HMICFRS

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services

National Child Protection Inspection Post-Inspection Review

Cleveland Police
23–27 July 2018

November 2018

ISBN: 978-1-78655-742-1

www.justiceinspectorates.gov.uk/hmicfrs

Contents

1. Introduction

The 2017 inspection

In May 2017, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)[1] conducted a child protection inspection of Cleveland Police.

In September 2017, we published the report of our findings. This concluded:

> 'The chief officer team has a clear and unequivocal commitment to protecting vulnerable children. This is widely recognised by the staff, officers and other agencies with whom HMICFRS spoke as part of this inspection. However, while some improvements have been made, the force needs to take further action in strengthening its safeguarding practice, some of which needs to be done as a matter of urgency, in order to protect adequately those children most at risk.'

In 2016, the force conducted a review of demand for its services. Following this review, it allocated additional resources to the departments responsible for child protection. It also made significant changes to the governance and oversight arrangements that shaped the force's approach to child protection and vulnerability.

Overall we found that work being done by the force was improving outcomes for vulnerable children. Its focus on vulnerability was translating into positive action in its child protection work. In particular:

- The force had combined previously separate teams to create the vulnerable, exploited, missing, and trafficked (VEMT) team. This provided a more joined-up approach to the areas affecting the safety of children. It was a clear example of the force's considered and innovative approach to child protection.
- The VEMT team worked alongside the children's charity, Barnardo's. It focused its investigation and problem-solving skills on reducing the risks faced by vulnerable children.
- The force worked with other safeguarding organisations to establish the local children's hub. This improved the safeguarding of children through early and effective intervention.

[1] This inspection was carried out before 19 July 2017, when HMIC also took on responsibility for fire and rescue service inspections and was renamed HM Inspectorate of Constabulary and Fire & Rescue Services. The methodology underpinning our inspection findings is unaffected by this change. References to HMICFRS in this report may relate to an event that happened before 19 July 2017 when HMICFRS was HMIC. Citations of documents which HMIC published before 19 July 2017 will still cite HMIC as the publisher.

- Operation Encompass[2] was already in place within the force. This had led to improvements in how the force notified schools of any children affected by domestic abuse.
- Child sexual exploitation (CSE), and domestic abuse where children were present, were included in force performance data sets.

These were encouraging findings. We also acknowledged the force's work with other safeguarding organisations, from chief officer to practitioner level. This had led to a culture of continuous improvement and more effective joint working, which was improving outcomes for children.

However, we also discovered some weaknesses in the force's approach to child protection:

- We found that investigations often lacked evidence of supervision. This meant they sometimes lost their focus, leading to inconsistent outcomes for children.
- We were concerned about the force's response to children who were reported missing. We assessed a number of cases of missing children. We found a failure to properly assess risk or undertake prompt and effective enquiries to locate children – many of whom were reported missing on a regular basis.
- The force needed to improve its approach to children detained in custody, who are often vulnerable and have complex needs. In the cases we examined, we could find no evidence of referrals being made to children's social care for an assessment of safeguarding needs. In addition, in none of the cases where children were charged with an offence and denied bail were they transferred to alternative accommodation provided by the local authority. This meant that children were being detained unnecessarily in police custody.

The report of the 2017 inspection therefore made a series of recommendations aimed at improving child protection practice by Cleveland Police.

The 2018 post-inspection review

In November 2017, the force showed HMICFRS its action plan setting out how it intended to respond to our recommendations. Since then, we have continued to monitor the force's improvement activity. In July 2018, we conducted a post-inspection review to assess progress.

[2] Operation Encompass is a national initiative where schools are informed when one of their pupils has been present or has been affected by an incident of domestic abuse. This enables schools to provide support to the child(ren) involved and offer practical help and information.

The review included:

- an examination of force policies, strategies, and other documents;
- interviews with officers and staff; and
- an audit of 33 child protection cases (related specifically to the areas for improvement set out in the 2017 inspection report).

Summary of findings from the 2018 post-inspection review

Since the May 2017 inspection, the force has taken steps to improve safeguarding practice and outcomes for vulnerable children. It has reviewed some of its structures, systems and processes, and put in place some good initiatives to help improve awareness of child protection issues. However, in some areas this good work has not translated into the expected frontline activity.

