National Child Protection Inspections

Essex Police
7 - 18 September 2015 and
28 September - 2 October 2015

March 2016

ISBN: 978-1-78655-107-8

www.justiceinspectorates.gov.uk/hmic

Foreword

All children deserve to grow up in a safe environment, cared for and protected from harm. Most children thrive in loving families and grow to adulthood unharmed. Unfortunately, still too many children are abused or neglected by those responsible for their care; they sometimes need to be protected from other adults with whom they come into contact and some occasionally go missing, or are spending time in environments, or with people, harmful to them.

While it is everyone's responsibility to look out for vulnerable children, police forces, working together and with other agencies, have a particular role in protecting children and ensuring that their needs are met.

Protecting children is one of the most important tasks the police undertake. Only the police can investigate suspected crimes and arrest perpetrators, and they have a significant role in monitoring sex offenders. Police officers have the power to take a child who is in danger to a place of safety, or to seek an order to restrict an offender's contact with children. The police service also has a significant role working with other agencies to ensure the child's protection and well-being, longer term.

Police officers are often the eyes and ears of the community as they go about their daily tasks and come across children who may be neglected or abused. They must be alert to, and identify, children who may be at risk.

To protect children well, the police service must undertake all its core duties to a high standard. Police officers must talk with children, listen to them and understand their fears and concerns. The police must also work well with other agencies to ensure that no child slips through the net and that over-intrusion and duplication of effort are avoided.

Her Majesty's Inspectorate of Constabulary (HMIC) is inspecting the child protection work of every police force in England and Wales. The reports are intended to provide information for the police, the police and crime commissioner (PCC) and the public on how well children are protected and their needs are met, and to secure improvements for the future.

Contents

1. Introduction

This report is a summary of the findings of an inspection of child protection services in Essex Police, which took place between early September and early October 2015. The report comprises nine chapters in three main parts. The first part provides information on the background to the inspection and to Essex Police. The second part focuses on the inspection findings, and the third part looks to the future and makes recommendations for improvement.

2. Background

Between October 2011 and March 2013, HMIC was involved, on a multi-agency basis, in a number of child protection inspections. Along with evidence of strengths and effective practice, these inspections highlighted areas for improvement, in particular: the quality of joint investigations; the identification of risk; dealing with domestic abuse; and the detention of children in custody.

To address these issues, HMIC decided to conduct a programme of single agency inspections of all police forces in England and Wales. The aims of the inspection programme are to:

- assess how effectively police forces safeguard children at risk;
- make recommendations to police forces for improving child protection practice;
- highlight effective practice in child protection work; and
- drive improvements in forces' child protection practices.

The focus of the inspection is on the outcomes for, and experiences of, children who come into contact with the police when there are concerns about their safety or well-being.

The inspection methodology builds on the earlier multi-agency inspections. It comprises self-assessment and case audits carried out by the force, and case audits and interviews with police officers and staff and representatives from partner agencies, conducted by HMIC.[1]

[1] Details of how we conduct these inspections can be found at Annex A.

3. Context for the force

Essex Police has approximately 5,150 staff. The workforce includes:

- 3,069 police officers;
- 1,633 police staff; and
- 262 police community support officers.[2]

Chelmsford is the major city in the force area and has a population of approximately 110,000. Other significant towns in the force area are Basildon, with a population of 178,000 and Colchester, with a population of 176,000.

The Essex police force area is served by three local authorities: Essex County Council, Southend-on-Sea Borough Council and Thurrock Council. The three local authorities are responsible for child protection within their boundaries. There are three separate local safeguarding children boards[3] (LSCBs) in the force area, one in each local authority administrative area.

The most recent Office for Standards in Education, Children's Services and Skills judgments for each of the local authorities are set out below.

Local authority	**Judgment**	**Date**
Essex	Good	January 2014
Southend-on-Sea	Good	June 2012
Thurrock	Good	June 2012

In Essex Police, public protection services are led by the deputy chief constable supported by a detective chief superintendent, two detective superintendents, three detective chief inspectors and two chief inspectors (the crime and public protection command). They are responsible for the public protection teams and staff who work centrally and whose roles include:

- strategy and policy;
- the dangerous offender management team (DOMT);

[2] *Police workforce, England and Wales, 31 March 2015, Home Office, July 2015*. Available at: www.gov.uk/government/statistics/police-workforce-england-and-wales-31-march-2015

[3] LSCBs have a statutory duty, under the Children Act 2004, to co-ordinate how agencies work together to safeguard and promote the welfare of children and ensure that safeguarding arrangements are effective.

- the disclosure and barring service;
- the co-ordination of multi-agency public protection arrangements (MAPPA);
- the police online investigation team (POLIT);
- the child sexual exploitation triage team;
- a proactive tactical domestic abuse team (Operation Shield);
- the central referral unit;
- the domestic abuse intelligence team (DAIT);
- the hate crime team;
- the protecting vulnerable person team;
- the sexual offence investigation team; and
- the missing person co-ordinator team.

The force and partner agencies have established a multi-agency safeguarding hub (MASH) in Thurrock where police, children's social care services and health services work together to protect vulnerable people. Those working in the MASH assess risks to individuals in a range of cases including those involving child abuse, domestic abuse and the abuse of vulnerable adults.

In the Essex and Southend local authority areas, the force and partner agencies have established joint domestic abuse triage teams (JDATTS) which assess risks to individuals in domestic abuse cases.

The MASH and JDATTs co-ordinate engagement in each area with multi-agency risk assessment conferences (MARACs).

Child protection services are managed centrally by the crime and public protection command and are also delivered locally by three child abuse investigation teams (CAITs). A CAIT is located in each of the three local policing areas (LPAs). Each CAIT co-ordinates engagement with and provides a representative at child protection case conferences for their area.

The commanders in charge of the LPAs are also responsible for six missing person liaison officers (MPLOs), two working in each LPA.

4. The police role in child protection

Under the Children Act 1989, the police service, working with partner agencies such as local authority children's social care services, health services and education services, is responsible for making enquiries to safeguard and secure the welfare of any child within their area who is suffering (or is likely to suffer) significant harm.[4] The police are duty-bound to refer to the local authority those children in need they find in the course of their work.[5] Government guidance[6] outlines how these duties and responsibilities should be exercised.

The specified police roles set out in the guidance relate to:

- the identification of children who might be at risk from abuse and neglect;
- the investigation of alleged offences against children;
- their work with other agencies, particularly the requirement to share information that is relevant to child protection issues; and
- the exercise of emergency powers to protect children.

Every officer and member of police staff should understand their duty to protect children as part of their day-to-day business. It is essential that officers going into people's homes on any policing matter recognise the needs of children they may encounter. This is particularly important when they are dealing with domestic abuse and other incidents where violence may be a factor. The duty to protect children extends to children detained in police custody.

Many teams throughout police forces perform important roles in protecting children from harm, including those who analyse computers to establish whether they hold indecent images of children and others who manage registered sex offenders and dangerous people living in communities. They must visit sex offenders regularly, establish the nature of risk these offenders currently pose and put in place any necessary measures to mitigate that risk.

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[4] Section 47 of the Children Act 1989, available at: www.legislation.gov.uk/ukpga/1989/41/section/47

[5] Section 17 of the Children Act 1989 places a general duty on the local authority to safeguard and promote the welfare of children in their area who are believed to be 'in need'. Police may find children who are 'in need' when they attend incidents and should refer these cases to the local authority. A child is 'in need' if he or she is disabled, unlikely to achieve or have the opportunity to achieve a reasonable standard of health or development, or if their health and development is likely to be impaired without local authority service provision.

[6] *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015 (latest update). Available from: www.gov.uk/government/publications/working-together-to-safeguard-children--2

To ensure that agencies co-operate to keep children safe and look after their welfare, each local authority must establish an LSCB. The three LSCBs in the Essex force area are made up of senior representatives from all agencies (including the police). They promote safeguarding activities, ensure that the protection of children remains a high priority across their area, and hold each other to account.

5. Findings: the experiences, progress and outcomes for children who need help and protection

During the course of the inspection, Essex Police assessed 33 cases in accordance with criteria provided by HMIC.[7] The force was asked to rate each of the 33 self-assessed cases. HMIC also assessed these cases and identified more weaknesses in practice than the force's self-assessors. Figure 1 below shows the assessments made by the force and HMIC. Inspectors selected and examined a further 40 cases where children were identified as being at risk. Figure 2 below sets out inspectors' assessments in these cases.

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

	Good	Adequate	Requiring improvement	Inadequate
Force assessment	12	16	3	2
HMIC assessment	3	2	8	20

Figure 2: Cases assessed only by HMIC inspectors

	Good	Adequate	Requiring improvement	Inadequate
HMIC assessment	5	3	8	24

During the inspection, 44 cases were referred back to the force by HMIC. Thirty of these cases required immediate action to be taken to ensure that children were protected. We were very concerned that a significant proportion of the cases assessed by both the force and HMIC (23 out of 33) were assessed as good or adequate by the force but were considered to be requiring improvement or inadequate by HMIC's inspectors. We were concerned in particular that the force's assessors had failed to identify weaknesses in these cases and therefore had not taken action to protect the children involved.

