient urgency to therefore properly protect vulnerable children.

Revisit findings: progress against the recommendations from the 2015 vulnerability inspection

In this section we set out the causes of concern, areas for improvement and recommendations from our December 2015 vulnerability inspection, as well as our findings from this revisit inspection.

Causes of concern from December 2015 inspection report

Causes of concern

The force's investigation and safeguarding of vulnerable victims was a cause of concern. There were weaknesses in the quality and consistency of child protection investigations and subsequent action to keep victims safe. The force needed to take urgent action to ensure services are improved and properly supervised. Accredited investigators within the safeguarding investigation units (SIUs) were fully trained but HMIC found examples of untrained staff investigating cases involving vulnerable people. The heavy workloads within the SIUs were having an impact on staff and affecting adversely the quality of service to some of the most vulnerable victims with whom the force dealt. Lack of capacity was resulting in delays to investigations and an inability to provide a consistently good standard of service.

Recommendation

The force acts to improve child abuse investigations, with particular attention to:

- staff awareness, knowledge and investigative skills;
- prompt responses to concerns raised;
- risk assessments that consider the totality of a child's circumstances and risks to other children;
- capacity of its investigators; and
- its audit, supervision and management of cases.

Revisit findings

HMIC was pleased to find that the force has taken a number of steps to improve the quality of its child abuse investigations. This has included a significant increase in the number of staff within its safeguarding units. In 2013/14 within public protection the force had 197 posts, comprised of 152 police officer posts and 45 police staff posts. In 2016/17 this has increased to 242 police officers and 72 police staff posts, a total of 314, equating to a 62 percent increase. In turn this has resulted in staff having far more manageable workloads of between on average 12 and 16 cases. In August 2015, 40 members of staff had completed the specialist child abuse investigation development programme (SCAIDP). In March 2016, this had risen to 120 with further officers being trained or due to commence the training.

The force has also changed its governance arrangements for public protection. It now holds a fortnightly public protection senior management team meeting, which includes all the heads of public protection departments such as the safeguarding investigation units (SIU), strategic leads for areas of work such as domestic abuse and missing and absent children, the public protection standards team (PPST) and representatives from human resources, finance and training. This provides the force with better strategic oversight and subsequent direction and allocation of public protection responsibilities.

The force's allocation of cases is now governed by its public protection guidance that clarifies which team should be allocated a case; for instance within the SIU, the sexual offences investigation team (SOIT), or the paedophile online investigation team (POLIT). The SOIT has also been divided into historic and non-historic cases. These actions have helped improve workloads and how the force manages cases.

The PPST, established in October 2015, comprises staff with expertise in public protection and provides a rigorous audit function for public protection cases. There are two staff in each of the three SIUs, and two staff based across both the SOIT and the POLIT. They complete reviews on public protection cases within the first seven days of an investigation, then after 28 days and at the conclusion of the case. PPST staff all use the same template to review a case. This enables them to record the principal elements of the investigation in a standard format, and to assess whether appropriate safeguarding activity has occurred. The PPST complete a monthly report, which is a standing item at the public protection senior management team meeting. This scrutiny enables the force to identify where practice is improving and where it still needs to make improvements. Being located within the public protection departments the team also provides practical advice and support to supervisors and investigators to help improve the management of the cases. Most staff welcome this development.

While individuals and teams receive information from the PPST to help improve their practice, it was not clear how the force as a whole records the learning from this

comprehensive audit programme. The force needs to ensure that it has processes to collate and disseminate this information to all its officers and staff effectively.

Since our last vulnerability inspection, staff have changed how they approach investigations. Where previously, they focused at an early stage of case building on gathering evidence (for instance by obtaining statements), they now seek to make an early arrest and then build the case. This reflects their improved understanding of vulnerability in SIU investigations.

In the five child abuse investigations we reviewed as part of this revisit, we found that the force's initial risk assessment, early evidence capture, referrals to partner agencies and supervision were good. The force also considered the needs of any child involved. In the first two days of investigations enquiries were thorough and well documented. However, some investigations appeared to drift, meaning that some actions and enquiries did not occur as early they should have done. The force needs to ensure that it is not missing investigative opportunities at an early stage of an investigation.