Some recommendations have been acted on swiftly, and improvements are therefore more evident in these areas of practice. For example, the force has improved its approach to the treatment of children in police custody. We found that frontline officers are better at obtaining the views of children affected by domestic abuse. This supports the development of more considered protective plans.

Innovative ideas such as Operation Protect, peer review audits, the 'Through the eyes of a child' campaign, and 'Adopt a shift' presentations (all described later on in this report) should continue to improve the force's ability to safeguard children.

The force has taken steps to understand its performance by auditing the quality of decision making in child protection cases. Although the sample sizes have been small, these have identified similar themes to this review. There is therefore an opportunity to enhance this function and bring together learning from all audit activity.

However, some areas of practice remain weak. We are still particularly concerned about how the force responds to children who go missing from care or from home. Even when significant vulnerabilities are known, activity to locate and safeguard these children is often absent. There is little evidence of multi-agency plans to investigate why these children are going missing, the risk posed to them when missing, what immediate action is required when they go missing, or how to prevent future missing episodes. In many cases the whereabouts of children with identified vulnerabilities are not known for extended periods of time. Nevertheless, the force responded promptly to our concerns and immediately amended their practice during our review to address them.

Since the initial inspection the force has introduced new processes to record information in cases where there are concerns about the welfare of children. However, use of the new forms is inconsistent and staff cannot access them easily.

This compounds the delays and omissions still evident in sharing information with partners. A new triage system, and further planned process changes in respect of standard-risk domestic abuse cases, might result in children being ‘missed’ from public protection notice forms. This could mean they are not referred to partners promptly and joint protective plans are not developed. At the time of our review the new system was only three weeks old and significant backlogs and delays were already apparent.

Cleveland Police recognises it needs to improve in certain areas. It understands what is required to ensure that it provides consistently good child protection practice. The force has taken some important and positive initial steps to address the recommendations from the 2017 inspection report, but accepts that it could still do more to improve its protective practices and outcomes for children.

2. Post-inspection review findings

Initial contact

Recommendation from the report of the 2017 inspection:

- Within three months, Cleveland Police should:
    - review its processes to ensure that its staff can draw together all available information from police systems in order better to inform their responses and risk assessments; and
    - ensure that its officers always record their observations of a child's behaviour and demeanour in records of domestic abuse incidents so that better assessments of a child's needs are made.

Summary of post-inspection review findings

In 2017 we reported that at busy periods within the force control room, the absence of relevant flags on the command and control system meant information held was not consistently informing decisions about risk. The force has taken steps to improve access to information for frontline staff, particularly in relation to registered sex offenders (RSOs) and children vulnerable to exploitation. But improvements to the command and control system had not been introduced at the time of this review.

The force has worked hard to improve officers' recording of a child's behaviour and demeanour at domestic incidents. It has provided 'Through the eyes of a child' training to all staff, supported by a concise set of notes used for quick reference. It has also included a 'Voice of the child' section in its new public protection notice. This is a positive attempt to encourage officers and staff to record the behaviour and demeanour of children who are affected by domestic abuse.

Detailed post-inspection review findings

The force has taken a number of steps to ensure its staff can draw together all available information from police systems. When a child's case is allocated to the VEMT team for investigation or problem-solving activity a VEMT marker is placed on Niche (their information management system). Therefore the fact that a child is vulnerable is quickly obvious to staff conducting checks to assess risk. Case audits have shown that these markers are almost always present.

Each child's profile page on Niche now includes a 'personal dossier' section. This summarises information relating to ongoing safeguarding matters and plans. However, the use and content of these dossiers is inconsistent. We saw examples of comprehensive entries with joint activity to reduce risk clearly documented. But there

is often no clear indication of what activity is taking place, with only non-specific comments relating to meetings attended.

The force has introduced Operation Protect. This is an initiative in which the sex offenders management unit (SOMU) works more closely with neighbourhood policing teams to raise awareness of sex offender management. It gives neighbourhood officers and police community support officers (PCSOs) the opportunity to accompany them for a day. This is a positive and innovative approach to increasing the potential intelligence about those posing a risk to children.

