National Child Protection Inspections

Surrey Police
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Foreword

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

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

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

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

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

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

Contents

1. Introduction

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

2. Background

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

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

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

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

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

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

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

[3] These consist of police constables supervised by a police sergeant. They have responsibility for,

3. Context for the force

Surrey Police has approximately 3,650 staff. The workforce includes:

- 1,863 police officers;
- 1,497 police staff; and
- 123 police community support officers. [2]

The force serves a population of 1.1 million residents. It is the most densely populated county in south-eastern England, with a growing population. Significant towns within the force area are Guildford, Woking and Reigate.

The Surrey police force area is served by one local authority, Surrey County Council, which is responsible for child protection within its boundary, and one local safeguarding children board (LSCB).

The most recent Office for Standards in Education, Children's Services and Skills judgments for the local authority is set out below.

Local authority	**Judgment**	**Date**
Surrey	Inadequate	June 2015

In Surrey Police, services to protect vulnerable people are led by the assistant chief constable (ACC) responsible for specialist crime, supported by a detective chief superintendent, a detective superintendent and a detective chief inspector. They have responsibility for central public protection teams whose remits include:

- strategy and policy;
- the co-ordination of the force's engagement with multi-agency risk assessment conferences (MARACs);
- co-ordination and attendance at child protection case conferences;
- the sex and violent offender unit
- the co-ordination of multi-agency public protection arrangements (MAPPA);
- the sexual offence investigation unit (SOIT);

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

- the paedophile online investigation team (POLIT);
- the complex abuse unit; and
- the diversity crime unit.

The force and partners have established a multi-agency safeguarding hub (MASH), where police, children's social care services and mental health services work together to protect vulnerable people. The MASH assesses risk to individuals in a range of cases (child abuse, domestic abuse and vulnerable adult abuse) and shares information with other agencies.

In April 2015, Surrey Police devolved responsibility for safeguarding investigation units (SIUs) to its three geographic policing divisions. Divisional commanders each have responsibility for these units whose remit involves the investigation of child abuse, vulnerable adult abuse and domestic abuse. Divisional commanders also have responsibility for 'missing from home' teams[3]. These units and teams are each led by a detective superintendent and a detective chief inspector is responsible for their day to day management.

At the time of the inspection (June 2015), Surrey Police had developed and was implementing an action plan to improve its services to protect children at risk of harm. Inspectors took account of this plan and assessed the action being taken to implement it. The findings of our inspection relate to the practices of the force as we found them in June 2015. Where we consider that concerns highlighted by our inspection, and set out in this report, will be addressed by the continued implementation of the action plan, we have made no further recommendations for improvement. However, where we consider that more work is required, we have made recommendations for the additional action that the force now needs to put in place to ensure that children in Surrey are adequately protected.

[3] These consist of police constables supervised by a police sergeant. They have responsibility for, and investigate, all cases of people who are reported to the police as being missing from home. They are supported by other teams in the force as required.

4. The police role in child protection

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

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

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

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

Many teams throughout police forces perform important roles in protecting children from harm, including those who analyse computers to establish whether they hold indecent images of children and others who manage registered sex offenders and dangerous people living in communities.

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[4] Section 47 of the Children Act 1989.

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

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

They must visit sex offenders regularly, establish the nature of risk these offenders currently pose and put in place any necessary measures to mitigate that risk.

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

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

During the course of the inspection, Surrey Police assessed 31 cases[7] in accordance with criteria provided by HMIC. The force was asked to rate each of those 31 self-assessed cases. HMIC also assessed these cases and identified more weaknesses in practice than the force's self-assessors. Figure 1 below shows the assessments made by the force and HMIC. Inspectors selected and examined a further 37 cases where children were identified as being at risk. Figure 2 below sets out inspectors' assessments in these cases.

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

	Good	Adequate	Requiring improvement	Inadequate
Force assessment	3	9	10	9
HMIC assessment	3	1	7	20

Figure 2: Additional cases assessed only by HMIC inspectors

	Good	Adequate	Requiring improvement	Inadequate
HMIC assessment	7	5	9	16

During the inspection, 17 cases were referred back to the force by inspectors with a request that immediate action be taken to ensure that children were protected. We were very concerned that some of those cases referred to the force for immediate action were cases that had been self-assessed as inadequate by the force in February 2015 in preparation for this inspection. Although the force assessors had judged the cases to be inadequate and requiring further action, the additional steps necessary to protect children had not been undertaken.

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

Initial contact

Inspectors found examples of a good initial response by frontline staff when there was a clearly defined child protection concern which required immediate attention. Staff in the force control room had been trained recently in child protection matters such as child sexual exploitation, female genital mutilation and honour based violence. There were good examples of control room staff acting quickly, obtaining as much information as possible and passing the case to frontline officers or a specialist child protection officer for immediate attention, such as in cases of neglect.

In some straightforward cases examined, officers responded quickly. They carried out prompt enquiries, searched for suspects and used their power to arrest where necessary. For example,

- the action taken when a woman involved in a collision had failed to stop and a young child was seen in the car. Officers made inquiries immediately to identify the owner of the car and went to her home. They found the driver intoxicated and her eight-year-old daughter in her sole care. The mother was arrested, a strategy discussion[8] took place and information was shared quickly with children's social care services. This resulted in a joint decision on the action needed to protect the child and appropriate care being found for her.

We found evidence in some cases that when further input was necessary – for example, a joint visit with children's social care services or a medical examination – this was organised promptly. Officers were sensitive when undertaking initial contact and interviews; they engaged well, sometimes taking the first steps through an intermediary (an accredited communications specialist) and gaining the support of the parents. Careful attention to this first stage was successful in building a rapport with children and obtaining good evidence to support prosecution. This was evident in the steps taken when a ten-year-old girl had been upset at school and subsequently reported that her mother's partner had touched her in a sexual manner. A joint visit with children's social care services took place promptly, the child was listened to and the interview handled sensitively. The man was arrested and the girl taken to a foster carer. The investigation plan was clearly documented.

