HMICFRS

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

National Child Protection Inspection Post-Inspection Review

Suffolk Constabulary

10–14 July 2023

Contents

Introduction

Our 2022 inspection

In July 2022, HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) inspected how well Suffolk Constabulary keeps children safe. We made ten recommendations in the Suffolk – national child protection inspection report.

The 2023 post-inspection review

In July 2023, we returned to the constabulary to undertake a post-inspection review.

During this inspection we:

- examined constabulary policies, strategies and other documents;
- interviewed constabulary leaders and some senior managers from the Suffolk Safeguarding Partnership, operational police managers, and spoke with frontline personnel; and
- audited 30 child protection cases (17 cases were good, 7 required improvement and 6 were inadequate).

Summary of findings from the 2023 post-inspection review

It is clear to us that Suffolk Constabulary is addressing the concerns that led us to make ten recommendations in our 2022 national child protection inspection report.

There are now effective governance structures to help leaders understand and provide the right level of service. Leaders use a regularly updated action plan to check on progress to improve the constabulary's child protection arrangements.

All the personnel we spoke with are enthusiastic and actively seeking to develop high-quality child protection services.

Leaders review their child protection and safeguarding arrangements and seek to match resources and capability to demand. There are specialist child protection officers and other safeguarding personnel on teams for each of the three constabulary areas. This is appropriate because these personnel need to work closely with other agencies in the areas where children live.

The constabulary works effectively with other organisations in the Suffolk Safeguarding Partnership to co-ordinate child protection practice. Senior managers from other child safeguarding organisations told us of their joint work with the police to improve services so that outcomes are better for children.

The constabulary has made the changes and improvements needed to meet most of the recommendations we made in our 2022 report. However, in other areas further work is required.

Terminology in this report

Our report contains references to ‘national’ bodies, strategies, policies, systems, responsibilities, processes and data. In some instances, ‘national’ means applying to England and Wales. In others, it means applying to England and Wales and Scotland, or the whole of the United Kingdom.

Leadership, management and governance

Recommendations from the 2022 inspection report

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.

Summary of post-inspection review findings

The constabulary works closely with its safeguarding partners to make sure appropriate arrangements are in place for children who need safe places to stay.

Managers have reviewed and refocused the multi-agency risk management meetings for exploited children.

There have been improvements in the timeliness and quality of information gathered in interviews with vulnerable children who had been reported as missing from home.

The philomena protocol for missing children is being successfully implemented in local authority children's homes.

Safeguarding partners have improved their risk-assessment and information-sharing processes so vulnerable children get better services.

Detailed post-inspection review findings

The constabulary works closely with its safeguarding partners to make good arrangements for children who need safe places to stay

The Suffolk Safeguarding Partnership has introduced formal escalation and risk register processes to help it to manage and resolve any complex concerns safeguarding organisations raise.

It has used these processes to increase the availability of alternative accommodation for children charged with criminal offences and denied bail before their court appearances.

Nationally there are severe shortages of this type of accommodation and for secure accommodation for detained children. The local authority and the police took the initiative to increase provision of alternative accommodation in Suffolk. They advertised in the community and have now provisionally identified four new specialist foster care places. They are training the foster carers and the service is due to start in October 2023.

Some children taken into police protection also urgently need safe accommodation while children's services work to arrange longer-term support for them. But police and children's services staff don't always initially agree about the need to remove children from their homes.

Managers from both organisations are working together to build a closer understanding of incidents when the police need to use their child protection powers. They have agreed to review all these incidents, using audits and discussions between managers to improve working practices. This shows that the partnership is determined to improve communication to support better joint child protection work.

Most multi-agency risk management meetings are now more effective

In 2022, we saw that the constabulary worked closely with its safeguarding partners within multi-agency risk management meetings to plan safeguarding activity to reduce risk and harm to children. These meetings consider the best way to help the children who are most vulnerable to criminal abuse and exploitation. But we found that the terms of reference and agendas for some meetings weren't focused enough.

This created some duplication of activity and overlaps in case management. It also meant that there were delays in interventions to safeguard children, such as children who were high risk due to a high number of missing episodes. Sometimes the agenda of multi-agency risk management conferences (MARAC) didn't clearly include affected children.

The constabulary organises its county-wide operational services into three policing areas. East area is based in Lowestoft, west area is based in Bury St Edmunds and south area is based in Ipswich. The safeguarding partnership uses this structure to arrange multi-agency child exploitation (MACE) meetings, missing person meetings and MARACs for families affected by domestic abuse.