Operation Protect also gives neighbourhood teams access to the 'Imap' system which allows them to self-brief about the RSOs residing in their area. This should further enhance intelligence-gathering. There is also increased use of briefing and local tasking in respect of RSOs, through daily briefing and the tasking and co-ordination group meetings. These are used to highlight specific individuals and create tasks for neighbourhood policing teams to support the work of SOMU.

During the 2017 inspection we noted that call-takers within the control room did not have access to warning markers. This impeded their ability to identify risk, particularly at busy periods. In our 2018 revisit we found that RSO addresses are still not routinely flagged on the force's command and control system, and control room staff do not routinely check a caller's details on Niche. This can mean that officers attending calls are not aware that the caller or person involved in an incident is an RSO. Two incident logs were inspected relating to calls made by managed offenders – in neither case was there any information or indication that the caller was an RSO. The force reports that the introduction of new IT to resolve this is imminent. However, this has not yet been implemented.

Although officers did not have full access to Niche on their mobile devices, this was expected in autumn 2018. This will help officers to make prompt decisions based on the fullest information.

The force has worked hard to improve officers' recording of a child's behaviour and demeanour at domestic incidents. It has provided 'Through the eyes of a child' training to all staff, supported by a concise set of notes used for quick reference. This is a positive attempt to encourage officers and staff to record the behaviour and demeanour of children who are affected by domestic abuse. They are asked to consider and record what life is like through the eyes of a child living in the household. This information includes:

- whether the child has been seen;
- their views and opinions;
- their welfare;

- whether they are well-presented; and
- the condition of the house.

Although there have been improvements, adequate recording is inconsistent. We reviewed a case where officers attended a domestic abuse incident and observed and recorded the demeanour of the five children present. They noted the children were upset by the incident and promptly submitted their observations on the correct form. The detailed information was shared with children's social care and with their respective schools through Operation Encompass, so that additional support could be offered to them. However, in another example the attending officer reported seeing children but did not report speaking to them. The officer did not describe the children's demeanour or the living conditions. The details of the two youngest children were missing from the report.

The force has issued body-worn video cameras to all response staff. It has made the use of these cameras mandatory when attending domestic abuse incidents. This is positive and enhances the ability to record the demeanour of children, providing evidence in criminal investigations. It also helps joint safeguarding planning with partners.

A new public protection notice form has been introduced to assist officers. It has a section which specifically deals with the voice of the child, regardless of the initial concern. However, this form was only introduced at the beginning of July, so we are unable to assess what effect it has had.

Assessment and help

Recommendation from the report of the 2017 inspection:

- Cleveland Police should immediately undertake a review, together with children's social care services and other relevant organisations, to ensure that the force is fulfilling its statutory responsibilities as set out in Working Together to Safeguard Children. As a minimum, this should include:
    - the assessment of risk, how information is shared and the development of joint protective plans; and
    - recording on police systems decisions reached at meetings to ensure that staff are aware of all relevant developments.

Summary of post-inspection review findings

In 2017, we reported that workload pressures and staff vacancies within the protecting vulnerable people (PVP) support hub had contributed to a significant backlog of standard-risk domestic abuse incidents awaiting assessment. There were also multiple ways in which information could be shared with partners.

These combined to create delay in sharing information and impeded the ability to assess escalating or cumulative risk.

The force has made efforts to resolve the staffing problems but has found this difficult owing to problems with recruitment and sickness. A new public protection notice form has been introduced to bring together the multiple ways of sharing information in one document. The force has also introduced a triage system which prioritises the reviewing and sharing of information relating to children.

Detailed post-inspection review findings

Rather than having multiple ways of sharing information, the force has now created a single public protection notice form. This is completed and submitted by an officer or staff member to report on and share information across the force and with partners in relation to areas of vulnerability, including child protection and domestic abuse. The form includes a section to record the behaviour and demeanour of a child and what the child has said. Although it was anticipated that this form would be in place by the end of 2017, it was not introduced until 2 July 2018. Therefore, we have not been able to assess whether it's had a positive effect.

