HMICFRS

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

National child protection inspection post-inspection review

Kent Police

8–12 March 2021

Contents

Introduction

Our 2019 inspection

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

In September 2019, we published our findings. We reported that the chief constable, his senior team and the police and crime commissioner (PCC) were committed to protecting vulnerable people, including children.

The force had made significant changes to its operating structure. This included investing in new teams to focus on different aspects of vulnerability and child protection – for example, missing and child exploitation teams (MCETs) and vulnerability investigation teams (VITs). The force had increased the number of officers dedicated to vulnerability and there were good staffing levels in teams managing those posing a risk to children, such as registered sex offenders (RSOs).

Our inspection found that the officers and staff who manage demanding child abuse investigations were dedicated. But, in too many cases, we found inconsistent practice and decision making. We were also concerned about other aspects of practice. These included how the force manages the welfare of children while they are in police detention; the process for referring child protection concerns to the local authorities; and how the force uses its powers for taking children into police protection.

While the force was clearly committed to improving child protection, decisions about children at risk weren't always effective. Specific areas for improvement included:

- how calls for assistance were first assessed and assigned, to ensure that the response was appropriate;
- speaking to children – particularly very young ones – recording their behaviour and demeanour, and making sure their worries and views were heard and informed decisions for their welfare (the force had instigated a campaign to address this issue just before our inspection, but it was too early for us to assess how effective it was);
- considering the wider risks posed to children when they were missing or living with domestic abuse, to enhance protective planning (such as implementing Operation Encompass, in which police officers notify participating schools about domestic abuse incidents affecting children);
- supervision of investigations, to make sure investigative opportunities were pursued and there weren't unnecessary delays to cases;
- making sure children weren't inappropriately kept in police detention or brought to police stations as a place of safety for prolonged periods;

- fully assessing the level of risk in child protection cases before sharing concerns with safeguarding partner organisations, so that referrals were made when needed; and
- making sure supervision in offender management teams included a focus on cases where offenders were a risk to children, or where vulnerable children and adults were identified by staff.

The 2021 post-inspection review

In October 2019, the force gave us its action plan. This set out how it intended to respond to our recommendations. Since then, we have continued to check its improvement work.

Methodology for the revisit and impact of COVID-19

The methodology for this inspection was adapted because of the COVID-19 pandemic. We agreed arrangements with the force for a safe and effective inspection, working within national guidelines.

Our inspection took place remotely, using video calls for discussions with police officers and staff, their managers and leaders, and online reviews of incidents and investigations.

During this inspection we:

- examined force policies, strategies and other documents;
- interviewed senior leaders, managers and supervisors; and
- audited 38 child protection cases (11 cases were good, 9 required improvement and 18 were inadequate).

Summary of findings from the post-inspection review

The force is keen to improve the quality of its responses and services to protect children. Senior leaders have continued to develop the New Horizons strategic plan, which focuses on reducing vulnerability and dealing more effectively with those who may harm children.

The force has reviewed its structures, processes and procedures and has made positive changes. These include introducing vulnerability hubs, which increase specialist support to frontline responders and victims of abuse.

Leaders recognise the harm caused by domestic abuse. They have persuaded safeguarding partner organisations that children affected will benefit from full implementation of Operation Encompass. They've also introduced Operation Encompass Plus to notify safeguarding partner organisations in education and healthcare of child protection concerns arising from incidents that don't involve domestic abuse.

The arrangements we saw in the force control room (FCR) are much improved. The force has worked exceptionally hard to improve its recognition of risk. It has also worked hard to respond appropriately and on time, supported by advice and

information from its systems. Its initial responses to domestic abuse and missing children are also much better.

Good governance arrangements (such as the child-centred policing board) allow leaders to understand the quality of performance. We saw that the force continues to develop its information management systems so that both quantitative and qualitative data is used to understand demand, capability and outcomes. This means that leaders are aware of organisational risks that, if not addressed, will undermine the force's effectiveness in tackling vulnerability.

One of these risks is the force's ability to investigate complex crimes, such as child and domestic abuse, more effectively. The force has identified a skills and capability gap in its VITs. It has responded by reorganising and prioritising specialist investigator courses for staff. But the quality of domestic abuse investigations still needs to improve. We graded none of the seven domestic abuse audit cases as good.

Online offending is growing worldwide, and the force has invested in enhancing its capability to meet this increasing demand. It has refined its risk assessment processes. Previous delays in digital forensics examinations have been significantly reduced. The force has advanced plans to increase staff in the police online investigation team (POLIT). It has a good rationale for tasking less complex investigations to non-specialist teams.

The force has reviewed its standard operating procedures (SOP), including the SOP for investigation. This is positive.