The partnership reviewed the MACE and missing persons meeting arrangements and agendas. This has led to more education and voluntary sector organisations participating in these meetings and increased attendance. Pre-MACE meetings are now held to make sure that only appropriate subjects are included, which reduces overlap and duplication with other risk-management and child protection meetings. The partnership also now uses an updated version of its exploitation risk assessment tool.

During our July 2023 inspection, we examined MARAC records and observed a meeting. The meeting was well chaired with good multi-agency attendance. Positively, we saw the participants considered how best to safeguard the children in the cases they discussed. But meeting chairs and police managers told us that the results of the safeguarding actions set at MARACs weren't reviewed at future meetings.

This concerns us. The results of safeguarding actions should inform the meeting about the current level of risk to families. This would help it decide if other protective services are needed.

Police managers told us they are supporting a partnership review of the MARAC.

Arrangements to reduce risk for missing children have improved

In February 2023, the constabulary introduced a new policy for missing children. Personnel in the contact and control room must now initially grade missing children as either medium or high risk. It means they don't record missing children incidents as low risk or no apparent risk.

The policy also means the constabulary uses the specialist missing person system COMPACT to record details of these incidents. COMPACT records are shared automatically with the multi-agency safeguarding hub (MASH) and with the constabulary's specialist missing persons advisers. The missing persons advisers share information with the local authority to improve the quality of information about children who go missing.

In our last inspection, we found that information from local authority return home interviews with children who have been missing was often delayed and out of date by the time the police received it. This has improved. Now, social workers and staff from the family support charity Anglia Care Trust generally complete these interviews with children and share the information without delay.

The constabulary and children's services are introducing the philomena protocol. This helps staff in children's homes to understand their responsibilities for those they look after and when they should contact the police if the child isn't at home. The staff are trained and given guidance on recognising risks to children in their care and on providing the police with accurate information to help find those missing more quickly.

The protocol isn't yet fully adopted across all the children's homes, but the joint work continues to promote its benefits. So far this initiative has reduced the number of missing children reports for looked after children by approximately one third. Children's services and police managers told us the protocol had reduced inappropriate demand on their staff. This helps them to focus more on children at higher risk. It also means that looked after children aren't stigmatised or treated differently because their carers make inappropriate missing-from-home reports to the police.

This successful joint work means the partnership is more effective in how it safeguards children. It has encouraged the partnership to develop other initiatives. The police and their partners support the expansion of Operation Encompass to tell schools about missing children incidents.

Information-sharing and risk-assessment processes have improved

We found the safeguarding partners had reviewed their MASH arrangements and made some changes to practice so that:

- police researchers routinely used information from the Police National Database in their assessments;
- all domestic abuse incidents affecting children under the age of five are automatically referred to children's services; and
- children's services are routinely notified in all cases where children are assessed as vulnerable due to domestic abuse, risk of exploitation or having been missing from home.

The MASH decision-makers have been trained and given updated guidance about the new arrangements. This reinforces the importance of including full research of the constabulary's own intelligence records, so that cumulative risk from repeated low-level incidents is considered.

Leaders and managers have good-quality information so they can prioritise safeguarding for vulnerable children

The constabulary's child protection delivery board oversees work to improve its child protection and safeguarding services. This meeting is attended by senior managers with responsibility for child protection and other leads from across specialist teams and the constabulary areas. It lets them work closely together and co-ordinates their activities.

Leaders monitor performance. They use Power BI technology to assess and understand levels of demand and the results of their actions to protect children from harm.

Police personnel who attend the child protection delivery board share their knowledge of issues such as vulnerability, missing and exploited children, and specialist child protection investigations. This knowledge comes from their attendance at other constabulary meetings.

Child protection managers benefit from information provided by the constabulary's internal audit team. It gives them feedback about the quality of their investigations and the outcomes for children.

We saw that managers are reinforcing the importance of police personnel recording the voice of the child. This is a training priority. We saw that the innovative ARTHUR prompt it had introduced was increasingly used by non-specialist officers in investigations and to make referrals to children's services.

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.

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 MASH team.

The improvement in referrals from non-specialist officers shows the success of the training programme. But the constabulary's specialist child protection personnel didn't often use this prompt. Overall, the recording of the voice of the child, and consideration of it, was less effective in their investigations.

Recording of children's ethnicity and cultural heritage remains inconsistent

In the cases we audited, we saw that the constabulary's personnel were inconsistent in how and when they recorded information about children's ethnicity and cultural heritage. Leaders know about this problem but haven't intervened sufficiently with training and supervisory oversight to change and improve current practice. As a result, the risk and vulnerability inherent to some children and families isn't fully considered and understood. And this means they may remain at risk despite their contact with police.

