HMICFRS

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

National Child Protection Inspection Post-Inspection Review

Gwent Police

13–17 January 2020

Contents

Introduction

The 2019 inspection conducted by HMICFRS

In February 2019, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) inspected how well Gwent Police keeps children under the age of 18 safe.

In June 2019, we published the report of our findings. This concluded that the then chief constable, his senior team and the police and crime commissioner (PCC) were clearly committed to protecting vulnerable people, including children. This showed in both the PCC's police and crime plan and the force's priorities.

We found strong evidence of senior officers working to improve how the force manages the risks to children, and to meet the continued increase in demand for child protection. For instance, the force was going to add 30 more investigators to its public protection unit (PPU). The unit was also going to be restructured so that it could cope with demand.

Throughout our inspection, we found examples of good work by frontline officers responding to incidents involving children. Officers and staff we spoke to who manage child protection investigations were committed and dedicated. They often work in difficult and demanding circumstances.

Gwent Police has put a lot of time and energy into safeguarding the health and wellbeing of its officers and staff.

Partner agencies such as local authority children's social care services and members of the local safeguarding children's board told us that joint working arrangements are strong and effective. Although we found that some joint working arrangements required further development, this was positive feedback for the force.

The case audits that formed part of our inspection highlighted a need to improve some of the force's responses to children in need of help and protection. Senior leaders are clearly committed to this policy. However, decisions taken about children at risk weren't consistently better as a result.

Specific areas for improvement included:

- making sure officers took the time to speak to children to understand their experiences;
- the way the force recorded, assessed and shared information with partner agencies;
- how information was recorded on police systems;

- the practices used when managing those who pose a risk to children; and
- the treatment of children detained in police custody.

In addition, we did see areas of strong practice. This was evident in:

- the first point of contact (FPOC) with the force via the communications suite;
- the control room, where call takers and despatchers were good at identifying risk, thanks to the way the control room operated;
- joint investigations into abuse, including online abuse, which were of a good standard when completed by specialist officers; and
- the training given to officers and staff, which was good.

The 2020 post-inspection review by HMICFRS

In August 2019, the force showed us its action plan for responding to our recommendations. Since then, we have continued to monitor its improvement activity. In January 2020, we conducted a post-inspection review to assess its progress.

The review included:

- an examination of force policies, strategies, and other documents;
- interviews with officers and staff; and
- an audit of 43 child protection cases, related specifically to the areas for improvement set out in the 2019 inspection report.

Summary of findings from the 2020 post-inspection review

Since our February 2019 inspection, the force has worked hard to improve its safeguarding practice and the outcomes for vulnerable children. It has worked with its safeguarding partner agencies and reviewed its systems, procedures and processes. There has been significant investment in training investigators and frontline staff.

In 2019, after recognising the increasing demands on its PPU, the force committed to restructuring its investigative teams and increasing its PPU staffing by 30 investigators. However, officers to fill these extra posts aren't yet in place. This is because they can't be released from other roles to become trainee investigators until new recruits have completed their training. In addition, planned direct recruitment to detective roles hasn't yet happened.

With this long delay to the planned restructuring, officers investigating child abuse are dealing with higher workloads than the force would like. In the West PPU, officers describe their workloads as having doubled since the current staffing levels were agreed.

The force needs to assure itself that it has a review process to assess the impact of any further delay or changes to the agreed plan.

However, within the current structure, the force has maintained staffing levels. And it has been able to supplement the Operation Quartz team, which investigates exploitation, in the East area.

The force continues to invest in training specialist officers and staff. Almost all PPU investigators have received specialist child abuse training except those new to their roles. The force has good oversight of this training need and 12 places are available in 2020.

The Early Action Together programme is a national project funded by the Home Office. It seeks answers to address the lack of early intervention and preventative activity when adverse childhood experiences are evident. Through this programme, the force has trained 1,100 frontline, custody and control room officers and staff in awareness of adverse childhood experiences. The training encourages their practice to be informed by children's exposure to trauma.

Additional workshops for officers and staff on submitting better public protection notices (PPNs) aim to improve the quality of information shared with children's social care. This has produced improvements, but more work is needed to improve consistency.

