HMICFRS

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

# National Child Protection Inspection

## Suffolk Constabulary

18-29 July 2022

# 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, though, 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. Some of them occasionally go missing, or end up spending time in places, 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 organisations – have a particular role in protecting children and meeting their needs.

Protecting children is one of the most important things the police do. Police officers investigate suspected crimes involving children and arrest perpetrators, and they have a significant role in monitoring sex offenders. They can take a child in danger to a place of safety and can seek restrictions on offenders' contact with children. The police service also has a significant role, working with other organisations, in ensuring children's protection and wellbeing in the longer term.

As they go about their daily tasks, police officers must be alert to, and identify, children who may be at risk. To protect children effectively, officers must talk to children, listen to them, and understand their fears and concerns. The police must also work well with other organisations to play their part in ensuring that, as far as possible, no child slips through the net, and to avoid both over-intrusiveness and duplication of effort.

His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) 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 the police protect children and secure improvements for the future.

# Contents

# Summary

This report is a summary of the findings of our inspection of police child protection services in Suffolk, which took place in July 2022.

We examined how effective the police's decisions were at each stage of their interactions with or for children. This was from initial contact through to the investigation of offences against them. We also scrutinised how the force treated children in custody. And we assessed how the force is structured, led and governed, in relation to its child protection services.

## Main findings from the inspection

During our inspection, we examined 72 cases in which the police had identified children at risk. We assessed the force's child protection practice as good in 27 cases, requiring improvement in 24 cases and inadequate in 21 cases.

We saw good practice in how the force responds to children involved in incidents where they needed immediate protection. And the force's child protection investigators work effectively with partner organisations to help children get better end results.

The force has used learning from the National child safeguarding practice review into the murders of Arthur Labinjo-Hughes and Star Hobson to improve the way its officers and staff respond to vulnerable children. This helps the workforce understand why it is important to speak to children and record their demeanours and wishes. It means that officers make better decisions to safeguard children and they make timely referrals to get children help.

We also saw managers dip-sampling and checking the quality of specialist teams' child protection investigations. As a result, most investigations prioritise safeguarding children and progressing investigations to bring about the best results for victims. And we found examples of police officers and staff from other safeguarding partners sharing and discussing information so they could make better decisions to help children.

We found some areas of strength in the force's child protection arrangements, including:

- a committed and enthusiastic workforce, with a clear focus on the voice of the child;
- high-quality multi-agency child protection investigations;
- good management of sex offenders; and
- good care and treatment of detained children.

But the force needs to make significant changes to the way it assesses and responds to the risk affecting some vulnerable children. Poor risk management is severely reducing the effectiveness of its safeguarding response to:

- children who are missing from home;
- children who are vulnerable to sexual and criminal exploitation; and
- children who are victims of abuse on digital media and when indecent images are shared between peer groups.

The force isn't making best use of its intelligence capability to support operational responses to these vulnerable children – for example, in the control room. And the force isn't using its intelligence and analytical products well enough to support its tactical and strategic planning – for example, in multi-agency problem-solving and in multi-agency arrangements to reduce the risk to missing children and those at risk of exploitation.

We also found the force could improve its multi-agency safeguarding hub (MASH) arrangements to make sure all children who need early-help referrals receive them. The processes in place at the time of our inspection mean information about single incidents affecting children is seen in isolation as low risk. Officers and staff don't always assess it against information about risk and vulnerability already held on the MASH systems. This means intervention to help some children is delayed until risk reaches the critical stage.

## Conclusion

Suffolk Constabulary needs to make changes to improve some of its child protection arrangements and practices.

Managers need to understand the implications of risk for all vulnerable children and respond without delay to reduce the risk of harm. This means quickly identifying repeat victims, and perpetrators who exploit children, then escalating interventions to prevent harm. The force's information systems and risk-management structures aren't clearly aligned to prioritise this need or to allow the force to check the results of its responses. And there is uncertainty about which teams should investigate some complex risk. This includes high-risk missing children incidents and criminal and sexual exploitation cases.

The force has systems and meetings for overseeing its activities. These include multi-agency arrangements, which help it understand and co-ordinate all aspects of child protection activity. But these aren't fully effective. The force should refine these arrangements to include recent intelligence about high risk. It should consider this risk against the other information it knows about a child's vulnerability. This will help the force improve its safeguarding interventions and let managers know if their arrangements are effective or if they need to be adjusted.

The force fully participates in multi-agency safeguarding arrangements with partner organisations in the Suffolk Safeguarding Partnership (SSP). But force managers know about some longstanding and repeated operational difficulties that sometimes stop the force giving the best child protection response. At the time of our inspection, there was no formal SSP mechanism in place to record these problems or the action taken to resolve them.

We found that the officers and staff who managed demanding child abuse investigations were committed and dedicated. Specialist child protection personnel work with staff from partner organisations in timely investigations, which focus on getting the best end results for children.

Leaders understand they must help their frontline personnel work effectively to help children. They use national learning from the tragic death of Arthur Labinjo-Hughes to encourage officers and staff to focus on children's needs. They do this by training officers and using the innovative ARTHUR prompt (see Leadership, management and governance) to support them operationally.

But non-specialist personnel don't always have enough guidance to respond effectively to complex child abuse, such as online sexual exploitation. And the force doesn't have enough forensic digital capability to deal with the demand from online cases.

# 1. Introduction

## The police's responsibility to keep children safe

Under section 46 of the Children Act 1989, a constable is responsible for taking into police protection any child they have reasonable cause to believe would otherwise be likely to suffer significant harm. The same Act also requires the police to inquire into that child's case. Under section 11 of the Children Act 2004, the police must also keep in mind the need to safeguard and promote the welfare of children.

Every officer and member of police staff should understand it is their day-to-day duty to protect children. Officers going into people's homes for any reason must recognise the needs of any child they meet and understand what they can and should do to protect them. This is particularly important when officers are dealing with domestic abuse or other incidents that may involve violence. The duty to protect children includes those detained in police custody.

The National Crime Agency's *strategic assessment of serious and organised crime (2021)* established that the risk of child sexual abuse continues to grow, and is one of the gravest serious and organised crime risks. Child sexual abuse is also one of the six national threats specified in the Strategic Policing Requirement.

## Expectations set out in the Working Together guidance

The statutory guidance published in 2018, Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children, sets out what is expected of all agencies involved in child protection. This includes local authorities, clinical commissioning groups, schools and voluntary organisations.

The specific police roles set out in the guidance are:

- identifying children who might be at risk from abuse and neglect;
- investigating alleged offences against children;
- inter-agency working and information sharing to protect children; and
- using emergency powers to protect children.

These areas are the focus of our child protection inspections. Details of how we carry out these inspections are in Annex A of this report.

# 2. Context for the force

Suffolk Constabulary is responsible for policing the county of Suffolk. Its workforce comprises:

- 1,300 police officers;
- 893 police staff;
- 37 police community support officers;
- 117 special constables; and
- 145 volunteers.

The force serves a population of 761,246 people, of which approximately 20 percent are children. Suffolk covers an area of 1,466 square miles, including the large towns of Ipswich, Bury St Edmunds and Lowestoft, and widespread rural areas. The local authority is Suffolk County Council.

There are three policing areas across the county: East (centred at Lowestoft), West (centred at Bury St Edmunds) and South (centred at Ipswich). These areas are subdivided into 16 community policing teams. Each area has a multi-agency community safety partnership, which helps the police and other partners co-ordinate joint activity to reduce community vulnerability.

The force control room, known as the contact and control room, is based at the headquarters near Ipswich.

A force collaboration between Suffolk and Norfolk Constabularies means a Joint Justice Services Command provides custody services. There are six facilities: four in Norfolk and two in Suffolk, with a total capacity of 146 cells. The two Suffolk facilities are at the force headquarters and in Bury St Edmunds. People arrested in the East area are taken to the Great Yarmouth facility in Norfolk.

Suffolk Constabulary and the police and crime commissioner for Suffolk recently published the Police and Crime Plan 2022–2025.

Safeguarding partnerships are required by the Children and Social Work Act 2017. Suffolk Constabulary works closely with partners to safeguard children. Chief officers attend the SSP, which brings together statutory and other partner organisations that provide services for vulnerable children and adults across the county. The SSP publishes an annual report.