[7] The case types and inspection methodology are set out in Annex A.

Initial contact

Inspectors found examples of a good initial response by frontline and specialist staff when there was a clearly defined child protection concern which required immediate attention. These included good examples involving cases of neglect of control room staff acting quickly, obtaining as much information as possible and passing the case to frontline or specialist child protection officers for immediate attention.

In some of the straightforward cases that we examined, officers responded quickly, carried out prompt enquiries, searched for suspects and used their power to arrest where necessary. For example, a member of the public saw a woman striking a young child in the face and shaking the pram. Officers immediately went to the scene and found the mother and child who had a bloody nose. They arrested the mother, gathered evidence and promptly informed children's social care services and specialist child protection officers. This resulted in a joint decision being taken on the action needed to protect the child from further harm and appropriate care being found for him.

We found evidence in some cases that when further action was necessary – for example, a visit jointly with children's social care services or a medical examination – this was organised promptly. There was also evidence that officers were sensitive when undertaking initial contact with a child and in interviews; they engaged well, gaining the support of the parents. Careful attention to this first stage was successful in building a rapport with children. This was evident in the steps taken when an eight-year-old boy who had autism told a teacher that his father had bitten him, leaving him with a mark on his neck. A strategy discussion[8] took place promptly, followed by a visit jointly with children's social care services. The child was listened to and the interview handled sensitively. It was established that he had no injuries and that the incident related to play fighting which the child had not enjoyed. The parents were visited and guidance and support was provided to the family. The investigation plan was also clearly documented.

Inspectors were, however, very concerned about delays in the initial response to domestic abuse incidents. We found significant backlogs in the force control room. Although the force had recognised and made some important steps in reducing this backlog, on 1 September 2015, there were still 120 domestic abuse cases which had not received an appropriately timely police response. The oldest incident dated back

[8] Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm there should be a strategy discussion involving local authority children's social care services, the police, health services and other bodies such as the referring agency. This might take the form of a multi-agency meeting or phone calls and more than one discussion may be necessary. A strategy discussion can take place following a referral or at any other time, including during the assessment process. *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015 (latest update). Available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

to 6 August 2015. Some incidents in the backlog were related to high-risk victims of domestic abuse that should have received a response much sooner. There may have been other cases in this queue involving vulnerable people, including children.

Essex Police had established a domestic abuse intelligence team (DAIT). The team is responsible for updating police records with new information when officers attend a domestic abuse incident. However, due to the high volume of work in the DAIT, staff had not always updated these records, and consequently relevant information had not been passed to frontline officers. This meant that officers had in some cases incorrectly assessed risk when dealing with a domestic abuse incident. In one case, a woman called the police and told them that she was hiding in bushes near her home because her partner had threatened to kill her and her child. The officer found the woman and then spoke to the suspect and told him not to return to the home. However, the officer had not been told by staff in the control room that the partner was a high-risk perpetrator of domestic abuse who had been discussed at a MARAC. This was because that information had not been recorded on police records by the DAIT. Nor had the officer been told that the suspect had previously assaulted two ex-partners and had tried to strangle them. The officer failed to take any action in respect of the threats made by the woman's partner and susequently the suspect returned to the home the following morning and assaulted her.

Officers told inspectors that they routinely recorded the details of children when present at domestic abuse incidents. However, the introduction of a new IT system[9] had removed a prompt for officers to check on the welfare of children. This meant that in some cases details of the children and their demeanour were not recorded on police records. A child's demeanour, especially in those cases where a child is too young to speak to officers, or where to do so with a parent present might present a risk, provides important information about the impact of the incident on the child. It should inform both the initial assessment of need and any referral to children's social care services. Nor did the force undertake routine audits to ensure that checks on children were taking place. Inspectors examined seven cases related to domestic incidents and involving children. In only two was it recorded that the children were seen and their welfare checked. Where officers had failed to record this at the first point of contact, the need for checks was often not identified at a later stage and therefore appropriate referrals for further support were not made to other agencies, such as children's social care services.

Inspectors considered that the force's response to children missing from home was poor. We examined seven cases involving missing children. The force's approach

[9] This is intended to provide a single IT system to manage police investigations, intelligence and defendants (in terms of both custody management and case preparation) across all forces using the new system. The system aims to provide frontline officers and staff with access to more detailed and up-to-date information than is currently the case, while reducing bureaucracy. This is intended to help swiftly build a comprehensive picture of suspects and of crime and incident patterns.

was assessed as good in one case, requiring improvement in three and inadequate in the remaining three. In five of the seven cases, the initial assessment was incorrect and subsequent police actions were poor. This included children being incorrectly assessed as being at a lower level of risk than was warranted by the significant concerns about them recorded on police systems. In addition, important information from multi-agency safeguarding meetings was either not recorded or was not readily accessible to staff. This meant that all relevant information on a child was not drawn together and that risk assessments and subsequent police responses were poor.

For example, a 15-year-old girl was categorised as 'absent' although she was at risk of child sexual exploitation and had been reported missing on 10 previous occasions.[10] An adult man had also been violent to her in the past. Record keeping for this child was poor, and important information from safeguarding meetings had not been recorded on police systems. A trigger plan (a plan to locate a child quickly when he or she goes missing frequently) was not in place, and there was no evidence that longer-term protective measures to reduce the risk to her had been considered. A strategy discussion involving all relevant agencies had taken place in November 2014. However, at the time of the inspection in September 2015, the case file had not been updated to record any action taken to protect her.

We concluded that the initial police response to child protection incidents was inconsistent and a cause for concern. This was due to the inconsistent and sporadic use of child protection 'flags' on police systems, poor record keeping, the lack of recorded and readily accessible information from safeguarding meetings, and problems associated with the introduction of the new IT system. As a result, staff did not have all available information to make an effective assessment of the risk posed to children.

[10] In April 2013, ACPO introduced a new approach to missing persons, involving two categories: 'missing' and 'absent'. A 'missing' person is defined as "anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be subject of crime or at risk of harm to themselves or another." An 'absent' person is defined as a "person not at a place where they are expected or required to be" and people categorised as such should not be perceived to be at any apparent risk. It is expected that cases classified as 'absent' will be monitored by the police and escalated to the 'missing' category if risk increases.

Recommendation

We recommend that Essex Police immediately puts in place an action plan to ensure that as a minimum:

- control room staff assess risks to children, paying particular attention to drawing all relevant information together at an early stage as part of that assessment, and ensure frontline staff are alerted to relevant information;
- incidents are not downgraded or the response delayed without proper justification and without appropriate checks having been made on the welfare of any children involved;
- any concerns about an incident involving children at risk are escalated if police have been delayed in attending; and
- relevant intelligence to assess risk is routinely updated on police systems in a timely manner and is readily available to frontline officers when attending incidents.

Recommendation

We recommend that, within three months, Essex Police ensures that officers always check on the welfare of children and record their observations of a child's behaviour and demeanour in domestic abuse incident records, so that a better assessment of a child's needs can be made.

Assessment and help

There were some good examples of inter-agency work, such as the development of the multi-agency safeguarding hub (MASH) in Thurrock and the joint domestic abuse teams (JDATTs) in Southend and Essex. There were also examples of agencies working well together – identifying risks, making plans to reduce these risks and supporting children and families. The MASH had improved the flow of information between partners about children at risk of harm. For example, a 17-year-old boy reported that he had been assaulted by his mother and step-father. A timely strategy meeting was held in the MASH and a joint visit took place to see the boy and his parents. The safety of the boy and a sibling was considered by police and social workers. Evidence was gathered to support a prosecution, such as taking photographs of the boy's injuries. His views were sought and he was listened to throughout the investigation.

We were, however, concerned to find that Essex Police did not have a standard procedure for frontline officers to pass on child protection concerns. Officers reported concerns about children through a variety of methods, such as in person or by email or a phone call to a child abuse investigation team (CAIT). There was no standard risk assessment and no visible audit trail or oversight of these referrals. HMIC considers this to be poor practice and inspectors could not determine whether information had been passed on to the MASH or a CAITs, nor whether risks had been identified and action taken.

Inspectors found that the procedures for domestic abuse cases applied in the MASH in Thurrock provided an adult and child-focused service and that staff in the MASH routinely conducted prompt assessments and considered early help for children. However, the multi-agency JDATTs in Southend and Essex provided a less effective service. The JDATTs were solely responsible for adult domestic abuse cases, without a specific focus on child protection matters such as assessing the risk to the child and considering early intervention. The force and partner agencies recognised that the difference in ways of working between the MASH and JDATTs was an area that required improvement and further development was underway. However, the difference in local authority and multi-agency partnership arrangements that inspectors observed mean that, until this has been addressed, safeguarding practices for children across Essex Police will be inconsistent.

