HMICFRS

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

National child protection inspection post-inspection review

Durham Constabulary

4–8 October 2021

Contents

Introduction

Our 2019 inspection

In October 2019, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) inspected how well Durham Constabulary keeps children safe.

In March 2020 we published our findings.

We found that the chief constable, her senior team and the police, crime and victims' commissioner were clearly committed to protecting vulnerable people, including children.

The constabulary had appropriate representation in the two safeguarding partnership arrangements (as defined by the Children and Social Work Act 2017) and were involved in various subgroups.

We also found that the constabulary had put a lot of time and energy into improving the health and wellbeing of its staff.

Throughout the inspection, officers and staff we spoke to who managed child-related investigations were committed and dedicated to their roles. They were often working in difficult and challenging circumstances, with some teams saying they were under significant pressures.

A programme had begun to give vulnerability training to officers, staff and police community support officers (PCSOs).

We identified that further work was required to ensure that senior leaders could test what was working well on the front line, and that there was appropriate and effective supervision.

The cases we examined showed that the force needed to improve some of its responses to children who needed help and protection.

Areas for improvement included:

- recording decisions, actions, joint discussions and safeguarding plans to ensure an appropriate focus and understanding of each child's needs and the risks they may be exposed to;
- the overall response for children reported missing, which was inconsistent and inappropriate for some children;
- the management of registered sex offenders by local neighbourhood PCSOs and officers, and the associated training for this role;

- the assessment of risk in domestic abuse cases deemed to be medium or low risk, and the effect of cumulative risk and its impact on children; and
- ensuring that appropriate adults for children detained in police custody were requested as early as possible to provide support.

We also saw examples of good work. Specific areas include:

- the constabulary's commitment to welfare support for officers and staff;
- use of body worn video to record evidence;
- joint welfare visits to those children who were not in contact with services, and were home educated; and
- use of a protocol with children's care homes to improve joint planning and agree responses when children placed in care go missing.

However, improvements were needed, and we made a series of recommendations.

The 2021 post-inspection review

In April 2020, the constabulary sent us a letter outlining the work it had completed in response to our recommendations and we continued to monitor its progress. In October 2021, we conducted a post-inspection review.

During this inspection we:

- examined force policies, strategies, and other documents;
- interviewed senior leaders, managers, and supervisors; and
- audited 29 child protection cases.

Summary of findings from the post-inspection review

Following our 2019 inspection, the constabulary immediately formed a vulnerability gold group to drive the improvement required in its response to children.

The constabulary has taken steps to better understand the service it provides to children. It has also provided many training opportunities throughout the organisation to improve its response and outcomes for children.

The constabulary conducts a range of audits and reviews case samples in many areas focusing on vulnerability and child protection. This has improved the quality of these services. The reviews are centrally co-ordinated by the accuracy and improvement team. Areas of good practice and learning points are recorded, discussed with individual officers and supervisors and passed on throughout the force. Results are reported to senior managers where response and improvement plans can be managed. The force also works with its statutory safeguarding partners to improve multi-agency practice where relevant.

The control room response to incidents involving children, including those who are reported missing and when children are in immediate need of protection, has improved. Better training for its staff and improved governance processes have led to a more appropriate use of the appointment system for responding to calls in most cases we looked at.

Officers and staff have received more training in how to work with children. They record details about how the child presented and how they were feeling. In most cases, this has led to an improvement in the quality of safeguarding referral forms being submitted to children's social care services. This allows joint protective plans to be developed considering the wishes of the children. We continued to see good use of body worn video.

The force has improved the way it deals with cases when children are reported missing from home or care. Its risk assessments and investigations consider the wider context when a child goes missing, not just immediate circumstances. We found an impetus to find children when they were missing. But the constabulary needs to improve how it records information from prevention interviews with children after their return.

The number of investigators on specialist investigation teams has been increased and more training provided. But there are still not enough accredited investigators to meet demand.

We are concerned about the constabulary's response to children at risk of online sexual exploitation. It needs to do more to prioritise investigations where children may be at risk. Information sharing with statutory safeguarding partners in these cases also needs to improve to ensure children can be protected at the earliest opportunity.

The response to, and recording of, cases when children are in immediate need of protection has improved. Officers make good decisions to protect children and work well with children's social care services to ensure they are safeguarded in the longer term.