The plan to appoint a dedicated vulnerability trainer in April 2020 demonstrates the force's determination to build on the progress it has made.

An interesting initiative funded by the PCC has resulted in a social worker being present in the control room. The worker gives prompt access to social services information and guidance to staff dealing with vulnerable children. This had been recently introduced at the time of our visit, so it was too soon to assess its impact, but it offers significant opportunities to the force and potentially the Service.

During our 2019 inspection, we found that the force had recently begun to review the quality of its practice in some investigations. However, this concentrated on the length and outcomes of investigations, such as whether and when offenders were charged. It didn't focus on the outcomes for children and standards of safeguarding practice, such as whether investigations had focused on children's needs.

In our revisit, we were encouraged to see that the head of public protection had introduced more qualitative practice reviews. This is beginning to give senior leaders better oversight of standards and has identified some areas for improvement. It has also shown that the force still has more to do to better understand its performance.

This is a new innovation that needs to find its place alongside other audit activity, such as that in the custody suite and the force control room. The force also needs to think about how to achieve consistency in its audit function, how findings can be brought together to identify themes, and how it can measure improvement.

Improvements are still needed in some areas of child protection practice, such as investigations by non-specialist staff, and the force's response when children go missing.

During our revisit, we audited the force's work in 43 case files. We assessed its practice as good in 15 cases, requiring improvement in 19, and inadequate in nine.

However, the force can demonstrate improved practice through the steps it has taken to address the recommendations from our January inspection. This is particularly

evident when the force detains children in custody, manages those who pose a risk to children, and uses police protection powers.

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

Post-inspection review findings: Initial contact

Recommendation from the report of the 2019 inspection

> We recommend that Gwent Police acts within three months to make sure that children's concerns and views are obtained and recorded (including noting their behaviour and demeanour), to help influence decisions made about them.

Summary of post-inspection review findings

The force has trained most of its officers and staff about the impact of adverse childhood experiences. In addition, workshops are helping officers and staff understand what information should be recorded in PPNs, which includes the concerns of children, and their behaviour and demeanour.

We have seen some examples of officers clearly documenting children's wishes and concerns, and then making decisions accordingly. However, opportunities to understand the views of children are still often missed, or those views are not recorded.

Detailed post-inspection review findings

The force has put a lot of effort into training its officers and staff

Through the Early Action Together programme, the force has trained 1,100 officers and staff to recognise adverse childhood experiences. This training includes information about how trauma can affect children.

At the time of our visit, the force was holding a series of workshops to help officers and staff understand what information to include in PPNs.

An aide-memoire and internal communications have supported the training

The force has designed an aide-memoire which summarises PPN guidance. A proforma has also been created to be completed and added to the PPN. This includes a section to record the concerns of children, and their behaviour and demeanour.

Intranet briefings are used to reinforce these messages. This channel of internal communications is also used to encourage officers to use their body-worn video.

Opportunities to understand the views and concerns of children are still often being missed or not recorded

We saw some examples of officers clearly documenting children's wishes and concerns, and referring to these when making decisions, particularly when the proforma was used. We also saw some good use of body-worn video. However, in most of the cases we audited, there was little evidence of officers and staff speaking to children to understand their lived experiences and using this information to help them make decisions.

Post-inspection review findings: Assessment and help

Recommendation from the report of the 2019 inspection

> We recommend that Gwent Police immediately undertakes a review, together with children's social care services and other relevant agencies, to ensure that the force is fulfilling its statutory responsibilities, as set out in the All Wales Child Protection Procedures, in respect of the assessment of risk, how information is recorded and shared, and the development of joint protective plans.

Summary of post-inspection review findings

The force has worked with relevant agencies to create information sharing and decision making hubs in three local authority areas. This has improved the timeliness of some strategy discussions. Access to early intervention services has also improved in some areas.

However, the quality of information in the PPNs we saw was still varied, and not always shared when it should have been. We also saw some delays in holding strategy discussions.

Detailed post-inspection review findings

Decisions made by staff during strategy discussions are now reviewed promptly

In 2019, we noted that, following strategy discussions, a sergeant should review all decisions when a single agency response is agreed. For example, when a criminal investigation wouldn't be in the best interests of the child. However, with a backlog of 700 cases, such decisions weren't being reviewed until long after they had been made.