There are still lengthy delays in recovering evidence from IT equipment such as mobile phones and computers. Mobile phones can take up to six weeks to be examined; and computers up to six months. This may mean that offenders are on police bail for long periods and victims wait for excessively long periods of time for their cases to reach court. The force has addressed this by outsourcing evidence recovery for some items, and the POLIT team triages some of its work. Delays in receiving charge decisions from the Crown Prosecution Service (CPS) have also caused delays, however the arrival of two CPS lawyers in Guildford should help to alleviate some of the backlog.

With the increase in staff into public protection posts, the rigour around auditing cases and improved senior management supervision, HMIC was pleased to find that the force has made significant progress in addressing this cause of concern. As a result it is providing a better service to a greater number of vulnerable victims.

Causes of concern from December 2015 inspection report

Causes of concern

The force's response to missing and absent children was a cause of concern. The force had a poor understanding of the scale and nature of the issue as it had only partially analysed information held by the force and partner agencies. Understanding the reasons why children repeatedly go missing from home and working jointly with other services to prevent further incidents can provide a much more effective approach to safeguarding and managing the risks.

Staff were not always clear as to what the process is, and consequently who is ultimately responsible for the investigation. This lack of clarity may lead to investigations not being as effective as possible. Risk assessments were not consistently carried out and supervisors displayed a poor understanding of risk factors when completing and reviewing risk assessments of missing children, leading to inconsistent decisions and inappropriate grading.

Recommendation

- To address this cause of concern, the force should review immediately its approach to reports of missing children, specifically those who persistently go missing or absent, and ensure it puts in place measures to understand the issue, risk-assess reports of missing children and carry out appropriate investigations and safeguarding activity.

Revisit findings

The force has produced a missing person scoping document, to provide it with a limited understanding of the scale and nature of the issues. While this includes locations from where children go missing and names of those children who repeatedly go missing, it is limited in its content as it does not include partnership data and the information about absent children is hard to interpret. This is due to the force recording this on its command and control system (ICAD) rather than its records management system (NICHE) in line with how missing persons are recorded. This means the force still does not fully understand the full scale of the issues it faces so cannot manage its response effectively.

HMIC was pleased to see however that the force has reviewed and revised its approach to reports of missing and absent children. Although the force introduced a new procedure for missing persons management and investigation (in March 2016), most frontline staff are unaware of it. That said, the force's scrutiny of missing persons at its daily divisional and force management meetings is effective: we found good supervision.

As a result of the force's training and awareness sessions, and its circulation of important messages about the importance of dealing robustly with missing and absent children, officers generally understand how to assess the level of risk to a child, and the actions they need to take. An officer explained to us how he had recently dealt with a missing 14-year-old with learning disabilities. He identified her as being at risk of sexual exploitation and as a result assessed her as high risk. She was subsequently found and referred to the child sexual exploitation (CSE) coordinator in order that longer term safeguarding actions were undertaken.

On 1 April 2016, the force and its local authority partners commissioned the charity Missing to conduct follow-up interviews with all children who are found after being reported missing. Interviews at the time of the inspection were made by telephone, although the charity will conduct them in person later in 2016. It was too early for us to assess the impact of the initiative, but it should provide the force and partners with information to help prevent further missing occurrences, and provide intelligence to help locate children should they go missing again.

Each division has a CSE and missing person's team. The force also has two centrally-held posts of a missing person's co-ordinator and a CSE co-ordinator (for which it is recruiting). The area patrol team (APT) has clear responsibility for the investigation of missing persons. The missing person's co-ordinator's responsibility is to work with partners such as the local authority, to intervene early and to identify ways of reducing the risks to people that go missing. In the longer term this will assist the force to identify patterns of those people who go missing regularly, where they go missing from and where they are found.