The constabulary has improved its model for dealing with registered sex offenders. We found the quality of offender management to be better. But enhanced co-ordination between the different teams with responsibilities for managing registered sex offenders would further improve the recording of information and ensure all required action is taken to protect children.

The detention of children in police custody has improved. But more work is required to ensure appropriate adults arrive promptly to support them, children are not detained in police custody unnecessarily after charge, and safeguarding referral forms are submitted to children's social care services where necessary.

Of the 29 child protection cases we audited, the force's response in nine was good. In 16 it required improvement and in four cases it was inadequate.

Conclusion

Durham Constabulary has had, and continues to have, a focus on child protection matters at a strategic level.

This includes a continuing development of its practice through a programme of training, providing guidance, monitoring performance and regular testing through audits.

The force has worked systematically to address the recommendations from our 2019 inspection and can demonstrate clear improvements in most areas as a result. It now needs to build upon these foundations to achieve consistently better outcomes, focusing on areas where most improvement is needed. This includes children at risk of online sexual exploitation and children detained in custody.

We are encouraged by the force's progress and confident of its continuing commitment to making further improvements.

Initial contact

Recommendations from the 2019 inspection report

We recommend that Durham Constabulary immediately reviews the application of the diary appointment system used within the control room.

We recommend that Durham Constabulary, within three months, makes sure that children's concerns and views are obtained and recorded (including noting their behaviour and demeanour). This will help influence decisions made about them.

Summary of post-inspection review findings

Durham Constabulary has made improvements to the way control room staff assess risk to children and the way it reviews the quality of those decisions. It has refreshed the training it gives staff and more guidance is available to them. This has improved the initial response to incidents involving children.

The use of body worn video by officers continues to be a strength. But improvements need to be made to prevention interviews when children return after being missing from home or care.

Detailed post-inspection review findings

Control room staff have received more training

Since our 2019 inspection the constabulary has delivered a programme of training for control room staff to address the issues we highlighted. This has included refreshed THRIVE training to encourage call handlers to consider wider safeguarding factors when risk assessing incidents. New call handlers have been trained in basic investigation techniques to encourage an investigative approach when taking calls. Safeguarding specialists have delivered the force's own training programme, Through the Eyes of a Child, to call handlers to broaden their understanding of how incidents can affect children.

The constabulary regularly reviews the effectiveness of decisions made in the control room

Cases are reviewed to monitor the effectiveness of the control room's initial response and deployment decisions to incidents involving children. Between 8 percent and 10 percent of relevant calls are sampled monthly. We examined data from these samples and found that the constabulary had assessed most calls to have been correctly graded. The constabulary found that details of the children involved had been recorded and the risk to them had been considered through the THRIVE process. The sampling process is governed through constabulary threat and risk meetings.

Supervisors in the control room and members from the assessment and improvement team also review a sample of live cases to ensure there is an appropriate response and provide immediate feedback to control room staff.

The use of follow-up appointments was mostly appropriate, but requires improvement in some domestic abuse cases

We examined the use of the appointment system to respond to calls from the public by sampling incidents in WebStorm, the constabulary's command and control system. We did this on Monday 4 October 2021 and Thursday 7 October 2021. We looked at 50 percent of the appointments that were live on these days: 36 in total.

In these cases, the use of diary appointments was appropriate with no safeguarding concerns identified. We also found that additional checks had been implemented in the control room. For example, dedicated diary co-ordinators perform additional checks and research to ensure that a diary appointment is still appropriate, then complete further THRIVE risk assessments.

We also reviewed a sample of 20 domestic abuse incidents scheduled for a diary appointment. We found this to be an appropriate response in 16 cases. But in the remaining four cases, all of which involved children, the final deployment decision was driven by demand and not risk.

The control room had correctly identified that a diary appointment shouldn't be given due to the level of risk. But due to the demand from other incidents and a lack of resources, officers were not deployed. The cases were then reallocated to be dealt with through a diary appointment despite the identified risk. This led to delays ranging from four to seven days. During this time, the identified risk was not addressed, nor was there a reassessment of that risk.

Body-worn video is used effectively to record what children say and the conditions they live in

We continued to see good use of body-worn video to record the living conditions of vulnerable children and record their demeanour, thoughts, wishes and feelings. This included cases where children were taken into police protection or were victims of crime, and during prevention interviews following their return after being reported missing. This continues to be a strength for the constabulary. Body-worn video is also used to inform strategy discussions and meetings with safeguarding partner organisations. This is positive as it aids joint decision-making and the formulation of effective plans for vulnerable children.