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

Although there were systems in place in the control room to assess risk and provide supervisory oversight of all incidents, inspectors found the initial response to child protection concerns to be inconsistent. We found that some incidents assessed by call-takers were handled less well and this resulted in a delayed response. In some cases, the risk was assessed as low without the children involved being seen and their welfare checked. These cases were passed to a non-specialist team (the Hear It and Solve It team) in the control room, which had responsibility to resolve incidents over the telephone within 48 hours. For example:

- a mother reported that her ex-husband had taken her ten-year-old daughter without her consent. This was categorised as non-urgent and passed to the 'Hear It and Solve It' team. However, information on police systems had not been drawn together. If this had taken place, officers would have known that there had been previous concerns about the child's father, who had been banned from the child's school due to his volatility. The girl was also the subject of a child protection plan as a result of her sexualised behaviour, poor parenting on the part of her mother and neglect. The police failed to respond effectively to the report and the child was left in the care of her father for a week. Despite further concerns from the school about the father's 'instability', no inter-agency response was considered and the case was closed.

- a mother of four children reported ongoing problems with her ex-husband. The disputes between them had escalated after he found out that she had become pregnant by a new partner. This incident was graded as a low priority. However, there were a number of previous reports of assaults and injuries to children in the household which had been discussed at an initial child protection case conference[9]. The officer dealing with the case telephoned the victim and advised her about civil action she could take to protect herself and her children. Neither a child notification form, nor a domestic abuse risk assessment was completed, and the case was closed. This was a chronic and escalating situation and the woman and her children should have been seen by police. Inspectors considered that this was likely to be a high risk case and warranted referral to a MARAC.

In addition, the ad hoc use of child protection warning signs and other markers on police IT systems, compounded by poor record keeping and the lack of visibility of

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

information from safeguarding meetings, had an impact on both the immediate and longer term police response.

Inspectors found that the police response to children missing from home was poor. In five of the seven such cases examined, the initial assessment and subsequent actions were inadequate. In six of these cases the child was graded as being at medium risk of harm, although significant concerns were recorded on police systems. For example, a 15-year-old girl was graded as being at medium risk despite her having been reported missing on 10 previous occasions and concerns about her relationships with older boys, one of whom was a registered sex offender (RSO). Records showed that the child was considered to be one of the children at the highest risk of sexual exploitation in Surrey, but no trigger plan (a plan to locate a child quickly when he or she goes missing frequently) or long-term protective measures were in place to reduce the risk to her. Investigative opportunities to identify potential perpetrators had been delayed for over four months. A strategy discussion involving all relevant agencies took place in February 2015 but at the time of the inspection the case file had not been updated with any action taken.

Although most officers routinely checked on the welfare of children when attending a domestic abuse incident, this was not always the case. Some children were not seen or spoken to alone when this would have been appropriate (i.e. if the presence of a parent might inhibit a child expressing their view). The behaviour and demeanour of a child was often not recorded. A child's demeanour, especially in those cases where a child is too young to speak to officers, or where to do so with a parent present might present a risk, provides important information about the impact of the incident on the child. It should inform both the initial assessment of need and any referral to children's social care services. In one case examined, police received a referral from a children's charity reporting ongoing physical and verbal abuse against children and their mother. Previous intelligence held by police indicated that the father had assaulted them. Officers attended the home and spoke with the mother but did not speak to the children. There was a failure to recognise immediate risk to the children or to check on their welfare.

A number of these areas are included in the aforementioned action plan and are being addressed by Surrey Police. We consider that the force needs to bring much greater pace and purpose to implementation. We also consider that further action is required and make the following recommendations.

Recommendation

We recommend that Surrey Police immediately takes steps to ensure that as a minimum:

- control room staff assess risks to children, paying particular attention to drawing all relevant information together at an early stage to form part of that assessment;
- incidents are not downgraded without proper justification and without appropriate checks having been made as to the welfare of the child; and
- any concerns about an incident involving children at risk are escalated if police have been delayed in attending the incident or alleged crime.

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

Assessment and help

Inspectors found some good examples of inter-agency work, such as the development of the MASH. There were examples of agencies working well together – identifying risks, making plans to reduce these risks and supporting children and families. The MASH had improved the flow of information to and from partners about children at risk of harm. For example,

- a report was received that a four-year-old child was being struck with a belt and left at home alone. The case was immediately identified by staff in the MASH as a cause for concern, a strategy meeting was held and officers were sent to the home. The parents were arrested and the child taken to a safe place. A prompt and well documented investigation took place with regular updates recorded, including the outcome of a strategy meeting to determine the action needed to protect an unborn child.

Officers regularly submitted child notification forms[10] to the MASH, and these were generally of good quality. If a child is considered to be at risk of significant harm, there may be a need for a child protection plan and an initial case conference will be arranged. Staff in the MASH attended most initial child protection conferences.

[10] Locally, police officers must make a referral to children's social care services on an agreed form, providing information about their concerns. This referral must be made as soon as possible when any concern of significant harm becomes apparent.

However, the volume of information flowing into the MASH was high, with approximately 17,000 child notifications a year coming from police alone. Inspectors found considerable delays in the police assessment of notifications. Staff told inspectors that it was not unusual to have a backlog of over 800 cases, including those of domestic abuse, waiting for assessment. The force had recognised the risk, and as a temporary measure had moved non specialist staff into the MASH to reduce the backlog. However, the backlogs returned to similar levels when temporary staff were withdrawn. The oldest case awaiting assessment had been submitted ten weeks prior to the date of the inspection.

Many of these cases are likely to be low risk, but it is probable that there are some cases about which the force should be concerned and taking action. There was a delay in screening information, and in some cases a failure to conduct thorough research. This was exacerbated by a lack of specialist knowledge in some staff. Consequently risks were not always identified. For example:

- a mother was concerned that her 12-year-old son was being sexually groomed. He had been found with large sums of money and goods and would not tell her where and from whom he had got them. His mother described other warning signs of sexual exploitation. The boy's behaviour had changed. He was going missing from home and visiting a man known to the family, at a nearby food outlet. The case was reviewed in the MASH four days after the report. Police identified that a strategy discussion was required. However, there was no record to show that this took place or what actions were agreed. Seven days after her initial call, the woman contacted the police again to ask what was happening. After ten days, children's social care services also contacted the police requesting an update on the case. It was over two weeks before a strategy discussion took place and three weeks before a joint visit from police and social workers. The mother's concerns were re-affirmed by the boy's sister. Although police suspected the boy was being groomed, the case was closed and no further action was taken because the boy did not report that a criminal offence had taken place.

Inspectors were concerned to find that in more than half of the cases examined (31 out of 58) there was no record of a strategy discussion or meeting having taken place with children's social care services. In cases where strategy discussions or meetings had taken place in the early stages of an investigation, further meetings to review progress were rare. Inspectors concluded that, in these cases, it was unclear how well agencies had worked together to safeguard children effectively.