In 2017 we reported that there was a significant backlog of standard-risk domestic abuse incidents awaiting assessment, due to workload pressures and staff vacancies within the PVP support hub. This meant that the force was far less able to assess escalating or cumulative risk. It was also not identifying children who were repeatedly witnessing domestic abuse.

A new triage system has since been introduced. This prioritises the sharing of reports with partner organisations when children are present. This includes sharing information with children's social care and also with schools, through Operation Encompass. Case audits showed that where a child is identified as being present at a domestic abuse incident, for example, and their details are included in the public protection notice, this information is shared promptly. However, we were disappointed to find that in the three weeks since it was introduced there was already a backlog of 143 medium-risk and 337 standard-risk domestic abuse reports requiring attention. This is a significant number. Reports that involve children are prioritised, but only if their details are recorded on the public protection notice. If the child's details are not included then the report will not been seen by specialist staff, for an unknown length of time.

We conducted a dip-sample of this backlog. One case in the standard-risk queue related to an incident of domestic abuse. The submitted public protection notice did not have details of the children in the family, nor that a ten-month-old child was present at the time of the incident. This child was already on a child protection plan and this was flagged on Niche. As such, the report was missed by the triage system and there would have been a significant delay in sharing this information with children's social care.

We sampled 37 standard cases (11 percent of the total). Grading was found to be appropriate in 35 of the cases. Of the cases sampled, nine involved children that required referral to children's social care. In six cases appropriate information-sharing took place in a timely manner. However, in three cases (8 percent of the sample size) there had been no assessment of the need to share information with children's social care, because the children's details were missing. The oldest of these reports had been submitted almost three weeks earlier.

The force states that a plan is in place for patrol sergeants to take responsibility for standard-risk public protection notice reports. These reports will not be seen by specialists within the PVP hub. Within this new model it will be important to ensure that those making decisions about risk are properly trained to recognise and consider cumulative risk. They will also need to recognise the wider effect of domestic abuse on children when making decisions about how to respond.

Investigation

Recommendations from the report of the 2017 inspection:

- Cleveland Police should immediately improve practice in cases of children who go missing from home. As a minimum, this should include:
    - improving staff awareness of their responsibilities for protecting children who are reported missing from home and, in particular, those cases where it is a regular occurrence;
    - improving staff awareness of the links between children going missing from home and the risk of sexual exploitation;
    - improving staff awareness of the significance of drawing together all available information from police systems, including information about people who pose a risk to children, better to inform risk assessments;
    - ensuring that staff are aware of the need to pass this information from police systems, including information about people who pose a risk to children, on to other agencies; and
    - identifying the range of responses and actions that the police can contribute to multi-agency plans for protecting children in these cases.
- We recommend that, within three months, Cleveland Police improves its child sexual exploitation investigations, paying particular attention to:
    - improving staff awareness, knowledge and skills in this area of work;
    - ensuring a prompt response to any concern raised;

- undertaking risk assessments that consider the totality of a child's circumstances and risks to other children; and
- improving the oversight and management of cases (to include auditing of child abuse and exploitation investigations to ensure that standards are being met).

Summary of post-inspection review findings

In 2017, we found some good individual examples of police child protection work. However, we were concerned about the protection of some children who regularly go missing from home, and those at risk of abuse or exploitation. The force has worked with partner organisations to develop and introduce a new protocol for children who go missing from home or care. This is supported by the force's own missing persons guidance and a list of suggested response options.

All frontline staff have received face-to-face training from a specialist officer in relation to CSE. Student officers and trainee detectives also benefit from specific training from child protection specialists. This is supported by video training to staff, including those in the force control room. The training highlights the links between the risk of abuse and exploitation and children going missing from home. However, the aims of these initiatives have not yet consistently translated into operational activity, particularly when a child is reported missing.

Detailed post-inspection review findings

The force has taken steps to improve its practice in relation to children going missing from home or care. The Tees missing from home or care protocol has been developed to provide guidance to staff and partner organisations across the county when a child goes missing. The aims of the protocol are to:

- prevent children going missing from home or care;
- ensure effective safeguarding of missing children;
- locate children;
- outline actions Cleveland Police and local authorities will take in relation to missing children; and
- promote information-sharing between the force and the four local authorities to reduce future missing episodes.