We are encouraged that staff have embraced the need to assess vulnerability more thoroughly and that the force has improved its supervision of missing persons investigations. We will measure the impact of the missing person coordinators and the work of Missing during our effectiveness inspection in autumn 2016.

We were disappointed to find that the scoping document of missing children did not include partnership data and that the absent data was limited due to the fact that the force records absent persons on ICAD rather than on NICHE. Until it does, the force and its partners will not fully understand the scale of the problem or be able to deal effectively with some of the most vulnerable children in its communities.

Areas for improvement from December 2015 inspection report

Areas for improvement

- The force should improve the way it identifies, assesses and responds to risk and vulnerability by ensuring its contact staff consistently use processes available to support decision-making and that information from systems is consistently made available to attending officers.

Revisit findings

In the control room and contact centre, the force has improved its systems for assessing the risk in respect of missing and absent children. While some processes are still in their infancy, staff understanding of these processes is good.

Contact centre and control room staff have received training on the CSE national decision making model (NDM), tackling domestic abuse and missing and absent persons. The focus for staff is on identifying vulnerability and understanding how to assess risk.

The PPST recently reviewed how missing persons are assessed when initially reported to the contact centre. Staff now apply a SNAPPER risk assessment if following the application of the NDM it is decided that an officer will not be deployed to deal with the matter. SNAPPER considers the following elements: sexual, neglect, any exploitation, physical, professional and emotional factors. This ensures that all relevant information has been considered in deciding how to deal with the case.

Response intelligence officers are located in the control room twenty four hours a day, seven days a week. They have access to force IT systems containing information about an individual or groups including missing people, particularly those considered to be high risk. This means the force can complete a better risk assessment at an early stage and take action to locate the missing person at the earliest opportunity.

The incident command and deployment system (ICAD) which records missing persons, when initially reported to the police, has limited functionality. It does not recognise a name or a phone number which previously may have been recorded on the system, although it does recognise an address previously used. Missing and absent children are recorded on the force crime management and intelligence system Niche, which uses ‘flags’ to identify children who have gone missing previously.

The force recognises that it needs to improve its IT systems, however its training and implementation of new working practices is improving its risk-based assessments of missing and absent children. Staff also feel more confident and empowered in their role.

Areas for improvement from December 2015 inspection report

Areas for improvement

- The force should improve its compliance with the duties under the *Code of Practice for Victims of Crime* specifically in relation to victim personal statements and keeping victims informed regarding the progress of their case.

Revisit findings

In November 2015 the *Code of Practice for Victims of Crime*,[1] a national requirement for all forces, was amended. In January 2016 most sergeants in Surrey Police received training from the criminal justice lead on compliance with the code, including the requirement to take a victim personal statement (VPS) at the outset of the investigation. The force has circulated messages regarding the importance of complying with the code and provided a step-by-step guide to all staff. The force also circulated a video on its intranet site explaining the requirements. Some staff had also received training from the detective sergeant or inspector in the SIU to reinforce the message.

Staff awareness of the requirements of the code was good, although the force does not monitor its compliance or whether it takes VPSs in crime investigations. On occasions they are taken at the same time as a crime report is received, but they are often taken much later in an investigation by the victim care team or other specialist units. There is no reason why a VPS cannot be taken both at the start of an investigation and, later, at court (prior to a sentence being imposed); the force should consider encouraging staff to do this. With the new policing in your neighbourhood (PIYN) operating model taking effect and APT officers now taking responsibility for more of the cases they attend, the force has an opportunity to ensure that the victim's voice is heard at a much earlier stage of the investigation.

[1] *Code of Practice for Victims of Crime*, Ministry of Justice, 2015. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/476900/code-of-practice-for-victims-of-crime.PDF

Since our last inspection, staff are now more aware of their responsibilities in respect of the victims' code and VPS. Despite this, APT officers stated that caseloads and shift patterns affect adversely their ability to contact victims and update them on the progress of their cases with the necessary frequency. For example, the six-day shift pattern means that case officers can have difficulty contacting victims, only being able to make personal contact on four out of ten days if they are working the early or late shifts.