Staff told inspectors that they had not received any clear guidance on recording minutes of, or actions arising from, strategy discussions or meetings, to ensure that these were available and visible. Records were held in numerous locations: on e-mail, in officers' personal notebooks and on police systems. As a result, information about decisions taken to protect children was not immediately or readily available to

staff. This created a risk that actions may not be completed within agreed timescales, or not completed at all. In addition, officers in SIUs did not have sufficient information about any safeguarding plans in place. When information is not readily available, it is difficult to assess cumulative risk to children. This can result in poor decision making and a failure to protect children who are already believed to be at risk of significant harm.

To improve the situation, responsibility for undertaking strategy meetings had recently been moved to staff in the SIUs. Staff perceived that this had improved the timeliness of meetings but it was too early for inspectors to assess the impact of this development at the time of the inspection.

Inspectors were pleased to find that the force had introduced some innovative ways to help protect vulnerable children. For example, together with the local authority the force provided pocket-sized mobile phones to children believed to be at high risk of harm, such as those living in children's homes and identified as being at risk of sexual exploitation. The phones were programmed with emergency numbers that a child could call if they needed help. Youth intervention officers were also working in schools dealing with low level crime. They provided advice to parents and families who needed support and also educated children in online safety.

In cases where children went missing or absent from home, police and multi-agency intervention was very inconsistent. We found staff had a poor understanding about the need for and benefits of early identification and intervention with children who frequently go missing or are recorded as absent. In cases where children lived in local authority care or were identified as at high risk of sexual exploitation, meeting structures were in place. However, children at risk falling outside of these criteria were not always identified and as a result crucial assessment and help was not considered for them.

Inspectors were also concerned at the lack of independent return interviews[11] for children who go missing from home. These interviews, which may be provided by a children's charity, can provide a wealth of information about the reasons why children are running away, particularly where this is becoming more frequent and the child is reluctant to speak to police or other agencies. When a child goes missing from home, it is recognised as a warning sign that the child may be at risk or suffering exploitation. The local authority is responsible for making arrangements for return interviews. Whilst return interviews were conducted for children in local authority

[11] When a child is found, they must be offered an independent return interview by the local authority. Independent return interviews provide an opportunity to uncover information that can help protect children from the risk of going missing again, from risks they may have been exposed to while missing or from risk factors in their home. Further information can be found in *Statutory guidance on children who run away or go missing from home or care*, Department for Education, January 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf

care, this service was not in place for all children. Frontline staff expressed frustration about the largely reactive approach to children who were frequently reported missing or absent. The force has properly used its influence as a partner to strongly encourage the local authority to extend these independent return interviews to all children. It is understood that this will be happening from April 2016.

Cases of children who were considered at high risk of sexual exploitation were discussed at multi-agency conference meetings for missing and exploited children (MAECC) which took place every four weeks in each policing division. Children discussed at these meetings were allocated to a named officer with an expectation that the officer would engage with the child and co-ordinate activity according to the safeguarding plan. Although there were good individual examples of action taken to protect children in some of these plans, other children did not have appropriate support. The plans in place were generally of a poor standard. There was little evidence of contact with children, and information and activity were not recorded.

The force refers all domestic abuse cases that are assessed as high or medium risk to a MARAC for longer-term safeguarding plans to be put in place. However, inspectors were concerned about the force's handling of domestic abuse cases graded as standard risk (a lower risk). Cases were closed without a specialist reviewing them in the MASH. As a result, children who were witnessing repeat incidents of domestic abuse were not identified, nor were cases involving cumulative risk (arising from persistent lower level incidents) being referred to the MARAC. This may be leaving vulnerable victims and children at risk. For example,

- a grandmother was concerned about her daughter and two-year-old grandson. She noticed that both had injuries and suspected that her daughter's new partner was responsible. This case was graded as standard risk and no action was taken. The grandmother continued to report further concerns after her grandchild was hospitalised and sought support to request information for a Clare's Law application[12]. Although research revealed that her daughter's partner had a history of assaulting a previous partner and was not allowed contact with his own child because of domestic abuse, no further action was taken. No disclosure was made to the child's mother and a MARAC referral did not take place. There were two further reported domestic incidents but neither resulted in a MARAC referral. A child protection conference eventually took place as a result of domestic abuse, but no markers were placed on police systems.

[12] Clare's Law – the Domestic Violence Disclosure Scheme – is designed to provide victims with information that may protect them from an abusive situation before it ends in tragedy. The scheme allows the police to disclose information about a partner's previous history of domestic violence or violent acts. The Domestic Violence Disclosure Scheme is named after Clare Wood who was brutally murdered in 2009 by her former partner George Appleton, who had a record of violence against women.

We were told that the force intended to change this practice and introduce a process to review standard risk cases.

In conclusion, we were concerned about the force's overall response to children involved in domestic abuse situations. As noted previously, poor and inconsistent assessment in the control room, compounded by officers' lack of understanding about cumulative risk, meant that children were left exposed to the risk of further harm.

Surrey's local sexual assault referral clinic provides a service for children who have been sexually abused, and the facility offers support and supplies information about services provided by other agencies. Counselling and therapeutic care are also available to support victims of abuse. However, staff reported that at night children have to travel long distances in order to receive paediatric care. This is clearly not in the best interests of vulnerable children who have experienced a traumatic event.

A number of the concerns identified in this section are included in Surrey Police's action plan. The force needs to ensure that implementation gains real traction over the coming months. In addition, we make, the following recommendation for further action.

Recommendation

> We recommend that, within six months, Surrey Police works with partner agencies to ensure that timely forensic medical examinations are conducted in sexual abuse cases involving children.

Investigation

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

For example, the force had invested in additional supervisors to provide expertise and guidance to staff working on child abuse investigations. Staff had also been moved into SIUs to fill vacant posts. However, staff reported that additional work, such as child sexual exploitation investigations and the management of action plans to support children at high risk of exploitation, had recently been re-directed into SIUs and had increased their workload. The force recognised that, notwithstanding the additional investment, there was still more to do to meet the existing demand.

Inspectors found that many investigations were inadequate or required improvement. Although there were examples where immediate safeguarding concerns were considered, in the majority of cases officers failed to recognise wider risks – such as

the identification of other children who were being abused and suspects who posed a risk to other children. Clear warning signs of child sexual exploitation were also missed.