But we are worried that many child protection investigations aren't being progressed effectively. Recording investigative activity is generally poor or inconsistent and supervisors don't always give enough direction to progress cases to a successful outcome. Delays and drift in cases undermine the confidence of vulnerable victims. Sometimes, we found that victims weren't referred to safeguarding partner organisations, or the referrals made didn't include all vulnerable people.

Managers review incidents and investigations. The force has introduced Operation Promise to audit investigation quality. But these activities can sometimes be several months later, when it is too late to change outcomes.

The force has developed two universal prompts to help staff to recognise and record concerns about vulnerability.

- VVOWS – a briefing format that reinforces the need for all staff to record the voices of children; and
- AWARE principles – a checklist to encourage staff to develop their professional curiosity and record information about children's vulnerability in a structured way.

VVOWS	AWARE
V – voice of child/ vulnerable adult	A – appearance
V – victims	W – words
O – offenders	A – activity
W – witnesses	R – relationships and dynamics
S – scenes	E – environment

These prompts aren't yet being used consistently across the whole force. This needs to improve, so that leaders can be assured that children's welfare and safety is being accurately recorded, leading to improved outcomes for children.

The force works with organisations such as social services and education to develop and improve multi-agency arrangements to safeguard children. This work can be complex and take time. It is impressive that Operation Encompass and Encompass Plus have been widely adopted across the county. These projects are important to protect and promote the welfare of the most vulnerable children.

Nationally, closer multi-agency working has proved effective in child protection. We saw there are opportunities in Kent to progress multi-agency arrangements, for example in POLIT, where earlier joint risk assessment with partner organisations could improve prioritisation.

Developing multi-agency arrangements further should improve the efficiency of the referral process for exchanging information which promotes child welfare. For example, direct access to children's social care services (CSC) systems would let central referral unit (CRU) staff identify children assigned to social work teams. Staff would get relevant information promptly and some of the CRU backlog would be reduced.

Despite strong progress against some of our 2019 recommendations, the force has yet to make sure all its systems and staff are focused on getting better outcomes for children. Our specific areas of concern are that:

- staff don't consistently record children's worries, behaviour and demeanour;
- decision making for safeguarding referrals needs to be more effective;
- not all staff in specialist investigation units are trained or have the skills needed for the role;
- the POLIT process is not fully assessing the risk posed by online offenders;
- the supervision of child protection investigations and recording of activity remains inconsistent;
- the level of training of the management of sexual and violent offender (MOSOVO) team is reducing the effectiveness of decision making; and
- the custody team doesn't consistently record information and get timely support for especially vulnerable children who are detained.

As part of our routine monitoring of all police forces, we will continue to evaluate the force's performance against these findings and will instigate closer scrutiny if needed.

Post-inspection review findings: initial contact

Recommendations from the 2019 inspection report

> We recommend that Kent Police should immediately review its assessment processes within the FCR, to ensure that child protection incidents are appropriately prioritised. This should include the creation of response or 'trigger' plans for those children frequently reported missing.
>
> We recommend that, within three months, Kent Police should take steps to ensure that it records all relevant information properly and makes it readily accessible in all cases where there are concerns about the welfare of children. Guidance to staff should include:
>
> - reinforcing the importance of 'golden hour' principles to secure best evidence of offences;
> - ensuring that children's concerns, behaviour and demeanour are recorded; and
> - making sure that effective safeguarding measures are implemented.

Summary of post-inspection review findings

FCR risk assessments clearly focus on the vulnerability of children and families, and help staff to prioritise the police response. Incidents assessed as potentially high risk are reviewed by FCR supervisors so that the response remains appropriate.

Trigger plans are in place and readily accessible to help officers find missing children without delays.

Information held on police systems is readily available to staff, and warning markers are used to flag vulnerable children and those who pose a risk to them. Specialist staff in the CRU are available 24/7 to advise and support responding officers to safeguard children.

Generally, the frontline response to child protection incidents has improved. Guidance and training on 'golden hour' principles is apparent in entries on police reports. The use of body-worn video at domestic abuse incidents is consistently high.

However, frontline responders are still not consistently speaking to children, recording their demeanour or detailing the effect of an incident on the child's welfare.

Detailed post-inspection review findings

Managers made changes in the FCR, improving the effectiveness of the first response to child protection incidents

After our 2019 inspection, the force reviewed and reinforced the focus of its FCR staff on responding quickly to incidents where they are concerned for vulnerable children. Staff have had extra training in using the risk assessment process effectively and assigning the right level of response.

Supervisors audit incidents as they happen and check to make sure that the right flags and markers are entered on to force records. The force's governance and scrutiny process also checks compliance. The force told us that FCR flagging is more than 90 percent accurate. They found most incorrectly flagged records occurred because staff included a few incidents that didn't actually need a child protection marker – just to be sure – as opposed to missing incidents.