Managers and staff from the force work closely with professionals from these partners to co-ordinate operational services and make them as effective as possible.
For example, staff from these partner organisations are based together at the MASH.

## Recent inspections

The most recent Ofsted inspection (April 2019) of children's social care services provided by Suffolk County Council reported:

| Judgment | Grade |
|---|---|
| Overall effectiveness | Outstanding |

# 3. Leadership, management and governance

## The force has clear plans that align with its priorities

Suffolk Constabulary and the police and crime commissioner have published their plans and strategies, which clearly describe how the force will prioritise the following to prevent harm to its communities:

- tackling vulnerability;
- fighting crime;
- respond to the public; and
- working in partnerships.

It was clear that the force had prepared for this inspection and had considered the findings and recommendations we made to other forces inspected in this national child protection inspection programme. We found that leaders had made some changes to improve the force's approach to online child abuse, and to how officers and staff responding to incidents treat children who are affected.

## Good governance structures are in place and the force uses data to monitor incidents

There is a clear governance structure covering all the force's public protection responsibilities. An assistant chief constable is the vulnerability lead. Performance data is available to inform leaders and managers about changes in demand and whether there is enough capability in place to deal with it.

The force has good levels of information about incidents and crime. This information is available to leaders and most staff. Power BI technology allows users to select the data and information they want to use. It means the force can monitor numbers and types of incidents, and it can take actions to understand changes to risk and vulnerability in the community. This also helps managers establish which training would benefit the workforce.

The force recognises that it has a young and relatively inexperienced workforce, particularly at the frontline. It supports officers to get the supervisory skills they need by providing training before promoting them to sergeant. This is known as the 'stripes course'. And the force is developing similar training for potential inspectors.

The force has developed its quality assurance processes, which involve supervisors routinely dip-sampling incidents and investigations. Information from well-focused audits is vital for managers to understand the end results of their teams' activity.

These processes have driven improvements in the focus and timeliness of safeguarding investigations. This results in better outcomes for children because the workforce's decision-making better considers children's circumstances.

Force leaders recognise that changes to the force culture are fundamental to the rate of progress it makes in improving its responses for children. It promotes a strong message about the voice of the child throughout the workforce. It supports this with training and a prompt based on the ARTHUR mnemonic (see below). This has resulted in a rise in entries in its system that include the voice of the child from 243 in February 2022 to 700 in June 2022. We also found that the voice of the child is recorded well in investigation records.

## The force holds a range of meetings, which helps it review its approach

The force holds a range of meetings. The deputy chief constable chairs the force's monthly performance board. The detective chief superintendent chairs the bi-monthly force vulnerability board. And the monthly child protection delivery board, attended by senior managers, deals with subjects such as the force's response to children affected by domestic abuse, exploitation and trafficking, and to children missing from home.

The crime, safeguarding and investigation management meeting gives information about staffing levels and current demands on services. This helps managers make sure the force has enough capability in place to deal with the workload.
These managers monitor the number of staff in investigation and safeguarding teams and their skills and training levels. They work with managers from the learning and development team to provide specialist courses, so the force has enough capability in place to manage the demand.

Managers and staff update and respond to priority incidents and changing operational demand, and they attend a series of daily meetings. The aim of these meetings is to inform managers about high-risk incidents so they can review the level of the force's response and, if necessary, quickly put in place additional resources and improve capability. But we found these managers didn't effectively escalate activity to reduce risk to some children at high risk from exploitation or when they are missing from home.

**Innovative practice: promoting the voice of the child with learning from the Arthur Labinjo-Hughes case**

Suffolk Constabulary has introduced the mnemonic ARTHUR, which it uses to train officers to assess incidents and promote the voice of the child:

**A** – Are there children present?

**R** – Review the circumstances to identify and assess risks.

**T** – Take time to speak with children, ask them how they are feeling and record what they say. Use body-worn video (BWV).

**H** – How do they appear? Look for warning signs such as demeanour, malnourishment, neglect and lack of safe supervision.

**U** – Understand their wishes, thoughts and feelings.

**R** – Record [on force systems] using a 'protecting vulnerable people' form. Include the voice of the child, add detail in the log and notify the multi-agency safeguarding hub (MASH) safeguarding team.

## Managers don't use data and information well enough to reduce risk to some vulnerable children

The force holds tasking and co-ordinating meetings in which managers use intelligence and data from the force systems. This supports risk assessment and allocating the right officers, staff and resources to tackle problems. But some area-based managers don't prioritise work to reduce the risk to certain children who regularly go missing or who are being exploited.

Leaders need to be clearer about what good-quality end results mean for those who receive its support and services. To do this, managers need to better understand what the current data says about the force's response to risk and vulnerability.

Some of the force's records aren't good enough. For example, it doesn't record ethnicity or heritage well enough in its incident and crime records. The force needs to address this gap quickly because it undermines its ability to reduce risk in some particularly vulnerable communities.

The force recently reviewed its intelligence capability. The unit is well staffed, but its analysis doesn't always give managers the information they need to tackle crime and reduce risk.

Improved oversight, understanding and management by senior leaders is urgently needed to make the force's approaches more effective, particularly to missing children and child sexual exploitation (CSE).

## Senior leaders should develop a child sexual exploitation strategy that is informed by regularly updated information

The force's understanding of CSE isn't fully supported by a comprehensive and regularly updated intelligence profile. So, it doesn't use its own information, or that of its partners, well enough to disrupt offenders or reduce risks to children known to be vulnerable to exploitation.

Although the force and its safeguarding partners have developed successful strategies in some areas, they haven't developed a CSE strategy that is informed by regularly updated information.

The force's current response to CSE vulnerability involves awaiting crisis because its CSE responses are muddled by unclear systems and allocation practices for investigating and dealing with risk. Staff are unclear about their responsibilities for dealing with CSE. The current situation means there isn't a robust system in place to adapt to changing risk for children and to intervene effectively to prevent escalating harm. Leaders need to review and provide clarity about teams' roles so they can promptly assign cases to officers and staff with the skills and capacity to help children.

## Leaders don't have the right skills to oversee and direct the force's approach to missing children

The response to missing children incidents is also not good enough. The force told us its policy is to respond to all missing children as high-risk investigations, but we didn't find this to be the situation. We found too many cases in which vulnerable children were reported missing multiple times.

For example, the force's records for three children in local authority care showed extremely high numbers of reports of them as missing from home. The children had 105, 151 and 175 records of missing episodes respectively. The force also had other information about risk to these children. Despite daily risk-management meetings, and multi-agency meetings about missing children and children at risk of exploitation, the force's managers didn't effectively intervene. And there wasn't an appropriate multi-agency response to reduce the children's vulnerability.

The force's approach to missing children is disjointed, with some leaders lacking the expertise to oversee and direct it. This means the force can't fully understand what it needs to do to reduce the risk to children. Although force policy grades all children as high risk, it doesn't respond to their needs in that way.

Senior managers and leaders don't scrutinise the outcomes of inquiries about missing children. And they don't use qualitative information to tackle the problem and keep the children safe. The current situation suggests a disconnect between the actions of some senior managers, their staff and the force's priorities.

## The force contributes to multi-agency safeguarding arrangements, but these aren't always fully effective

The force works closely with statutory safeguarding partners as part of the SSP. Senior staff members at these partner organisations confirmed they have good working relationships with the force at strategic and operational levels. This means senior leaders can quickly work to resolve issues that need a multi-agency resource or response.

The MASH in Ipswich covers the whole county for children and adults. We found no backlogs in police cases waiting for MASH assessment decisions to provide services to help vulnerable people.

But we found that the MASH didn't fully research all domestic abuse incidents in which children were affected. This is because of limitations in the processes the force currently uses. We also found that multi-agency risk assessment conferences (MARACs) didn't focus effectively on identifying risk and planning appropriate interventions for victims of domestic abuse and their children.

Safeguarding partners in Suffolk, including the force, also work together in meetings to deal with criminal and sexual exploitation of children and repeatedly missing children. But we found that these meetings didn't always fully focus on reducing risk and would benefit from a review of their terms of reference.