Staff reported that owing to a lack of capacity in SIUs, non-specialist staff were routinely investigating child protection cases. Inspectors were concerned that these officers did not have the knowledge, experience and training to effectively safeguard children. For example, thresholds for sharing information with partner agencies and working jointly with children's social care services were not well understood. As a consequence, Surrey Police was failing to comply with statutory guidance set out in *Working Together to Safeguard Children*. Supervisors also reported that as a result of heavy workloads, they were unable routinely to supervise investigations and therefore no quality assurance took place.

Inspectors were concerned to find cases that displayed a lack of investigative action, unnecessarily long delays and little evidence of any meaningful supervisory oversight. This was compounded by a lack of inter-agency work and resulted in failures to safeguard and protect children. For example:

- children's social care services raised significant concerns about a 14-year-old girl. The child had made multiple disclosures to various professionals and her mother that she had sex with older men; she was also reported to have miscarried. The girl had sent sexually explicit pictures to numerous men who were easily identifiable by conducting basic enquiries. The men were not arrested, crimes were not recorded and an investigation did not take place until two months after the report. Investigations were conducted in isolation. There was a delay of 17 months in completing the analysis of media devices. Following initial discussions, the agencies did not come back together to review the case and collate information. There was little supervisory oversight and a failure to recognise the child's vulnerability by police. Inspectors were alarmed that one supervisor's assessment of a child's sexual relationship with a 20-year-old man was because he was "genuinely interested in a relationship with the child, rather than to exploit her".

The force frequently used voluntary attendance[13] at a police station to interview suspects of child abuse crimes rather than arresting them. Although this can be beneficial in saving police time, it is crucial that options are carefully considered. No force policy was in existence at the time of the inspection and full consideration of the appropriate use of voluntary attendance for those suspected of abusing children did not take place. Evidence may be lost if, for example, house searches do not take

[13] The Police and Criminal Evidence Act 1984 (section 29) recognises that a person may voluntarily attend a police station or any other place where a constable is present, or accompany a constable to a police station or any such other place, without having been arrested and for the purpose of assisting with an investigation.

place: offenders, alerted to the need to attend the police station, could dispose of evidence in the meantime. If an arrest has not been made, suspects cannot be made subject to bail conditions while the investigation proceeds. As a consequence, police lose a crucial tool for managing the behaviour of those suspected of offending against children.

Inspectors found cases where voluntary attendance was used and items of evidence usually seized as part of a post-arrest search were not recovered. Appropriate use of bail conditions to control the alleged behaviour of the suspect had not been used to protect the child. This can, understandably, undermine victims' confidence in the police.

We were concerned to find cases where children were not medically examined and interviewed following reports of assault committed by a relative. This was a recurring theme in the cases assessed by inspectors. In five of the eight cases examined that involved assaults on children by their parents the investigation was inadequate – it appeared to inspectors that the children were not believed. Family members responsible were removed from the address but arrested and interviewed much later. The delay and failure to gather evidence meant that no further action was taken in many of the cases. Several investigations were closed, with the agreement of supervisors, on the basis that the case had been brought as a consequence of over-chastisement. Without a full joint investigation taking place, safeguarding measures were not considered to protect the child. For example,

- a 13-year-old girl had reported to school that she was being regularly assaulted by her parents. Her father held her down while her mother beat her with a wooden spoon or a shoe. The school had warned the father previously after he admitted hitting his daughter. The child had a history of self harming. This case was allocated to a detective who had not been trained in child protection. The child was spoken to at school, given literature about 'ChildLine'[14] and taken home. Her mother denied the assaults and reported that the child had sent a naked picture of herself to someone over the internet. Although further reports of concern were received by the police, an investigation did not take place. A strategy discussion was held four months after the initial report of assault, by which time the situation had deteriorated significantly. The child was not believed throughout this case and appropriate safeguarding measures were not put in place.

[14] ChildLine is a UK based charity that offers a confidential and private counselling and support service to children and young people, up to the age of 19 years, in regard to concerns they may have about anything that may be bothering them.

The paedophile online investigation team (POLIT) investigates all cases referred by the National Crime Agency's Child Exploitation and Online Protection Command (CEOP)[15], other forces or with the discretion of supervisors. The remit of the team was restricted to cases where the perpetrator had a known address in Surrey. If a perpetrator's address was unknown, or they lived outside the force area, investigations were carried out by non-specialist teams. As a consequence, some victims of online child sexual exploitation received a different level of service.

At the time of the inspection there were 104 cases held within the POLIT; 44 cases dated back 18 months and had not been investigated, nor had they been referred to children's social care services. As a result, wider safeguarding activity to protect children at risk from perpetrators had not taken place. This had been identified in an internal review just prior to this inspection and formed part of a report outlining a number of recommendations to change practice within the team and address areas requiring improvement.

In one case, a man suspected of engaging with children online in sexualised chat was identified as a school caretaker living in the grounds of a school. It was 12 days before he was arrested. An early scan of his computers revealed contact with three females under the age of sixteen. The suspect was given bail conditions to live at his home address - the caretaker's house in the school grounds. This decision was very concerning. It took another four weeks before a strategy discussion was held, but inspectors found no record of information shared between agencies or actions agreed. Soon after being bailed, the man moved out of his address. It was several months before police realised he had gone missing because no checks had been made to ensure that he was complying with his bail conditions and his whereabouts were unknown. There was no plan in place either to prioritise the computer examination or to locate the man.

Surrey Police had invested in training and equipping frontline staff to carry out a triage function on digital media (computers and phones) seized. The force had outsourced work to external companies to help to reduce the backlog of work in the force's digital forensic team. Recently this had included the examination of material relating to some indecent image cases.

[15] The National Crime Agency's CEOP Command (formerly the Child Exploitation and Online Protection Centre) works with child protection partners across the UK and overseas to identify the main threats to children and co-ordinates activity against these threats to bring offenders to account. It works to protect children from harm online and offline, directly through NCA-led operations and in partnership with local and international agencies.

However, inspectors found that that sexual offence cases were being filtered and very few high risk cases, such as those involving children, were being sent to external companies for analysis. Consequently, child protection cases were being dealt with less expeditiously than those the force had categorised as low risk. Furthermore, in spite of this investment, there was a backlog of 163 cases (a total of 584 exhibits) involving computers and phones at the time of our inspection, the oldest dating back to January 2015.

Inspectors were also concerned to find that delays of six to eight months were not unusual in cases sent to the Crown Prosecution Service (CPS) for review and charging decisions.