The quality of supervision has improved substantially. Because of this, the relatively young workforce in the FCR is confident in its approach and follows force policy. For example, an incident flagged as child protection can't be closed without an update on the welfare and voice of the child.

An FCR team does daily dip tests on incidents against the force's operating guidance. Feedback goes direct to each FCR operational team, so they understand the quality and outcomes of their activity.

Beyond this initial feedback, the force monitors data and performance in monthly meetings. This allows managers to understand trends and patterns of calls, to improve responses further. Any learning from these reviews is included in FCR staff training events. Themes in staff training are scrutinised against future FCR performance to reassure managers that improvements have been made.

The force recognises that missing children are especially vulnerable and works to find them without delay

Officers from the force MCET now routinely create intervention plans for children who have been reported missing three times. These plans contain information about each child's circumstances and vulnerability, which helps officers to find and safeguard them quickly if they go missing again.

Officers now record intervention plans on force systems, so the information is widely available. This is an improvement on previous practice, when vital information often wasn't immediately accessible to responding officers. Vulnerable children are safer as a result of the new practice, because responders will always have access to information about how risk and vulnerability affects each child. This means officers are better informed, understand risks to individual children and respond well to their needs.

Frontline response is supported by specialist advice, but officers are still not seeing and speaking to vulnerable children

The flags used by FCR staff alert CRU staff to review active incidents and support responding officers with specialist advice.

The force has introduced vulnerability hubs to support investigators in the division's vulnerability investigation teams. Vulnerability hubs are staffed by safeguarding co-ordinators. They help officers deal with over 45,000 domestic abuse incidents a year, reviewing open domestic abuse incidents and advising responding officers so they can prioritise actions. This extra support is intended to improve the quality of initial investigations and outcomes for vulnerable families.

Despite this extra support, we found that responding officers inconsistently record the voices of children in domestic abuse incidents and don't always record enough information for effective referrals to other organisations.

Case study

The mother of an autistic 13-year-old child called 999 after being assaulted and thrown out of her home by her drunk partner. She reported that her child was also upset by the abusive behaviour.

The FCR assigned an immediate response. They advised the victim to go with her child to a friend's house and wait for officers. The responding officers recorded the incident as a standard-risk domestic abuse crime and made an Operation Encompass referral to the local authority as the child was home schooled.

Nothing was recorded to indicate if the child was seen or spoken to. No child protection referral was made to CSC, even though the child was vulnerable because of their autism and the effect of domestic abuse.

Police didn't speak to the child again. The case record was updated 19 days after the incident, noting that the victim no longer wished to support any investigations as her partner had "changed" and was back at home. The investigation was closed without further action taken against the perpetrator or referring the child for support.

Post-inspection review findings: assessment and help

Recommendation from the 2019 inspection report

> We recommend that Kent Police should immediately review referral processes for domestic abuse cases involving children to ensure that relevant information and risks are shared appropriately with the local authority (this should include a review of processes within the central referral unit to ensure that cases involving cumulative risk and hidden harm are correctly identified).

Summary of post-inspection review findings

Officers now notify all local authority schools about children affected by domestic abuse incidents. This arrangement is being expanded to let organisations that provide early help, and schools, know about safeguarding concerns arising in other types of incident.

The force has yet to fully address our concerns that it doesn't consistently identify or refer cases to CSC when children are vulnerable to cumulative risk or hidden harm.

Detailed post-inspection review findings

The force has implemented Operation Encompass

Since our 2019 inspection, the force has worked constructively with its safeguarding partner organisations to implement Operation Encompass. This introduces nationally recognised good practice in which police officers notify participating schools about domestic abuse incidents affecting children. The scheme is well received and widely adopted throughout Kent. It means that school staff have information when they need it, to help safeguard and support the welfare of vulnerable children.

The force reviewed its safeguarding practices during the pandemic and is now developing Operation Encompass Plus. This includes other child protection risks and incidents affecting children beyond domestic abuse situations, such as missing episodes and child exploitation concerns. This is a positive project that promotes children's welfare and engages the wider safeguarding organisations.

Guidance for officers responding to domestic abuse incidents isn't consistently followed

The force has introduced a risk assessment form for domestic abuse incidents called DARA, which stands for domestic abuse risk assessment. This tool has a series of questions about adult victim experiences. Officers record the type of abuse, their assessment of the threat to the victim, and an initial risk assessment (graded standard, medium or high).

The form starts with clear guidance about recording details of children linked to the incident. This instructs officers to speak to and check the welfare of children. It also prompts them to record details of children's schools for Operation Encompass notifications.

But, in most of the cases we saw, the children were rarely seen or spoken to. Officers were recording children's names but there was scant information on the lived experiences of that child in an abusive household.

