# National Child Protection Inspection Re-inspection

West Midlands Police
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# Foreword

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

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

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

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

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

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

# Contents

# 1. Introduction

This report is a summary of the findings of a re-inspection of child protection services in West Midlands Police**,** which took place in July 2015. The initial inspection took place in June 2014 and the subsequent report was published in October 2014. The report comprises nine chapters in three main parts. The first part provides information on the background to the inspection and to West Midlands Police. The second part focuses on the inspection findings, and the third part looks to the future and makes recommendations for improvement.

# 2. Background

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

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

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

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

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

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

HMIC carried out a child protection inspection of West Midlands Police in June 2014 and published the report of this inspection in October 2014. In November 2014, the force provided HMIC with an action plan setting out how it intended to respond to the recommendations in the inspection report.

Follow-up activity by HMIC is an integral part of the National Child Protection inspection programme. It allows inspectors to assess the progress each force is making in its work to improve services for the safety and protection of children.[2] To this end, HMIC carried out a re-inspection of West Midlands Police in July 2015. The same methodology was used in all inspections carried out under the programme. This report sets out findings from the re-inspection in July 2015.

[2] The methodology for assessing and conducting post-inspection activity is set out on HIMC's website at: www.justiceinspectorates.gov.uk/hmic/our-work/child-abuse-and-child-protection-issues/national-child-protection-inspection/

# 3. Context for the force

West Midlands Police is the largest police force outside London with over 10,540 staff. The workforce includes:

- 7,133 police officers;
- 3,148 police staff; and
- 260 police community support officers.[3]

The force provides policing services to a population of around 2.74 million people. It serves a densely populated, predominantly urban area. Birmingham is the major city in the force area with a population of 1.1 million people.

The force has ten local policing units (LPUs), which are aligned with seven local authority areas. The local authorities are responsible for child protection within their boundaries and each has a separate local safeguarding children board (LSCB).[4] The seven local authorities within the West Midlands Police force area are:

- Birmingham
- Coventry
- Dudley
- Sandwell
- Solihull
- Walsall
- Wolverhampton.

The most recent judgments made by the Office for Standards in Education, Children's Services and Skills (Ofsted) for each of the local authorities are set out below.

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

[4] LSCBs have a statutory duty, under the Children Act 2004, to co-ordinate how agencies work together to safeguard and promote the welfare of children and ensure that safeguarding arrangements are effective.

| Local authority | Judgment | Date |
|---|---|---|
| Birmingham | Inadequate | March 2014 |
| Coventry | Inadequate | January 2014 |
| Dudley | Adequate | November 2011 |
| Sandwell | Inadequate | January 2015 |
| Solihull | Adequate | November 2011 |
| Walsall | Adequate | June 2013 |
| Wolverhampton | Adequate | June 2011 |

The current model for public protection in West Midlands Police was introduced as part of a major change programme called ‘Service Transformation’. This programme commenced in 2013 and culminated in the phased implementation of a new public protection unit (PPU) between 1 June 2014 and 30 November 2014.

The PPU comprises a central department with responsibility for the delivery of services relating to child protection (including child sexual exploitation), domestic abuse (including forced marriage and so-called honour-based violence), the management of registered sex offenders, the investigation of rape and serious sexual offences and missing persons. The PPU is also responsible for the:

- child abuse investigation teams (CAITs);
- sex offender management teams;
- vulnerable adult abuse teams;
- online child sexual exploitation team;
- central referral unit (CRU); and
- three multi-agency safeguarding hubs (MASHs).

A detective chief superintendent leads the PPU, supported by three superintendents and eight detective chief inspectors.

The LPUs are served by six child abuse investigation teams (CAITs) led by four detective chief inspectors who report to the head of the PPU.

Following a review of the force's structure for public protection, the programme of changes that began in June 2014 was expanded to include the recruitment of an additional 370 police officers and 16 police staff. As a result of this increase, the force has introduced specialist domestic abuse teams in each LPU and dedicated teams of staff to attend initial child protection conferences.