The force has worked hard to clear this backlog. All such decisions are now reviewed promptly, which is a significant achievement.

The force has worked with its partner agencies to create co-located hubs in three of the five local authority areas

We were encouraged to see that the force is continuing to work with its partner agencies to improve the way information is shared and how that information contributes to improving outcomes for children.

In Newport, Blaenau Gwent and Torfaen, police and social care services now work alongside each other, sharing information and holding face-to-face strategy discussions. There is an ambition to adopt the same approach in the remaining two local authority areas. However, in all three hubs, children's social care usually decides as a single agency whether a strategy discussion is required, based largely on the content of the PPN. The sergeant present then contributes to that discussion.

The quality of PPNs is still variable

In 2019, we found that officers and staff emailed a PPN directly to children's social care services when they had a concern for a child. The quality of these forms was mixed, with little or no research about the family circumstances.

The force has introduced a process to make sure an incident log remains open until a supervisor has reviewed the PPN. This is intended to improve PPN quality. Through our audits we saw that when the proforma, as discussed above, is used, the quality of the information is usually of a high standard. However, most PPNs we saw didn't include the proforma. These were of a much lower quality, even when they were reviewed by a supervisor. This means that information sent to children's social care is sometimes incomplete.

Some information isn't being shared when it should be

Officers are still emailing PPNs directly to the relevant local authority. As the quality of the PPNs is variable, this means incomplete information is still being shared, without relevant family circumstances or other information.

We also found that PPNs regularly aren't sent in the manner they should be. Staff in the force central referral unit (CRU) and the hubs carry out a manual search of all PPNs relating to child concerns. They then check with their social care colleagues to make sure they have received them. However, we found examples of errors in filling out the form that meant they were missed even after this time-consuming second check.

We continued to see delays in holding some strategy discussions

When they require a police contribution to a strategy discussion, children's social care services invite the hub sergeant. In areas without a hub, or when the hub sergeant isn't present, staff from the CRU contribute to the meeting. The CRU also contributes to strategy meetings about children already known to children's social care services.

Strategy discussions happen swiftly when the need is clearly urgent. However, we saw several examples of delays in holding such discussions because of a lack of CRU resources or a delay in children's social care services contacting the CRU.

There is no written agreement between the partner agencies that clearly sets out what is specifically expected of the hubs. Rectifying this would help all partners understand better whether the hubs are meeting the needs of children at risk.

There is good access to early help services in some areas

In Newport, the force and the local authority have created an early intervention team to help families access preventative services. This team picks up cases where children's social care services decide that a matter reported in a PPN doesn't meet the threshold for statutory intervention. The team members phone the family on the same day to introduce themselves. They follow up with a 'what matters' call within two days to better understand their specific needs. After that, the team may also visit the family to provide advice.

When a further safeguarding concern is evident, this is escalated through the children's social care services computer system. However, we were told this has happened in only 6 percent of cases.

The force is aware of these issues and is carrying out a full review

We were reassured that the force is aware of all of the issues we raised and is continuing to work with its partner agencies to resolve them. Additional funding has been secured to extend the contract of the Early Action Together partnership lead, who was due to complete a full review of all aspects of the Early Action Together programme by the end of March 2020.

Recommendation from the report of the 2019 inspection

> We recommend that within three months, Gwent Police improves practice in cases of children who go missing from home. As a minimum, this should include a review of how information is recorded, and making staff more aware of:
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> - their responsibilities for protecting children who are reported missing from home, especially when this happens regularly;
> - the importance of investigating where a child has been, and who with; and
> - their responsibilities for conducting and recording prevention[1] interviews when children return home.

Summary of post-inspection review findings

The force is good at identifying the risk to children who are reported missing. We saw some examples of proactive work to find them. However, the response to missing children was inconsistent, with some delays in initiating enquiries to find them.

We also saw that strategy discussions are often not held when children are reported missing. This restricts the force's ability to contribute to longer-term protective planning.

[1] The police have a responsibility to ensure that the returning person is safe and well. The purpose of the prevention interview is to identify any ongoing risk or factors that may contribute to the person going missing again.