The constabulary uses intelligence from its systems to support child safeguarding arrangements

The constabulary uses its intelligence and analytical products to support the Suffolk Safeguarding Partnership's work. Specialist intelligence personnel gather and assess intelligence from the constabulary's information systems. This includes relevant information provided by the safeguarding partnership. In addition, the constabulary has a community email facility to encourage people to tell them about crime, antisocial behaviour and vulnerability.

Personnel assess intelligence in a timely manner. Intelligence potentially requiring immediate action is considered by the daily management meeting. If information is assessed to identify threat, harm and/or risk, it is considered by the constabulary's monthly tasking meetings or multi-agency risk management meetings such as MACE.

Records of delegated tasks are kept on constabulary systems with a process in place to update them. Managers can see results or if additional intelligence is needed, such as more information to plan how to disrupt gangs who exploit children.

Each policing area has personnel to provide intelligence to support the daily management meeting and frontline operations. This information helps officers to develop the best methods to deal with threats to vulnerable people in communities.

The constabulary could do more to develop information about child sexual exploitation risk

The safeguarding partners know they can share information about child sexual exploitation (CSE) through the MASH referral system or within MACE meetings. But we didn't see any records of MACE meetings where this type of information was recorded.

There isn't currently a constabulary-wide CSE intelligence profile. CSE profiles benefit from accurate partnership information. They can inform strategic decision-making and help specialists develop comprehensive and layered tactical approaches to deal with complex risk.

We didn’t find any active CSE operations or strategies for preventing CSE risk, or for disrupting lone offenders exploiting children or those acting in groups.

Intelligence managers told us they are confident that their systems will identify emerging CSE risk at local and cross-border levels.

There was currently no information to concern them that children in the county were at risk of organised or group-based CSE. But we did see some records of individual CSE criminal investigations.

We also saw that the risk in some sexual abuse investigations isn’t always identified as CSE by investigating officers and intelligence specialists. This means that opportunities to disrupt CSE perpetrators may not be taken.

There is a disruption plan in the south constabulary area for gang-related crime, supply of drugs and criminal exploitation. This plan is structured with a 4P-approach so there is a clear operational methodology. Managers assign specialist capability and resources to support it. They monitor the results of all activity to understand the progress it makes. This indicates that the constabulary can address complex or group-based CSE risk if these concerns arise.

Initial contact

Recommendation from the 2022 inspection report

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.

Summary of post-inspection review findings

Revised procedures for missing children are in place, but they aren't always followed. Control room personnel record their risk assessments to help responding officers.

Missing children aren't always graded effectively, and the supervision of investigations can be inconsistent and delayed.

There are better processes to reduce risk for repeatedly missing children.

The constabulary promotes the use of the philomena protocol.

Detailed post-inspection review findings

Revised procedures for missing children are in place, but they aren't always followed

In February 2023, the constabulary introduced revised missing person procedures that follow guidance in the College of Policing's missing persons authorised professional practice. Key personnel, including people in the contact and control room and frontline managers, have been trained in the new procedures and there is a flow chart to show what they should do when children are reported as missing.

Specialist intelligence personnel are present in the contact and control room daily between 7am and 2am and can help high-risk missing person investigations. This does mean there is a five-hour period when they aren't immediately available to help. To mitigate this gap, some contact and control room personnel are receiving specialist intelligence research training.

We saw records of contact and control room personnel checking police systems for information about risk to children and using it in their risk assessments. This helps direct frontline officers to find the children quickly.

The constabulary has improved contact and control room risk assessments for missing children. But we still saw incidents when initial risk gradings were delayed. There were further delays in frontline personnel confirming risk assessments when they were assigned the investigations.

Frontline supervisors told us they received training on the updated COMPACT system for managing investigations to find missing people. They know how to contact system experts for their advice. All felt more confident about the system and understood the benefits of using it correctly.

Information about current missing children is always included in area and constabulary-wide daily management meetings so managers can decide if they need to allocate additional resources to find the children.

The supervision of missing children investigations can be inconsistent and delayed

We saw some improvements in supervision since the revised missing person procedures were introduced. But there are still delays. This includes delays to initial risk grading by contact and control room supervisors and area duty inspectors acknowledging their responsibility for the incident. In some cases, we also saw delays to completing risk assessments, assigning relevant investigation plans and recording reviews.

In three of our case audits, overnight investigations weren't prioritised or progressed as they should have been. This meant delays in activity to find the child.

The procedures require missing children to be graded as high or medium risk. They require high-risk missing children investigations to be overseen by CID supervisors. But we saw high-risk incidents without any overnight CID oversight and delays in CID supervisors reviewing the investigations.