Essex Police had recently removed a triage risk assessment for medium risk domestic abuse incidents and had given responsibility to frontline staff to make the initial risk assessment on both these and standard (lower) risk cases, with no specialist assessment being carried out in the DAIT. However, we found that frontline officers had not been made aware of this change. Frontline staff and their supervisors were unsure of their responsibilities or how to properly discharge them. They did not have access to all relevant information to enable a full assessment to be made of the risks to victims. This meant that cumulative risk might not be identified, leaving victims and children at risk.

Furthermore, we found cases where vital information had not been recorded. It was apparent from minutes of MARAC meetings and cases we examined that referrals had not been made to children's social care services at the time of incidents. As a result, immediate safeguarding measures required to keep children safe were not routinely being considered until some time after concerns were raised.

In March 2015, due to a significant increase in the number of high-risk domestic abuse cases, a backlog had developed for cases to be discussed at a MARAC. This had led to delays of up to 12 weeks at the time of the inspection in September 2015. To address this, the force and partners had introduced a preliminary meeting to filter cases. However, attendance was often restricted to the police, probation service and

children's social care services. We were concerned that this meeting was not effective because it did not have the same wide range of involvement of other agencies as the established MARACs.

The force reported that the MARAC Joint Operational Governance Group had commissioned three evaluations of the effectiveness of the JDATTs from senior members of children's social care services, SafeLives, and the manager responsible for multi-agency public protection arrangements (MAPPA). However, inspectors were not provided with any evidence that the force had evaluated the effectiveness of the new practice. HMIC had serious concerns about this new procedure, finding a number of cases which should have been discussed at a MARAC but which were not. For example, a case involving a woman who had been assessed as being at a high risk of harm was initially filtered out at a preliminary meeting and was not therefore considered at that stage at a MARAC. It was not until she reported that she had been raped by her partner that the case was referred to a MARAC and a safeguarding plan put in place.

HMIC also had serious concerns about the failure to undertake strategy discussions for children in need of protection. Strategy discussions were relevant in 62 of the cases that inspectors examined. In 42 of these, there was no evidence that a strategy discussion or meeting had taken place with children's social care services or that information had been shared with them. Any joint plan to investigate the case and safeguard children had not been recorded on police systems. In cases where strategy discussions had taken place in the early stages of an investigation, further meetings to review progress had often not been held. We concluded that, in these cases, it was unclear how well agencies had worked together to safeguard children effectively. When information is not readily available, it is difficult to draw information together to assess the risk to children. This can result in poor decision making and a failure to protect children from further harm.

As noted in the case of the missing 15-year-old girl above, Essex Police did not always consider the use of trigger plans when children go missing. This meant that crucial information to aid officers to locate children was not available. Furthermore, we found that children were not always flagged on police records to highlight the risk of sexual exploitation. In many of the cases involving missing children that inspectors examined, the risk of sexual exploitation was not recognised. As a result, children who were clearly at significant risk were not appropriately assessed and action to locate and safeguard them was not accelerated.

For example, a mother was concerned about her 15-year-old daughter who was considered to be at a high risk of sexual exploitation and frequently went missing from home. She reported that her daughter was returning home with large amounts of money and feared she was selling sex. Essex Police had also received intelligence that her friends were at risk of sexual abuse. Three months after these concerns were raised, there was still no record of a joint plan to protect the girl, she

was not flagged on police records as at risk of sexual exploitation and there was no trigger plan in place to escalate activity should the girl go missing again. Furthermore, there was no investigation of the steps that had been taken following a report of sexual assault against her, nor of the other vulnerable children identified at risk in this case.

We found a lack of recognition and understanding by frontline staff of the warning signs that children were at risk of sexual exploitation. We were also concerned about inappropriate language on police records which failed to recognise the risk to a child. On one record, for example, an officer had written 'the female is thought to be a high risk CSE victim, but is independent and savvy enough to look after herself and is street smart'.

As noted in the earlier section on 'Initial contact', the force's initial response to missing children was poor. We also found that police and multi-agency intervention in these cases was very inconsistent. Staff lacked understanding of the need for and benefits of early assessment and intervention for children who frequently go missing or who are recorded as absent. The force had created six missing person liaison officers (MPLOs), two of which were located in each LPA. However, we found inconsistencies in their roles in practice across the force. For example, MPLOs attended strategy meetings for missing children at their discretion. However, these officers had not been trained in, or had guidance been provided to them about, specialist child protection matters. They were therefore unable to contribute effectively to safeguarding meetings to protect children. In one case, a child had been reported missing 40 times and no strategy discussion had been held or multi-agency plan put in place to protect the child from harm. The MPLO had not understood that a strategy discussion at an early stage should have taken place.

We were also concerned about the lack of independent return interviews for children who go missing from home. These interviews (which may be provided by a children's charity) can provide a wealth of information about the reasons why children are running away, particularly where this is becoming more frequent and the child is reluctant to speak to police or other agencies. The local authority is responsible making arrangements for return interviews. Some progress had been made. A position had recently been funded by the force, for Barnado's to assist with return home interviews of vulnerable children within the Essex local authority area. In addition, a more recent venture between the police and crime commissioner, the force and the Children's Society provided child sexual exploitation support workers to engage with children at risk of exploitation, including those who repeatedly go missing.

Whilst return interviews were conducted for children in local authority care, this service was not in place for all children. HMIC was told by the force that there were plans to extend the service; however, arrangements were not in place at the time of the inspection and timescales for implementation were uncertain. Frontline staff

expressed frustration about the largely reactive approach to children who were frequently reported missing or absent.

HMIC was pleased to find that the force had recently improved police attendance at initial child protection conferences (ICPCs),[11] although attendance remained variable across the force area. Between June and August 2015, police attended 85 percent of ICPCs and 49 percent of review conferences. Attendance at ICPCs varied from 97 percent in the south area to 85 percent in the west of the force. Essex Police and children's social care services across the force area had recently agreed that police would attend only those cases where they were involved. Despite this, among the cases we examined were ones where police should have attended case conferences but had not. In addition, there had been no evaluation to assess the impact of this change in practice. HMIC concluded that Essex Police did not always fulfil its responsibilities to attend child protection conferences when required to do so in accordance with the statutory guidance Working Together to Safeguard Children.

There is a sexual assault referral centre[12] (Oakwood Place) in the force area, which provides a service for children who have been sexually abused. It offers support and supplies information about services provided by other agencies. However, the provision of independent sexual violence advisors for children across the force area is limited. Paediatric cover in Essex has reportedly been problematic for some time. The force has worked with partners to improve the hours in which the forensic examinations can now take place. This includes a number of hours at weekend, in addition to Monday to Friday. While Essex has worked hard to improve services for children, staff reported that examinations at night are delayed and children have to travel long distances in order to receive paediatric care. This is not in the best interests of vulnerable children who have experienced a traumatic event.

[11] Following section 47 enquiries (see chapter 4 above), an initial child protection conference brings together family members, the child, where appropriate, and those professionals most involved with the child and family, to make decisions about the child's future safety, health and development. If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth. *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015 (latest update). Available at: www.gov.uk/government/publications/working-together-to-safeguard-children--2

[12] A sexual assault referral centre provides services to victims of rape or sexual assault regardless of whether the victim reports the offence to the police or not. These centres are designed to be comfortable and multi-functional, providing private space for interviews and examinations, and some may also offer counselling services.

Recommendation

We recommend that Essex Police immediately undertakes a review, together with children's social care services and other relevant agencies, to ensure that the police are fulfilling their responsibilities as set out in Working Together to Safeguard Children. As a minimum, this should cover:

- attendance at and contribution to strategy discussions and initial child protection conferences;
- recording and communicating decisions reached at meetings; and
- how partner agencies refer child protection matters to the police, with a view to reducing delays and improving the timeliness of assessments.

Recommendation

We recommend that, within three months, Essex Police takes steps to 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, in particular in those cases where absences are a regular occurrence;
- improving staff awareness of the significance of drawing together all available information from police systems, including information about those who pose a risk to children, to better inform risk assessments;
- ensuring that staff are aware of the need to pass this information on to other agencies; and
- providing guidance to staff that identifies the range of responses and actions that the police can contribute to multi-agency plans for protecting children in these cases.

Recommendation

We recommend that, within six months, Essex Police:

- takes steps with partners to ensure timely forensic medical examinations are conducted in sexual abuse cases involving children;
- undertakes a review of the initial risk assessment process in domestic abuse cases to understand whether processes are consistently applied by staff and to ensure cumulative risk to children living with domestic abuse is identified and addressed; and
- takes steps with partner agencies to evaluate its current MARAC arrangements, including preliminary meetings to filter cases, to ensure that vulnerable people including victims and children are protected at an early stage.

Investigation

There were some examples of good investigations, particularly when cases were straightforward and the suspect was easy to identify. Officers considered the best approach for interviewing children, seeking evidence from a range of sources and making good arrangements to pursue and apprehend those responsible for causing harm.