Detailed post-inspection review findings

The force continues to make good use of research to identify risk

Through our case audits, we continued to see that the staff who work in the FPOC team conduct thorough research when a child is reported missing. Risk is recognised and the response is usually graded appropriately.

We saw examples of proactive enquiries to find children and evidence of good supervisory reviews. We noted that some children were spoken to when they returned to understand where they had been, who they had been with and whether they had been exposed to risk.

We saw some delays in initiating enquiries to find children

However, we also saw examples when conflicting demands meant that, although the risk was identified, activity to trace children in line with that risk was delayed or didn't happen at all.

In some cases, the detail from prevention interviews (safe and well checks) was cursory or absent altogether. This may have been because the child didn't engage with the officer, but, if so, that often isn't recorded. In these circumstances, there is still an opportunity to record the voice of the child through their demeanour and behaviour.

Opportunities to share information and develop longer-term protective plans are being missed

We saw little evidence that officers are submitting PPNs to refer missing episodes to children's social care. The missing children team routinely sends respective local authorities a list of resident children's missing episodes, but we saw no evidence that this prompted strategy discussions. Indeed, in Newport, the local authority asked to stop receiving these notifications.

Important, rich information could be reported through submitting a PPN. That might include where the child had been and who with, and other family issues affecting their behaviour. This would allow children's social care services to better understand the risk. The force could also consider the need for strategy discussions to help prevent future missing episodes. This would also provide an opportunity to explore any links to exploitation or other abuse.

The force's own audits have identified similar themes

The head of public protection has included children reported missing as one of his themes for continuing audits. In the limited number that have been conducted, he has identified similar themes to those that we found. We are therefore reassured that the force knows where it needs to improve in this area and is working to do so.

The current review includes the missing children team

The force and its safeguarding partner agencies are currently reviewing the role, positioning and functions of the Gwent missing children team. This review forms part of the whole-system approach mentioned above.

We were pleased to learn that funding is to continue for the return-home interview service, which will be provided by the charity Llamau. At this stage in an episode, children can give a wealth of information about why they are running away, particularly where this is becoming more frequent and the child is reluctant to speak to police or other agencies.

Recommendation from the report of the 2019 inspection

> We recommend that, within three months, Gwent Police reviews its processes and practices to make sure that its staff can draw together all available information from police systems in order to better inform their responses and risk assessments.

Summary of post-inspection review findings

The force has begun to make better use of Niche, the single police information management system. The Operation Quartz team maintains a master occurrence log for some children, which summarises current safeguarding activity.

We saw improved recording when police protection powers were used. Outcomes from strategy discussions were often clearly recorded.

Detailed post-inspection review findings

Safeguarding information is usually clearly recorded when children are at risk of exploitation

When a child is believed to be at risk of exploitation, the Operation Quartz team creates a master occurrence log within the child's Niche record. This makes it much easier for other officers to quickly understand the current risk to those children. The record summarises their current Operation Quartz and social care status and any investigation updates, multi-agency referral information and minutes from exploitation meetings.

The force can extend the use of such records to include other children at risk.

Recording practices are generally better, but some improvements are still required

Throughout our case audits, we generally found improvements in how the force is recording decisions, investigative activity and outcomes from meetings. This was evident in custody records, in documentation relating to the use of police protection powers, and when offences were committed by managed offenders.

However, as noted above, the quality of information in PPN reports was inconsistent. And although we saw good investigative plans and supervisor reviews in many investigations, recording of safeguarding activity was still inconsistent.

The force is still using the missing individual risk assessment form (MIRAF). These are recorded on a separate database, but this is dated and difficult to search. The force plans to stop using the form and to make better use instead of the master occurrence log. Officers and staff will have better access to current relevant information as a result. It will also make it easier to analyse patterns, trends and risky locations.

Post-inspection review findings: Investigation

Recommendation from the report of the 2019 inspection

We recommend that, within three months, Gwent Police should improve its child protection and exploitation investigations, paying particular attention to:

- improving staff awareness, knowledge and skills in this area of work;
- working with its partner agencies to ensure a prompt response to any concern raised;
- improving how information is recorded so it is accessible;
- improving the oversight and management of cases; and
- working with partners to make the best use of multi-agency meetings.