Investigation oversight of missing children assessed as medium risk is assigned to area inspectors.

Overall, we found an improvement in supervisors using bespoke approaches to direct investigations. But some simply repeated previous assessments. We saw one incident where a supervisor used inappropriate child-blaming language.

Case study: delays in supervision and responses to find a high-risk missing child

The constabulary received a missing person report about a 13-year-old girl who had previously been reported as missing from home by her family on 31 occasions.

The call handler used a questionnaire to record information about the child's vulnerability. They identified information on the police systems about known risks to the child from sexual and criminal exploitation, that she was vulnerable because of poor mental health, and that she misused solvents and cannabis. But the call handler didn't make an initial risk grading for the missing person incident.

Although there was a recorded missing person response plan for the child, the call handler didn't use this or quickly allocate the investigation to officers. There was no record of any contact and control room supervisory oversight.

The first recorded risk assessment was made by a frontline officer approximately three hours after the initial report. The officer graded it as a medium-risk investigation. The risk assessment wasn't endorsed by a supervisor until four hours later.

Eight hours after the child was reported missing, a supervisor carried out a review. They used victim-blaming language in their assessment, including "it is not unusual behaviour" and "she always returns within 24 hours". The supervisor recorded some generic investigative enquiries, but these weren't based on information specific to the child.

It wasn't clear who was allocated to lead the investigation, or what the priorities were. Officers didn't refer to or follow the response plan to help find the child. The investigation didn't make any overnight progress and no meaningful updates were recorded.

The duty inspector first reviewed the investigation 12 hours after the child was reported as missing. They raised the grading to high risk because she hadn't returned home overnight.

Shortly after the inspector's review, officers found the girl in a park and returned her home. The officers interviewed the girl and completed a risk assessment, but it was superficial and didn't include any focus on the voice of the child. This meant opportunities to communicate with her and gather vital information to reduce the risk of future harm were missed.

There are better processes to reduce risk for children who go missing on a regular basis

Repeatedly missing children are reviewed by the area missing persons advisers. These advisers create a response plan when a child is reported as missing 3 times in 42 days. The plans are flagged on police systems.

We found the constabulary has improved its use of these plans. They are more comprehensive and easier to access by personnel who need to use them to find the missing child. Positively, frontline officers we spoke with knew how to get the information and told us they used it. But we still saw cases when the plans weren't used.

The missing persons advisers schedule discussions with safeguarding partners about children who go missing repeatedly. They jointly decide if a child should be discussed at a strategy meeting or referred to the monthly multi-agency missing persons meeting. Records of strategy discussions and missing persons meetings are recorded on police systems so they are accessible to operational personnel.

The missing persons advisers also make sure that relevant risk information, such as risk of criminal and sexual exploitation, drug use and mental health vulnerability, are recorded on police systems. This information is referred to and taken into consideration by personnel making risk assessments and reviewing missing person investigations. We saw that the information, including child abduction warning notices, is clearly visible on the child's COMPACT record and also against the adults who present the risk.

The constabulary uses information from its records to reduce risks to vulnerable children

The constabulary is making better use of information from the COMPACT system to reduce risk to missing children. The missing persons advisers monitor COMPACT records and gather information to update risk assessments and response plans. They use this information to decide which children should be considered by the monthly multi-agency missing persons meetings.

But we found COMPACT records aren't always made when children are found quickly. Most frontline officers only complete a child risk assessment form in these situations. The forms are checked by police MASH personnel who inform children's services and the area missing persons advisers. This arrangement means the constabulary and relevant partners are aware of all missing children.

This practice is appropriate, but the true numbers of missing episodes can't be found solely on the COMPACT system. It is important that missing persons advisers check that, when there are delays in starting COMPACT records and the child is found, frontline officers have completed a child risk assessment form to record that missing episode. This helps other colleagues to understand the real level of risk to some children, particularly those who are running away from abuse or being exploited.

The constabulary promotes the use of the philomena protocol

The philomena protocol encourages carers, staff, families and friends to compile useful information that can help in quickly and safely finding children if they go missing from care. This joint approach also helps children's home staff to work with children and prevent them going missing. This, in turn, helps to protect those that are the most vulnerable.

The constabulary is promoting the use of the philomena protocol and uptake by staff in children's homes has been positive. Numbers of missing children reports for looked after children have reduced by about one third since our last inspection.

Assessment and help

Recommendations from the 2022 inspection report

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.

Summary of post-inspection review findings

Managers have reviewed and improved MASH processes.

MASH processes identify children at risk of abuse and exploitation.

Good quality assurance processes check that referrals are made when there are concerns about child abuse and exploitation.