For example, a neighbour alerted police that children were leaning out of an upper floor window and their mother appeared to be drunk. Police attended promptly, gained entry to the house and found the mother drunk. Steps to safeguard the children were taken immediately and they were placed in foster care, and the mother was arrested. Decisions and actions taken jointly with children's social care services were effective and clearly recorded on police systems.

Essex Police had invested in deploying a significant number of additional staff to child abuse investigations. As described in the earlier section, ‘Context for the force’, there are three specialist child abuse investigation teams (CAITs), one in each LPA. However, we found that almost half of the officers in the CAITs were not trained in safeguarding children and did not have experience of undertaking child protection investigations. HMIC acknowledges the difficulties raised by deploying additional staff in CAITs and in providing them with the essential training required for this role and recognises the efforts the force have taken, such as the introduction of an induction programme, a “buddy” system and ensuring all new officers commenced the detective induction training. However, we were concerned that these officers did not have the knowledge, experience and training to safeguard children effectively. For example, thresholds for sharing information with partner agencies and working jointly with children’s social care services were not well understood. As noted above,

attendance at strategy discussions was often poor because of a lack of awareness about when these should be undertaken. As a consequence, Essex Police was failing to comply with the statutory guidance Working Together to Safeguard Children. While HMIC recognises that the force had invested in additional supervisory officers in order to manage the deployment of additional staff, this had not changed practice. Effective support and case management were not in place. Supervisors reported that as a result of heavy workloads, they were unable routinely to supervise investigations and therefore no quality assurance of cases and limited development of staff took place.

Most of the investigations assessed by inspectors were considered to be inadequate or requiring improvement. Although there were examples where immediate safeguarding concerns were considered, in the majority of cases officers failed to recognise wider risks – such as the identification of other children who were being abused and suspects who posed a risk to other children.

We found cases lacked action to progress investigations, unnecessarily long delays and little evidence of any meaningful supervision. These problems were compounded by a lack of inter-agency work and resulted in failures to safeguard and protect children. In many of the cases we examined a single-agency investigation by children's social care services was conducted, despite the criteria for a joint investigation with police having been met.

For example, in July 2015 the mother of an eight-year-old girl reported that her daughter had been raped by a number of boys, aged ten and eleven and who attended the same school. It was decided in a strategy discussion that the case should be investigated by children's social care services without police involvement. The child was not interviewed or forensically examined and no police investigation was initiated at this stage. Following a further complaint and more victims being identified in August 2015, it was decided that the child should be forensically examined at the SARC. This development still did not trigger a police response and the matter continued to be pursued in isolation, with children's social care services investigating the case without police involvement. It was only when the matter was reviewed at the end of September 2015 that a police supervisor intervened and directed police officers to investigate the case. HMIC was concerned to find that this was not an isolated case but common practice.

Furthermore, Essex Police did not have a multi-agency specialist team to tackle sexual exploitation and these investigations were handled by different teams across the force. However, officers did not have the experience or skills to manage these cases effectively. We examined 12 cases involving the sexual exploitation of children and assessed the force's approach to be adequate in one, requiring improvement in one and inadequate in ten. We found that there was a failure to identify other victims and to arrest offenders, poor recording and unacceptable delays, compounded by a lack of supervision of cases and their progress.

There were other delays in investigations, including in cases investigated by the police online investigation team (POLIT), in digital forensic examinations and in preparing cases for court.

The POLIT investigates all cases referred by the National Crime Agency's Child Exploitation and Online Protection Command and by other forces, and other cases at the discretion of supervisors. The remit of the team was restricted to cases where the suspect had a known address in the force area. If a suspect's address was unknown, or they lived outside the force area, investigations were carried out by non-specialist teams. As a consequence, some victims of online child sexual exploitation received a different level of service.

HMIC was concerned to find significant delays of up to 18 months in cases investigated by the POLIT. We found cases had taken too long to progress. Officers reported that workloads were unmanageable, contributing to unacceptable delays. In the cases we examined, victims and suspects had been identified but had not been spoken to, and further investigative and safeguarding actions had not been taken to protect them. For example, in one case, an adult man contacted a 15-year-old girl offering cash in return for sex. The initial response was slow and lines of enquiry were not expedited despite a number of other victims being identified. It was four months before basic research was undertaken and it was only at this stage that the suspect was identified as an employee working for children's social care services. He had accessed information relating to domestic abuse victims through workplace computer systems and had attempted to make contact with their children to groom them as he knew they were vulnerable. Twenty three other profiles that were potentially those of children were identified, in which parents or carers had not been contacted by the force. Supervision of this case was poor, the investigating officer had twice been changed and there were repeated references recorded on police systems that excessive workloads had led to delays.

Although HMIC's sample size was small, we were concerned that governance and oversight of the POLIT was inadequate and that senior officers had not identified these significant failings.

The force's digital forensic unit is responsible for the analysis of computers and digital media. We found that there were significant backlogs; the oldest case was 12 months old. At the time of the inspection in September 2015, there were 53 cases awaiting examination. The force was taking nearly twice as long as it aimed to complete examinations. We were, however, encouraged to find that the force was working to reduce the backlog and had invested £35,000 in outsourcing work to external companies. In addition, the force had recruited additional staff and extended the unit's operating hours.

A protocol and good practice model,[13] supported by a range of agencies including the police and local authorities, describes the manner and timescales in which third party material (such as information held by children's social care services) is applied for, secured and produced in criminal and family court proceedings. There was confusion in Essex Police about what material should be applied for, who would provide it and the timescales for this to take place. The time taken to obtain information required by the courts from partner agencies had resulted in significant delays in securing charging decisions from the Crown Prosecution Service (CPS). The force had not escalated this issue to partners at the time of the inspection.

A protocol with the CPS had been introduced to expedite cases involving children under 10 years old through the criminal justice process. The protocol provides guidance about the use of intermediaries[14] where appropriate. Inspectors found in the cases examined for this inspection that this protocol had been misinterpreted and applied incorrectly. Children who did not need an intermediary had waited 10 weeks to be interviewed due to a lack of trained intermediaries being available; they could have been interviewed much sooner.

Staff reported significant delays in sexual offences cases sent to the CPS to review and decide on any charges. We were informed that senior officers had raised the issue with the CPS but the problem persisted.

Notwithstanding the delays described above, we were very concerned about the general poor standard of most child abuse investigations. Overall, we concluded that too many cases fell significantly short of the standards required for an effective investigation. Cases were closed without an investigation or were investigated in isolation by social workers or by police without the involvement of children's social care services when they should have been involved. Many investigations took too long to progress, with poor supervision, and this resulted in a lack of protection for victims, reduced victim confidence, the loss of evidence and a failure to address the

[13] The *Protocol and Good Practice Model* aims to facilitate the timely and consistent disclosure of information and documents between the local authorities, the family justice system, the police and the Crown Prosecution Service. It is intended to provide a more streamlined and standard process, thereby expediting court hearings. *2013 Protocol and Good Practice Model – Disclosure of information in cases of alleged child abuse and linked criminal and care directions hearings*, published jointly by the Association of Chief Police Officers, the Association of Directors of Children Services, the Association of Independent Local Safeguarding Children Board Chairs, the Crown Prosecution Service, the Department for Education, HM Courts and Tribunals Service, the Local Government Association, the President of the Family Division, the Senior Presiding Judge for England and Wales, and the Welsh Government, October 2013. Available at: http://library.college.police.uk/docs/APPREF/Protocol-and-good-practice-model-2013.pdf

[14] An intermediary facilitates communication between the police, prosecution and defence legal teams and/or the court and a witness to ensure that the communication process is as complete, coherent and accurate as possible. The intermediary is impartial and neutral and their duty is to the court.

continuing risk from offenders. Although the force had increased capacity in its CAITs, it still has much more to do to improve the standards of investigations.

Recommendation

We recommend that Essex Police immediately acts to improve child abuse and child sexual exploitation investigations with particular attention to:

- staff awareness, knowledge and skills;
- responding promptly to concerns raised;
- risk assessments that consider the totality of a child's circumstances and risks to other children;
- how the force identifies, disrupts and prosecutes perpetrators involved in child sexual exploitation;
- the capacity of investigators;
- the audit, supervision and management of cases;
- improving governance in the POLIT; and
- the 2013 protocol and good practice model to secure third party material in a timely manner.

Recommendation

We recommend that Essex Police continues its discussions at a senior level with the CPS to address delays in advice and charging decisions.

Decision making

There were some examples of effective decision making by frontline staff to protect children, such as in circumstances which involved removing a child from their family. It is a very serious step to take a child into police protection and we found that some cases were handled well to safeguard children. For example, police were called to a young child walking in bare feet in the street and wearing pyjamas. Officers quickly established where the child lived and returned him home. The officers checked the child’s living conditions and gave advice to the family. A prompt referral was made to children’s social care services.

As noted in previous sections, inspectors were very concerned about the poor standard of recording on police systems across the force. Accurate and timely recording of information is essential for good decision making in child protection matters. Important information was often missing or there were delays in recording it

on the system. This included delays in recording the outcome of strategy meetings (minutes were often not taken) and failures or delays in updating records of the progress of an investigation. In addition, details of contact with children and families were often not recorded. In the majority of investigations that we examined for this inspection, inspectors found significant failings to record information.