Summary of post-inspection review findings

We saw examples of good investigations with evidence of prompt joint working and a focus on safeguarding as well as investigative activities. This was usually when specialist child abuse investigators were responsible for the investigation.

The standard of investigations was generally poorer when conducted by non-specialists.

Detailed post-inspection review findings

The force makes sure its specialists receive the right training

The force has made sure the team responsible for investigating child abuse is fully staffed within the current structure. All members have been given specialist child abuse investigator training, or are awaiting it, as have their supervisors. Operation Quartz teams support their investigation of exploitation. These teams are also fully staffed, with a dedicated detective sergeant and, in Newport, support from seconded response officers.

Operation Quartz teams have shifted their focus to include the investigation of offenders and offences as well as support for victims. Team members attend exploitation strategy discussions, and specialists conduct the investigation of exploitation offences.

Investigations carried out by specialist officers are usually good

The standard of investigations remains inconsistent. Some are well managed and appropriately supervised. The better investigations demonstrate joint working, with investigative and safeguarding considerations clearly identified and addressed. We saw some prompt strategy discussions leading to prompt joint working and investigative activity. We also saw clear investigation plans and evidence of regular supervisory review and support. These were generally being conducted by child protection specialists.

The mothers of 12 and 13-year-old girls called the police to report that their daughters had been raped by a 13-year-old boy. A specially trained officer was deployed promptly, and strategy discussions were held about all the children. Safeguards were put in place for all three of them, and consideration given to the risk the boy posed to others.

A joint investigation was agreed and undertaken by specialist police officers and social workers. An intermediary was used to help communication during interviews with the girls. Their views and concerns were clearly recorded.

A detective sergeant regularly reviewed the case and the progress of the investigation was also well recorded. The case was finalised promptly.

When offences are investigated by non-specialists, the standard is often lower

In some cases, there was little consideration or investigation of wider safeguarding risks, particularly the risk an offender poses to others who weren't the subject of the original report.

We saw missed opportunities to examine devices which were likely to contain valuable evidence, and delays in visiting victims.

A family friend reported to the police that a 16-year-old girl was being groomed by a 55-year-old man using Facebook. He had asked her to meet for sex. She told him she was only 12 years old, but he wasn't dissuaded.

Officers were deployed promptly. They took screenshots of the messages, but didn't seize the girl's phone for further examination. It was clear the offender had other Facebook 'friends' who appeared to be schoolgirls.

The man was identified and found to have a conviction for raping a child.

A PPN was submitted, but we saw no evidence of a strategy discussion or joint working. Officers who weren't specialists in child abuse carried out the investigation.

The offender was arrested, and his devices were seized. He made some admissions, but the force released him under investigation, rather than using bail conditions to mitigate the risk he posed to children.

We saw no evidence that further enquiries were conducted about other children he might have contacted or had access to.

There were delays in the investigation and we asked the force to review its practice in this case.

There are unnecessary delays in visiting children at risk

We saw some delays in holding strategy discussions and in jointly visiting children. We saw three cases where it had been agreed that a joint investigation was required and that the police and children's social care services should visit the children together. But the visits were allocated to response or neighbourhood officers, rather than specialist protection staff. In one case, the visit was placed in a diary system, and yet the children at risk weren't seen for a week.

A joint investigation is agreed when there is a belief that children are suffering or at risk of significant harm. Officers are therefore being deployed to conduct specialist joint visits with social workers when they don't have the necessary skills and experience. This means that signs of other abuse, such as neglect or non-accidental injury, may be misunderstood or missed altogether. We were told this is common practice when the perceived criminal offence would fall outside the PPU's responsibility to investigate.

In another case we saw, a perpetrator was suspected of sexual offences against two children. The offence against the younger child was allocated to the PPU for investigation. The other case was initially allocated to the criminal investigation department (CID), then to response officers. Again, this caused unnecessary delay and potentially a poorer outcome for the child.

The force has taken some steps to improve, but needs to do more

Officers who are trained in video interviewing children now work alongside specialist child abuse investigators for a month to gain further experience and develop their experience. PPU managers have also attended training days to raise awareness of child protection matters among frontline sergeants. However, the force needs to do more to make sure that child protection investigations are allocated to those officers with the skills and competence to carry them out well.