The force published operational guidance for missing persons in July 2017.
A refreshed guide with a list of suggested response options was introduced in April 2018. The guide explains why it is so important to get the response right.
It uses real examples of Cleveland cases, which is very effective. The principles are that at every stage of a missing persons investigation, the focus should be on

locating the person safely, reducing any risk posed to that person or others, and helping to prevent recurrent episodes. The list of suggested response options provides practical guidance to help officers locate a missing person. It highlights the importance of having an investigative mind-set and the potential links to CSE.

Local authorities carry out return home interviews to understand why a child has gone missing. The force has introduced an intelligence-sharing form to allow the local authority to report intelligence from those interviews to the police. This should help to develop future protective plans and assist in locating a child more quickly should they go missing.

When a child has gone missing three times in 90 days, or has been graded as high risk, they are discussed at the VEMT team meeting. This is a multi-agency practitioner group that meets monthly. We reviewed the minutes in relation to 17 children who were discussed at Hartlepool VEMT practitioner group between February and June 2018. In all cases there was good representation by partner organisations and good information-sharing in relation to the child and their circumstances. The voice of the child and their parent/carer was also clear. We found that when a case is allocated to VEMT, flags are consistently added to the Niche system. Our audit of cases showed that when a case is allocated to the VEMT team, either for investigation or to support a child, the activity and recording of activity is often of a high quality.

In eight of the 17 cases reviewed, limited or no action had been raised. In the nine cases where actions were raised they were relevant and appropriate, with timescales set for updates. There is therefore an opportunity to improve how the organisations work together to develop joint plans to locate a missing child more quickly. This would help guide decisions based on a wider assessment of risk, rather than just the incident. None of the cases we audited included trigger plans,[3] which is also a missed opportunity.

The force has an initiative called ‘adopt a shift’. Through this, all frontline officers receive a face-to-face input from a specialist officer about CSE. This is followed by a CSE video training package highlighting the links between missing episodes and CSE. This training has been delivered to all staff including control room staff through their managers. The force was unable to say whether any officers did not receive the training, as no record was kept.

VEMT officers now provide an input to student officers and PCSOs in initial training. Student officers also spend a week with the PVP hub as part of their training. Trainee detectives spend a month with the PVP hub as part of their initial crime investigators’ development programme. While at the PVP hub, each officer receives a safeguarding handbook with an introduction from the head of public protection.

[3] A trigger plan is a plan to locate a child quickly when they go missing.

This contains useful information about various areas of vulnerability including child protection.

The introduction of the guidance, structures and processes described demonstrates the force's intent to respond to our recommendation. However, case audits reveal this is not yet translating into frontline activity and outcomes for children are inconsistent.

During this review, we audited eight cases relating to children reported missing. All were inadequate for several reasons.

Children looked after by the local authority are often recorded as having 'no apparent risk' associated to their being missing. This is despite them having been missing multiple times previously, when there were clear risks and the whereabouts of the child was not known. This was also noted in the force's own internal audit in September 2017.

When graded correctly (for example medium risk) there is often little or no activity to locate the child.

In all of the cases audited there was no referral to children's social care so that a strategy discussion could be held to share information and develop joint plans. This was evident even when a looked-after child had been missing over 48 hours. A strategy discussion is mandated in the Tees protocol in these circumstances.

A 13-year-old child was reported missing by her mother. She had a VEMT warning flag and a significant history of missing episodes. The force control room correctly graded the episode as medium risk but no activity took place to locate her for eight hours, after which local officers were passed a description. Her mother reported information about an address where the girl might be, but this was not visited. Her father then contacted the police to report that she was outside his address and being aggressive. This prompted police attendance and the child was taken home to her mother. No enquiries were conducted to establish who she was with at the address mentioned by her mother or whether they posed a risk to children.

Missing persons are repeatedly recorded incorrectly within the command and control system. Incidents are often categorised initially as 'lost and found property', 'suspicious circumstances' or 'concern for welfare'. This can still be the case when the incident is finalised. This means that incidents linked to the person's record in Niche are not shown as 'missing'. This makes it difficult to assess cumulative risk, because when researching the child's history, every incident needs to be reviewed, regardless of its apparent heading.