The constabulary and its partners have reviewed and strengthened the effectiveness of multi-agency risk management meetings for children at risk of abuse and exploitation.

MARACs have some ineffective and inefficient processes.

Detailed post-inspection review findings

Managers have reviewed and improved MASH processes

MASH police managers working with multi-agency partners have reviewed their arrangements and processes. Changes described in the leadership, management and governance section of this report have improved the thoroughness of research and risk assessment for police referrals. This means that information about risk to children from outside the constabulary's area and cumulative risk to children from low-level incidents is now included.

The police MASH team routinely check the Police National Database when assessing risk to children in domestic abuse incidents. This helps them to understand the context of previous incidents within and outside the constabulary area. They record this research on police systems so all personnel responding to incidents know about the family history and latest risk assessment. This information is shared with MASH partners.

The new approach incorporates national learning about younger children's vulnerability. And police routinely make referrals when children are affected by domestic abuse. This means these children can benefit from multi-agency services at an earlier stage. It helps partner organisations work more effectively to prevent risk escalating, rather than reacting at the point of crisis.

Managers told us that the number of referrals for children had increased. The quality of information meant that these were appropriate and necessary. It means that more children are safeguarded.

MASH processes identify children who are vulnerable or at risk of abuse or exploitation

MASH personnel check the COMPACT system and the local authority's system for reports of missing children. They make referrals to the local authority missing persons co-ordinator for children if these haven't already been sent by investigating officers. They also make sure that children's social workers are informed and updated when the children are found.

The constabulary records and updates risk assessments for children vulnerable to exploitation on its systems. This information is shared with the local authority and used to devise plans at MACE meetings to reduce risk.

Investigating officers refer child victims of online abuse to the MASH. The information from the MASH helps investigators understand other risks for these children and helps to identify other potential victims. It also means that schools are included in strategy meetings and helps children and their families to get better support.

Managers routinely audit MASH processes

The MASH partners jointly check their teams' work using quality assurance processes. There are monthly audits for:

- sergeants' decisions about recording crime and non-crime reports received by the MASH team;
- referrals to the NHS; and
- cases where police research isn't completed.

These audits help managers understand the effectiveness of their arrangements to identify risk and share information with other organisations. This makes sure that police MASH personnel pursue opportunities to get children early help from the most appropriate organisation or multi-agency risk-management forum.

As the MASH doesn't operate over weekends, we saw some delays in police referrals to other organisations. But the prioritisation process to focus on high-risk cases means these delays aren't excessive.

The MASH team deals with many referrals. This indicates that the constabulary's personnel want to get help to vulnerable children. MASH personnel do identify some poor-quality referrals and provide feedback to officers about how to improve their work.

Positively, we saw that frontline personnel were increasingly using the ARTHUR prompt to record the voice of the child. It wasn't always used, but MASH managers' efforts to promote it is improving the quality of police referrals.

Some children are vulnerable to abuse or exploitation because of their cultural heritage, for example through trafficking or forced marriage. As stated earlier in this report, our case audits identified inconsistency in the recording of children's ethnicity and cultural heritage in domestic abuse and child protection referrals. Constabulary leaders need to address this.

The safeguarding partnership has improved its risk management arrangements for children who are vulnerable or at risk of abuse or exploitation

The constabulary and its safeguarding partners have reviewed the terms of reference and the operational practices of their multi-agency risk management meetings for children who are at risk of exploitation or who are missing.

MACE and missing children's meetings are held every month in each of the three constabulary areas. The agenda is determined in a pre-meeting where multi-agency personnel assess which vulnerable children need to be assessed and discussed by the main panel.

This helps the panels focus on the highest-risk children. The risk to the children discussed in MACE meetings is complex. The meetings allow specialists from across the partnership to work together to reduce the children's vulnerability.

The membership of the meetings has been reviewed and additional organisations from specialist safeguarding and education now routinely attend. This means that more information is provided and assessment is improved. It also means the panel can increase the services provided for the children and comprehensively check if their plans to reduce risk are working.

Multi-agency child exploitation meetings are more effective

All children discussed by the MACE meeting are risk assessed using a recently revised partnership tool. This is also used to score any new referrals of concerns about exploitation risk to children. The panel uses the tool to monitor the results of the services and activities they direct to help the child. This information informs the panel's decisions about whether children will continue to be included in the MACE system or no longer require MACE intervention and can be released to less intensive services.

The constabulary makes good use of information on its systems to tell frontline personnel about children at risk of exploitation. When children are subjects of MACE interventions, a 'CSE open' flag is added to their records on the constabulary's Athena system. When a child is no longer the subject of MACE interventions, the CSE flag is removed.