The SSP doesn't have a formal process for partner organisations to challenge one another when things aren't working effectively. We found several problems the force could have formally escalated to the SSP. These include:

- There is a lack of emergency local authority accommodation for children taken into police protection.
- There is a lack of alternative accommodation for children charged with offences and refused police bail before court. The local authority responsibility to accommodate these children is rarely met.
- Some children's home staff don't carry out their responsibility to help find looked after children before reporting them missing to police. They should make initial inquiries to locate children, as described in the Philomena protocol.
- Information from return home interviews is often very delayed and out of date by the time it reaches the force.
- Although there is some mental health triage capability, police officers have to spend too much time managing mental health crises on behalf of partner organisations.

**Recommendations**

- We recommend that Suffolk Constabulary immediately works with its statutory safeguarding partners to resolve problems that are reducing the effectiveness of multi-agency arrangements to safeguard children.
- We recommend that, within three months, Suffolk Constabulary reviews how it collects, assesses and uses information about crime, vulnerability and risk. This is to make sure leaders and managers have good-quality information to prioritise safeguarding measures to reduce risk for vulnerable children.
- We recommend that, within three months, Suffolk Constabulary works with its partner organisations to review strategic and operational risk-management meetings for children at risk of exploitation, children reported as missing, and children in families included in multi-agency risk assessment conferences. This is so that good-quality partnership information is presented to support clear and effective strategies and decisions, reducing risks for the children who are included in these meetings.

# 4. Case file analysis

## Results of case file reviews

For our inspection, Suffolk Constabulary selected and self-assessed the effectiveness of its work in 35 child protection cases. Under HMICFRS criteria, the cases selected were a random sample from across the area.

Our inspectors also assessed the same 35 cases.

**Cases assessed by both Suffolk Constabulary and us**

Force assessment:

- 7 good
- 22 require improvement
- 6 inadequate.

Our assessment:

- 11 good
- 11 require improvement
- 13 inadequate.

Our inspectors selected and assessed 37 more cases during the inspection.

**Additional 37 cases assessed only by us**

- 16 good
- 13 require improvement
- 8 inadequate.

**Total 72 cases assessed by us**

- 27 good
- 24 require improvement
- 21 inadequate.

## Breakdown of case file audit results by area of child protection

**Cases assessed involving enquiries under section 47 of the Children Act 1989**

- 8 good
- 2 require improvement
- 0 inadequate.

Common themes include:

- Officers acted promptly and evidence was secured.
- Officers spoke with children and recorded their wishes and demeanours.
- Referrals to children's social care (CSC) services and the MASH were good.
- Safeguarding and investigation plans were clear and child-centred.
- Joint working with partner organisations was good.
- Supervision and direction were good.

**Cases assessed involving referrals relating to domestic abuse incidents or crimes**

- 3 good
- 4 require improvement
- 3 inadequate.

Common themes include:

- Officers acted promptly.
- Body-worn video (BWV) was inconsistently used.
- Officers inconsistently recorded the voice of the child.
- Initial investigations weren't always child-centred.
- Referrals to CSC services weren't always on time.
- Evidence about child abuse wasn't always secured.

**Cases assessed involving referrals arising from incidents other than domestic abuse**

- 2 good
- 3 require improvement
- 4 inadequate.

Common themes include:

- Officers made timely referrals to CSC and mental health services.
- Officers didn't consistently record the voice of the child.
- Control room staff used THRIVE to decide the type of approach.
- Joint investigations and safeguarding planning were inconsistent.
- Responding officers didn't always secure evidence.

**Cases assessed involving children at risk from child sexual exploitation**

- 3 good
- 8 require improvement
- 5 inadequate.

Common themes include:

- There were frequent delays to investigations.
- There was little effective joint working with CSC services.
- Risk assessments were ineffective.
- Investigations weren't child-centred and missed vital evidence.
- The child abuse image database was inconsistently updated.
- Officers didn't record the voice of the child.

**Cases assessed involving missing children**

- 0 good
- 0 require improvement
- 7 inadequate.

Common themes include:

- Risk assessment was ineffective.
- There were inappropriate delays in responses;
- There was no child-centred decision-making.
- Record-keeping was poor.
- Referrals to CSC services were inconsistent.
- There was poor supervision.

**Cases assessed involving children taken to a place of safety under section 46 of the Children Act 1989**

- 4 good
- 0 require improvement
- 2 inadequate.

Common themes include:

- Officers contacted CSC services without delay.
- Officers spoke with children and recorded their views.
- Officers made MASH referrals for the children.
- Record-keeping was inconsistent.
- There were sometimes delays in finding appropriate accommodation for children.

**Cases assessed involving sex offender management in which children have been assessed as at risk from the person being managed**

- 5 good
- 2 require improvement
- 1 inadequate.

Common themes include:

- Records were detailed and clearly assessed risk.
- There was good supervision of records.
- Managers made timely referrals to CSC services about risk to children.
- There was effective multi-agency working.

**Cases assessed involving children detained in police custody**

- 0 good
- 4 require improvement
- 2 inadequate.

Common themes include:

- All children were seen by healthcare professionals.
- Referrals were made to CSC services.
- CSC services didn't provide alternative accommodation for children and the police didn't challenge this.
- Appropriate adults attended for all children, but there were some delays.
- Reviews of detention were timely and often in the presence of the children.

# 5. Initial contact

## Leaders understand they need to improve the force's response when called by members of the community

Suffolk Constabulary has a single contact and control room (CCR), located at its headquarters. The police and crime commissioner has recently confirmed more funding will be provided to help the force improve the timeliness and quality of its response to calls from the public.

The CCR receives many calls from people, or relating to people, with mental health vulnerabilities. The force works with health providers, so from 2pm to midnight, there is usually a mental health specialist nurse either present in the CCR or contactable, to advise staff about children in crisis.

Managers have strengthened the way call handlers use THRIVE assessments. A set of standard questions is in place to help call handlers gather information about domestic abuse risk. Inspectors routinely review incidents to make sure risk is graded according to the information the force holds. CCR staff have received training on the voice of the child, and they know to tell responding officers about the presence of children at incidents. We found records of this good communication in some of the cases we analysed. It meant there was usually a good response to child protection incidents.

## Contact and control room staff know what to do when they receive calls about domestic abuse incidents

CCR staff and managers have received training to help them understand the importance of the voice of the child. The training used the case of Arthur Labinjo-Hughes to highlight what can go wrong when the child's voice isn't considered. CCR staff now prioritise incidents involving vulnerable children and they alert responding officers to children at risk.

CCR staff prioritise domestic abuse risk. This means the force's approach doesn't involve inappropriate diarised appointments. We reviewed 20 diary appointments dating between 26 May 2022 and 26 July 2022 for incidents where children were present. None were domestic abuse incidents.

When the force's CCR staff believe domestic abuse incidents need to be acted on as a priority, they don't have to complete a THRIVE assessment. This is because a decision has already been made to attend the incident as soon as possible. This is sensible as it reduces duplication and bureaucracy. But we also found some other incidents in which CCR staff didn't complete THRIVE. Managers need to look out for these cases as sometimes staff aren't identifying vulnerability quickly enough.

## Officers at domestic abuse incidents use body-worn video inconsistently

Officers attending domestic abuse incidents don't use BWV consistently. Some officers miss opportunities to record evidence and initial accounts. They don't always record the voice of the child. Some responding officers make sure they speak to children alone, without their parents present. This is important as it gives children an opportunity to make disclosures. But sometimes officers speak to the children without considering the environment those children live in. Or they record the environment but don't speak to the children. This means they lose opportunities to fully understand what life is like for these children. We also found some cases of officers using BWV but the video files not being clearly attached to force records.

When we told the force about these matters, managers acted immediately and updated the BWV policy.

The force supports Operation Encompass and officers use an automated process to notify the MASH of all domestic abuse incidents affecting children. MASH staff give information to the children's schools to help school staff support and protect those children. In 2021 the force made 3,304 Operation Encompass notifications.

Under an innovative scheme, the force directly gives general practitioners information about patients at risk from domestic abuse. This improves multi-agency vigilance for vulnerable families.

But we found that officers rarely recorded children's ethnicity or information about their cultural heritage. Some communities are disproportionately affected by domestic abuse, so-called honour-based violence, forced marriage and other culturally supported abuse. The lack of recording means the force doesn't have a clear understanding of these vulnerabilities in its communities.