We saw that officers made Operation Encompass notifications when they should and flagged these cases to the CRU. But not recording the voice of the child meant that, in many cases, the CRU didn't have enough information to support referral decisions. This means that children affected by domestic abuse may not be offered the help and assistance they need, or that help may be delayed until the child has been more severely harmed.

The force's assessment process is inefficient and ineffective in identifying risk and hidden harm

Despite the positive development of Operation Encompass, for some children, the force's main child protection referral process remains inefficient and ineffective.

CRU managers told us around 300 cases are waiting to be assessed before referral, which will take several days to work through. In the meantime, more cases will be added. Sometimes, backlogs of up to six or seven days can only be cleared by paying staff overtime. These significant systemic delays impede the force's risk assessment system for child protection.

The current system doesn't allow frontline or investigating officers to make child protection referrals to CSC themselves. Instead, they use a flag on the force system to bring the incident to the attention of CRU staff, who then assess the case record. CRU and CSC staff hold prompt strategy meetings for high-risk child protection cases that are clearly flagged. But there is no comprehensive triage process to flag or prioritise high-risk notifications in the general CRU queue or to identify cases already open to CSC for immediate notification.

In most cases, CRU research is limited to a review of the force systems over the previous six months. The force doesn't yet have electronic access to all names on Kent's CSC database. If they did, they could swiftly identify children in open cases and quickly pass information to social workers. This would also reduce the backlog and focus CRU risk assessments on those cases with unknown and hidden risk.

CRU supervisors decide if the latest incident meets the Kent children safeguarding partnership's criteria for either a CSC child-in-need assessment or a child protection referral. Only cases that meet this level of concern are referred to the local authority. This means that the CRU is unlikely to refer children to CSC when the report is of a standalone incident, or when a reported incident isn't considered serious.

This is a significant concern because, in many of the case records, we found that the voices of children were absent, or records didn't include enough detail (and so gave little context about how the incident affected the child). We also saw that officers didn't always consider the need for safeguarding measures to reduce children's vulnerability.

In these cases, CRU decisions are being made based on limited or incomplete information. Some children who should have been signposted for early help, CSC assessments and other interventions, weren't being referred. Delays in accessing these services could leave children exposed to harm.

Post-inspection review findings: investigation

Recommendation from the 2019 inspection report

We recommend that, within three months, Kent Police should produce a plan to improve its child protection investigations, paying attention to:

- undertaking risk assessments that consider the whole of a child's circumstances and risks to other children;
- improving the oversight and management of cases (to include auditing child abuse and exploitation investigations to ensure that standards are being met);
- the accuracy and timeliness of recording activity and planning; and
- ensuring that investigations are allocated to those with the skills and experience to manage them effectively.

Summary of post-inspection review findings

Generally, we found a good approach to cases that are clearly identified as needing a child protection investigation. The CRU provides valuable 24/7 specialist advice and starts swift strategy discussions with CSC managers. Specialist child protection officers record and include the voices of children clearly. Staff in child protection teams are prioritised for specialist training and have manageable workloads. CRU staff and safeguarding co-ordinators hold strategy meetings with CSC staff to start and progress investigations. Investigating officers now have unrestricted access to body-worn video recordings when they need it.

However, officers and supervisors assigned to domestic abuse investigations aren't always properly trained. This means that many domestic abuse investigations where children are affected were impeded by ineffective supervision, investigative delays and poor focus on the voice of the child.

The POLIT is fully staffed and caseload was appropriate. But investigation records were sometimes ineffectively supervised, and the voice of the child wasn't properly recorded and considered.

Detailed post-inspection review findings

The force has yet to improve the overall quality of record keeping and planning in all child protection investigations

The child-centred policing board is informed about the quality and effectiveness of investigations. Senior leaders can see data obtained by the force's inspectorate, and from their governance and scrutiny processes. Leaders have reviewed the SOP and they have issued guidance to help supervisors make their reviews more effective.

Frontline officers are contacting the CRU for safeguarding advice that supports risk assessments and makes sure investigative activity is accurately recorded.

The force still has delays in some child protection investigations. But managers are working to reduce the numbers of older investigations. Regular oversight meetings are designed to prioritise investigative activity, to reduce the backlog.

We found that the quality of child protection investigations varied significantly. Those assigned to VIT child protection officers were generally better investigated. It was clear that the officers and their supervisors understood the importance of completing child-focused investigations on time. Case records were detailed, and strategy discussions and investigation plans focused on achieving the best outcomes for children.

The force has invested in improving the capability of its three divisional VIT child protection teams. This means that the force is maintaining staff numbers and training them at levels suitable to the teams' workloads. We found these teams' investigations were generally effective, with good supervision in most cases. The voices of children were considered and used to inform decision making.