The force has introduced a crime supervision guidance document. This requires a sergeant to review cases every 14 days and an inspector to review them after 56 days. However, in the cases we audited there was limited evidence of this being used. This means that most cases do not have a consistently good level of supervision. This leads to unnecessary delay and a loss of direction in some cases.

The link between missing episodes and CSE is often not recognised. In addition, we found that when looked-after boys are reported missing, the use of language within incident logs is often not appropriate. Phrases such as 'he is capable of looking after himself' or 'is putting himself into criminality and drug use' are used, failing to recognise the risk posed to these children by those who wish to criminally exploit them.

A 17-year-old girl was reported missing. She was looked after by the local authority and had a VEMT warning marker because of her vulnerabilities. Four hours after the initial report a control room supervisor decided that she was to be treated as missing and graded the risk as medium, but a patrol was not deployed and there was no activity to trace her. A patrol was eventually sent to the home seven hours after the original report. The girl returned to the home during the early hours of the following morning. She contacted police to report she had been given drink and drugs and raped while missing from the home. There was a good and prompt initial response and a detective sergeant did review the case initially, however there was no detailed investigation plan and no evidence of any of the suggested enquiries having been completed.

A 16-year-old boy looked after by the local authority had many vulnerabilities. There was information on the police system from the care staff that he displayed violence and was associating with older males. They were exploiting him financially and coercing him into testing and selling drugs. He was reported missing 25 times in the ten weeks prior to this review and on 23 of these occasions he was shown as 'no apparent risk'. We reviewed all 25 missing episodes and did not find mention of the above concerns when the control room inspector recorded their no apparent risk rationale. Their decision was based on the child being 16 and able to look after himself, therefore not being at risk. In most of the cases he was missing overnight, with the longest period being more than 50 hours.

We were encouraged to note that prompt action was taken by the force to review the operating process and educate decision-makers within the force control room during the post-inspection review.

The force has a small performance and quality review team with limited resources. They have taken the innovative step of setting up a peer-review process with a view

to increasing their capacity for audit activity. However, they have not yet had capacity to audit CSE cases. The audits they have completed, in relation to child protection and domestic abuse cases, have led to very useful learning. There is therefore an opportunity to use this process to audit CSE cases to ensure the force's expected standards are being met.

Decision-making

Recommendation from the report of the 2017 inspection:

- Within three months, Cleveland Police should take steps to ensure that all relevant information is properly recorded and is readily accessible in all cases where there are concerns about the welfare of children. Guidance to staff should include:
    - what information should be recorded (and in what form) on systems to enable good quality decisions;
    - the importance of sending the information to the correct police department and/or relevant partner agency; and
    - the importance of ensuring that records are made promptly and kept up to date.

Summary of post-inspection review findings

In 2017 we reported that information, particularly in relation to strategy meetings, safeguarding plans and contact with children and families, was frequently incomplete or missing entirely. All are essential for good decision-making in child protection matters.

The force has introduced a template to be completed by officers who attend strategy discussions. This document summarises the discussion and details what actions are to be taken. It is then uploaded onto the Niche system. The children allocated to the VEMT team also have a personal dossier (as described in 'initial contact' above). We found inconsistent use of both.

Detailed post-inspection review findings

The strategy meeting template introduced by the force helps officers who attend and contribute to strategy discussions to record a summary of what was said in the meeting. Agreed actions should also be recorded and the form should be uploaded to Niche. This means that officers and staff responding to future incidents will be able to understand the level of risk present, and make decisions based on the whole risk. However, in our case audits, we did not find the templates being used. As a result, the force still does not record all information properly and in a way which is easily accessible to their staff.

Children allocated to the VEMT team have a personal dossier added to their Niche record. The quality of the information contained within these is consistent. Case audits revealed that when a child is on a child protection plan there is often an appropriate flag on the Niche system. The force informed us that it plans to enhance this by including summarised details of the reasons for the child protection plan. However, this is not yet in place.