The constabulary has provided training to officers and staff to improve how they interact with children

During the inspection, we saw a focus on raising awareness of the importance of listening to children. The force's own training programme, Through the Eyes of a Child, is a recognised constabulary brand. Officers and staff are aware of their responsibility to seek children's views and concerns and note how children look and behave. This has led to an improvement in the timeliness and quality of safeguarding referral forms being submitted, which helps to identify risk to children.

However, the quality of information recorded after prevention interviews with children who have been missing requires improvement. The constabulary has created a specific template but despite the form's prompts, insufficient detail was recorded in all the cases we looked at. This is important as children's social care services reviewing the report won't be aware of the child's thoughts and needs or have the information needed to make the best decisions for the child. A laminated guide about missing children cases has recently been provided to officers. The guide includes questions to ask when interviewing children who have returned home after being missing. This may lead to improvements in the quality of information being recorded.

Assessment and help

Recommendation from the 2019 inspection report

We recommend that Durham Constabulary immediately improves practice in cases of children who go missing from home. As a minimum, this should include:

- making sure its officers and staff recognise risk factors;
- taking account of those risk factors in its work to locate missing children;
- making its officers and staff aware of their responsibilities for protecting children who are reported missing from home, especially when this happens regularly; and
- demonstrating awareness of the importance of investigating where a child has been, and who they have been with.

Summary of post-inspection review findings

The response to children reported missing from home or care has improved. We found risk assessment processes and investigations to be good. The constabulary has processes in place to analyse the quality of its response.

The constabulary works well with other safeguarding organisations to problem solve and reduce the number of missing episodes. But the constabulary can improve the way it works with children's social care services to co-ordinate independent return home interviews.

Detailed post-inspection review findings

Since the 2019 inspection, new missing person guidance has been issued by the constabulary to improve its response when children are reported missing from home or care. We also found that improved training and briefing sessions have been delivered to officers and staff.

Investigations to find missing children have improved

We found that the initial response to reports of missing children is good. THRIVE risk assessments are used well, with additional research about the individual child and their wider circumstances, such as previous history and associates. This information is used to determine the level of risk and the required policing response. Investigations are proportionate and we saw appropriate enquiries being generated and completed to find missing children. Prevention interviews are routinely taking place, which is positive, but, as previously stated, the quality of recorded information is not of the required standard.

The information collected through local authority return-home interviews is reported back to the police, although sometimes delayed

The two local authorities in the policing area, Durham County Council and Darlington Borough Council, complete their own return-home interviews with children following missing episodes. Details are fed back to the police missing person co-ordinators and added to the force's computer system, Red Sigma. This information can be used to help find children should they go missing again.

The return-home interview is a local authority statutory function and should be completed within 72 hours. However, we found a backlog of 86 interviews waiting to be completed by Durham County Council and 69 completed but not yet updated in police systems. It is positive that this issue has been prioritised by constabulary senior leaders through the Durham Safeguarding Children Partnership. Analytical work has been commissioned and a multi-agency task and finish group has been set up to try to resolve the problem.

The constabulary's missing person co-ordinators use a spreadsheet to record continuing work about missing children and information about return-home interviews. The wider organisation has no access to this wealth of information about missing children and the interventions required or taking place. The information would help officers and staff when making risk assessments and decisions about investigations to locate children in later missing episodes.

The constabulary and other safeguarding organisations work together well to try to prevent children from going missing

We saw good multi-agency work to try to problem solve and reduce episodes for children who are missing regularly. This includes working with the local authority exploitation teams and collaborating through multi-agency meetings.

The constabulary has recently introduced its Buddy Scheme, which nominates 15 PCSOs as points of contact for looked after children living in care homes or foster placements. This is designed to build trust with the young people who are regularly reported missing, with the aim of reducing the number of missing episodes.

There are also plans to introduce a peer mentor scheme. A small cohort of children have been identified who have previous experience of the care system. It is intended that they will offer support to children who are still in care. While these are positive innovations, it is too early to test their effectiveness.

Case study

A 13-year-old boy was reported missing by his stepmother. He had been missing six times in total and four times in the previous six weeks.

The control room response was good. A THRIVE risk assessment was completed and reviewed by a supervisor. The case was assessed as a medium risk, which was appropriate in the circumstances.

The boy returned home before police attended but a missing person record was created in Red Sigma. A prevention interview was completed by the allocated officer who submitted a safeguarding referral form. Partner organisation intervention was required due to the number of missing episodes.