The force has also invested in its POLIT capability. Extra staff and changes to working practice have reduced workloads to a manageable level and reduced investigative delays. The force is investing further in POLIT to support increased proactive investigations.

In the cases we reviewed, offences involving children sending indecent images to other children were investigated proportionately. They were child centred and put both the victim and suspect at the heart of the investigation. Officers made separate safeguarding referrals to CSC for victims and offenders.

The force has an effective and efficient process for forensic examination of devices and categorising images for levels of indecency. This prevents delays, and evidence is returned on time and according to operating procedures.

POLIT investigations are routinely recorded on force systems, so that staff on other teams have access to information about cases that are in development. This means new information relevant to the risk threat and harm for individuals linked to the investigation can be seen and acted on.

But we found investigation plans in POLIT cases were consistently going unrecorded. The absence of case planning was often compounded by only sparse records of

investigative work. The lack of detail meant that supervisors didn't know about all relevant factors. Consequently, supervisor entries were often brief and lacked detail.

This meant that, too often, force records of POLIT investigations couldn't support important case decisions. The voice of the child wasn't always adequately recorded and considered by officers. And, in cases without records of strategy meetings, it was unclear if planning or joint working with other bodies was taking place.

Similarly, the voice of the child was also inadequately recorded in the cases we reviewed of investigations of non-internet-enabled child sexual abuse.

When records lack detailed information, it makes investigative reviews difficult. It can also cause problems in the handover of cases to new investigating officers, and it can be hard to justify closing investigations.

We also saw cases where relevant information about ethnicity, culture and heritage wasn't recorded. Missing, incomplete or inaccurate data can reduce the force's understanding of risk and undermine its ability to respond effectively to vulnerable individuals and communities.

The force doesn't have enough capability to effectively manage all investigations where children are at risk

The force has provided extra support and updated guidance to its investigative staff. But it isn't yet in a position to routinely allocate investigations to those with the skills and experience to manage them effectively.

Staff in the domestic abuse VITs are mostly unqualified detectives. These teams are largely formed by attaching non-detective local policing officers (with at least 18 months' service), who are posted for 12 months.

The team supervisors, who are critical to developing and supporting effective practice, are also challenged in this role. There are few qualified detective sergeants, and some have limited experience. Other supervisors are unqualified as acting-sergeants or as team leaders. This means that some child protection investigations aren't managed effectively.

We saw some investigations involving children in families affected by domestic abuse just drifting, or stopping without explanation. One of these cases was closed despite including offences that still needed investigation. In another high-risk domestic abuse case, the offender was arrested. But nothing further was recorded for two months on either of the two crime reports linked to the investigation.

We also saw delays in investigating officers contacting victims. In one example, a 17-day delay after the incident was reported meant that the victim disengaged and wouldn't support any investigation.

In most domestic abuse cases, we didn't see records of officers seeing or speaking to children. This suggests the force's training to its staff on the importance of capturing the voice of the child isn't getting through. In some cases, the VVOWS prompt that the force designed to remind officers to record children's demeanour and circumstances

was misused. Officers only recorded a child's name and included no meaningful information on their lived experiences in an abusive household.

The supervision of these cases was ineffective as it didn't address the investigative shortcomings of the staff. Neither did it support or direct junior and less experienced staff towards achieving better outcomes for children.

Risk assessments in child protection investigations are inconsistent

Officers responding to child protection incidents are supported by specialists in the CRU. This means that the initial investigators get information from strategy discussions, and joint working with social workers starts sooner. This is a strength, as information about risk is available for planning investigative and safeguarding priorities.

But, in other cases, where the CRU is only informed of child protection concerns by officers flagging their reports, decisions to refer cases to CSC can be made on limited information. If investigating officers don't understand or record all relevant information, including the voice of the child, referrals to CSC might not happen. In these situations, strategy discussions and joint working to investigate and safeguard children will be delayed until other concerns are raised.

VIT investigative officers are supported by police staff safeguarding co-ordinators, who hold strategy meetings with other organisations to agree and plan investigation strategies. But safeguarding co-ordinators aren't trained detectives.

Children who are thought to be at risk of significant harm are assessed in child protection case conferences where child protection plans are agreed and monitored. These are not investigations, but involve multi-agency safeguarding arrangements to protect children from harm. The force's current practice is that investigators/detectives attend or provide risk assessments to support these arrangements.

The force should review how it deploys its staff so that it can align its workforce capability, knowledge and skills to the tasks at hand.

The POLIT allocation policy and risk assessment process has been rationalised. These changes have reduced the team's active workload from over 700 investigations to a manageable 200+. This allows the team to investigate new cases without lengthy delays. It also increases opportunities for the team to proactively investigate intelligence about offenders who distribute indecent images of children and, in doing so, to identify potential risk to children at an earlier stage.