Police detention

Recommendation from the report of the 2017 inspection:

- Within three months, Cleveland Police should undertake a review (jointly with children's social care services and other relevant agencies) of how it manages the detention of children. This review should include, as a minimum, how best to:
    - ensure that all children are only detained when absolutely necessary and for the absolute minimum amount of time;
    - assess, at an early stage, the need for alternative accommodation (secure or otherwise) and work with children's social care services to achieve the best option for the child;
    - ensure that custody staff comply with their statutory duties to complete detention certificates if a child is detained for any reason in police custody following charge;
    - ensure that custody staff make a record of all actions taken and decisions made on the relevant documentation; and
    - improve awareness among custody staff of child protection (including the risk of sexual exploitation), the standard of risk assessment required to reflect children's needs, and the support required at the time of detention and on release.

Summary of post-inspection review findings

In 2017, we found that risk assessments for children detained by the police were generally of a good standard and appropriate adults (who offer support to children in custody) attended promptly. However, many children entering custody have complex needs and are likely to be vulnerable and in need of safeguarding support. In many cases we found a referral to children's social care services was warranted but there was no evidence of any referrals being made. We were also concerned that some children were being unnecessarily detained when they should have been transferred to alternative accommodation provided by the local authority. The force has taken significant steps to improve how it manages the detention of children, particularly

when alternative accommodation is required. The local authority has agreed to keep a place available at a local care home for this purpose. The force has worked on educating its staff, with a focus on alternatives to police detention. This has led to a reduction in the number of children coming into custody and those being detained after charge.

Despite these improvements, we saw examples of children being detained for longer than necessary, often overnight, before being released or charged. In addition, throughout the case file audits there was no evidence of any referral forms being submitted for a child in custody when complex needs or vulnerabilities would have warranted further support.

Detailed post-inspection review findings

The force, together with children's social care, has completed a review aimed at improving the availability of suitable alternative accommodation. There is now a place permanently available at a local care home for children who are charged and who need alternative accommodation. Getting access to secure accommodation remains difficult. But we did see evidence of this being sought and subsequent juvenile detention certificates being completed when it was not available or appropriate.

Custody sergeants have also been trained in relation to their responsibilities as set out in the children in custody concordat.[4]

The force has worked hard to reduce the number of children arrested, by promoting alternatives such as voluntary attendance and restorative justice. It reports a reduction from 1,141 children detained in 2016 to 840 in 2017. The number of occasions when bail was refused has also reduced, from 23 in 2017 to four at the time of our review in 2018.

The custody office in Middlesbrough has a vulnerability area. This means that children can be booked in in a quieter environment and detained in a designated wing, to reduce the negative effects of detention.

However, case audits revealed that although there is always a risk assessment of the child when brought into custody, this usually doesn't inform decisions about treatment or length of detention. In some cases, children were detained overnight when this was not necessary. In one case, a 16-year-old boy reported he was suffering from anxiety and depression; he later reported feeling suicidal and sick. He asked to see a nurse but was not seen by a medical professional during his detention.

[4] The concordat on children in custody provides guidance for police forces and local authorities in England on their responsibilities towards children in custody. Last updated June 2018.

We found that appropriate adults[5] often do not attend at the time rights are given. Their attendance is more likely to be arranged to attend to coincide with interviews, for example.

When a child is detained overnight the review of their detention is often conducted when they're asleep. When this happens, there is no record that they have been informed later about the review.

In all the cases we audited, there was no apparent referral to children's social care, even when there were clear vulnerabilities.

> A 13-year-old boy was arrested for causing damage to the care home where he lived. He had previously been missing from home and at risk of CSE. Information was available on police systems that he also suffered from panic attacks but none of these problems were noted in his risk assessment on detention. He was later released on bail with a condition to reside at the home he had damaged. A referral to children's social care was not made and there was no evidence a strategy discussion took place with partners to agree a shared plan.

This problem has already been identified by the force and there is a plan to introduce a 'tick box' for child suspects within a crime report. This will remind officers to consider the vulnerability of the child. This is an encouraging development but had not been implemented at the time of this review.

[5] An appropriate adult is a parent, guardian, social worker or, if no person matching this description is available, any responsible person over 18. In England and Wales, an appropriate adult must be called by the police whenever they detain or interview a child or vulnerable adult. They must be present during a range of police processes, including intimate searches and identification procedures, to safeguard the interests of children detained or questioned by police officers.