The missing person co-ordinator requested a multi-agency meeting. This led to continuing multi-agency work to support the boy and try to prevent future missing episodes.

But there was no evidence of a local authority return-home interview taking place.

There are quality assurance processes in place to continue to improve the constabulary's response to missing children

After the 2019 inspection, the constabulary created sampling processes to test the quality of work relating to missing children and identify where improvements are needed. The sampling has developed over time and is now conducted daily by inspectors. The data collected is largely numerical but there is some qualitative analysis. More detailed qualitative analysis is also provided through the children and family scrutiny panel.

This monthly meeting conducts in-depth analysis into child safeguarding cases, including missing children, according to a thematic schedule. Learning points are discussed with individual officers and supervisors and, where required, action taken. Wider learning is shared throughout the constabulary. These processes provide an opportunity for the constabulary to continue to improve outcomes for children reported missing.

Investigation

Recommendation from the 2019 inspection report

We recommend that, within three months, Durham Constabulary should improve its child protection and exploitation investigations, paying attention to

- allocating investigations to teams with the skills, capacity and competence to carry them out well;
- improving the way cases are recorded, overseen and managed; and
- sharing information with children's social care services at the time that a risk to a child is known.

Summary of post-inspection review findings

Some progress has been made in recruiting and accrediting investigators to the specialist safeguarding investigation teams, but there are still not enough to meet demand.

The standard of recording and supervision within investigations has improved but is still inconsistent.

We remain concerned about the sharing of information with statutory safeguarding partners when children are at risk of online exploitation. We also identified some cases that hadn't been actioned where children may be at risk.

Detailed post-inspection review findings

The constabulary has invested more resources in its specialist safeguarding teams since the 2019 inspection

The position has improved since our last inspection, but the constabulary acknowledges that the recruitment and retention of safeguarding investigators remains a challenge. The constabulary is planning further investment in its safeguarding teams in a drive to ensure it can meet demand. For example, there is a current open-ended advert to recruit a further ten detective constables for these teams.

The constabulary has invested considerable resource into training and awareness raising

To meet the recommendations of the 2019 inspection, changes have been made to policies and processes and these have been communicated to staff. We saw that the safeguarding section of the force intranet contains lots of good information to assist officers and staff when they are dealing with vulnerable people, including children.

The constabulary has invested in delivering a wide range of training to specialist and frontline officers and staff. Some departments, such as the control room and custody teams, have their own dedicated training officers. This is also a positive step to ensure that appropriate training is provided.

Safeguarding investigation team officers have been, or are in the process of being, trained and accredited under the initial crime investigators development programme and the specialist child abuse investigation development programme. But approximately 40 percent of investigators in these teams are not yet fully accredited. This may mean that not everyone investigating the most serious and complex abuse of children has the required skills. This could leave children at risk. The constabulary is aware of this and has a planned programme of further courses to try to close this gap. Positively, it has developed the capacity to provide these courses internally.

There are many other examples of training being provided throughout the organisation, often by specialist officers. While this is a positive step, there is little central co-ordination of the training being delivered so it may be difficult to identify gaps in the knowledge of teams or individuals. Also, there has been limited evaluation of the training to understand how effective it is. However, the development of 'carousel training' – where the neighbourhood policing team (NPT) receives short training sessions from a range of specialists at a single event – is an innovative approach to professional development.

The recording and supervision of investigations is inconsistent

We saw some good examples of investigations being conducted in the constabulary. They had full records containing detailed investigation plans and regular supervisory entries directing the case.

But in some cases the recording of actions was poor so it wasn't always clear what had taken place. We also saw a lack of quality supervision in some cases. These cases had brief or no investigation plans and little evidence of the investigation being driven appropriately. The constabulary needs to continue to improve this.

We saw good use of THRIVE risk assessments within investigation logs. They were used at the start of each investigation and again at the conclusion to ensure that risk was appropriately identified and managed, which is positive.

We remain concerned about the sharing of information when children are identified as being at risk in online child sexual abuse and exploitation (OCSAE) cases

The constabulary has introduced a new process to ensure that cases where a risk to a child has been identified are prioritised and dealt with as high risk, meaning that action and information sharing processes are expedited. However, we found that this process is not always followed.