## The response to reports of missing children is confused and ineffective

CCR staff complete THRIVE assessments or missing person questionnaires to record information about missing children. The force policy is to initially assess all missing children as high risk. We found some CCR staff made records and put information about the child from force systems onto the missing person system, COMPACT.

But we found that the force doesn't respond to all high-risk missing children in accordance with the College of Policing Authorised Professional Practice. It doesn't always prioritise actions to find missing children, and these cases aren't always overseen by a detective.

We found delays of up to six hours before area-based duty inspectors acknowledged and assessed the risk in some missing children incidents. During this time little, if any, investigation or action takes place to find the child. It is unclear who is responsible for incidents at this stage because the CCR staff don't direct missing child investigations.

The area inspectors' responses to missing children are variable. And reviews are often delayed and inconsistently recorded. We found generic supervision, which meant inquiries and tasks weren't focused on the risk to the individual child, and they weren't robustly reviewed. We found supervisors had recorded inappropriate comments about missing children, such as:

- "missing through choice";
- "this is not unusual"; and
- "will always return".

These mindsets undermine the force's ability to recognise children's vulnerabilities and the risks to them. It may help explain why its response to missing children isn't good enough.

Supervisors don't consistently update and review COMPACT records. This means they don't know about, and can't evaluate, some results of activity. Some missing children aren't recorded on COMPACT at all. For example, if the child returns home before the CCR transfers the incident to an area-based officer, no one makes a COMPACT record. This means missing persons advisors, MASH and CSC services don't know about the incident. As a result, the force and its partners don't fully understand the risks to some frequently missing children.

The force doesn't have its own 24/7 intelligence capability, and out-of-hours intelligence provision is limited because it shares it with Norfolk Constabulary. This means most intelligence checks for missing children are made by staff who don't have the right skills.

We also found that vulnerability flags and risk warning markers for missing children weren't consistently in place on the force's systems. And when we found reports with markers for CSE, criminal exploitation, alcohol or drug misuse, these factors weren't always included in the risk assessment.

Child abduction warning notices (CAWNs) can be effective in disrupting the activity of people the police consider to be a risk to a child. They should be attached to a child's COMPACT record so frontline staff know about the risk from these people. But even when we found CAWNs in place, investigation plans didn't refer to them when children were reported missing. We also found the force doesn't always record CAWN markers against both the child and the adult on its systems. So, frontline staff don't always know about these risks or the need to prioritise inquiries accordingly.

The force doesn't have enough trigger plans in place to help focus its officers' response to repeatedly missing children. Managers told us that the force had eight trigger plans on its systems. It also uses a similar process called fast action response plans to hold information. But there was no rationale or consistency about which should be used.

We analysed the cases of three vulnerable children who were repeatedly reported missing from local authority children's homes. The force records showed these children had been reported missing 105, 151 and 175 times respectively. There were no trigger plans or fast action response plans in place for these children.

**Case study ineffective response to a child who is repeatedly reported missing**

Staff in a children's home contacted the force's contact and control room and reported one of the boys in their care as missing. The boy had previously been reported missing more than 100 times.

There was no trigger plan for him on the force's systems, but he was subject to a child abduction warning notice, which was recorded on COMPACT. The child abduction warning notice had been made to prevent a particular adult from being with the boy. It contained details of that adult.

Contact and control room staff completed a THRIVE assessment and graded the incident as medium risk. The recorded rationale was: "He is a regular missing person."

Staff didn't assign any initial lines of inquiry to find the boy and the risk assessment wasn't checked by a supervisor for approximately four hours.

The first inspector's review was made approximately five hours after the boy was reported missing. This review endorsed the medium-risk status because the child was missing frequently.

No officer was assigned overall responsibility for the inquiries to find the child. The investigation drifted without meaningful supervisory direction. One inspector recorded: “Due to high demand, high-risk threat arrests and missing persons arguably of greater immediate need for attention have trumped the ability to progress this investigation.”

The boy returned to the children’s home by himself.

There was limited information to show that the police, social workers and children’s home staff communicated effectively with the child to form joint plans and reduce the risk.

No one sought the voice of the child on this occasion.

## The force and its safeguarding partners don’t make effective use of the Philomena protocol

Many forces and their safeguarding partners – particularly local authority children’s homes – have implemented the Philomena protocol. The protocol encourages carers, staff, families and friends to compile useful information that could be used to help quickly and safely find children if they go missing from care.

This joint approach helps to stop children going missing and is recognised as a way of protecting some of the most vulnerable children.

Managers told us that despite recognising its benefits, they have yet to fully implement the protocol in Suffolk.

**Recommendation**

- We recommend that Suffolk Constabulary immediately improves its arrangements and practices for responding to incidents of missing children. This should include:
    - having regard to the College of Policing Authorised Professional Practice;
    - using the Philomena protocol;
    - improving risk assessment for missing children;
    - improving the way it supervises responses; and
    - improving the way it collects and uses information to prevent incidents of missing children.

# 6. Assessment and help

## Safeguarding partners work well together in the multi-agency safeguarding hub

The police MASH team is based with staff from the partner organisations. A detective inspector leads the police team, which is made up of highly motivated officers and staff. They work effectively with staff from other safeguarding partners. The team works office hours from Monday to Friday and there are no delays during these periods. On Monday mornings, the team quickly assesses the weekend's referrals and deals with priority cases first. This means at the time of our inspection, there were no backlogs in the police MASH processes.

MASH staff have received a wide variety of multi-agency training to support them in their role. Subjects have included:

- CSE;
- county lines;
- children's mental health;
- bruising in children; and
- faith-linked child abuse.

Police managers monitor the training and skills of MASH staff. For example, they found that supervisors who weren't trained to specialise in child protection needed to attend the specialist child abuse investigation development programme.
They understood this skill is essential for supervisors who make decisions for the force in multi-agency child protection strategy meetings.

Decision makers from MASH agencies sit and work together, reviewing and discussing information to inform their joint decisions. They are supported by multi-agency staff and robust external links to other professionals. This means they have ready access to the information they need. The police allocation policy is clear and investigations are allocated to the most appropriate police teams.

Police officers and staff make good-quality and timely protecting vulnerable people (PVP) referrals, which are reviewed by MASH staff. These referrals often include the voice of the child. There is also a risk-grading process, which has clear timescales for researching cases and sending them directly to operational teams for strategy discussions or to be filed as a record only.

MASH officers and staff hold fast-track strategy meetings to plan joint child protection investigations. They make decisions such as who will visit and when to assess children and gather evidence. Most joint visits happen on the same day or the following day. This shows effective multi-agency working, prioritising children's needs.

The MASH process includes a triage, which uses assessed risk to determine timescales. High-risk cases move through the system within four hours. For medium-risk cases the timescale is 24 hours, and it is 48 hours for low-risk cases. This means officers and staff always prioritise referrals identified as high-risk cases, even at busy times.

The police staff in the MASH have access to CSC services' systems, so they see that some PVP referrals are open cases (for example, a child on a protection plan with a dedicated social worker). They forward these referrals immediately to the relevant professional.

The force contributes to multi-agency safeguarding planning for children and its officers and staff always attend initial child protection conferences. They also complete research and reports within the statutory review process.

## Multi-agency safeguarding hub processes in Suffolk don't always recognise high risks affecting some children

The MASH holds a monthly multi-agency quality assurance meeting, but it doesn't include open cases, or cases that are triaged out of the MASH research process.

Police in the MASH triage out around half of their PVP referrals, including open cases. Some of these are for children in standard-risk domestic abuse incidents and for matters assessed as low-risk referrals. MASH staff told us that for these referrals, their practice is only to complete checks on the local authority's system. This means they don't research wider police systems such as the Police National Database unless the PVP referral indicates other forces may hold relevant information.

Risks to a child may not be apparent from a single incident. MASH staff could get a better understanding by checking police systems for previous incidents or other relevant information. We found this problem in the partnership's response to children who were frequently reported missing from children's homes and were involved in open cases. We also found this MASH practice causes delays in escalating interventions for some children known to be at risk of criminal exploitation and CSE.