However, we found that officers don't routinely contact safeguarding partners in other bodies such as CSC, schools and healthcare to get up-to-date information about people resident in or associated with identified premises and households. Instead, officers refer concerns to CSC after they have connected children to addresses (for example, while executing a search warrant). This practice means that risk assessments may be less effective, as important information known to other bodies isn't included in planning investigations to protect children.

We saw cases across the range of child protection investigations where a lack of detail adversely affected planning and decision making. Risk assessments often

weren’t detailed enough to identify all the vulnerability and officers didn’t always make safeguarding referrals when they should. Supervisors’ oversight on investigation records was often brief and opportunities to direct activity were missed. For example, when police research identifies that a child at an address has a social worker, the risk assessment should reflect that this status doesn’t negate all risk for the child or indicate that they aren’t being harmed. An effective risk assessment should include a balance of concern for the child with the degree of support being provided by the social worker.

Post-inspection review findings: decision making

Recommendation from the 2019 inspection report

We recommend that, within three months, Kent Police should take steps to ensure that it records all relevant information properly and makes it readily accessible in all cases where children are taken into police protection. Guidance to staff should include:

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

Summary of post-inspection review findings

The force now electronically records incidents in which officers use protective powers. Frontline staff record their rationale and make good use of the power to protect children. Officers seek advice from CRU staff who immediately contact duty social workers.

Information is inconsistently recorded on the case notes. The voices of children aren't always included. Case updates and records of designated officer (DO) decisions are often insufficient to explain the safeguarding plans and the outcomes for children.

Detailed post-inspection review findings

The force has a new electronic system that supports operational staff when they are protecting children

Officers now record the use of child protection powers on electronic FREVVO forms on the force system. This is a positive step, as it means all information about the incident is readily available to responders and force managers. It also potentially gives officers a better understanding of a child's circumstances and vulnerabilities. This will support future decisions and focus on getting better outcomes. However, staff are not yet fully confident in using FREVVO to its full potential.

We were told that there had been an increase in the number of children being protected using Section 46 Children Act 1987 powers. The force monitors these incidents and holds regular meetings with CSC managers to provide assurance that officers use the power appropriately.

CRU staff are available 24/7 and provide specialist safeguarding advice to FCR staff and frontline responders. They also liaise quickly with CSC staff. We saw an example of the CRU speaking to out-of-hours social workers before the responding officers reached a child. It meant that those officers were provided with more context about the risks, which allowed an initial plan to protect the child to be agreed quickly.

Officers make good decisions to exercise the protective powers but recording activity remains poor

We saw that responding officers understood the use of the power and their decisions were correct. They recorded detailed rationale on their decisions for taking children into police protection. These officers also communicated effectively with the children, their parents, other carers, and the CRU. CRU staff and social workers liaised without delay and provided advice and direction to the responding officers. This helped everyone to understand the action being taken and to have their voices heard.

But after the initial entries, case records were less detailed. Sometimes, the voice of the child was very clear, with detail about demeanour, feelings and wishes recorded (showing that officers were sensitive to the children's distress). In other cases, recording was poor, which meant some relevant information might not be considered when making decisions.

We saw some records of strategy discussions and outcome strategy meetings being held, but these weren't always clearly recorded. The forms weren't comprehensively updated as the incident progressed. The missing information included:

- the time the power started;
- activity logs;
- supervisory reviews;
- rationale for discharging the power; and
- the time the power ended.

The force must focus its activity to get better outcomes for children

When officers find children in situations where they are at risk from significant harm, they can place them under police protection for up to 72 hours. This is an emergency power and should only be used when officers believe it to be necessary and proportionate. Police inspectors must personally oversee and direct the safeguarding activity. This means making sure the children's best interests are kept to the forefront by officers speaking with them, their parents and carers. Police should also hold strategy discussions with social workers to agree and plan for the care of the children.

In too many cases, we found records weren't consistently being updated by officers and inspectors. In one case, there was a note of the incident on the main force system, but no FREVVO form completed. This meant much of the important detail about the incident wasn't recorded.

Officers in most cases recorded the time the power started, but inspectors rarely recorded why the power had stopped and when. This suggests that inspectors aren't involved enough or actively overseeing the welfare of the children. It means that the

force doesn’t always have accurate records of the safeguarding arrangements in place or the plans to mitigate future risk. Potentially, officers responding to future incidents won’t know about earlier police protection incidents or know the details of previously agreed arrangements.

Sometimes, officers detain children in police buildings for a long time while arrangements are made to find suitable accommodation. Police stations aren’t suitable places for children to be held. It is important that delays in transferring children are minimised and officers should record these situations so that the force can work with CSC to improve arrangements.

The force assesses police protection incidents in its governance and scrutiny process and through daily CRU and VIT supervisor reviews. Managers get information about the quality of force performance but are yet to fully put into practice the changes needed to improve outcomes for children in these situations.