We found four cases had been allocated to non-specialist investigators after being graded as medium or low risk using KIRAT, a screening tool that assesses the risk from online offenders. These cases all had children associated with their addresses. At the time of our inspection the cases hadn't been actioned and should have

been allocated to the specialist digital intelligence and investigation (DII) team. Information about the risk to these children hadn't been shared with statutory safeguarding partners. This potentially left them at risk.

The visibility of OCSAE cases is also a concern as information about these cases is contained on a standalone spreadsheet maintained in the DII. Without access to this spreadsheet, it isn't possible to tell when information about the risk to children becomes known, or what action is taken. This means senior managers can't effectively oversee the response to OCSAE cases.

Some cases on peer-to-peer file sharing systems hadn't been actioned

The constabulary uses a peer-to-peer file sharing system to identify people sharing indecent images of children online. The system is checked weekly and high-risk cases are extracted and an investigation launched.

We identified that in the last year six investigations had been commenced. But there were 20 more cases where perpetrators in the Durham area hadn't been investigated and it isn't known what access they had to children. We were told that the DII officers will receive further training to make sure the system is used effectively to manage the risk to children.

The national child abuse image database isn't being used effectively

We identified that the constabulary hadn't uploaded any images to the national child abuse image database (CAID) for about a month. We were told that a lack of equipment and technical issues were making this process difficult for investigators.

This delay affects CAID's efficiency. New and previously uncategorised images discovered by Durham Constabulary will not be searchable for other forces. They may also be missed when using triage equipment to scan an offender's device as the image's unique digital fingerprint – known as a 'hash' – won't be registered on CAID. This reduces the ability of police forces to identify and safeguard children. There is a wider impact as online platforms use the hash from CAID to scan for abuse imagery. This allows them to identify and remove images and alert police forces.

Decision-making

Recommendation from the 2019 inspection report

We recommend that, within three months, Durham Constabulary ensures that:

- offences are investigated; and
- all relevant information is properly recorded and made readily accessible in all cases where there are concerns about the welfare of children.

Guidance to staff should include:

- advice on what information they should record (and in what form) on their systems to enable good-quality decisions; and
- an emphasis on the importance of ensuring that records are made promptly and kept up to date.

Summary of post-inspection review findings

Improvements have been made to procedures when children are taken into police protection.

Detailed post-inspection review findings

Following the 2019 inspection, the constabulary introduced a new process for when children are taken into police protection. This is designed to improve recording and accountability by the designated officers and to ensure that children are safeguarded where needed. The process aims to ensure information is shared with children's social care services promptly, a strategy discussion or meeting takes place, and an investigation instigated where necessary.

We saw officers making good decisions to protect children supported by good records

In the cases we looked at, the decisions made by officers attending an incident to take children into police protection were appropriate. This was supported by good use of body worn video to record what the children said, how they appeared and the conditions in which they were living.

Designated officers detailed clear rationales on the incident log to explain why they used emergency powers, noting the time they commenced, but not always when they were no longer required. We saw early contact with children's social care services to find children a safe place to stay.

We also saw that good-quality safeguarding referral forms were being submitted by officers. Information was shared with children's social care services swiftly.

The constabulary works well with other organisations to implement longer-term plans to protect children

The constabulary's strategy team is automatically notified when children are taken into police protection through a tag placed on the incident log in the control room. This directs additional scrutiny to these cases to ensure the police and multi-agency response is appropriate and co-ordinated. In each of the cases we looked at, a strategy meeting had taken place to ensure that joint protective plans were put in place.

Where appropriate, criminal investigations were commenced, and in some cases parents were diverted to Checkpoint, the constabulary's reoffending reduction programme, to address underlying problems. For some families, this approach will be in the child's best interests as their parent or parents will be supported to improve their and their child's situation.

Case study

Four children, aged four, eight, nine and 11, were taken into police protection following a call from a member of the public in the early hours of the morning. Their parents were found by police to be very drunk and they were arrested for child neglect as they couldn't look after their children properly.

The officers used their body worn video and spoke to all four children to record how the incident had affected them. The emergency social worker was contacted and after appropriate checks the children were placed with a family member.

The designated officer recorded a full rationale for the action taken and recorded when the emergency powers had started and when they had finished.

The officers submitted a detailed safeguarding referral and a strategy discussion with children's social care services took place the following morning.

The investigation was well recorded and supervised. Both parents admitted child neglect and were referred to Checkpoint.

A further strategy meeting took place to plan for the longer-term safeguarding of the children.