The force's new IT system had seriously impeded its productivity and ability routinely to access information to inform and manage risk effectively. We found that information on child protection cases was recorded in multiple places, including paper files and various separate IT systems. Important information had not been transferred to the new system and as a consequence was not readily accessible to all staff conducting research to assess risk to make effective decisions. This is a significant threat to the force's ability to protect vulnerable children. We were told by frontline officers that the processes for assigning tasks within the new system were overwhelming, with one supervisor having a list of 500 actions.

Taken together, the significant concerns identified in previous sections of this report – including inconsistent risk assessments and poor judgment in the control room; inappropriate allocation of cases to non-specialist staff; poor recording and lack of ready access to crucial information on police systems; delayed and inadequate investigations and failure to understand wider risks – are indicative of a failure by Essex Police to make consistently good decisions to protect children.

Recommendation

We recommend that Essex Police takes immediate steps to ensure that all relevant information is properly recorded and readily accessible in all cases where there are concerns about the welfare of children and, as a minimum, provides guidance to staff on:

- what information (and in what form) should be recorded on systems to enable good-quality decisions;
- the value and relevance of ensuring that records are made promptly and kept up to date; and
- carrying out quality assurance checks on records and providing feedback to police officers and staff.

Trusted adult

In some cases, it was clear that when the concern was serious and immediately recognised as a child protection matter, the approach to the child or parents was carefully considered, and the best ways to engage with the child were explored.

This was evident, for example, in the case of a seven-year-old boy who his aunt believed had been assaulted and neglected by his mother. The child was listened to by officers throughout the case and the timing of a formal interview was carefully considered to ensure it had the least impact on him. When the child later decided he did not want his mother to get into trouble, other options were considered to safeguard him. Officers engaged with the family to ensure the outcome was in his best interests and he was protected from further harm.

Inspectors found that because of poor recording practices it was difficult to assess in many of the cases we examined whether a child had been listened to, or whether any support had been provided to them and their families. In most of the cases assessed, police officers recorded very little about the views of the children involved, the effect of an offender's behaviour on a child or the outcomes for the children.

Moreover, in some cases, police behaviour did not gain the child's trust and children were not listened to or believed. For example:

- a 15-year-old girl reported that her mother had tried to strangle her and had injuries that corroborated her complaint. She told officers that this had happened before and that this assault had been witnessed by a friend. The child and witness were interviewed and the child's injuries were photographed. The mother was arrested and interviewed. She denied the assault and also told officers that she thought her daughter was being sexually exploited. The case was reviewed by a sergeant who decided that no further action should be taken as the mother had 'provided a full account, was credible and the injuries minor'. The child had not been believed in this case and her views were not recorded. In addition, no further action was recorded in respect of the sexual exploitation concerns;

- a 13-year-old boy attended school and reported he had been assaulted by his mother again, and had a bruise on his leg. The family were known to children's social care services and a case conference was due to be held. A sergeant reviewed the case and directed that children's social care services should continue the investigation without any police involvement. The child told a teacher that the bruise had been caused because his mother had restrained him but he subsequently withdrew the allegation. Case conferences were held but police did not attend. Inspectors found information held by the force in paper records relating to the child that revealed there had been previous serious concerns for the child, and that his mother had

admitted assaulting him in the past. It was also reported that she felt overwhelmed with emotion and once she started to hit him, she was unable to stop. She had further disclosed pushing him out of a stationary car during one outburst. This information had not been shared by Essex Police or considered throughout this case, and left the child at significant risk of harm.

Essex Police has much more to do to show that it understands the behaviour of adolescents and children with troubled lifestyles, and to consider more options for the best approaches to support these children. Gaining the trust of children who do not always consider themselves at risk or regard themselves as victims can take time.

Recommendation

We recommend that, within six months, Essex Police:

- records the views and concerns of children;
- records any available outcomes at the end of police involvement in a case;
- informs children, as appropriate, of decisions made about them; and
- ensures that information about children's needs and views is regularly made available for consideration by the police and crime commissioner, and to service managers, to inform future practice.

Managing those posing a risk to children

Essex Police has a dedicated unit to manage known registered sex offenders (RSOs): the dangerous offender management team (DOMT). Inspectors found that there was a backlog of intelligence reports waiting to be recorded on the Visor system (a national computer system to manage RSOs). In addition, we were told that there were significant delays in conducting visits to RSOs. This was caused by staff shortages, the introduction of an enhanced risk assessment and complications with Visor and non-compatible local IT systems. Additional staff had been recruited but a backlog of 50 visits remained at the time of the inspection. This risk had been identified by the force and was being reviewed on a daily basis and we were encouraged to find there had been some reductions in the backlog.

Inspectors were pleased to find that the force routinely and proactively monitored RSOs. Essex Police frequently deployed covert resources from other teams in the force to ensure conditions attached to sexual harm prevention orders[15] (SHPOs)

[15] A sexual harm prevention order can be made under the Sexual Offences Act 2003 by a court in respect of an individual who has been convicted, or cautioned for a relevant offence and who poses a

were being adhered to. The force also used remote monitoring software to assess and limit RSOs' internet activity. Staff reported that applications for SHPOs were processed swiftly due to the efficiency of the force's legal service team. Nevertheless, we found that apart from those specifically targeted, there were another 600 sex offenders with restrictions under a sexual offence prevention order (SOPO).[16] Staff reported that these offenders were not being actively managed. For example, a SOPO had been sought in respect of an RSO, who had previously been convicted of the rape of a five-year-old child, because the offender reported that he had had thoughts of sexually abusing children and was visiting parks. This was supported by intelligence gathered by the force. A SOPO was granted two months later but there was no record to show that local officers were either made aware of this or were engaged in any action to ensure that the conditions applying to this dangerous sex offender were managed, despite his ongoing risk to children.

Although RSOs were flagged on police systems so that frontline staff could be made aware of those living in their area who posed a risk to children, we found practice was inconsistent across the force. Staff reported that they were not aware of all RSOs living locally.

Multi-agency public protection arrangements (MAPPA) include meetings to share information to support multi-agency risk assessments and formulate effective risk management plans to manage the risk of serious harm posed by dangerous offenders, including RSOs. We were very concerned about the operation of these arrangements in Essex. Meetings were not well-attended by agencies and minutes of meetings indicated that the force was not represented at the appropriate level of seniority. This was found on occasions to be a member of police staff, rather than at the nationally agreed appropriate senior officer level.[17] In addition, few other key agencies were present when their input would have been critical to creating an effective risk management plan to protect vulnerable people, including children, from those posing the most risk of harm. We examined the minutes of six meetings and found the response to the management of risk in the cases assessed to be inadequate overall.

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risk of sexual harm to the public in the UK or children or vulnerable adults abroad. It may impose any restriction the court deems necessary for the purpose of protecting the public from sexual harm.

[16] A civil order previously available under the Sexual Offences Act 2003, prior to its amendment by the Anti-social Behaviour, Crime and Policing Act 2014 which made provision among other things for sexual harm prevention orders.

[17] Guidance issued by the Ministry of Justice sets out appropriate levels of seniority for both the chairman and attendees at MAPPA meetings. The meeting should be chaired by a police or probation representative of senior rank. The level of seniority required for police chairmen or attendees varies depending on the level of risk posed by the offenders being considered. In some instances, an inspector (or equivalent) will be required; a superintendent (or equivalent) is required for those offenders posing the highest risk of harm. See further at: www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2

For example:

- an offender had been released from prison after a nine year sentence for committing multiple rapes. The level of risk posed by him was not recorded in the minutes of the meeting. The meeting was not well-attended by agencies, with only Essex Police and the probation service present. We were concerned to find that there was no children's social care services representative or officers from the area where the man had been released. An action from a previous meeting for the police to inform victims about his impending release had not been completed and the man was living back in the community. His victims had not been warned or given the opportunity to prepare themselves for his release.

- an offender was due for release from a mental health institution after three years detention for treatment in hospital, following his diversion by the court from prison. He was described as a very volatile young man with a history of violence, arson, possessing offensive weapons and sexually harmful behaviour towards children. The primary concern of the meeting was the management of the offender's mental health and the risk he posed in the community. The meeting was not well-attended; there was no representative from children's social care services or an officer from the area into which he was to be released. The police representative was not a police officer but a member of police staff and the meeting was not chaired by a senior probation or police officer as set out in national guidance. There was little recorded information about the risk posed by this offender or the plan to manage him in the community.

The force highlighted high-risk sex offenders at daily management meetings held at different levels within the force, but there was little wider management either of those suspects on bail or those being sought because they had been linked to child protection related offences. Therefore, aside from those specialist officers who managed sex offenders, there was limited knowledge or management of perpetrators who posed a risk to children.