There is a similar problem in the way the force assesses risk to some child victims of online abuse. These cases include members of peer groups distributing indecent images of children and unknown people threatening to publish images of children unless they pay money. The force often sees these events in isolation. In these cases, it should be putting in place a multi-agency response to support these children.

We also found that PVP referrals don't always record the ethnicity and cultural heritage of children. This means the force may not be identifying vulnerabilities from culturally supported abuse early enough. And MASH staff don't routinely give feedback to officers about their referrals unless they want to include more information on the record.

## Some of the force's internal and multi-agency risk-management processes are ineffective

The force holds management and tasking meetings internally to make sure there is an effective response to high-risk and complex cases. And every month officers meet with staff from safeguarding partners to reduce children's vulnerability in the multi-agency criminal exploitation (MACE) meeting, the missing children tasking meeting and in multi-agency risk assessment conferences (MARACs) for high-risk domestic abuse. But we found that these meetings weren't always effective.

The MARAC we saw didn't have robust safety planning for children. It also didn't result in a clear decision about who was responsible for making sure the actions to reduce risk to children, decided in the meeting, were in place.

This concerns us. Each month there are well-attended MARAC meetings in each of the force's three areas. They give safeguarding partners opportunities to identify which families are at high risk from domestic abuse and to decide on joint safeguarding strategies. But the force and other safeguarding partners need to carefully manage these strategies, putting in place clear actions and records that can inform the approach taken in the event of new incidents.

**Case study: three examples of ineffective multi-agency risk assessment conferences practice**

1. A domestic abuse perpetrator had threatened to kill his current partner. Those present at the multi-agency risk assessment conference (MARAC) didn't consider that he had ongoing contact with his young daughter from a previous relationship. They didn't include this child in safety planning or make a referral to children's social care (CSC) services about that child's vulnerability.
2. Those present at the MARAC discussed a domestic abuse incident that featured risks of so-called honour-based violence and rape. The perpetrator was expected to return to the family home after the police investigation had closed. Meeting attendees didn't consider or implement a safety plan for the four children in that family before the perpetrator was due to return home.

3. A MARAC discussion found that a child needed a referral to CSC services. This need was identified by a health visitor not present at the meeting. That health visitor had raised concerns about the child's vulnerability in a household where there was domestic abuse. No one in the MARAC took responsibility for making sure a referral was sent to CSC services.

## The force is working with the local authority to prevent domestic abuse incidents

The force's domestic abuse perpetrator unit uses a screening process to select 33 perpetrators for its programme. It involves 18 weekly face-to-face sessions, focusing on the perpetrators' relationships, triggers and the root causes of their offending. The perpetrators are then involved in designing a safety plan for their own families. The domestic abuse perpetrator unit staff review the perpetrators' progress jointly with social workers. They have found significant positive outcomes from involving these offenders in the work. The children in the offenders' families are no longer included in child protection or child-in-need plans.

## There is a disjointed approach to managing risk for missing children

Information about children currently missing is included in the area and force-wide daily management meetings. This gives managers progress updates and risk status so they can decide if they need to use additional capability to find these children. But they don't consider all reports of missing children because incidents that are closed within a short period are generally not included on the missing person system, COMPACT.

Each area command has a missing persons advisor, but their work isn't consistent or centrally co-ordinated to improve the force's overall understanding of this subject. Missing persons advisors use their professional judgment, rather than a force-wide risk assessment, to raise the subject of repeat missing children at the force's tactical tasking and co-ordination group meetings. And even if missing children are accepted as high risk at force level, there isn't a clear system to manage the operational response and understand the results.

This disjointed approach extends to decisions about which missing children should be included in multi-agency strategy meetings. The force told us that when a child is reported as missing 3 times in 90 days, a strategy meeting may be held. But CSC services makes this decision alone. At the time of our inspection, there was no system for the police to call strategy meetings for missing children. And the force doesn't routinely record the information from these strategy meetings on its own systems. This means it can't use that information to inform its plans to protect the children and to respond to any new incidents.

It also means the information on force systems isn't complete. Flags and warning markers about risk to children frequently reported missing aren't always accurate or consistently in place. And when they are in place, managers don't always use them.

For example, three children in local authority care have been frequently reported as missing – 105, 151 and 175 times respectively. The force knows these children are vulnerable to CSE and criminal exploitation because there are some warning markers on its systems. But managers don't use that information to decide what level of intervention the force and partner organisations should make so they can reduce the risks to these children.

This is clearly a management responsibility and risks should be identified at a much earlier stage. The current systems are failing these children. These systems don't help keep children safe as the force doesn't identify and address the factors that cause children to go missing.

**Case study: the force doesn't identify high risk to a vulnerable missing child or prioritise her in a referral for multi-agency action**

A teenage girl living in a local authority care home has been reported to police as missing more than 100 times.

Care home staff contacted the police because the girl had left with her older sister at 11.03pm, which was against their rules.

Contact and control room staff recorded the incident on a COMPACT record. But they didn't use a missing person's report or carry out a THRIVE assessment. They didn't grade the incident as a high-risk missing child, despite this being the force's policy.

The incident was assigned to the area response teams, but it was more than two hours before a supervisor acknowledged it. The supervisor failed to assign any priority actions to find the child. Three and a half hours after the incident was opened, the area inspector reviewed the case and assessed it as medium risk.

The inspector noted that the child was at risk of child sexual exploitation. But the inspector recorded their opinion that the child's behaviour was "in her usual parameters" and that she would "return home at her own volition". The inspector's instructions were a generic list. For example, it said to check addresses. But no addresses were listed.

An officer updated the incident after five hours. They had left a message on the child's phone but had decided not to check a possible address for her boyfriend because it was late at night. They passed the investigation to the morning shift.

Officers located the child at a hotel, in bed with a male. But the record didn't contain information about how the police found the missing child at the hotel. Other girls and older males were at the hotel at the same time.

Even though the child is frequently reported as missing, the police didn't have a trigger plan in place with information to help them find her quickly. We did see an out-of-date fast action response plan, but officers didn't refer to it while dealing with this incident.

The officers who found the girl completed a prevention interview with her. But they didn't complete a protecting vulnerable people form or make a referral to children's social care services about the risk involved in this incident.

There was no systematic management review in place for this incident. This means the force didn't fully assess the risk or escalate the case for an appropriate multi-agency response, which could have protected the child and disrupted those who are a risk to her.

## There is a disjointed approach to managing the risk of criminal exploitation and child sexual exploitation

CSE is one of the threats specified in the Government's *Strategic Policing Requirement*.

Suffolk Constabulary splits its arrangements for dealing with child exploitation between area-based staff and specialist investigation units. This is similar to its approach to missing children.

Intelligence from force systems about vulnerability and exploitation supports force-wide and area-based tasking and co-ordinating meetings. This process helps managers allocate resources and track the outcomes of the force's operational responses. Managers allocate CSE and criminal exploitation investigations according to the seriousness or complexity of the case, or a team's capacity to take on the work.

But the force sometimes allocates CSE investigations to officers and supervisors who aren't trained in child protection or in investigating complex child abuse. We found investigations sometimes drifted and officers repeatedly missed opportunities to gain evidence. There are often multiple investigations for the same victims, or involving repeat perpetrators. But there isn't an effective force-wide oversight of criminal exploitation and CSE to make sure victims receive a better service.

One officer co-ordinates the force's criminal exploitation and CSE work with partners. That officer hasn't been trained for this role. The officer has little contact with the superintendent who is the force's strategic lead for CSE.

The force and partner organisations take part in MACE meetings so they can work together to help vulnerable children and disrupt offenders. The co-ordinating officer provides support at all MACE meetings, including the pre-MACE meetings the force holds for each of its areas.

A superintendent attends the MACE strategic meeting. But a local authority CSE co-ordinator decides the agenda, using a risk-assessment scoring tool to select which children they will include in the meeting. Officers told us this process only includes confirmed evidence, not emerging intelligence. This means that some children whose risk of harm from exploitation is changing or increasing aren't included in the meeting. In these cases, multi-agency interventions can be delayed until there is significant harm or crisis.

The force doesn't consistently update the records of decisions and outcomes from these meetings. This means its systems don't always have flags or warning markers in place, or they're not updated with new information that would help frontline staff.