In summary, inspectors were very concerned about the generally poor standard of many child abuse investigations. Overall, we concluded that too many cases fell well short of the expected standards required for a good investigation. Many took too long to progress, and this resulted in lack of protection for victims, reduced victim confidence, loss of evidence and continuing risk from offenders. Although the force had increased capacity in its SIUs, it still has much more to do to improve the standards of investigations.

A number of the concerns identified in this section are addressed by the action plan that Surrey Police is in the process of implementing. As previously indicated, implementation warrants sustained focus and close scrutiny. We also consider that further action is required and make the following recommendation.

Recommendation

> We recommend that, within three months, Surrey Police provides clear guidance to staff in the use of voluntary attendance for suspects in child abuse cases to ensure that:
>
> - no opportunity is lost for the seizure of evidence;
> - protective measures are in put in place to reduce the risk to the child; and
> - cases are dealt with expeditiously through the criminal justice system.

Decision making

There were some examples of good decision making by frontline staff to protect children, such as in circumstances which involved removing a child from their family. It is a very serious step to take a child into police protection. Inspectors found that efforts were quickly made to safeguard the children. For example, police were called to a young child walking in the street in pyjamas and bare feet. Officers quickly

established where the child lived and returned him home. The officers checked the child's living conditions and gave advice to the family. A referral was made to children's social care services.

When officers attend an incident in Surrey where there is a concern for a child, as well as taking any necessary action to protect the child, they should complete a child notification form. This form outlines the incident, the risks to the child and any action taken. An incident may be minor and require no further police action, but the record is important because it enables patterns of abuse to be identified. However, Surrey Police did not have a procedure in place to assess whether forms had been completed. The form was completed at the discretion of the officer dealing with the case and inspectors found cases where a form should have been completed and sent to children's social care services but had not. As a result, joint risk assessments to protect children were not made by agencies in a timely manner and Surrey Police were failing to comply with statutory guidance in *Working Together to Safeguard Children*.

The standard of recording on police systems across the force was poor. Accurate and timely recording of information is essential for good decision making in child protection matters. Important information was often missing or there were delays in recording it on the system. This included delays in recording the outcome of strategy meetings (minutes were often not taken) and failures or delays in updating records of the progress of an investigation; in addition details of contact with children and families were often not recorded. In the majority of investigations examined, inspectors found there were significant failings to record information.

Inspectors found cases where vital information had not been recorded. It was apparent from minutes of MARAC meetings and other cases examined that referrals had not been made to children's social care services at the time of the incident. Therefore, immediate safeguarding measures required to keep children safe were not routinely being considered until well after the event

Inspectors found some specialist departments working in isolation. Teams recorded crucial information and activity in respect of very vulnerable children on standalone paper records which were not visible to other staff. For example, a 15-year-old girl was reported missing from home. Although frequently reported missing, she was assessed as medium risk. She was believed to be with a man whose identity was known. If checks had been made on information already held on police records, and considered at an MAECC, it would have become clear that there were previous concerns about young people engaging in sexual activity and drug taking with this adult. The case might have been assessed as high risk and managed with greater urgency. This was a frequent theme in missing from home cases, particularly where children had been identified as at risk of sexual exploitation and had been discussed at an MAECC.

Taken together, the significant concerns evidenced in previous sections – inconsistent risk assessment and judgments in the control room; inappropriate allocation of cases to non-specialist staff; poor recording on police systems; delayed and inadequate investigations and failure to understand wider risks – are indicative of a failure by Surrey Police to make consistently good decisions to protect children.

We consider that the action already identified by Surrey Police to improve its services to protect children has the potential to address the issues of concern identified in this section of our report. Consequently, we make no further recommendations in this area. However, the force needs to maintain its focus on the implementation of the action plan and evaluate the impact on outcomes for children.

Trusted adult

In investigations where police officers were seriously concerned about children and immediately recognised child protection issues, processes were carefully considered. This led to stronger relationships between a child and the police.

This was not always the case when children were at risk of sexual exploitation, in more complex cases involving adolescents, for children who went missing from home, or when police received reports of physical abuse within the family. The examples referred to in previous sections of this report are indicative of a force with a poor understanding of and response to these cases. There is more to do to understand the behaviour of adolescents and children with troubled lifestyles, and to consider more options for the best approaches to support these children. Gaining the trust of children who do not always consider themselves at risk or regard themselves as victims can take time.

In most of the cases assessed, police officers recorded very little about the views of the children involved, the effect of an offender's behaviour on a child or the outcomes for the children.

As noted above, in most of the cases assessed as inadequate, delays in progressing enquiries left the child and family unaware of what was going to happen next.

In some cases, police behaviour did not gain the child's trust. For example:

- A 14-year-old girl was persuaded to send indecent images of herself to men and the images were then circulated around school by other pupils. The images were believed to be on the tablet device of a fellow pupil suspected of circulating the images around school. This was never seized and the suspect was dealt with by way of voluntary attendance at the police station, meaning that evidence was lost because her home was not searched for the device. At the time of the inspection, enquiries to identify the men who had persuaded her to send images to them had not progressed – some three months after the report. There was no record of the victim being updated or referred to any

other agencies for support, although it was known she was being bullied at school as a result of the incident.

- A ten-year-old old child told a teacher that his mother had slapped him and then chased him up the stairs, trying to strangle him, before picking him up and throwing him against the bathroom wall. There was no investigative action taken – he was not interviewed by specialist officers or medically examined. The reason given on police records was that it 'was not in the public interest because his mother had mental health issues and was distressed at what she had done'. The child's views were not sought and the matter was closed without further police action taking place, or any apparent consideration for the impact of the mother's mental health on the child and his sibling.

In light of the action already identified by Surrey Police to improve its services to protect children, and our earlier comments about the importance of rigorous implementation of the action plan, we make no additional recommendations in this area.

Managing those posing a risk to children

Multi agency public protection arrangements for registered sex offenders were generally good and meetings were well attended by agencies. Risks to children were identified, plans were put in place and neighbourhood officers were alerted to specific sex offenders living in their area.

Inspectors were pleased to find that staff conducted proactive operations – using surveillance techniques to monitor those offenders who posed a greater risk. Sex offender managers attended daily tasking meetings in divisions to share information about those posing most risk of harm. There were good partnership arrangements in Guildford where the co-location of probation officers with the police enabled joint visits to take place.

However, staff reported delays in conducting visits within national timescales[16] and attributed this to the demands of a new procedure for completing risk assessments. There were 20 scheduled visits to sex offenders that were overdue at the time of the inspection. The unit had staffing levels in line with national guidance. However, this did not take account of the additional risk assessment work arising from the new procedure.