Post-inspection review findings: Decision making

Recommendation from the report of the 2019 inspection

> We recommend that, within three months, Gwent Police works with its partner agencies to ensure that children are taken to appropriate places of safety when police protection powers are used. All relevant information is to be recorded properly and made readily accessible in all cases where there are concerns about the welfare of children. Guidance to staff should include:
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> - what information they should record (and in what form) on their systems to enable good decision making; and
> - an emphasis on the importance of ensuring that records are made promptly and kept up to date.

Summary of post-inspection review findings

Improved IT and training for officers and staff have led to a significant improvement in recording the use of police protection powers. Designated officers' initial rationale, regular reviews of the use of the power, and handing over of responsibilities to colleagues were all evident.

The force has also made sure that children aren't taken to a police station when those powers are used.

Detailed post-inspection review findings

Improved IT and training have led to a significant improvement in recording

Since the time of our inspection, the force has been using a new Niche form to better record the use of police protection powers. When the form was introduced, all inspectors received additional training about the force's expectations of them when they are considering or using the powers.

Our audits show that officers and staff understand the powers well. All three audits demonstrated a good standard of recording. The powers were used appropriately, and their use was regularly reviewed.

There was good evidence that designated officers handed over responsibility to their colleagues at the end of their shift.

We saw good joint working with children's social care services

We audited cases showing that officers made prompt contact with children's social care services. Children weren't taken to police stations, and longer-term protective planning began earlier.

Longer-term planning was documented in the Niche records. Therefore, officers attending subsequent incidents can be clear about a child's family circumstances and have the information they need to make good decisions for that child.

Post-inspection review findings: Managing those who pose a risk to children

Recommendation from the report of the 2019 inspection

We recommend that, within three months, Gwent Police acts to improve its management of registered sex offenders, paying particular attention to:

- how it deals with those offenders who do not comply with notification requirements; and
- how it engages with partner agencies to protect children at risk from managed offenders.

Summary of post-inspection review findings

Better performance data reporting and daily management meetings are improving practice. This includes recording and investigating notification offences.

We saw some good joint working with the probation service and children's social care services to mitigate risk to children.

Detailed post-inspection review findings

Improved performance data reporting provides better management oversight

Since our 2019 inspection, the force has reviewed the performance information that is available to managers. A detailed data report about the performance of the team is produced monthly. It is encouraging that this includes information about offenders who breach court orders and notification requirements. It also includes information about engagement activity with neighbourhood teams. This demonstrates the force's continuing work to improve the amount of intelligence it receives from frontline staff.

The inspector who leads the team now holds a daily management meeting with her staff and a representative from the probation service. This provides better oversight and understanding of workload demands. Regular risk assessments of offenders are being completed within agreed timescales. Visits to offenders to regularly monitor their risk level were also completed promptly.

Notification offences are regularly recorded and investigated, but some are missed

In 2019, we found that notification offences were rarely recorded or pursued. This meant that risk, offending patterns and compliance with offenders' legal obligations weren't well understood. We also found that offenders were often not attending the police station to register, as required by law.

Through our case audits in our revisit, we saw improved practice. Breaches of notification offences are now usually followed up with appropriate activity to record and investigate them. However, although overall practice was generally good, we saw some examples where offences weren't recorded, or were dealt with without adequate investigation.

The performance data reported to managers includes only those offences that are recorded correctly. Therefore, the force needs to do more to make sure all offences are recorded when they come to light.

Offender managers appear to be working better with other agencies to safeguard children

We saw examples of good joint work with partner agencies, including probation and children's social care services, to understand risk and safeguard children. Offender managers are now better at following up with children's social care any concerns about the submission of PPN reports.

We also saw examples of offender managers following up reports with phone calls to social workers so they could reassure themselves that children were being appropriately safeguarded. However, we noted other examples when this should have been done sooner.

Post-inspection review findings: Police detention

Recommendation from report of the 2019 inspection

We recommend that, immediately, Gwent Police should undertake a review (jointly with children's social care services and other relevant organisations) of how it manages the detention of children. This review should include, as a minimum, how best to:

- make sure that children are detained only when necessary, and for the absolute minimum amount of time;
- make sure that appropriate adults attend the police station promptly;
- make sure that officers consider the needs of the child and make referrals to children's social care when necessary;
- make sure that custody officers know the circumstances in which alternative or secure accommodation are required;
- assess, at an early stage, the need for alternative accommodation (secure or otherwise) and work with children's social care services to achieve the best option for the child; and
- when alternative accommodation cannot be found, escalate the issue to seek a resolution.