There is a single dedicated referral unit for child protection covering the whole force area. Multi agency safeguarding hubs (MASHs) have been established recently in Birmingham, Sandwell and Coventry, and at the time of our re-inspection in July 2015, West Midlands Police had agreed with partners to roll out this model across the force area. Furthermore, the force had reached agreement with partner agencies to deliver a consistent model for safeguarding across the West Midlands, although implementation had not yet started at the time of our re-inspection.

# 4. The police role in child protection

Under the Children Act 1989, the police service, working with partner agencies such as local authority children's social care services, health services and education services, is responsible for making enquiries to safeguard and secure the welfare of any child within their area who is suffering (or is likely to suffer) significant harm.[5] The police are duty-bound to refer to the local authority those children in need they find in the course of their work.[6] Government guidance[7] outlines how these duties and responsibilities should be exercised.

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

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

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

Many teams throughout police forces perform important roles in protecting children from harm, including those who analyse computers to establish whether they hold indecent images of children and others who manage registered sex offenders and dangerous people living in communities. They must visit sex offenders regularly, establish the nature of risk these offenders currently pose and put in place any necessary measures to mitigate that risk.

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[5] Section 47 of the Children Act 1989.

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

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

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

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

During the course of the inspection, West Midlands Police assessed 33 cases in accordance with criteria provided by HMIC. The force was asked to rate each of the 33 self-assessed cases. Practice was viewed as good by the force assessors in 14 of the cases, adequate in 4 cases, requiring improvement in 6 cases and inadequate in 9 cases.[8] HMIC also assessed these cases, rating 5 as good, 6 as adequate, 10 as requiring improvement and 11 as inadequate. One was not assessed because the information required by inspectors to review the case was inaccessible[9]. Inspectors selected and examined a further 54 cases where children were identified as being at risk. Nine were assessed as good, 7 as adequate, 19 as requiring improvement and a further 19 as inadequate.

## Initial contact

### Recommendations from the October 2014 inspection report

- We recommend that West Midlands Police immediately ensures that there are procedures in place to:
    - escalate any concerns about an incident involving children at risk if, for whatever reason, police have been delayed in attending the incident or alleged crime; and
    - ensure that the incident is not downgraded without proper justification, and the appropriate checks have been made on the welfare of the child.
- We recommend that, within three months, West Midlands Police ensures that officers always record their observations of a child's behaviour and demeanour in domestic abuse incident records, so that a better assessment of a child's needs can be made.

### Re-inspection findings

In most of the cases examined, officers responded quickly to clear and specific concerns raised about children, such as abuse or neglect of a child. They undertook a wide range of initial tasks, such as checking on the immediate safety of children and gathering relevant information before making an assessment of a child's needs. There were examples of officers using good judgment, identifying risk and

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

[9] This case related to an investigation that had been classified for security reasons.

considering a course of action that was in the child's best interest. When further action was necessary, such as a joint visit with children's social care services, this was often arranged quickly. Officers undertook thorough initial enquiries and used their powers to arrest when necessary. Examples included:

- the steps taken when a mother contacted police stating that her seven-year-old son had been assaulted by his father whilst staying with him. A strategy meeting[10] and a joint investigation with children's social care services were undertaken promptly. Officers attended with social workers and the father was interviewed. Officers gave careful consideration to the boy's needs, and a medical examination was handled sensitively. The early contact and engagement with children's social care services ensured that longer-term safeguarding measures were initiated promptly; and

- the action taken when a woman was seen assaulting her son by a member of the public. When officers attended they found the mother to be intoxicated and immediately checked on the welfare of all four of her children. Protecting the children was at the forefront of the decision-making process. Officers identified that they were already the subject of a child protection plan and ensured that appropriate referrals were completed to ensure longer-term safeguarding planning was undertaken. Officers used their powers to protect the children whilst offences of neglect were investigated.

As a result of concerns from the previous inspection, control room procedures had been reviewed and revised guidance had been issued to all staff on how to respond to child protection concerns through the force wide Operation Sentinel[11] training programme. This training included a focus on children involved in domestic abuse situations to ensure that officers recorded observations about a child's behaviour and demeanour and control room staff escalated concerns about a child to an inspector if police were delayed in attending the incident.