Staff working in the sex offender management unit were clear about their responsibilities, assessed risk and took action to reduce it. On occasions, a more rigorous approach should have been taken. For example,

[16] National guidance on multi-agency public protection arrangements is published by Ministry of Justice and is available at: www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2

- concerns were raised about a sex offender having contact with a child. Although the child had told her mother, she continued to have a relationship with the sex offender. Children's social care services were not informed until seven months later. There was no record of any action taken to restrict the sex offender's behaviour or evidence of the child having been spoken to and safeguarded.

Although registered sex offenders were flagged on police systems so that frontline staff could be made aware of those who posed a risk who were living in their area, practice was inconsistent across the force. Staff reported that they were not aware of all registered sex offenders living on their patch.

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

On some occasions officers took action against perpetrators of child abuse, but in most cases this was unacceptably slow. The response was weaker in child sexual exploitation cases. In 16 of the 20 cases examined, named offenders were not arrested in a timely manner. When children did not support prosecutions, little action took place. This should not have prevented officers obtaining intelligence, identifying offenders, and determining the risk they posed to other children.

Some of the cases examined were of grave concern. For example,

- a report was received from CEOP that an anaesthetist working in a hospital had been connected to the downloading of indecent images of children. After a delay of two weeks, a warrant was executed at the man's home and media devices seized for examination. A referral was made to children's social care services in relation to children in his family to whom he had access. However, no consideration was given to the protection of children with whom he came into contact in his professional capacity in the hospital. No strategy meeting took place. Six months later, items seized from his home address were examined. Officers found images filmed through a keyhole in what appeared to be a hospital. It was only at that point that the potential wider safeguarding implications were recognised and a strategy meeting held with appropriate professionals.

A strategic group chaired by the assistant chief constable responsible for specialist crime had been established for child sexual exploitation. This group had introduced multi-agency training to raise awareness of the issue in secondary schools and delivered an internal awareness raising campaign in the force to help staff identify risk factors associated with sexual exploitation. Although this group was in the early stages of development at the time of our visit, inspectors consider that it provides a

good basis for the force to develop and strengthen its plans for identifying, disrupting and prosecuting perpetrators. We look to this group to lead and direct improvements in the force's work in this area and make no further, specific recommendations.

Police detention

Inspectors examined seven cases of children in detention. The youngest were 14 years old; the oldest, 16. Six were boys, and one was a girl. They had been detained on suspicion of offences that included burglary, robbery, criminal damage, trespassing on a railway and breach of bail conditions.

Inspectors judged that the force's approach in five of these cases required improvement and was inadequate in the other two. In none of the cases reviewed was it considered to be good.

Inspectors were told by custody staff that Surrey's appropriate adult volunteer scheme provided a quick and efficient response to support children who had been detained in police custody. This was also evident from the cases reviewed by inspectors.

The youth intervention team had worked effectively to reduce offending (and arrests of children) and a recently commissioned independent evaluation confirmed that position.

Inspectors were also pleased to find that Surrey Police did not detain children in police cells under the provisions of section 136 of the Mental Health Act but took them to hospital, which is in the best interests of the child.

The number of children arrested by Surrey Police had fluctuated in recent years, but the percentage detained overnight had increased. In 2012, 1,894 children were arrested and 455 (24 percent) were detained overnight, whilst in 2013, 1,965 children were arrested and 527 (27 percent) were detained overnight and in 2014, 1,629 children were arrested with 470 (29 percent) being detained overnight. In the vast majority of these cases, the result of the detention was to bail the child prior to charge. Although the number of children arrested reduced between January 2014 and May 2015, the percentage detained overnight remained the same. Inspectors concluded that children continued to be detained unnecessarily in police cells overnight.

In the 7 cases examined by inspectors, all of the children were under 17 years of age and all were charged and refused bail by the custody sergeant. In these circumstances, the local authority is responsible for providing appropriate accommodation if a child is to be detained.

It should only be in exceptional circumstances (such as during extreme weather) that transfer of the child to alternative accommodation would not be in their best interests.[17]

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

At the time of the inspection, a protocol had been agreed between Surrey Police and Surrey County Council to address the provision of alternative accommodation for children who may otherwise be detained in police custody, but had not yet been implemented. It was therefore too early for inspectors to assess the effectiveness of the proposed arrangements. The force informed inspectors that the local authority does not have secure accommodation (as opposed to residential, non-secure care places) in the area. The force had developed training for custody staff and this was due to take place in July 2015.

When a child is held overnight in police cells, the custody officer should complete a detention certificate[18] to present to the court to explain the circumstances. The form had been completed in only two of the seven cases assessed. Consequently, important information, such as the justification for detaining the child in police custody overnight, was not recorded or shared with the court.

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

- a 16-year-old was found sleeping rough in a disused pub. He was found with stolen property and arrested for burglary. On arrival in the custody suite he

[17] Under section 38(6) of the Police and Criminal Evidence Act 1984 a custody officer must secure the move of a child to local authority accommodation unless he certifies it is impracticable to do so or, for those aged 12 or over, no secure accommodation is available and local authority accommodation would not be adequate to protect the public from serious harm from him.

[18] Under section 38(7) of the Police and Criminal Evidence Act 1984, when a child continues to be detained in police custody after charge because there is no alternative accommodation, a certificate must be completed by the custody officer. This is to certify that the continued detention was necessary and to explain the circumstances.

asked for a solicitor and for his mother to be informed of his arrest. PACE Code C sets out the circumstances in which the notification of arrest may be delayed and requires decisions to do so to be recorded and the detainee informed.[19] There were lengthy delays - it was twelve hours before his mother was informed and five hours before he had contact with an appropriate adult - but the reasons were not recorded. Not only is this a breach of PACE, it restricted the boy's access to support, over the 49.5 hours he remained in custody. The justification for holding the child incommunicado was not recorded, nor was there any indication that that the reasons for this had been explained to the child. He was not transferred to local authority secure accommodation after being charged and was refused bail because no other accommodation was available. A referral was not made to children's social care services about the child sleeping rough and his mother not wanting him to return home.

In a similar case, the custody record showed that a 16-year-old was held in custody for 67 hours. It was 18 hours before custody staff recorded that he had eaten only biscuits since his arrival, and offered him a meal; there was no record of any food being offered prior to this. There was no rationale recorded as to why the child had not been bailed.

We consider that the action already identified by Surrey Police to improve its services to protect children has the potential to address the issues identified in this section of the report and make no further recommendations. The force's focus should be on the implementation of the action plan.