Summary of post-inspection review findings

We saw significant improvements in the way the force deals with children who are detained. Custody officers, staff and healthcare professionals have all received extra training. We saw that the circumstances in which alternative accommodation should be requested was understood.

Appropriate adult attendance was better, and the force was better at sharing its safeguarding concerns about detained children with children's social care services.

Detailed post-inspection review findings

The force has taken steps to make detention less traumatic for children

Two custody suites are in use in Gwent, Newport and Ystrad Mynach. At Ystrad Mynach, a separate room is now used to book in children. In Newport, this facility isn't available, so adult detainees are kept away from the booking-in area while children are there.

All children now receive a pamphlet that makes their rights and entitlements easy for them to understand.

Wherever possible, children are detained in cells away from adult detainees. We acknowledge, however, that the design of the custody suites means further improvements would prove problematic.

The force has provided extra training for custody officers and staff

The force has improved training for custody staff, including healthcare professionals, so that broader safeguarding issues are recognised and reported.

Training for custody sergeants now includes understanding when arrest is absolutely necessary in the cases of children. It has also given custody officers a better understanding of when alternative accommodation is required. It is a strong indicator of success that the force had detained only one child after charge in the three months before our visit.

The force is better at assessing the welfare needs of children in custody

All children entering custody should now receive a health and welfare check from a healthcare professional. The healthcare professionals have received training about the need to submit a PPN if they discover a safeguarding concern. The force now expects a PPN to be completed for all children who are brought into custody.

The force has a good understanding of what happens to children entering custody and their outcomes

The force's comprehensive performance framework includes a breakdown of the child's age, gender and ethnicity, and the length of time they spend in custody. It includes information about whether they were detained overnight or attended the station voluntarily.

In addition, this data allows the force to monitor those children whose detention has been declined, as well as whether PPNs are being submitted, whether custody officers are recording contact with appropriate adults, and the outcome of that adult's attendance.

The force has worked with other agencies to improve the treatment of children

A monthly monitoring and review panel for children who are detained, created with the local authority and other agencies involved, aims to work together to understand each other's concerns. It has discussed issues such as the prompt attendance of appropriate adults at custody suites.

As a result, the force and the youth offending service (YOS) have agreed a new protocol. At the time when a child who is looked after by the local authority is detained, the YOS sends an appropriate adult to be present. They attend again throughout the child's detention for interviews and other procedures when required. If there are welfare concerns about a child, the YOS is available to speak to the child by phone.

There are sometimes delays in appropriate adults attending

We were told that the new protocol works well when a child is looked after by the local authority. However, we saw unnecessary delays in attendance when the appropriate adult is a family member or carer.

Sometimes, their attendance is still arranged to coincide with events such as interviews, many hours after the detention is authorised. This prevents the early support of the child's welfare needs, rights and entitlements. We also saw delays when there was a dispute about whether a YOS representative or someone else should attend as the appropriate adult.

Audit activity mainly focuses on compliance with process rather than quality of practice

It is positive that the force conducts regular audits of its practice when a child is detained. However, this focuses on compliance with process, such as whether a PPN has been submitted, rather than on quality. As a result, although PPNs are now routinely submitted when a child is detained, the quality of their information remains inconsistent.

Our case audits showed that custody inspectors' reviews of detention were timely, but often they were conducted over the phone. Those carrying out the reviews also didn't recognise delays in the attendance of appropriate adults.

Next steps

There has been, and continues to be, a focus on child protection matters at a strategic level at Gwent Police. This includes its continuing work to develop partnership safeguarding arrangements across Gwent and to respond to our 2019 recommendations. The force is refining and improving its response to protecting children who are vulnerable and at risk.

While improvements are still needed in some areas, there have been important steps towards addressing our recommendations.

The force now needs to become more consistent in its practice and continue the assurance work it began with its audits. This will provide the information that it needs to understand the effect its ways of working have on children who need help and support.

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