While this is a good process for children known to be at the highest risk, more could be done for other vulnerable children. Other forces use CSE warning markers more broadly. This helps them to alert personnel about the potential for CSE vulnerability in children not yet in the MACE system. It also encourages intelligence collection to identify children at risk of CSE and trafficking.

Multi-agency risk management of missing children is more effective

The safeguarding partnership has better arrangements for children who are at risk when they are missing from home.

The constabulary's missing persons advisers work closely with the local authority missing persons co-ordinator. They hold monthly multi-agency meetings to manage and reduce the risk to vulnerable children when they are missing from home. These meetings complement the MACE meetings in the three constabulary areas.

Monthly missing meetings in each of the areas are co-chaired by police and children's services managers. Pre-meetings make sure the main meetings focus on high-risk children who are repeatedly reported missing.

All these meetings monitor the frequency of children's missing episodes and assess any changes in their vulnerability and risks to them. Managers decide what additional multi-agency support the children need. This structured approach gives the constabulary and its safeguarding partners a much clearer understanding of which children are most vulnerable when they are missing from home. It provides better quality information to support interventions to reduce risks to these children.

Multi-agency meetings for families at risk from domestic abuse have some ineffective and inefficient processes

Trained managers from the safeguarding partners chair MARACs, held monthly in each of the constabulary's areas. This is positive as it means that local organisations are aware of the families at risk from domestic abuse and can provide services to help and protect them.

The organisations jointly plan to reduce risk to adults and their children. We saw records were made about the risks and the actions proposed to reduce them.

The MARAC records we saw had approximately 50 outstanding actions dating back to January 2023. Although most of the actions were clearly set out and had a named individual responsible for their completion, no time frame was set for this to be achieved. Updates or results aren't routinely given in following MARACs.

The meeting we observed didn't deal with the outstanding actions other than by requesting attendees to update the MARAC co-ordinator about their status after the meeting. We were told that MARAC chairs routinely remind attendees at the start of meetings that there are outstanding actions that need to be completed.

MARAC co-ordinators regularly email organisations asking them to complete actions and provide updates on the results of the work.

We observed a MARAC. Risks to children were a clear priority throughout the cases discussed. In some incidents on the agenda, children's services had already closed the cases, but the MARAC allowed police and other organisations to raise concerns about continuing risks to the children. This allowed the meeting chair to raise actions that would provide services to help and protect those families. Sometimes this meant directing organisations to make new or further referrals to children's services.

The constabulary told us that the partnership is planning to review the terms of reference and practices of MARACs. This review should be prioritised.

Investigation

Recommendations from the 2022 inspection report

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.

Summary of post-inspection review findings

There is clear guidance and an allocation policy for investigating online child abuse.

Frontline officers lack the knowledge and skills to effectively investigate online child abuse.

There are better systems to secure timely forensic digital evidence.

The constabulary is increasing and improving its use of the child abuse image database, but officers don't clearly understand what they need to do to get all relevant images onto the system.

Detailed post-inspection review findings

There is clear guidance for investigating online child abuse

The constabulary has good guidance for personnel to follow when they investigate online child abuse offences.

Managers from the specialist internet child abuse investigation team (ICAIT) provide training for all new officers, detective constable courses and those on the specialist child protection course. This training gives officers clear guidance about what they should do to investigate crimes involving indecent images of children.

ICAIT managers told us they published guidance on the constabulary's systems to help non-specialist personnel improve the way they secure evidence, safeguard children and deal with offenders. They recently checked 200 crime records to understand the impact of this material and found that officers aren't always using the guidance. The constabulary needs to find other ways to improve investigations.

The allocation of child indecent image investigations is clear

The ICAIT has clear terms of reference to investigate referrals from national and international law enforcement agencies. An increase in the number of ICAIT personnel has increased its capacity to deal with the workload. We saw the ICAIT had approximately 200 live investigations.

The team grades and investigates all indecent images of children, including where there is physical sexual contact, except images shared between children where there are no aggravating factors. Non-specialist officers in the constabulary's three areas investigate when indecent images are shared between children.

The constabulary has employed additional digital support officers to support all its investigative teams, including frontline officers. Digital support officers provide specialist advice and assistance. They use specialist equipment obtained with Home Office funding to download digital files from victims' devices.

Many indecent image investigations allocated to frontline officers are ineffective

In some frontline investigations, we saw delays before officers spoke with victims and examined their devices. We saw cases in which officers only secured victims' phones for examination if they thought there were aggravating factors. Some officers simply deleted the images or made the device complete a factory reset so all existing files were removed. Some investigations were completed by officers phoning victims or their parents and asking them to delete the indecent image files.