Inspectors were pleased to find that the force had developed its response to tackling child sexual exploitation. We found examples of intelligence being developed and appropriate resources being deployed to pursue suspects. The force had started work to embed child protection and activity to disrupt child sexual exploitation into its covert intelligence unit; this included gathering intelligence by debriefing registered sex offenders and children believed to be at risk. However, as mentioned in the earlier section on 'Investigation', we were concerned about the inadequate management of investigations and lack of specialist staff to manage cases.

Although on some occasions officers took action against suspected perpetrators of child abuse, in most cases this was unacceptably slow. In 33 cases examined by inspectors an immediate arrest in relation to a child protection matter would have been appropriate. However, this took place in only eight of those cases. This failure was more pronounced in child sexual exploitation cases: in all 10 cases examined of this nature, there were delays either to make arrests or to take steps that would have made an arrest possible. When children did not support prosecutions, little action took place. This should not have prevented officers from obtaining intelligence, identifying suspects and determining the risk they posed to other children.

Some of the cases examined were of grave concern. For example, the mother of an 11-year-old girl reported that a 28-year-old man was contacting her daughter through the internet, using very sexualised language towards her and trying to arrange a meeting with her. There were clear lines of enquiry to identify the man. However, a dispute took place between two teams in the force as to who should investigate the case. It was not until 17 days later that a senior manager reviewed the case and directed that a crime should be recorded and that the POLIT should investigate the case. Over a month later, with no details of progress recorded on police systems in the meantime, the suspect was identified as an RSO who intelligence identified had previously attempted to entice three 10-year-old children into his home, where he had equipment that he had intended to use to commit sexual offences against them. Three months after the original report, the mother of the victim contacted the police and told them that the man's profile was still on Facebook and he had continued to contact young children. The man was finally arrested two days later. The poor standard of investigation, including unnecessary delays, meant that the case continued for a further 12 months. As a consequence, evidence was lost, exhibits were not examined and key witnesses were neither traced nor interviewed. Further offences linked to this dangerous offender were identified but no action taken.

Recommendation

We recommend that Essex Police takes immediate action:

- to reduce the delays in visiting registered sex offenders and to improve the management of and response to other offenders who are subject to restrictions under a sexual offence prevention order; and
- to undertake a review with partners to ensure attendance at MAPPA is at a suitable level to support the creation of effective action plans to protect vulnerable children from those who pose the most risk of harm.

Police detention

Inspectors were pleased to find that Essex Police operated specific vehicles to respond quickly to incidents involving a person showing signs of mental health issues and that any children in this position were taken to a dedicated youth mental health facility. We found there had been no children detained under section 136 of the Mental Health Act[18] in the last five months.

HMIC examined six cases of children in detention. The youngest were 13 years old; the oldest was 17 years old. Five were boys, and one was a girl. They had been detained on suspicion of offences that included burglary, robbery, criminal damage and assault. Inspectors assessed one case as requiring improvement and five as inadequate.

When a child is held in custody, typically overnight, having been charged, the custody officer should complete a detention certificate to present to the court to explain the circumstances. The requirements for completing this certificate were met in all six cases we examined. However, we found that the form had been completed in only three of them. Consequently, important information, such as the justification for detaining the child in police custody overnight, was not recorded or shared with the court.

Inspectors were concerned to find poor record keeping in the cases examined. Important information setting out the legal grounds for the serious step of detaining a child, the rationale for refusing bail, the reasons for delaying contact with others (such as an appropriate adult), and an explanation as to why a child was not transferred to local authority accommodation when required, was often not recorded. For example:

- a 13-year-old boy with a history of self harm was arrested in connection with a robbery. On arrival in the custody suite he asked for a solicitor and for his mother to be informed of his arrest. The child was not told about his rights whilst in custody and was placed in a cell. There was no record of the rationale for placing him in a cell (rather than a detention room) or for failing to inform him of his rights. Two reviews of his detention took place, but he was still not informed of his rights or entitlements. There were also delays. It was, for example, three hours before he was allowed to speak to his mother, and again the reason for the delay was not recorded. When a decision was later made that the child should remain in custody, the rationale and grounds were unclear on the police record.

[18] Section 136 of the Mental Health Act 1983 allows a police officer to remove an apparently mentally disordered person from a public place to a place of safety. Although a place of safety can include a police custody suite, these should only be used in exceptional circumstances and it is preferable for the person to be taken directly to health facilities such as a hospital.

HMIC concluded that children were being detained unnecessarily in police cells overnight. In the six cases examined, all of the children were under 17 years of age and all were charged and refused bail by the custody sergeant. In these circumstances, the local authority is responsible for providing appropriate accommodation if a child is to be detained. It should only be in exceptional circumstances (such as during extreme weather) that transfer of the child to alternative accommodation would not be in his or her best interests.

In none of the cases we examined were children transferred into the care of the local authority. In rare cases, secure accommodation might be needed if the child poses a high risk of serious harm to others. However, there was a lack of knowledge on the part of custody staff about when secure accommodation might be required.
We found that in all six cases we assessed children had been remanded in police custody when the threshold had not been met, and either residential (non-secure) care places should have been requested at a much earlier point or the child should have been considered for bail. In only one case had custody staff made a request to the local authority for accommodation after a decision to refuse bail, and that was (incorrectly) for secure accommodation.

In this case, a 13-year-old girl had been arrested for causing damage to her mother's patio window. This was the child's first offence. She was held in custody overnight when secure accommodation was, incorrectly, requested. No rationale was recorded for requesting this type of accommodation, alternatives to bail or arrest were not considered and the child spent 19 hours in custody before the case was withdrawn at court the next day.

HMIC was told that the provision of alternative accommodation for children had been escalated to the relatively new Essex Police Youth Strategy Board. Discussion was underway with managers from the Youth Offending Service and Family Operations in Essex County Council, and some progress had been made to provide non-secure accommodation. No action had been taken in respect of provision in either Thurrock or Southend. The matter had not been raised at the LSCBs to address the risk posed to children and young people.

The appropriate adult scheme[19] for the area covered by Essex County Council had been re-contracted to Open Road for 12 months from 1 April 2015, replicating the previous contract. Essex Police were not engaged in this arrangement and had not been consulted about it. The specification is for Open Road to provide an appropriate adult service between 7.00am and 11.00pm every day. The lack of

[19] An appropriate adult is a parent, guardian or 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 police whenever they detain or interview a child or vulnerable adult. They must be present for a range of police processes, including intimate searches, and identification procedures, to safeguard the interests of children detained or questioned by police officers.

provision overnight means that children are being unnecessarily detained in custody. For example, in one case, the mother of a 17-year-child was contacted at 7.30pm but refused to attend the police station. The appropriate adult service was not called until 9.16am the following day.

Recommendation

We recommend that, within three months, Essex Police reviews how it manages the detention of children. Essex Police should request the assistance of children's social care services and other relevant agencies in this review. The review should include, as a minimum, how best to:

- improve awareness on the part of custody staff of child protection, the standard of risk assessment required to reflect the needs of children, and the support they require at the time of detention and on release;
- assess at an early stage the likely need for secure or other accommodation and work with children's social care services to achieve the best option for the child;
- ensure that custody staff comply with statutory duties and complete detention certificates to the required standard if children are detained in police custody for any reason;
- ensure that custody staff make a record of all actions and decisions on the relevant documentation; and
- secure adequate appropriate adult provision in the force.

6. Findings: leadership, management and governance

Protecting vulnerable people is a priority for the force and the PCC and is reflected as such in the police and crime plan.[20] The chief constable, his chief officer team and the PCC all have a strong commitment to child protection and there was clear evidence of work progressing at a strategic level to improve the force's ability to manage identified risks concerning the safeguarding of children.

In January 2015 Essex Police identified that child protection investigations in one area within the force had fallen significantly below the standards expected. The force subsequently referred a number of cases to the IPCC for investigation. The chief constable gave his public commitment to a full review of the force's child protection arrangements to ensure that the force was appropriately responding to and protecting children in all three LPAs.

HMIC acknowledges that this review by the force demonstrates a commitment to improve the safeguarding of children and it is encouraging that Essex Police is working towards a better understanding of the demand within public protection to design future services. However, during our inspection, HMIC found that the existing structure had created some inconsistencies in standards of practice across the force area. This was exacerbated by a significant lack of cohesion between the crime and public protection command and the three LPAs on child protection matters. Local senior officers were not aware of critical public protection matters in their area and considered that child protection arrangements were the sole responsibility of the crime and public protection command. It was not possible to assess at the time of the inspection whether the review will provide the force with a more consistent framework to meet the needs of children effectively. We found some examples of visible leadership, such as the recent concerted drive to change the strategic direction of the force and provide more focus on public protection, working more closely with partners better to protect children. Many staff we spoke to were clear that protecting children was a priority for the force and that senior officers in the newly formed crime and public protection command had taken some important steps to improve standards since its implementation in January 2015. However, overall, we found that the ambitions and aspirations of chief officers were not being realised in child protection practice on the frontline.