The force still needs to ensure that it has systems in place to monitor compliance with the code, so that victims are listened to and are updated on their investigation regularly in accordance with their wishes.

Areas for improvement from December 2015 inspection report

Areas for improvement

- The force should improve the way it works with partner organisations to share information and safeguard vulnerable people, specifically in relation to making referrals to other organisations of children at risk.

Revisit findings

Since our last vulnerability inspection partners, including representatives from the local children's safeguarding board, children's services and the National Health Service described greater consistency in attendance at meetings, knowledge of public protection issues and visibility from senior officers within the force. They reported a sense of urgency to make progress particularly in relation to the response to CSE and missing and absent children.

However, the multi-agency safeguarding hub (MASH)[2] – still being redesigned – is some way off providing the appropriate level of service to provide an effective partnership arrangement. Children's, adult and mental health services are co-located but there is no representation from health, education, youth support services, probation, or independent domestic violence advisors (IDVAs).[3] While

[2] A MASH (multi-agency safeguarding hub) co-locates principal safeguarding agencies to better identify risks to children (and in some areas, vulnerable adults), and improve decision-making, interventions, and outcomes. A MASH enables the multi-agency team to share all appropriate information in a secure environment, and ensures that the most appropriate response is provided to effectively safeguard and protect the individual.

[3] IDVAs (independent domestic violence advisors) are advocates who work separately from the police to address the safety of victims (and their children) who are at high risk of harm from intimate partners, former partners and family members.

youth support services are not co-located within the MASH they are fully integrated into the force's youth team. No strategy discussions or any safeguarding meetings are held in the MASH, which would be a far more effective way of managing a range of public protection cases.

There are two methods for Surrey Police officers and staff to make referrals into the MASH. If an officer uses his or her mobile data terminal, then the information goes straight to the police staff in the MASH to assess, research and validate the level of risk before onward referral to the appropriate team or teams. If a desktop computer is used the information goes straight to partners in the MASH without any form of assessment or triage. While we did not find a backlog of information waiting to be assessed by the MASH, the referral process for information submitted by desktop computer does not include supervision to check its accuracy, content and quality. This means that some partners in the MASH may be receiving information unnecessarily and of poor quality.

We found little progress since our previous vulnerability inspection to integrate more partners and move to a seven-day service located on non-police premises with a single referral route. While the force and its partners informed us about a strong working relationship between Surrey Police and its partners, it has not translated into a fully functioning co-located partnership MASH. The MASH and Early Help Programme Board (which includes senior representatives from the police and its partners) has recently developed a comprehensive plan to integrate partners more fully into the MASH, which has an implementation date of 1 November 2016.

We found that the force and its partners are undoubtedly keen to work together and share information, and are doing so. However, a lack of progress on MASH arrangements is preventing the force and its partners having an effective integrated system in place.

Areas for improvement from December 2015 inspection report

Areas for improvement

- The force should improve its response to children at risk of sexual exploitation by ensuring it understands the nature and scale of child sexual exploitation; and that its officers provide the appropriate safeguarding support to children assessed as at medium and high risk.

Revisit findings

An interim partnership analysis of child sexual exploitation (CSE) was commissioned by the Surrey CSE strategy group and produced in December 2015, which examined the extent and nature of CSE in Surrey. While it is not a complete picture as it did not

include health and probation data, the analysis has provided the force with a baseline of the scale of the problem.

HMIC welcomes the recently-implemented weekly CSE partnership triage panels as a means to ensure that those children identified as being at risk of sexual exploitation are identified early and safeguarding measures are taken. These are relatively new and have taken the pressure off the monthly multi-agency exploited children conferences (MAECCs), which were becoming overloaded with cases.

Supervisors reported that information sharing between Surrey Police and its partner agencies (such as children's services) has improved. The MAECCs and triage panels now mean that information is shared more promptly and as a result children at risk of CSE are referred to other organisations for support far more quickly. The understanding of the nature and scale of CSE is better, as is safeguarding support to children assessed as at medium or high risk of sexual exploitation.