This approach is ineffective. It means that offences aren't being correctly identified, recorded or investigated. Some victims who need safeguarding may not be identified. And opportunities to disrupt offenders, which may include other children who may also be victims, are missed.

The constabulary has produced an excellent leaflet with information about how to safely remove indecent images from devices and phones. Some frontline officers told us they knew about it, but contact and control room personnel we spoke with weren't aware of the resource. This means it is inconsistently used.

The practice of deleting indecent images without fully investigating the content also means the images aren't included on the child abuse image database to help investigators who find the images in future cases.

Frontline investigators don't always consider the risk to a child's siblings or friends

Frontline officers don't always fully consider the vulnerability of siblings or friends of the victim in their investigations. Supervisors don't consistently check that investigations include an assessment of any risks to other children before they close them. We only saw one frontline investigation into indecent images of children where officers or their supervisors investigated to see if images were distributed more widely.

Investigating officers don't always refer child indecent image victims to children's services in a timely manner. This means that they only use police information to make safeguarding decisions for children. We didn't see any records of investigating officers considering the voice of the child. We also didn't see records showing officers considered the implications of the abuse for the child and their wider peer group.

There are better systems to secure timely forensic digital evidence

The digital forensic unit (DFU) has improved its operating practices. DFU personnel have worked effectively to reduce the time it takes to examine devices for evidence of a crime. Leaders understand the importance of getting digital evidence of online child abuse to investigators. There is a service level agreement for the timeliness of examinations and the DFU achieves these time frames more regularly. The constabulary will introduce advanced equipment to speed up device examination and increase DFU capacity in September 2023.

Additional digital support officers are trained to support all officers to investigate online crime. They triage digital devices before officers make a forensic submission to the DFU. This is effective and efficient practice, making sure DFU examinations are prioritised and more focused.

The prioritisation process means that examinations of high-risk devices are all within the unit's agreed time frames. It also means that older submissions continue to rise up the schedule. If investigating officers have concerns about the timeliness of examinations, they can escalate them to their detective inspector for resolution.

The constabulary uses specialist resources against high-risk online child abuse

ICAIT officers use digital triage equipment in their operations, such as when searching suspects' premises, to help them decide which devices should be seized.

The cybercrime department has digital media investigators, who offer good specialist digital forensic triage capability to help officers identify and secure evidence at crime scenes. Investigators request help from the cybercrime team when planning operations and search warrants. Digital media investigators support about 50–60 high-priority operations a month.

Managers look for solutions to provide faster forensic evidence from suspects' digital devices. A full file extraction from a mobile phone currently takes about 24 hours. Another examination method using the SPEKTOR system doesn't provide a full forensic download but helps officers to see if any suspect files are on a computer. SPEKTOR isn't suitable for mobile phones. ICAIT investigators told us that in high-risk cases they plan ahead and arrange custody time extensions to complete investigations before charging or releasing suspects.

The constabulary is increasing and improving its use of the child abuse image database

ICAIT managers told us they were improving their officers' investigations and how they used technology to safeguard children from becoming indecent image victims.

The constabulary has employed two victim identification officers who support the constabulary's contribution to the national drive to keep children safe from online abuse and exploitation.

These officers upload digital evidence and images onto the national child abuse image database. They also support investigating officers by attending crime scenes and joining search warrant operations.

When DFU examiners find indecent images of children, they instruct the investigating officers to contact the victim identification officers to determine which ones need to be uploaded onto the child abuse image database.

The victim identification officers also proactively search the constabulary's systems for these types of investigations to help officers identify children and upload relevant new images onto the child abuse image database. This means that the identities of some child victims are confirmed without delay.

The victim identification officers' managers are now seeking to increase the ways they use the child abuse image database's capabilities. This is positive because we saw that present practice didn't always include officers uploading photographic images of locations where online offending took place. Entering these locations can help other investigators to identify those who abuse and exploit children. Managers told us they are also working towards using the system's facial mapping system to identify victims.

The constabulary is investing in increasing the bandwidth of its own digital link to the child abuse image database to reduce the time it takes to enter files and receive information.

Non-specialist teams don't always use the child abuse image database effectively for online investigations

Most frontline and specialist officers knew of the child abuse image database. But they were uncertain about its full capability.

The constabulary's approach to uploaded images of child sexual abuse isn't yet consistent. As stated earlier in our report, most of these investigations are allocated to non-specialist officers. We found that in most of these incidents, officers asked victims or their parents to delete any child abuse images from their phones and electronic devices. Or the officers took this action themselves.