Essex Police had introduced a series of mandatory computer based child protection training packages for officers and staff. In addition, a three-day face-to-face safeguarding training course had started to be provided to staff, a necessary step to improve awareness of child protection matters. Nevertheless, we were concerned

[20] The police and crime plan for Essex is available from www.essex.pcc.police.uk/

that this crucial training was scheduled to take two years to deliver to all frontline staff. Almost half of child protection staff had not been trained in the specialist child abuse investigator development programme, although there was a plan in place to achieve this over a 12-month period.

Throughout the inspection, it was apparent that some staff responsible for managing child abuse investigations were committed and dedicated to providing the best service for the child. Inspectors witnessed some good examples of child protection work by police officers, who displayed a mix of investigative and protective approaches. This ensured that safeguarding children remained central to their efforts while all criminal investigative opportunities were pursued.

Force governance arrangements for public protection had been recently developed to provide better oversight and scrutiny and to improve performance. Force and local tasking meetings had been refocused, but we found that a structure for daily meetings to enable the better management of child protection cases was ineffective because the crime and public protection command and three LPAs were not aligned. Meetings were conducted in isolation and consequently public protection matters did not feature in the daily LPA meetings. A monthly child and public protection improvement board had been implemented, to provide the force with better oversight of action plans and development work underway. However, these changes in governance had not translated into tangible improvements for children at the time of the inspection.

Essex Police were working with partner agencies to create more consistent ways to improve practice in the MASH and JDATTs and it was acknowledged by the force that further development work was required and underway. However, existing multi-agency arrangements meant that safeguarding practices for children in the three LPAs were inconsistent at the time of our inspection.

Essex Police serves diverse, multi-cultural communities. However, data on ethnicity did not appear to be used to improve services. Performance data and other information, for example on children's views and needs, were limited. This restricts the ability of the force, partner agencies and LSCBs to meet needs and improve services and outcomes for children.

Performance information for understanding outcomes for children was under-developed and flawed across the LPAs, and the level of information available is currently limited due to limitations in the new IT system. We acknowledge that the force is continuing to develop a better performance framework. A new performance governance meeting has been introduced, which is a step in the right direction.

The force has recognised that good analysis could provide a better understanding of problems and had produced profiles identifying the risk of child sexual exploitation at force level. As noted above, we did find some good practice in the proactive targeting of some offenders suspected of sexually exploiting children. However,

HMIC considered the force's overall response in tackling sexual exploitation was under-developed and lacked focus and coordination. Although the force has prioritised child sexual exploitation, it has much to do understand the extent of offending across the force area and to develop an effective response to protect children. At the time of the inspection, there was limited evidence that frontline staff were aware of how to respond effectively to sexual exploitation and safeguard those children identified as being vulnerable. The force was in the process of providing training to all staff, but the timescale for doing so was long and it was too soon to assess the impact of this training on the quality of frontline practice.

Inspectors were concerned that the force's new IT system had seriously impeded its productivity and ability to access information routinely to inform and manage risk effectively. In addition, we found that information related to child protection cases was recorded in multiple IT based systems and paper files and therefore was not readily accessible to all staff, making research to assess risk difficult and time consuming. Although the force has the ability to flag children at risk and offenders who pose a risk to others within its systems, the use of these flags by staff was inconsistent. HMIC found that the risk to many children who were subject to child protection plans or at risk of sexual exploitation, and offenders who posed a risk to children, were not readily visible to staff.

Recording was an area of grave concern. In many of the cases examined, limited information had been recorded on force systems about what investigative or safeguarding tasks had been undertaken. Minutes of meetings and actions were often not recorded on police systems. HMIC consider that poor recording practices, compounded by the implementation of a new IT system, were undermining the force's ability to provide consistently good child protection services.

The force had significantly increased resources in CAITs and deployed additional supervisors to provide better oversight, scrutiny and management of child protection investigations. However, this commitment had not yet translated into improvements in police practice. Many of the newly recruited staff were untrained in child protection work and some reported that they did not want to work in the CAITs. Although we found some examples of good work by individual officers to combine investigative and safeguarding approaches effectively to protect children, we had significant concerns about the poor standard of child protection investigations in the cases examined. The majority of cases were found to be inadequate or requiring improvement. Unnecessary and sometimes protracted delays were a common feature in many investigations – this was particularly noticeable after the initial report had been taken, where we found little evidence of effective supervision. Investigations were dealt with in isolation, rather than jointly with children's social care services, by officers often untrained in child protection. This, and ignoring the risk to other children at risk and offenders who pose a threat to children, together with a lack of robust supervision, is concerning.

The force has more to do to understand the behaviour of adolescents and children with a troubled lifestyle, and to consider more options for the best approach to support these children. Gaining the trust of children who do not always consider themselves at risk or regard themselves as victims can take time. In most of the cases assessed, police officers recorded very little about the views of the children involved, the effect of an offender's behaviour on a child or the outcomes for the children. As noted previously, in most of the cases assessed as inadequate, significant delays in progressing enquiries left the child and family unaware of what was going to happen next.

Senior officers in the force were involved in partnership working, for example, the deputy chief constable had recently become a member of the Essex, Thurrock and Southend LSCBs. Partners reported that strong relationships were now developing across the force and spoke positively about senior officers' commitment to improve services for children. However, HMIC found senior officers in the three LPAs were not engaged in LSCBs, were unaware of the work of the boards, such as changes in policy and procedures, or that these could be a route to escalate concerns. Disparate practice had developed in the three LPAs and information and intelligence sharing was limited. As a consequence, children were receiving different services across the force, and action to mitigate risk to children was inconsistent, such as the procedures for the management of missing children.

Essex Police is undergoing a significant transition in improving its child protection services and much of the work is embryonic. However, a number of the changes made by the force were found by HMIC to be ill-considered and the wider impact not fully explored, causing the force's most vulnerable people to be exposed to further, unmitigated risks. For example:

- failing to ensure the transfer of crucial information relating to children contained in paper records and stand-alone systems onto new IT systems, meaning that risk to children was not visible to officers;
- the introduction without evaluation or assessment of a preliminary filter for MARAC referrals;
- the introduction without evaluation or assessment of changes to attendance at initial child protection conferences;
- re-directing the risk assessment of medium and standard (lower) risk domestic abuse cases to frontline staff without adequate support; and
- allowing a backlog of domestic abuse cases to develop in the force control room without full consideration of the risks contained within them.

In conclusion, inspectors have found that the force is not adequately protecting all children who are at risk due to widespread serious and systemic failings.

7. Findings: The overall effectiveness of the force and its response to children who need help and protection

Essex Police has taken some steps to improve child protection arrangements, such as the development of the crime and public protection command, the establishment of a MASH and significant investment in deploying additional staff on child protection work.

However, this commitment has not yet translated into improvements in police practice. There were some examples of good work by individual officers to combine investigative and safeguarding approaches effectively to protect children. However, the majority of cases examined were found to be inadequate or requiring improvement. In addition, with a lack of effective data analysis and poor record keeping, the force cannot demonstrate that it fully understands the nature and extent of problems in its area. Inadequate investigations dealt with in isolation by officers, often ignoring the risk to other identified victims and offenders, together with a lack of robust supervision, is concerning.

Management information for child protection is significantly underdeveloped and flawed. More needs to be done to understand and monitor the demands on the force and to identify and record outcomes of cases in order to improve and develop services. More frequent and intensive supervision of day-to-day work is needed – in particular to improve the standard of investigations. The force would benefit from undertaking regular reviews and audits in order to improve performance.

Changes in procedures introduced by the force, in an effort to deal with an increase in demand, for example in relation to attendance at case conferences and MARACs, had not been evaluated and were leaving vulnerable children at risk.

Furthermore, HMIC were concerned at the lack of cohesion between central public protection teams and teams in the LPAs. Disparate practice had developed and information and intelligence sharing was limited. Children were therefore receiving different levels of service within the force area and action to mitigate risk to children was inconsistent.

In conclusion, HMIC found that the force is not adequately protecting all children who are at risk due to widespread serious and systemic failings.

Leadership and senior management oversight needs to improve to ensure the weaknesses in practice identified in this inspection are addressed. HMIC will be returning to the force as a part of its national rolling programme of child protection inspections later in the year to assess the progress the force has made.

8. Recommendations

Immediately

We recommend that Essex Police immediately puts in place an action plan to ensure as a minimum:

- control room staff assess risks to children, paying particular attention to drawing all relevant information together at an early stage as part of that assessment, and ensure frontline staff are alerted to relevant information;
- incidents are not downgraded or the response delayed without proper justification and without appropriate checks having been made on the welfare of any children involved;
- any concerns about an incident involving children at risk are escalated if police have been delayed in attending; and
- relevant intelligence to assess risk is routinely updated on police systems in a timely manner and is readily available to frontline officers when attending incidents.

We recommend that Essex Police immediately undertakes a review, together with children's social care services and other relevant agencies, to ensure that the police are fulfilling their responsibilities as set out in Working Together to Safeguard Children. As a minimum, this should cover:

- attendance at and contribution to strategy discussions and initial child protection conferences;
- recording and communicating decisions reached at meetings; and how partner agencies refer child protection matters to the police, with a view to reducing delays and improving the timeliness of assessments.