[19] See section 5 (the right not to be held incommunicado) and Annex B (delay in notifying arrest or allowing access to legal advice) of PACE Code C Detention, treatment and questioning of persons by police officers, available at: www.gov.uk/government/publications/pace-code-c-2014

6. Findings: leadership, management and governance

Putting victims at the centre of the criminal justice system is a priority in the Police and Crime Plan for Surrey[20]. The plan requires the force to “deliver safe, satisfied and confident communities and relentlessly pursue those people that undermine them”. The force has developed a strategy to 'keep people safe from harm'. There are no specific public-facing priorities relating to child protection.

The chief constable and her command team are committed to improving services for children. We found some examples of visible leadership such as the child sexual exploitation campaign for frontline staff - ‘Identify it. Act’. Many staff we spoke to were clear that protecting children was now a priority for the force.

However, overall, we found a significant disconnect between the ambitions and aspirations of chief officers and child protection practice on the front line.

The force conducted a self-assessment of 31 cases for this inspection during January and February 2015 and assessed 9 as inadequate. As a result of the self assessment, critical safeguarding action had been directed by senior officers. When HMIC reviewed these cases in June 2015, it was clear that this protective action had not been carried out, nor had related investigations been prioritised and accelerated. There was a lack of detail and critical analysis in many of the cases assessed by the force. HMIC immediately referred these matters back to the force for the required action to take place and for consideration to be given to whether further investigation of the failings should be undertaken by the force’s professional standards branch.

Surrey Police was undertaking a review of public protection at the time of inspection. At the time of this inspection in June 2015, demonstrable improvements across the full range of child protection work had yet to be realised.

The force had recently devolved responsibility for SIUs to divisions (April 2015) and child protection was recognised as a priority by divisional commanders and their command teams. Most staff viewed this as a positive move which had resulted in more efficient resource allocation and better identification of risk within local teams. The force had also invested in bringing additional sergeants, inspectors and chief inspectors into the SIUs to increase supervisory oversight and support - this was also welcomed by all staff. It was, however, too early for inspectors to assess whether this new approach would improve practice across the policing area, not least because a number of those officers with responsibility for SIUs had limited experience in child protection. While they brought other valuable skills and

[20] The Surrey police and crime plan for 2014-17 can be accessed via: www.surrey-pcc.gov.uk/the-full-police-and-crime-plan-2/

experience, inspectors consider that a structured development plan for staff new to the SIUs would provide some necessary support for the demands of this specialist role.

Surrey Police had recently strengthened its governance arrangements for public protection to provide better oversight and scrutiny and improve performance. A weekly public protection meeting chaired by the ACC responsible for specialist crime had been established to provide the force with better oversight of high risk investigations. The three divisions each held fortnightly management meetings where relevant risks were discussed. A monthly divisional child sexual exploitation oversight board also took place to review all cases. At the time of our inspection the impact of these changes had yet to be felt.

Senior managers in Surrey Police were involved in partnership working, for example, with the Surrey Safeguarding Children Board. The ACC responsible for specialist crime chaired the recently convened a multi-agency child sexual exploitation strategy group. Information and activity was shared at senior management meetings with divisional commanders to ensure they were kept informed of areas for development, including changes in policy and practice.

At the time of inspection, the MASH was carrying a significant backlog of work. Staff reported that this was common and for the most part related to low-risk cases. However, it was likely that there were some cases about which the force should be concerned and taking action. We were told that work was underway to consider risk assessment and demand management in the MASH as part of the work the force had initiated to better understand demand across public protection as a whole.

Performance information for understanding outcomes for children was under-developed and inconsistent across the force area. A more comprehensive performance framework was under development and a ‘safeguarding risk management process’ had been introduced for the most vulnerable and for offenders who posed most risk. Inspectors considered these to be steps in the right direction.

However, we found very little oversight and scrutiny of performance within SIUs. As a result, the standard of investigations and their outcomes were not well understood. One of the force’s aspirations, recorded in its child protection action plan, was to conduct regular audits of cases and for all cases to be assessed as adequate or better. However, at the time of our inspection, the force was unable to demonstrate that any audit of child protection cases had taken place.

Surrey Police’s IT system had impeded the force’s ability to identify and respond effectively to cases of child protection, including sexual exploitation. Markers and flags had recently been introduced for such cases but were not being applied routinely by staff. The force could not be confident, therefore, that relevant cases were visible on IT systems. This resulted in cases being dealt with in isolation and created intelligence gaps in respect of children. The force had identified the problem

and aspired to achieve full compliance with markers and flags being applied in all relevant cases. Progress was being monitored through the strategic crime and incident recording group.

Surrey Police had invested in training frontline staff in safeguarding; in particular, for patrol and neighbourhood officers who generally submitted good quality child notification forms. However, the force's overall response to adolescents and children who were vulnerable because of complex risk situations was weaker, and this was most noticeable in missing children and child sexual exploitation cases. Police failed to identify links to wider risks to children and from offenders, and this left some children at risk of harm. There is more to do to raise staff awareness and provide training across all areas of child protection, including on how to deal with children living in complex environments and tackle offenders who are a danger to children.

The force had recognised that good analysis could provide a better understanding of the nature and scale of problems and the risks of child sexual exploitation had been profiled at force level. However, inspectors were told that there was insufficient capacity to provide more detailed analysis in the three divisions. Inspectors were also told that there were few submissions of intelligence reports concerning child protection matters. Intelligence, research and analysis are essential for understanding the wider implications of child abuse (for example, identifying and disrupting an organised network or group of offenders who sexually exploit children).

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

Backlogs in the analysis of computer and mobile phone devices had resulted in delays in investigations of up to six months. There were delays of up to eight months as a result of cases awaiting charging decisions from the CPS. These issues need to be addressed urgently as part of the wider public protection review.

Despite the force's efforts to improve practice, inspectors had serious concerns about the poor standard of child protection investigations. Unnecessary and sometimes protracted delays were a common feature of investigations after the initial report, and there was little evidence of supervisory oversight.

Inspectors found the force had more to do to understand the behaviour of adolescents and children with a troubled lifestyle, and to consider more options for the best approach to support these children. Gaining the trust of children who do not always consider themselves at risk or regard themselves as victims can take time. In most of the cases assessed, police officers recorded very little about the views of the children involved, the effect of an offender's behaviour on a child or the outcomes for

the children. As noted previously, in most of the cases assessed as inadequate, significant delays in progressing enquiries left the child and family unaware of what was going to happen next.