Post-inspection review findings: managing those posing a risk to children

Recommendation from the 2019 inspection report

> We recommend that, within three months, Kent Police should review its approach to providing appropriate information on registered sex offenders to neighbourhood police teams and ensure that staff in the MOSOVO teams understand their responsibilities to make appropriate referrals when they consider that a child may be in need of safeguarding support.

Summary of post-inspection review findings

Information about offenders' risk is now available on force systems. However, information provided to other teams is inconsistent and doesn't lead to better offender management.

Too many staff in MOSOVO teams are untrained. But they generally carry out good quality assessments and have manageable workloads.

Child protection referrals and safeguarding activity can be delayed by poor understanding and also by ineffective practices.

Detailed post-inspection review findings

Links with neighbourhood teams have improved but need more development

The force has made sure details of offenders are included in IT systems that are available to neighbourhood teams and responding officers. This is an improvement and means that risk, threat and harm assessments can be made with confidence to support all types of operational activity.

Specialist offender managers have developed training to inform and engage frontline staff. This aims to improve the understanding of non-specialists about the risks posed by offenders being managed in the community. It also informs staff of the importance of contacting MOSOVO officers for advice or to discuss concerns about risk.

The force's practice of divisional MOSOVO teams giving a monthly top five offender briefing to increase intelligence from local officers hasn't been successful. The force has concluded that frontline divisional officers don't act in response to the briefings, but is yet to change practice or find other ways for staff to contribute more effectively.

Wanted and missing offenders are robustly risk assessed and pursued

The force has reviewed and improved processes and practice so that they are appropriate to the level of risk an offender poses to the community. Wanted or missing RSOs are never assessed as low risk or low priority.

The detective inspector in charge of the offender management unit is responsible for directing enquiries to locate these offenders. This supervisory oversight assures the force that wanted and missing RSOs are pursued as a priority. Information about outstanding suspects is produced for operational managers and senior leaders so they can understand and scrutinise activity and manage risk.

MOSOVO teams have enough staff, but they don't yet have the knowledge and training to get consistently high standards of safeguarding practice

Across the force, offender management teams are well resourced, and staff have time to manage caseloads from all levels of national guidance. Offender manager assessments are usually detailed. They include risk information and sometimes information from other bodies, and this suggests good professional curiosity.

Most visits to offenders are carried out by pairs of officers and are unannounced in line with national best practice. Visits continued during the pandemic and the team showed initiative in developing safe practice. Early in the outbreak some visits were replaced by phone calls. But calls were made by officers while outside the offenders' premises, which allowed them to check that they were present.

Despite this good practice, we found officers don't consistently time their visits to manage the assessed risk posed by individual offenders. Some visits are still arranged for a routine fixed time. This means that, despite knowing when there are significant events for offenders, the visits aren't scheduled to manage any potential change in risk.

There aren't enough experienced MOSOVO officers and supervisors. Too many are untrained, and some staff have been in these posts for two years. Training is being arranged but delays have made the units less effective in their safeguarding responsibility.

Breaches of an offender's notification requirements aren't always recorded. We saw cases where breaches identified in the report weren't recorded as crimes. This means that later decisions about an offender's management, and inclusion on the sex offender register, could be compromised by the lack of risk management information.

Some child protection referrals are delayed because officers don't make them soon enough. The force practice of flagging these cases to the CRU before referring to CSC may also introduce delays and undermine prompt and effective safeguarding activity. When waiting for responses from CSC, MOSOVO staff don't always escalate enquiries when they should, and instead rely on email responses.

MOSOVO staff don't always disclose appropriate urgent information that will reduce the risk to children. This means that in some cases, for example, where an offender has access to children associated with an adult they have contact with, there are delays in providing that adult with information about the risk to those children.

Post-inspection review findings: police detention

Recommendation from 2019 inspection report

> We recommend that Kent Police should immediately undertake a review jointly with children's social care services and other relevant organisations to satisfy itself that its management of children in police detention is appropriate and reflects the standards of current national best practice.

Summary of post-inspection review findings

There was a multi-agency review of children in custody. The force updated its guidance, emphasising the importance of putting the welfare of children in custody first. Children are usually treated well, and fewer are now detained. But appropriate adults don't always attend on time and referrals to children's social care don't always happen on time. The force also needs to improve how it finds other places for children to stay.

Detailed post-inspection review findings

The force has worked with others to reduce the vulnerability of children in police detention

A multi-agency review has helped the force improve its support for detained children. Better guidance for custody staff is readily available on force systems and is included in a document about what is expected for children in custody.

NHS Liaison and diversion staff, which support people of all ages who have learning disabilities, autism or a mental health condition in the criminal justice system, can now update force systems. They screen children in detention and pass on information about their vulnerability to officers. They also record this on force systems for later reference.