We recommend that Essex Police immediately acts to improve child abuse and child sexual exploitation investigations with particular attention to:

- staff awareness, knowledge and skills;
- responding promptly to concerns raised;
- risk assessments that consider the totality of a child's circumstances and risks to other children;
- how the force identifies, disrupts and prosecutes perpetrators involved in child sexual exploitation;
- the capacity of investigators;
- the audit, supervision and management of cases;
- improving governance in the POLIT; and
- the 2013 protocol and good practice model to secure third party material in a timely manner.

We recommend that Essex Police takes immediate steps to ensure that all relevant information is properly recorded and readily accessible in all cases where there are concerns about the welfare of children and, as a minimum, provides guidance to staff on:

- what information (and in what form) should be recorded on systems to enable good-quality decisions;
- the value and relevance of ensuring that records are made promptly and kept up to date; and
- carrying out quality assurance checks on records and providing feedback to police officers and staff.

We recommend that Essex Police takes immediate action to:

- to reduce the delays in visiting registered sex offenders and to improve the management and response to other offenders who are subject to restrictions under a sexual offence prevention order; and
- to undertake a review with partners to ensure attendance at MAPPA is at a suitable level to support the creation of effective action plans to protect vulnerable children from those who pose the most risk of harm.

Within three months

We recommend that, within three months, Essex Police ensures that officers always check on the welfare of children and record their observations of a child's behaviour and demeanour in domestic abuse incident records, so that a better assessment of a child's needs can be made.

We recommend that, within three months, Essex Police takes steps to 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, in particular in those cases where absences are a regular occurrence;
- improving staff awareness of the significance of drawing together all available information from police systems, including information about those who pose a risk to children, to better inform risk assessments;
- ensuring that staff are aware of the need to pass this information on to other agencies; and
- providing guidance to staff that identifies 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, Essex Police reviews how it manages the detention of children. Essex Police should request the assistance of children's social care services and other relevant agencies in this review. The review should include, as a minimum, how best to:

- improve awareness on the part of custody staff of child protection, the standard of risk assessment required to reflect the needs of children, and the support they require at the time of detention and on release;
- assess at an early stage the likely need for secure or other accommodation and work with children's social care services to achieve the best option for the child;
- ensure that custody staff comply with statutory duties and complete detention certificates to the required standard if children are detained in police custody for any reason;
- ensure that custody staff make a record of all actions and decisions on the relevant documentation; and
- secure adequate appropriate adult provision in the force.

Within six months

We recommend that, within six months, Essex Police:

- takes steps with partners to ensure timely forensic medical examinations are conducted in sexual abuse cases involving children;
- undertakes a review of the initial risk assessment process in domestic abuse cases to understand whether processes are consistently applied by staff and to ensure cumulative risk to children living with domestic abuse is identified and addressed; and
- takes steps with partner agencies to evaluate its current MARAC arrangements, including preliminary meetings to filter cases, to ensure that vulnerable people including victims and children are protected at an early stage.

We recommend that Essex Police continues its discussions at a senior level with the CPS to address delays in advice and charging decisions.

Recommendation

We recommend that Essex Police immediately acts to improve child abuse and child sexual exploitation investigations with particular attention to:

- staff awareness, knowledge and skills;
- responding promptly to concerns raised;
- risk assessments that consider the totality of a child's circumstances and risks to other children;
- how the force identifies, disrupts and prosecutes perpetrators involved in child sexual exploitation;
- the capacity of investigators;
- the audit, supervision and management of cases;
- improving governance in the POLIT; and
- the 2013 protocol and good practice model to secure third party material in a timely manner.

9. Next steps

Within six weeks of the publication of this report, HMIC will require an update of the action being taken to respond to the recommendations that should be acted upon immediately.

Essex Police should also provide an action plan within six weeks of the publication of this report to specify how it intends to respond to the other recommendations made in this report.

Subject to the responses received, HMIC will revisit the force no later than six months after the publication of this report to assess how it is managing the implementation of all of the recommendations.

Annex A – Child protection inspection methodology

Objectives

The objectives of the inspection are:

- to assess how effectively police forces safeguard children at risk;
- to make recommendations to police forces for improving child protection practice;
- to highlight effective practice in child protection work; and
- to drive improvements in forces' child protection practices.

The expectations of agencies are set out in the statutory guidance *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*,[21] published in March 2013. The specific police roles set out in the guidance are:

- the identification of children who might be at risk from abuse and neglect;
- investigation of alleged offences against children;
- inter-agency working and information-sharing to protect children; and
- the exercise of emergency powers to protect children.

These areas of practice are the focus of the inspection.

Inspection approach

Inspections focused on the experience of, and outcomes for, the child following its journey through child protection and criminal investigation processes. They assessed how well the service has helped and protected children and investigated alleged criminal acts, taking account of, but not measuring compliance with, policies and guidance.

The inspections considered how the arrangements for protecting children, and the leadership and management of the police service, contributed to and supported effective practice on the ground. The team considered how well management responsibilities for child protection, as set out in the statutory guidance, were met.

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[21] *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children,* HM Government, March 2015 (latest update). Available from: www.gov.uk/government/publications/working-together-to-safeguard-children--2

Methods

- Self-assessment – practice, and management and leadership.
- Case inspections.
- Discussions with staff from within the police and from other agencies.
- Examination of reports on significant case reviews or other serious cases.
- Examination of service statistics, reports, policies and other relevant written materials.

The purpose of the self-assessment is to:

- raise awareness within the service about the strengths and weaknesses of current practice (this formed the basis for discussions with HMIC); and
- serve as a driver and benchmark for future service improvements.

Self-assessment and case inspection

In consultation with police services the following areas of practice have been identified for scrutiny:

- domestic abuse;
- incidents where police officers and staff identify children in need of help and protection, e.g. children being neglected;
- information-sharing and discussions regarding children potentially at risk of harm;
- the exercising of powers of police protection under section 46 of the Children Act 1989 (taking children into a ‘place of safety’);
- the completion of Section 47 Children Act 1989 enquiries, including both those of a criminal nature and those of a non-criminal nature (Section 47 enquiries are those relating to a child ‘in need’ rather than a ‘child at risk’);
- sex offender management;
- the management of missing children;
- child sexual exploitation; and
- the detention of children in police custody.

Below is a breakdown of the type of self-assessed cases we examined in Essex Police:

Type of case	Number of cases
At risk of sexual exploitation	3
Child in custody	3
Child protection enquiry (s. 47)	6
Domestic abuse	6
General concerns with a child where a referral to children's social care services was made	3
Missing children	3
Police protection	3
Online sexual abuse	3
Sex offender enquiry	3

Annex B – Glossary

child	person under the age of eighteen
multi-agency public protection arrangements (MAPPA)	arrangements set out in the Criminal Justice Act 2003 for assessing and managing the risk posed by certain sexual and violent offenders; require local criminal justice agencies and other bodies dealing with offenders to work together in partnership to reduce the risk of further serious violent or sexual offending by these offenders
multi-agency risk assessment conference (MARAC)	locally-held meeting where statutory and voluntary agency representatives come together and share information about high-risk victims of domestic abuse; any agency can refer an adult or child whom they believe to be at high risk of harm; the aim of the meeting is to produce a co-ordinated action plan to increase an adult or child's safety, health and well-being; the agencies that attend will vary but are likely to include, for example: the police, probation, children's, health and housing services; there are over 250 currently in operation across England and Wales
multi-agency safeguarding hub (MASH)	entity in which public sector organisations with common or aligned responsibilities in relation to the safety of vulnerable people work; the hubs comprise staff from organisations such as the police and local authority social services; they work alongside one another, sharing information and co-ordinating activities to help protect the most vulnerable children and adults from harm, neglect and abuse

Office for Standards in Education, Children's Services and Skills (Ofsted)	a non-ministerial department, independent of government, that regulates and inspects schools, colleges, work-based learning and skills training, adult and community learning, education and training in prisons and other secure establishments, and the Children and Family Court Advisory Support Service; assesses children's services in local areas, and inspects services for looked-after children, safeguarding and child protection; reports directly to Parliament
police and crime commissioner (PCC)	elected entity for a police area, established under section 1, Police Reform and Social Responsibility Act 2011, responsible for securing the maintenance of the police force for that area and securing that the police force is efficient and effective; holds the relevant chief constable to account for the policing of the area; establishes the budget and police and crime plan for the police force; appoints and may, after due process, remove the chief constable from office

registered sex offender (RSO)	a person required to provide his details to the police because he has been convicted or cautioned for a sexual offence as set out in Schedule 3 to the Sexual Offences Act 2003, or because he has otherwise triggered the notification requirements (for example, by being made subject to a sexual offences prevention order); as well as personal details, a registered individual must provide the police with details about his movements, for example he must tell the police if he is going abroad and, if homeless, where he can be found; registered details may be accessed by the police, probation and prison service