The force has identified funding to employ a CSE analyst and each division has a CSE and missing person's team. Centrally, the force also has a missing and absent co-ordinator and is recruiting for a CSE co-ordinator. As two posts are still waiting for appointments to be made this is very much a work in progress, but should in time provide the appropriate support to frontline officers.

The force has provided specialist training in how to handle CSE to its staff and officers. During our inspection a number of staff told us that this training had had a considerable impact on them, and how it had improved their understanding of the issues that confront victims of CSE and how perpetrators of CSE act.

Missing children at risk of sexual exploitation are highlighted at daily briefings the force holds. A CSE assessment tool is applied for children who come to the notice of the police for the first time. The force has circulated clear regular messages to all staff about assessing the threat, harm and risk to children exposed to the threat of sexual exploitation.

Control room staff use 'trigger plans' for children who are reported as missing and have been identified as being at high risk of sexual exploitation. This means that when one of these children goes missing, the force already has a plan that it can expedite. We welcome this approach and consider that the force should extend it to a wider cohort of missing persons.

As a result of the training, the messages and the new processes that the force has implemented, staff have the knowledge and the information they need to start to assess and manage CSE risks more effectively.

However, Surrey Police still has work to do. The force's analysis of CSE needs to include more partnership information, it needs to appoint staff and induct them in their new roles (including the CSE analyst), and it needs to ensure that its work on missing and absent children complements fully its work on CSE.

Conclusions and next steps

Conclusions

Surrey Police has made good progress to improve its child abuse investigations. It has allocated more staff to public protection roles, there is good governance and a robust audit process of cases, which means that staff have lower caseloads and better supervision. We only reviewed five child abuse investigation cases as part of this revisit, but found in the cases we looked at that overall, the standard of investigation was good.

The force has also improved its missing person investigations. Staff understand the importance of assessing the risk thoroughly and taking appropriate safeguarding action. Supervision is better, including that at daily management meetings. The force needs to ensure that the scoping document on missing children includes data on children assessed as 'absent', and partnership data, as it means it still does not fully understand the scale of the problem.

The force does not monitor its compliance with the *Code of Practice for Victims of Crime*. Staff have been made aware of its importance and how the force expects them to comply with the code through presentations and email circulations; as a result staff are more aware of these expectations. The force takes victim personal statements, although more often prior to sentencing at court rather than at the time the crime is reported. The force needs to ensure that victims are receiving the service they can expect in line with the requirements outlined within the code.

The force has improved how it deals with cases of CSE. It has provided training to and raised awareness of all staff. It has also initiated a weekly partnership triage meeting in order to take appropriate timely action when a child is identified as at risk of sexual exploitation. Funding is in place to recruit a CSE analyst and all divisions will have a CSE co-ordinator, although some posts are yet to be filled. The force's analysis of CSE, like the missing person document, lacks some partnership data and the force needs to address this in order to fully understand the scale of CSE within the force area.

As a result of training, staff in the control room and contact centre now have a better understanding of how to assess risk. The force is aware of the limitations of its IT systems, particularly when searching systems for information on persons who have previously gone missing, and needs to find a solution to better support staff in these roles.

Most staff understand that assessing and dealing with vulnerability is a force priority. The force has worked hard not only to change the focus of officers and staff, but has allocated resources to public protection departments to deal with the demands and put processes in place to ensure it assesses risk more effectively. We were told

about new initiatives (such as the work with the Missing charity) that had started or were about to start and staff being allocated to new posts. The force needs to make sure it achieves these.

Next steps

HMIC will continue to monitor Surrey Police's progress against the two causes of concern and four areas for improvement set out previously in this report and in the *PEEL: Police effectiveness 2015 (vulnerability) – An inspection of Surrey Police* published on 15 December 2015. We look forward to seeing further progress during our effectiveness inspection in autumn 2016, and our forthcoming child protection re-inspection.