Managing those posing a risk to children

Recommendation from the 2019 inspection report

> We recommend that Durham Constabulary immediately acts to review and improve its management of registered sex offenders, paying attention to the current neighbourhood police team (NPT) model used for medium and low-risk offenders.

Summary of post-inspection review finding

Improvements have been made to the way that medium and low-risk registered sex offenders are managed. Their NPT single points of contact (SPOCs) have received better training but there remains some variance from College of Policing authorised professional practice (APP).

The co-ordination and completion of actions between NPT SPOCs and ARMS assessors needs to be further improved.

Detailed post-inspection review findings

The model of registered sex offender management has been reviewed and improved. But the constabulary is still not fully compliant with APP

Durham Constabulary has its own model for managing medium and low-risk registered sex offenders who have a SPOC in the NPT.

In our 2019 inspection we found that the constabulary was not fully following APP in the way registered sex offenders were being managed. This was in part due to the SPOCs not being trained to an accredited standard. This has improved as the current 52 SPOCs have received a five-day management of sexual and violent offenders (MOSOVO) and ARMS course. Further training has been delivered to ensure that their knowledge and skills continue to be developed. Visits to low and medium-risk registered sex offenders are now only completed by SPOCs who have received this training.

However, the constabulary is still not fully compliant with APP. The SPOCs are visiting registered sex offenders in uniform, not plain clothes as mandated. This could make the public aware of the offenders' presence in the community and put them at risk.

We also found that some registered sex offenders are being incorrectly placed under reactive management when they don't fulfil the criteria. These registered sex offenders have been issued with preventative orders by the court, such as sexual harm

prevention orders. This means the terms of the orders are not being proactively monitored through home visits, which increases the risk to the child.

The quality of offender management has improved, but better co-ordination between the ARMS assessors and SPOCs is required

We found that the quality of ARMS assessments and risk management plans completed by the public protection unit, a team of officers managing high and very high-risk registered sex offenders, and the SPOCs is good. The quality of information recorded after visits to registered sex offenders has also improved and registered sex offenders are generally better managed than in 2019.

There has been an increase in the number of ARMS assessors. There are now four officers and staff (equivalent to three full-time posts) who have responsibility for monitoring and managing the 653 registered sex offenders under the NPT model. In our 2019 inspection we found that the ARMS assessors had 604 tasks that needed to be completed in the national ViSOR system. We were pleased to find that this had significantly reduced to 31.

The NPT model relies on the SPOCs being tasked by the ARMS assessors to complete visits or other tasks on the Red Sigma action management system. The SPOCs then report back to the ARMS assessors. While this system has improved since our last inspection, we remain concerned about the monitoring and co-ordination of some of the work, particularly where children have been identified as at risk.

For example, we found that SPOCs were submitting safeguarding referral forms in relevant cases (although these were sometimes delayed), having identified when there was a risk to a child. But the referral forms hadn't been followed up by the SPOC or ARMS assessor with children's social care services. There was no update or evidence of a strategy meeting having taken place. So it wasn't clear that appropriate safeguarding measures were in place to protect those children. The constabulary needs to further improve how cases are overseen and monitored under this model.

The ARMS assessors are not using the action tabs on the ViSOR system, because the SPOCs don't have access to it. Instead they use the force's Red Sigma action management system. The ARMS assessors do not track the actions they have set and being responsible for the management of the registered sex offenders do not know if or when actions they have set have been completed until they receive a reply via the Red Sigma system. This could be rectified if the action tab on ViSOR was used in accordance with guidance.

Additionally, not all relevant information is transferred to the ViSOR system. For example, we saw a visit that had been recorded in Red Sigma but not transferred to ViSOR. Negative visits, where the police have not spoken to the registered sex offender, are generally not added to the national database. This means that if an offender moves to a different force's area, the information in ViSOR on their management and compliance will be incomplete. This could lead to inappropriate management and increased risk.

The NPT SPOCs directly managing registered sex offenders have competing demands, which can delay their response to tasks set by the ARMS assessors

The SPOCs are clearly committed and understand that their role in the management of registered sex offenders takes precedence above other work. Senior leaders in the safeguarding and neighbourhoods command have clearly set this as their expectation. However, we were told that SPOCs can come under pressure from their immediate supervisors to undertake other tasks to the detriment of their work managing registered sex offenders. This can mean visits are delayed. This issue was reported as a problem in 2019.