**Case study: ineffective responses to risk from child sexual exploitation**

A 14-year-old girl, subject to a child protection plan, is frequently reported as missing.

Police were concerned that she had been raped by an adult male. But she said the sexual activity had been consensual, and she wouldn't make a complaint.

Officers repeatedly contacted the suspect, who lived in another force area. They asked him to come to the police station for an interview. But he never attended.

Officers sent a request to the other force, asking officers from that force to speak to the suspect. But this was delayed. At the time of our inspection, it hadn't happened.

Professionals discussed the girl's situation in joint meetings, including multi-agency criminal exploitation, and in relation to her child protection plan. But the multi-agency criminal exploitation meeting outcome wasn't recorded. Any safety or disruption planning for the suspect also remained unrecorded and wasn't linked to the child on the force systems. There was no child sexual exploitation plan in place.

**Recommendations**

- We recommend that Suffolk Constabulary immediately reviews its risk-assessment and information-sharing practices so it can:
    - identify vulnerable children at the earliest possible stage;
    - identify those who are a risk to children;
    - assess what immediate action it needs to take to safeguard these children; and
    - refer children without delay to the most appropriate level of support.
- We recommend that Suffolk Constabulary works with its safeguarding partners and reviews the terms of reference and practices of all its multi-agency risk-management meetings, including those for children at risk of exploitation and domestic abuse and those who go missing from home.

# 7. Investigation

## There are good arrangements and supervision in specialist child protection investigation teams

Senior managers have a very good understanding of the capability and staff in the specialist teams that deal with complex child protection investigations. These teams include the safeguarding investigation units (SIUs) and the internet child abuse investigation team (ICAIT). Managers work proactively with colleagues from the force's learning and development team to recognise future training needs for specialist staff. They make sure this training is in place so the force can deal with the expected demand. There is also support and training for supervisors.

Leaders have made it clear they expect investigations to be supervised using an eight-point investigation plan. They conduct regular audits to make sure this practice is consistent and that activity such as recording the voice of the child always takes place.

The force gives SIU and ICAIT staff good well-being and psychological support. We found staff in these teams were highly motivated and determined to do their best to help protect children from abuse.

The force's investigation management unit and the MASH allocate investigations to the SIUs appropriately. And investigators quickly start work, in co-operation with partner organisations, so they can prioritise the best interests of the child.

SIU staff have high but manageable caseloads. The force gives them specialist training for interviewing children, such as *Achieving best evidence* and ABELS. But sometimes there are long delays when the police need intermediaries to help them get accounts from vulnerable children. We have also seen this problem in other forces.

We also found that the force doesn't always get children timely specialist support. This is because the Suffolk paediatric sexual assault referral centre only has limited availability. This means officers sometimes have to take children to be forensically examined at sexual assault referral centres in other areas, such as London.

But overall we found effective, child-centred investigations that were timely and that supported the child.

**Case study: an effective child protection investigation**

A five-year-old girl told school staff her mother had punched her, causing a black eye. The school contacted children's social care services and they immediately held a strategy discussion with police officers.

They recorded the assault and started a joint investigation. An officer worked with a social worker and together they visited the child at school. They carried out a joint assessment, speaking with the child to understand her views and vulnerability.

They identified that the child's one-year-old sibling was at home with her mother. They considered how to safeguard both children and arranged for them to stay with their father's family. This made sure both children were safe while the investigation and social work assessment took place.

A medical assessment with a paediatrician was quickly arranged. The examination confirmed that the injury was non-accidental.

The police interviewed the child's mother and decided upon an outcome with the safeguarding partners that was in the children's best interests.

We found the investigating officer's actions were recorded and supervised throughout the case. And the end result was clearly explained to the children.

## The force has improved the way it investigates online sexual abuse of children

The force has been proactive in improving the effectiveness of its ICAIT. In 2021 it reviewed the way it deals with notifications about online offenders from national and international law enforcement organisations. These include other forces, the National Crime Agency and law enforcement agencies such as the Child Protection System. The force has recently introduced new procedures to make sure it prioritises safeguarding children.

The force records referrals from partner organisations on its intelligence system. A detective sergeant assesses them before asking the MASH for any information from partner organisations' records about risk to the children involved. If ICAIT officers can identify the children, they consult with staff from CSC services to make sure they are fully prepared before going to these children's addresses.

The ICAIT records crimes appropriately on the force's system as soon as it accepts a referral. This means the wider workforce has access to relevant information about vulnerable children and suspects. We found records with good direction from supervisors about planning and prioritising officers' investigative and safeguarding activity.

Officers arrest suspects and apply police bail conditions. These help them protect children while they carry out investigations and evidential forensic examinations.

But there are some significant delays to digital forensic examinations of suspects' devices. Even though the force prioritises ICAIT investigations, it usually takes two to three months for investigators to receive results. But ICAIT staff told us there can be delays of up to nine months. The digital forensic unit (DFU) managers know these delays add to risk and make safeguarding interventions less effective. So, they aim to reduce the existing backlog and return most examinations within 75 days and priority cases within 30 days.

We found the force's ICAIT technical capability was under-developed. Its existing portable triage kit for examining devices at suspects' premises is ineffective. Triage during the early stages of investigations would help the force quickly classify 'first-generation' images, which the offender is likely to have created. This information is vital for identifying victims, gathering evidence and safeguarding children. But the current system, without adequate triage, means there can be delays before investigating officers get this information.

The DFU's terms of reference mean it is desk based and doesn't routinely work with investigating officers at crime scenes or while search warrants are being carried out. DFU staff support ICAIT with urgent device downloads while suspects are in custody, and triage with the extraction of data from those devices. The ICAIT sometimes arranges help from the force's cybercrime department, which has more up-to-date equipment to examine suspects' devices at crime scenes and during searches. But the force needs to improve its initial technical capability because it is currently missing some devices, and others are unsuccessfully examined by the DFU. This adds to delays in investigations.

## The force should improve the way it uses the national child abuse image database

The force has access to the national child abuse image database (CAID), which allows trained officers to view images and add images to the system. This can help officers identify victims faster when they're researching intelligence or investigating offences. Forces should use this system to help identify children and offenders. By adding confirmed information to CAID, forces help officers (locally, nationally and internationally) identify which indecent images are new and the children who are at risk.

But the force doesn't use CAID to its full potential. It doesn't upload images and information consistently or completely. There is a backlog, and although the force has introduced a new process, the updated capability isn't fully in place.

Officers don't always run facial mapping or scene photo searches on CAID. And they don't routinely check the system for images of missing children. Investigators can add images of vulnerable children to the system for evidence-gathering for facial mapping enquiries. This is useful in some investigations into child exploitation and when there are concerns about repeatedly missing children. But at the time of our inspection, this didn't always happen.

## The workforce is uncertain about how to investigate online child abuse

The force doesn't have clear guidance to help staff respond to cases of self-produced sexual images sent on digital devices (often known as sexting). This means frontline officers don't investigate these crimes well. And too often the safeguarding response for vulnerable children is ineffective.

Where frontline officers investigate online sexual abuse offences against children, they don't always speak to the children themselves. And they don't always seize phones and devices for examination of abusive images. This means the force often inappropriately gives parents the responsibility of deleting the images themselves. This action can't be checked. And it means the force misses wider safeguarding opportunities to assess crime, protect other children and contribute vital information to CAID.

Frontline investigators don't always consider wider safeguarding. They often focus on the offence reported and the sole child involved, without considering peers and siblings.

Police in the MASH tend to assess PVP reports from officers investigating many incidents of online sexual abuse offences against children as 'blue'. This means they are unlikely to result in multi-agency strategy meetings or assessments of the children's vulnerability. As a result, the affected children may not receive early help and support, for example, from school staff. This is a missed opportunity because we found examples of school staff and the force's schools officers carrying out good-quality safety work with children.

The force and its safeguarding partners have developed carefully planned lessons. They can provide these in schools or to cohorts of children where there is vulnerability. This might be following reports or investigations about children posting intimate photos on social media and in chat groups. The lesson plans and presentation slides we saw were relevant and helpful.

**Case study: an incomplete investigation and safeguarding response to online abuse**

School staff reported that a group of pupils (boys and girls in years 11 and 12) were sharing a video containing indecent images of a 14-year-old child.