Custody staff contact the Young Lives Foundation for specialist appropriate adult support for some detained children. The force supports a project in which a youth worker from the St Giles Trust will visit children who may be at risk of exploitation or recruitment by a gang. This supports early intervention work to reduce vulnerability for children whose risks are complex.

As well as the record of the grounds for detention, we saw separate entries in custody records explaining the need to detain each child. Custody officers also gave a good explanation for their decisions to detain children overnight and after they were charged

with offences. This shows that custody officers are focused on children's welfare and ensuring it is really necessary to continue to hold each child in police detention.

Fewer children are arrested and detained in custody

The force continues to reduce the number of children it arrests and detains in custody. Its vulnerability training for staff emphasises the impact of adverse childhood experiences, the need to record the voice of the child, and explains the threats to children from gangs and criminal exploitation. This helps officers consider alternatives to arrest. We were told that, since 2018, the number of children being held in custody has dropped by 40 percent.

Some children wait too long before they get support from an appropriate adult

When a child is detained, an appropriate adult should be identified and asked to attend the police station as soon as possible. This is to support the child's welfare needs, rights and entitlements.

We found delays in staff contacting appropriate adults, and other delays before they arrived. Sometimes, the arrival of the appropriate adult coincided with the child's interview, which could be many hours after their detention began. This means that some children are held without the support of an adult to explain formalities to them or advocate for their needs.

Some children are assigned a carer from custody staff to support, observe and help to make sure the care plan continues to reflect the child's needs. But the quality of carer activity varies and, during some periods, no carer was allocated.

The quality of information in custody records isn't always good

The force has improved its oversight and quality assurance processes for children in custody. The custody lead and daily management meetings scrutinise all cases of children detained overnight. Custody records are dip-sampled, and the force holds regular meetings to review custody operations and performance data.

But we didn't see custody officers recording their research on police systems before authorising detention, and this information wasn't always on risk assessments for detained children.

Custody staff also record the voice of the child inconsistently. We found an excellent example with detailed entries and the officer's empathy being shown. But, in another case, we saw no record of staff supporting or consoling a crying child who must have been very distressed.

Although we saw some good records, others were very unclear about appropriate adults' visits. In some, we saw confusing entries about the detained child's movements and interviews. This means that records don't examine the progress of the investigations enough, or balance that with the effect on the child of being in custody.

Reviewing officers must balance the progress of investigations against the impact of continued detention on the child's welfare. This may be compromised by missing or poorly recorded information. The custody chief inspector told us the force had already

identified this problem and had started training to improve the quality and consistency of detention reviews.

Custody officers don't consistently complete juvenile detention certificates (JDCs). We saw some good quality JDCs, but in one case there was no evidence of a post-charge JDC ever being completed. In another case, the JDC wasn't attached to the custody record, which meant that it couldn't be reviewed.

Custody officers know they need to find alternative accommodation for children refused bail, but planning and escalation must improve

Custody officers know that they must look for somewhere for a child to stay when they have been charged with an offence and refused bail. But too often this is left until after charge, when enquiries with the local authority should have been made earlier.

This means that requests for accommodation are often made late at night. By then, finding a place for the child will take too long, and it wouldn't be right to wake the child and move them.

The type of accommodation asked for from the local authority is generally appropriate, but we did see some inappropriate secure accommodation requests. In such cases, opportunities to release children from custody may be missed.

Although requests for secure accommodation are mostly appropriate, it wasn't achieved in any of the cases we saw. No record was made, however, of any escalation to a senior police officer when the local authority told custody staff that none was available.

Next steps

Kent Police still needs to improve some areas of its work to provide consistently better outcomes for children. There has been some strong progress, particularly in the way the FCR operates and supports frontline responders.

Despite the progress against some of our recommendations, the force has yet to make sure that all its systems and staff focus enough on achieving better outcomes for children. Our specific areas of concern are that:

- staff don't yet consistently record children's concerns, behaviour and demeanour;
- decision making for safeguarding referrals needs to be more effective;
- not all staff in specialist investigation units are fully trained or have the skills they need for the role;
- the POLIT process is not fully assessing the risk posed by online offenders;
- the supervision of child protection investigations and recording of activity remains inconsistent;
- the level of training of the MOSOVO team is reducing the effectiveness of decision making; and
- the custody team doesn't consistently record and get timely support for vulnerable children when they are in detention.

The force is developing its performance monitoring and auditing capability to inform leaders of what still needs to be done. But this inspection has shown that force leaders must intervene more to achieve the sustained improvement in all the areas where we have made recommendations.

As part of our routine monitoring of all police forces, we will continue to evaluate the force's performance against these recommendations and instigate closer scrutiny if needed.

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