It means that these deleted images aren't graded and uploaded on the child abuse image database. The database contains a store of searchable, graded digital images. It can help investigators know that the children are identified and safe. It also reduces duplication and unnecessary enquiries.

Although the constabulary has significantly improved its use of the child abuse image database, some further action is needed to use it at its full capability.

Police detention

Recommendation from the 2022 inspection report

> 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.

Summary of post-inspection review findings

Custody personnel understand they should find alternative accommodation for detained children.

The constabulary has worked with the local authority to increase the provision of alternative accommodation for children in police detention.

The constabulary and its partners have good oversight of custody arrangements for children.

Detailed post-inspection review findings

There are improved arrangements to provide alternative accommodation for detained children

In our 2022 inspection, we found the constabulary had good multi-agency arrangements to help children in police detention. This inspection finds that these good arrangements continue.

The local authority is responsible for providing alternative accommodation for children charged with offences but denied bail. In our 2022 inspection, we were concerned that there wasn't a routine or formal escalation process in place when the local authority didn't meet that responsibility. Detaining children in police custody is only in the child's best interests in exceptional circumstances, 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.

During our 2023 inspection, we saw the constabulary holds meetings with partners to make sure that the constabulary's facilities for detained children are as good as possible. All cells have now been approved as suitable for children. Refreshed guidance about accommodation options for children has been given to custody officers. And inspectors check that this is followed in their reviews of children's detention.

Nationally, there is only a very limited amount of alternative accommodation for detained children. So, it is important that when custody personnel make requests, they understand the difference between secure accommodation and alternative accommodation.

Positively, we found that custody personnel clearly understand the difference. We also saw that they made early requests to the local authority when secure accommodation was likely to be needed.

The custody team and local authority managers told us about a joint initiative to increase the availability of alternative accommodation for detained children. Four new specialist foster carers have been trained and these additional places will be available later in 2023.

Custody personnel don't always fully record their decisions about detained children

In two of the three child custody cases we audited, we saw that the local authority offered alternative accommodation for the detained child, but custody personnel decided it was unsuitable.

In one case the offence was murder. Custody personnel had clearly recorded the rationale to keep the child in police detention on the custody record. But in the case of a child who was charged theft and assault, it was unclear why the local authority accommodation was considered unsuitable.

Other than this case, we saw that custody personnel made good records about detained children. Managers gathered good performance information and used it to maintain effective custody arrangements. We saw the data included numbers of children in custody and the time they were detained. It also recorded details about appropriate adult attendance. Details of detained children were always reported to senior officers in the constabulary's daily management meetings.

Next steps

Suffolk Constabulary still needs to improve some areas of its work to provide consistently better outcomes for children. However, it has made some positive progress, particularly in the way it has trained frontline personnel to identify children's vulnerability and make good safeguarding referrals.

The changes and improvements the constabulary has made meet some of the recommendations we made in our 2022 *Suffolk – National child protection inspection report*, but in other areas further work is required. We have summarised the progress made against these recommendations below.

Leadership, management and governance

It is clear to us that the changes that Suffolk Constabulary has made have led to the improvements necessary to complete all the recommendations we made for leadership, management and governance.

Initial contact

The constabulary has made some improvements to its arrangements and practices to reduce risk for missing children. But further action is needed to build on this progress to make sure there is effective supervision in place for missing persons investigations. We do not consider that the constabulary has completed this recommendation.

Assessment and help

The partnership arrangements for assessing and sharing information have improved and are more effective in identifying vulnerable children who need service provision to reduce risks of harm. MASH processes are effective. The constabulary has completed this recommendation. The constabulary and its partners have improved the effectiveness of their arrangements for missing children and those children who are vulnerable or at risk of abuse or exploitation. Clearly the constabulary has completed these areas of the recommendation. But MARAC processes and arrangements still require revision to make sure the meetings are more effective in reducing risk to children. As a result, the constabulary hasn't fully completed this recommendation.

Investigation

The constabulary has made substantial improvements to its DFU processes and has completed this recommendation.

However, the guidance and supervision of non-specialist online child abuse investigation hasn't yet led to all the improvements needed. It means that these child victims, their peers and families aren't receiving a consistent level of service. The constabulary hasn't completed this recommendation.

Managers also need to improve all personnel's understanding of the importance of timely investigations to gather digital evidence and use it to effectively disrupt perpetrators of online child abuse. This includes making sure all investigators consistently use the child abuse image database. The constabulary hasn't completed this recommendation.

Police detention

It is clear to us that the constabulary has made the improvements necessary to complete the recommendation we made for children in police detention.

We found that senior leaders and managers are keen to complete this work. We will continue to evaluate Suffolk Constabulary's performance as part of our routine monitoring of all forces.

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