The force quickly sent area-based officers to the school and they investigated the incident. The officers prioritised safeguarding for the children and the multi-agency safeguarding hub held a multi-agency strategy meeting, including police and partner organisations. But the police didn't record the outcome of the meeting on their systems.

Officers established which children had the images on their phones and contacted their parents and carers to explain the situation and to arrange to delete the images. But this activity didn't involve the force's specialist digital forensics unit or internet child abuse investigation team. So, the force couldn't be sure that all the images had been removed from every device.

It also meant the force didn't properly grade the images and identify the depicted child, or add the images to the child abuse image database.

The force did send officers to work with the school, planning sessions for the pupils and staff on safe internet use.

But the force's records didn't show the outcome of any contact with children's social care services about the child whose images had been circulated.

## Recommendations

- We recommend that Suffolk Constabulary immediately establishes clear guidance for its responses to online child abuse and makes sure these responses are effectively supervised. This is so its workforce knows:
    - how to secure, preserve and remove indecent images of children on digital media;
    - which team is responsible for investigating online child abuse offences;
    - how and when to get specialist help and advice; and
    - to consider wider safeguarding for all children affected.
- We recommend that, within three months, Suffolk Constabulary reviews its capability to respond to online offending and to forensically examine electronic devices. This is to make sure it has an effective digital triage capability to examine devices for unlawful digital content. It should also reduce how long it takes for results of forensic digital examinations to be returned to investigating officers.
- We recommend that, within three months, Suffolk Constabulary makes better use of the child abuse image database so it can improve its investigations and safeguarding of child victims.

# 8. Decision-making

## The force uses police protection powers well, but record-keeping is often inconsistent

It is a very serious step to remove a child from a family using police protection powers. When there are concerns about children's safety, such as parents leaving young children at home alone or being intoxicated while looking after them, the force's officers handle incidents well. When they need to take immediate action, officers use their powers well to remove children from harm's way.

In the cases we examined, decisions to take a child to a place of safety were well-considered and made in the best interests of the child. Officers' decisions to protect children were positive and taken appropriately when they recognised risk of significant harm. This shows frontline officers have a child-centred awareness.

The force intranet gives good guidance for using police protection powers. It is accessible and easy to navigate. The guidance makes the role of police inspectors clear: they must take responsibility as 'designated officers', authorise police protection, and record decisions with rationale. But we found the force followed this policy in just three of the six relevant cases we reviewed. A standard approach would help the force understand when and why it uses the power.

We also found the force doesn't fully review handovers between designated officers. Without continuously reviewing the power, the force can't be sure if continuing to use it is proportionate and necessary. And in four of the six relevant cases we analysed, officers didn't record and explain the decision to end police protection powers.

We found officers always contacted CSC services when they used powers to protect children. And officers record good details about children's vulnerability and send them to the MASH without delay. But there were no records of strategy discussions or meetings for five of the six cases we reviewed. There should always be a strategy discussion with CSC services because police can only use their power of protection when an officer believes a child is suffering or is likely to suffer from significant harm.

## There are delays in providing safe accommodation for children after they are protected by police

Although officers contact CSC services without delay when they take children into police protection, we found that there could be significant delays before the local authority provided suitable accommodation for these children. So, police officers must remain with children for excessive periods of time until the children are safely placed with appropriate carers. In one situation, a vulnerable 12-year-old girl, who had run away from her children's home, was kept at a police station for 24 hours and then moved to a hotel before CSC services found her safe accommodation.

We found that police inspectors didn't challenge CSC services to provide children with a place to stay when there were delays. But the local authority doesn't have enough emergency accommodation for it to always be available when needed. At the time of our inspection, senior police leaders hadn't formally raised the problem within the safeguarding partnership.

# 9. Trusted adult

## The force works directly with schools and other groups of children to involve them in policing

The force encourages young people aged 13 to 18 to join its voluntary cadet units. The assistant chief constable is the regional lead for police cadets and the force makes sure the organisation is a safe place for these young people. It has designed the national vetting process for cadets and adult volunteers.

In Suffolk there are 154 cadets (90 male and 64 female). They meet weekly at different locations across the force area. The cadets are involved in various community events, including parades and helping with crime-prevention initiatives.

Police officers and staff also co-ordinate targeted lesson plans in secondary schools to educate children about the risks of exploitation.

Community-based officers liaise and work with school communities to build trust and relationships so children and school staff know who to approach if they are concerned about risk or vulnerability. They lead lessons and give information and advice on current threats to children from exploitation, weapons and online abuse.

The Mini Police programme allows the police to work with groups of primary school children in their local schools. They lead the children through a funded programme, which covers anti-social behaviour, internet safety, bullying, road safety and hate crime. So far 390 children from 6 schools have joined the programme.

# 10. Managing those who pose a risk to children

## A dedicated specialist team manages the risk from registered sex offenders

At the time of our inspection, the force's public protection unit (PPU) was managing 917 registered sex offenders in the community. This number increases yearly. There are currently manageable ratios of 64.5 offenders per manager. The workload is reduced due to the number of reactive management cases. This means staff have realistic workloads and the time to assess the complex risks from these offenders.

There are three PPU teams, aligned to the force's area command units. Each has a dedicated supervisor. This means there is good communication with local officers, who know about the presence of high-risk sex offenders in their local areas. They can give PPU staff intelligence to help them adapt to changes in offenders' circumstances.

But we found that the force records recorded sex offenders inconsistently on its systems. It records all offenders on the main intelligence system, Athena. But it doesn't routinely record all offenders and their addresses on the force's system for tasking and operational resource management. This means an officer responding to an incident may not know about the presence of sex offenders at the location.

All the PPU staff are trained in the management of sexual offenders and violent offenders and using the Violent and Sex Offender Register (ViSOR). Although the PPU team members, including the manager, are currently police staff, they communicate well with warranted police officer colleagues so they can arrange for offenders to be arrested without delay.

## Team and case record supervision is mostly effective

PPU staff use the active risk management system to determine how they manage registered sex offenders in the community. This means the force uses more resources on the offenders causing greatest concern. Police visit these offenders more often than those the force assesses as a lower risk.

There are no significant delays to the force seeing and assessing offenders' risk. We found good records of visits to, and interaction with, offenders, including an appropriate level of detail and with a structure that allowed the force to understand the reasons for the assessed risk.

The active risk management system assessments and risk-management plans highlight risks and usually contain bespoke actions to deal with them. They are well supervised, and it is clear that supervisors read and understand the plans and assessments. This helps the force prioritise which offenders should be dealt with most urgently if they reoffend or breach their notification conditions.

But we found that the force didn't complete all PPU ViSOR records in line with national best practice. Offender managers don't always use the system's 'relationship' field to record information about who offenders contact or interact with. Putting this information in the correct place makes sure all the system's users can clearly see associations. This helps them understand how well risk-management plans are working. Offender managers also currently record their actions in the main risk-management plan section. But they should be noting them on the ViSOR 'actions' tab so other users and supervisors can clearly access them.

The three team supervisors manage their teams' work on ViSOR separately. If one supervisor is away, the others don't automatically supervise the work of other staff. Instead supervisors delegate responsibility to an experienced but untrained member of their team. This results in an inconsistent approach to supervising high-risk offenders. The teams need more robust and consistent supervision arrangements.

## Offender managers work well with partner organisations to manage the risk from sex offenders

The force supports multi-agency public protection arrangements (MAPPA). Representatives from all appropriate agencies attend and contribute effectively to MAPPA meetings. PPU staff work closely with probation officers from the National Probation Service, who manage offenders subject to court-imposed licence restrictions.

We found some good examples of PPU staff acting quickly when they received information that offenders were a risk to children. Offender managers promptly notified children's social care services and the National Probation Service about changes in offenders' circumstances.

We also found records of good joint working with probation officers to jointly manage offenders' risk. And we found good joint action and information-sharing with housing and mental health service providers to support offenders and reduce their risk to the community.

Offender managers routinely make unannounced home visits to offenders in pairs. This practice is a vital tool to check on offenders' compliance with their risk-management plans. Unannounced visits allow offender managers to check offenders' associations and their use of digital media.