The force actively engaged with arrangements for managing high-risk offenders and inspectors found systematic information sharing and inter-agency plans to manage risk. There was regular attendance at meetings by officers of an appropriate seniority. Safeguarding issues were identified and considered. The force also conducted frequent and targeted activity against those sex offenders who posed greatest risk of harm, and those managing sex offenders took an active role in sharing information in daily meetings to highlight concerns about those posing significant risks.

The routine management of those suspected of offending against children was far less mature. The force did not scrutinise investigations to ensure that suspects linked to cases were routinely and actively pursued and their bail conditions managed effectively to restrict their behaviour. The force also needs to make full use of its powers to disrupt and prosecute those involved in child sexual exploitation. It needs to work with partners to develop a more proactive and preventative approach to protect children at risk.

Inspectors found good practice by the youth intervention team and an impressive reduction in numbers of children who re-offend. The force had also taken a strong stance on children arrested under the provisions of section 136 of the Mental Health Act. Inspectors were pleased to find that children with mental health problems were taken directly to hospital, not brought to custody suites.

In contrast, children were being unnecessarily detained in police custody post-charge when they should be transferred to the care of the local authority. The custody officer should complete a certificate to present to the court to explain the circumstances of a child's detention but inspectors found none were recorded in the cases examined. A new protocol had been agreed between the local authority and the Surrey Police to improve provision of alternative accommodation. The force should continue to work with the local authority to ensure that the protocol is implemented. Progress should be monitored, together with the impact on practice, and reported to the LSCB.

Inspectors reviewed Surrey Police's action plan to improve child protection services and found the force's assessment - that it was making good progress in many key areas of child protection - to be at odds with the findings from this inspection. This is a grave concern, as it calls into question the force's ability to understand what constitutes good practice across the full range of child protection matters.

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

Surrey Police has taken some steps to improve child protection arrangements, such as the ongoing development of the MASH and investment in additional staff for child protection work. Service reviews of child protection arrangements had been undertaken in May 2014 and December 2014.

Inspectors found a chequered picture with inconsistent practice across the force. In straightforward cases the response was often adequate. In most other cases, the response was often much weaker – most notably with adolescents, children at risk of sexual exploitation and those who regularly go missing from home. Training for frontline staff had improved awareness of safeguarding, but there is much more to do to demonstrate that all children receive a good service from Surrey Police.

The force needs to work with other agencies to develop a more proactive approach to tackling child sexual exploitation. Staff should be more alert to potential risk and harm in less obvious cases, for example, cases involving teenagers reluctant to co-operate and the link between CSE and those children who are missing from home.

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

It was apparent that some staff responsible for managing child abuse investigations were committed and dedicated to providing the best outcomes for children. Nevertheless, HMIC is concerned about the force's ability adequately to protect children who are at risk in Surrey because of the serious failings identified during this inspection: insufficient specialist (child protection trained) officers; the poor quality of many investigations examined by inspectors; the lack of intrusive supervisory oversight, and the paucity of management information and reviews to assess the quality of service. Leadership and senior management oversight needs to improve markedly to ensure the practice weaknesses found in this inspection are addressed with the urgency required.

Due to the seriousness of the failings, and the level and nature of our concern during this inspection (including those cases previously mentioned that were referred back for immediate action) HMIC has already made a number of recommendations for immediate action to Surrey Police. As a consequence the force initiated a review of every current child protection incident or investigation. This work began on 16 June following HMIC's first debrief to the force during the inspection fieldwork. The review involves independent oversight of the review of approximately 700 current child protection cases and will in respect of each case:

- identify any immediate safeguarding issues and themes requiring rapid improvement;
- identify any outstanding investigative actions that are to be completed or undertaken; and
- ensure that all children are adequately protected and their best interests are central to each investigation.

It is envisaged that as a result of this review, Surrey Police will be better placed to understand the reasons for the force's poor standard of child protection investigations and to establish whether the causes of concern are specific to particular locations or individual officers or more widespread. Further, it is envisaged that the review will provide the force with insight as to whether the underlying causes of poor practice relate to high workloads; lack of specialist investigative capability; poor professional practice and/or conduct; shortcomings in supervision; or a combination of these and other reasons. It is clearly imperative that the force fully understands this, so that action can be taken quickly to rectify the situation.

The force has provided HMIC with a copy of the terms of reference for the aforementioned review, together with an estimated time frame of the initial stages.

8. Recommendations

Immediately

- We recommend that Surrey Police immediately put in place an action plan to ensure as a minimum that:
    - that control room staff assess risks to children, paying particular attention to drawing all relevant information together at an early stage to form part of that assessment;
    - that incidents are not downgraded without proper justification and without appropriate checks having been made on the welfare of the child; and
    - that any concerns about an incident involving children at risk are escalated if, for whatever reason, police have been delayed in attending the incident or alleged crime.

Within three months

- We recommend that, within three months, Surrey Police ensures that officers always check on the welfare of children and record their observations of a child's behaviour and demeanour in domestic abuse incident records, so that a better assessment of a child's needs can be made.
- We recommend that, within six months, Surrey Police works with partner agencies to ensure that timely forensic medical examinations are conducted in sexual abuse cases involving children.
- We recommend that, within three months, Surrey Police provides clear guidance to staff in the use of voluntary attendance for suspects in child abuse cases to ensure that:
    - no opportunity is lost for the seizure of evidence;
    - protective measures are in put place to reduce the risk to the child; and
    - cases are dealt with expeditiously through the criminal justice system.

9. Next steps

Within six weeks of the publication of this report, HMIC will require a report from Surrey Police setting out progress in implementing the force's action plan to improve its services to protect children at risk of harm and the steps being taken to respond to the recommendations in this report.

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

Annex A
Child protection inspection methodology

Objectives

The objectives of the inspection are:

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

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

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

These areas of practice are the focus of the inspection.

Inspection approach

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

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

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

Methods

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

The purpose of the self-assessment is to:

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

Self-assessment and case inspection

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

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

- child sexual exploitation; and
- the detention of children in police custody.

Below is a breakdown of the type of self-assessed cases we examined in Surrey Police.

Type of case	Number of cases
At risk of sexual exploitation	3
Child in custody	3
Child protection enquiry (s. 47)	8
Domestic abuse	5
General concerns with a child where a referral to children's social care services was made	3
Missing children	3
Police protection	1
On-line sexual abuse	2
Sex offender enquiry	3

Annex B
Glossary

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

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

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