Police detention

Recommendation from 2019 inspection report

We recommend that, within three months, Durham Constabulary should:

- review its approach to securing appropriate adults for children as early as possible to provide support;
- review the recording and monitoring of arrival times, so that these can be measured, and delays identified and addressed;
- assess, at an early stage, the need for alternative accommodation (secure or otherwise) and work with children's social care services to review the provision and availability of both secure and alternative accommodation; and
- ensure that officers and staff consider the needs and vulnerability of a child in police custody and make appropriate referrals promptly to children's social care services.

Summary of post-inspection review findings

The constabulary has invested a lot of time and energy to improve the provision of appropriate adults and alternative accommodation for children detained in custody. But further improvement is needed.

Safeguarding referral forms are not always being submitted for children detained in custody when they would be appropriate.

Detailed post-inspection review findings

Some improvements were seen in the provision of appropriate adults to children in custody but there are gaps in records

Custody staff are expected to request the services of an appropriate adult within 30 minutes of the child's detention being authorised to ensure the child has support. In early 2020 the constabulary conducted its own review of custody records and found the time it took for appropriate adults to attend children was still unacceptable. Following the 2019 inspection and this force review, further training, guidance and direction was provided to custody staff on several occasions.

During our review we examined six cases where children had been detained in police custody. In five of these cases appropriate adults were contacted and arrived quickly. But in one case there was a delay of 15 hours between the request and arrival of an appropriate adult.

However, data we reviewed from September 2021 indicated that the 30-minute threshold was being met in just under 50 percent of cases. The same dataset indicated that the length of time between the appropriate adult being requested and their attendance varied from 28 minutes to 9 hours. The data showed that most cases where the adult did not attend within 30 minutes saw delays of 3 to 5 hours.

It is not clear how accurate this data is as it relies on the manual input and then extraction of information from the system used to record detention in police custody. The constabulary has developed several spreadsheets where data is recorded to inform performance management processes.

But we saw gaps in the recorded data. For example, the time an appropriate adult arrived had not been recorded in some cases. The performance data is discussed at the monthly custody and criminal justice governance meeting but the constabulary cannot be sure that it fully understands performance in this area.

The constabulary holds bi-monthly meetings with the appropriate adult service providers for the two local authorities. We were told that staffing problems in these services have contributed to delays in attendance. Problems have been discussed and prioritised through these meetings and we were told this has led to improvements.

Children are still being detained in police stations after charge when they should be transferred to alternative accommodation

We saw that custody staff consider the alternatives to detention both pre and post-charge, which is positive. But of the six cases we reviewed, alternative accommodation should have been provided for four young people who were denied bail after charge. In each of the four cases, custody staff contacted the emergency social work team, but suitable accommodation could not be found. In one case a 15-year-old boy was transferred to secure accommodation, which was appropriate given the circumstances of the offence.

The constabulary has developed an escalation process for cases when alternative accommodation isn't provided. Police managers should contact managers in children's social care services to try to resolve problems, but we saw no evidence of this taking place.

However, data is provided regularly to the local authorities about the number of children detained inappropriately overnight. We were told that Durham County Council has made new provision for alternative accommodation as a result, but it is too early for us to review the effectiveness of this.

Safeguarding referral forms are not always submitted for children detained in custody when appropriate

The constabulary does not mandate the submission of safeguarding referral forms for children detained in custody. In the cases we looked at, the referral forms submitted were completed by arresting or investigating officers and contained a good level of detail.

There was a clear explanation of the events and the investigation that caused the referral. On occasions the child's demeanour was described, but there was no

record of what the child said during their arrest and transfer to custody. It was not easy to understand how the child had been affected. This type of information is important to police and the other safeguarding organisations the force works with in assessing risk.

We saw a case where it would have been appropriate to refer a child from a complex background to children's social care services, but this didn't happen. We saw another where further detail should have been added to the referral form about disclosures in custody about suicidal ideations.

The arrest of a child should consider contextual and environmental risks as well as the circumstances of the arrest. This allows statutory safeguarding partners to assess risk based on all available information.

Next steps

Durham Constabulary has made good progress in response to our 2019 recommendations. But the force recognises that it still needs to improve in some areas to provide consistently better outcomes for children.

We are, however, confident that the force understands where it needs to improve. We are also satisfied that senior leaders have plans to make these improvements and to monitor progress.

As part of our routine monitoring of all police forces, we will continue to evaluate Durham Constabulary's performance in relation to these recommendations and instigate closer scrutiny if necessary.

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