Announced visits take place after unannounced visits have failed, or if they are pre-planned with probation officers.

A digital support officer is based in the PPU. They use equipment to examine how offenders use digital devices to access the internet and communicate on social media. Offender managers also use a polygraph to check offenders' verbal responses to questions about their activity. PPU staff make timely referrals to the MASH if they are concerned about risks to children.

Sexual harm prevention orders and sexual risk orders help forces manage the risk of some offenders. Generally, investigating officers at the force apply for these orders, but the force doesn't have a consistent approach. And many officers and staff are uncertain about their responsibility to apply for them. When the courts grant these orders, officers and staff place flags on the force's systems to alert the workforce to the offender's risks.

But some PPU staff told us the wording of the conditions on some of these orders is inconsistent with the information they hold about offenders' risk. They told us that in some of these cases, they need to apply to the courts to amend the orders so that they are fit for purpose.

At the time of our inspection, the force only had one sexual risk order. This suggests a lack of understanding about the legal tools that can protect the public from sex offenders.

# 11. Police detention

## The force understands children should only be detained in custody when absolutely necessary

Officers should arrest a child only when it is absolutely necessary. The force's officers arrest and detain fewer children than they did in previous years because they now find other ways of dealing with some children who commit offences.

All custody staff have a training day every ten weeks. Recently this has covered themes such as terrorism, radicalisation, child protection and how the MASH shares information and makes decisions. This has helped custody staff understand more about the force's approach to risk and vulnerability.

Custody staff complete risk assessments for every detained child, and these include questions about welfare and mood. They highlight any concerns at handovers.

Many children in custody have complex needs. They are often vulnerable and need support to keep them safe. Custody staff understand they need to speak to detained children to recognise any vulnerability and record the voice of the child. Speaking to the child, noting their demeanour and recording the voice of the child helps custody staff reduce risks. It also helps them refer concerns quickly to CSC services, who can help the child.

The custody facilities in Suffolk don't have bespoke child detention rooms. But if there are children in detention, custody staff try to keep adult detainees to a minimum to reduce contact. We saw that custody staff provide comfort packs for detained children, which include distraction items such as soft balls and reading materials.

The force always allocates female children a named female detention officer. This is to make sure it can sensitively approach health issues or concerns.

Inspectors carry out reviews in the presence of the detained children, checking on their welfare and the effects of detention on them. When decisions about children are made while they're sleeping, we found records of officers explaining those decisions to them after they wake up.

## There are good multi-agency arrangements to help children in police detention

Healthcare professionals assess the health and welfare of children in detention. These professionals are on duty in the custody facilities 24 hours a day. They can make entries on the force's systems, and they can help children by making direct referrals to CSC and other services.

Liaison and diversion staff are also present 7 days a week, from 7am to 6pm. They assess children and consider the most suitable outcomes within and outside the criminal justice system. Liaison and diversion staff review all children who are arrested, even if they don't see them while in custody.

The Anglia Care Trust provides appropriate adults to support children detained in the force's custody facilities. These adults are professional and arrive promptly, and the service operates 24 hours a day.

Custody managers regularly audit records to make sure they understand how well their teams deal with children in police detention.

## There is no formal escalation when the local authority doesn't provide alternative accommodation

The local authority is responsible for giving suitable alternative accommodation to a child charged with offences and denied bail. Only in exceptional circumstances is this not in a child's best interest (for example, if bad weather makes it impossible to transport them). In rare cases, such as when a child is at high risk of causing serious harm to others, they may need secure accommodation.

Custody staff understand the difference between secure and alternative accommodation. Two years ago, the force and local authority made a protocol, setting out the process for officers to request alternative accommodation.

But we found no examples of the local authority providing alternative accommodation for children who had been charged with criminal offences and denied bail.

When local authority accommodation isn't available, custody officers don't ask their managers for help finding an immediate solution. And leaders don't escalate these cases well enough with the local authority or the Suffolk Safeguarding Partnership.

**Recommendation**

- We recommend that, within six months, Suffolk Constabulary strengthens its working practices with local authorities to make sure children charged and refused bail are moved to appropriate alternative accommodation and not held in custody overnight.

# Conclusion

## The overall effectiveness of the force and its response to children who need help and protection

We saw good practice in the way Suffolk Constabulary responds to children who need immediate protection after being involved in incidents. And the force's child protection investigators work effectively with partner organisations to help children get better end results.

The force has used learning from the national child safeguarding practice review into the murders of Arthur Labinjo-Hughes and Star Hobson to improve the way its officers and staff respond to vulnerable children. This helps the workforce understand why it is important to speak to children and record their demeanours and wishes. It means officers and staff make better decisions to safeguard children and they make timely referrals to get children help.

We also saw managers dip-sampling and checking the quality of specialist teams' child protection investigations. As a result, most investigations prioritise safeguarding children and progressing investigations to bring about the best results for victims. And we found examples of police officers and staff from safeguarding partners sharing and discussing information so they could make better decisions to help children.

We found some areas of strength in the constabulary's child protection arrangements, including:

- a committed and enthusiastic workforce with a clear focus on the voice of the child;
- high-quality multi-agency child protection investigations;
- good management of sex offenders; and
- good care and treatment of detained children.

But Suffolk Constabulary needs to make changes to improve some of its child protection arrangements and practices. This includes its management culture.

Managers need to understand the implications of risk for vulnerable children and respond without delay to reduce the risk of harm. This means quickly identifying repeat victims, and perpetrators who exploit children, then escalating interventions to prevent harm. The force's information systems and risk-management structures aren't clearly aligned to prioritise this need and allow the force to check the results of its responses. And there is uncertainty about which teams should investigate some complex risk. This includes high-risk missing children incidents, and criminal and sexual exploitation cases.

The force has systems and meetings for overseeing its activities. These include multi-agency arrangements, which help it understand and co-ordinate all aspects of child protection activity. But these aren't fully effective. The force should refine these arrangements to include recent intelligence about high risk. It should consider this risk against the other information it knows about a child's vulnerability. This will help the force improve its safeguarding interventions and let managers know if their arrangements are effective or if they need to be adjusted.

The force fully participates in multi-agency safeguarding arrangements with partner organisations in the SSP. But although force managers know about some longstanding operational difficulties that hamper their child protection activities, they haven't yet formally escalated and resolved these problems within the SSP.

We found that the officers and staff who managed demanding child abuse investigations were committed and enthusiastic. Specialist child protection staff work with staff from partner organisations in timely investigations, which focus on getting the best end results for children.

But non-specialist staff don't always have enough guidance to respond effectively to complex child abuse, such as online sexual exploitation. And the force doesn't have enough forensic digital capability to deal with the demand from online cases.

We have therefore made a series of recommendations. If the force acts on them, they will help improve outcomes for children.

## Next steps

Within six weeks of the publication of this report, we require an update of the action the force has taken to respond to the recommendations where we have asked for immediate action.

Suffolk Constabulary should also provide an action plan, within six weeks of the publication of this report, setting out how it intends to respond to our other recommendations.

Subject to the update and action plan received, we will revisit the force no later than six months after the publication of this report to assess how it is managing the implementation of all 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 organisations are set out in the statutory guidance *Working together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children*. 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 focus on the experience of, and outcomes for, children following their journey through the child protection and criminal investigation processes. They assess how well the police service has helped and protected children and investigated alleged criminal acts, taking account of, but not measuring compliance with, policies and guidance.

The inspections consider how the arrangements for protecting children, and the leadership and management of the police service, contribute to and support effective practice on the ground. The team considers how well management responsibilities for child protection, as set out in the statutory guidance, have been met.

## Methods

- Self-assessment of practice, and of management and leadership.
- Case inspections.
- Discussions with officers and staff from within the police and from other organisations.
- 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 in the service about the strengths and weaknesses of current practice (this forms the basis for discussions with HMICFRS); and
- initiate future service improvements and establish a baseline against which to measure progress.

## Self-assessment and case inspection

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

- domestic abuse;
- incidents in which police officers and staff identify children who are in need of help and protection (for example, children being neglected);
- information sharing and discussions about children who are 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 ‘at risk’);
- sex offender management;
- the management of missing children;
- child sexual exploitation; and
- the detention of children in police custody.

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