Inspectors found that staff in the force control room were alert to risk and vulnerability, and generally knowledgeable when dealing with calls that clearly related to a child protection concern. Inspectors also found that the force's initial response to concerns about those who may pose an immediate and obvious risk to

[10] Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm there should be a strategy discussion involving local authority children's social care services, the police, health services and other bodies such as the referring agency. This might take the form of a multi-agency meeting or phone calls and more than one discussion may be necessary. A strategy discussion can take place following a referral or at any other time, including during the assessment process. *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015 (latest update), pages 36–37.

[11] Operation Sentinel is an initiative aimed at improving the service West Midlands Police provides to those at risk of harm.

children was often good. Officers undertook prompt and thorough enquiries and searched for suspects. However, there were some calls from the public where children were present and may have been at risk, where the assessment made of the level of threat did not take full account of the safety of the child. For example:

- a mother called 999 stating that she was being verbally assaulted by her partner who was drunk and had mental health issues. The caller stated that her partner had hurt her daughter in the past and she was concerned about her other two children who were also present. The control room operator incorrectly graded the call as requiring a non-immediate response and the officers who attended failed to gather all available information (for example, officers did not identify that the partner had previously threatened to 'slit the children's throats') to assist decision making. No domestic abuse, stalking and harassment and honour based violence (DASH) risk assessment was completed and once the partner was removed from the premises the incident was closed with no crime being recorded. Despite there being evidence of risk to the children, officers did not record that they had checked on their welfare; and.

- a 15-year-old boy in the care of the local authority had been charged with possessing a bladed implement and went missing following his release from police custody. He had been reported missing six times previously. The matter was not reported to police by his social worker for over nine hours and as a result the control room operator was not prepared to treat the boy as missing and closed the incident. Consequently there was little effort on the part of the force to locate the boy and when he returned no welfare checks were completed.

West Midlands Police had invested time and resources in training frontline officers on their role in safeguarding children. This had resulted in better awareness amongst staff and a sense of responsibility for child protection matters. Inspectors found some examples where officers worked well with other agencies to protect children and ensured that their needs were met. However, inspectors also found a number of cases where child protection concerns were not referred or escalated to the MASH or CRU when a child was at risk. In these cases there was insufficient regular and intrusive supervision to ensure the appropriate reports were completed and of a good standard. As a result, opportunities to intervene and safeguard children at an earlier stage were missed.

For example:

- officers executed a warrant to search for firearms and were concerned about the living conditions of the three children present. While arrangements were made to place the youngest child with her grandparents, there was no evidence of what, if any, safeguarding was put in place for the other two

children, and no evidence that any of the children were spoken to. There was no referral to children's social care services for a strategy discussion and no consideration was given to using police powers to remove the children to a place of safety; and

- a woman attended a police station to report that she had been assaulted by her husband and mother–in-law while holding her eight-month-old baby. While the allegation of crime was recorded and an investigation initiated, there was no evidence of a referral being made or a DASH risk assessment being completed. As a result, a strategy discussion did not take place until 13 days after the initial allegation when the incident was later referred to the Birmingham MASH.

Police usually attended incidents of domestic abuse promptly, and most staff spoken to were clear about their responsibility to record whether they had checked that any children present were safe and well. Although most officers routinely checked on the welfare of children when attending a domestic abuse incident, this was not always the case. Some children were not seen or spoken to alone when this would have been appropriate (i.e. if the presence of a parent might inhibit a child expressing their view).

A child's demeanour, especially in those cases where a child is too young to speak to officers, or where to do so with a parent present might pose a risk, provides important information about the impact of the incident on the child. It should inform both the initial assessment of need and any referral to children's social care services. In most, but not all, of the cases assessed by inspectors, frontline staff attending domestic abuse incidents had recorded their observations about the demeanour or behaviour of children. However, overall inspectors found a material improvement in the quality and frequency with which the behaviour and demeanour of children was recorded.

## Assessment and help

**Recommendation from the October 2014 inspection report**

- We recommend that, within three months, West Midlands Police undertakes a review of the CRU to ensure that:
    - the unit is fulfilling its purpose to receive, assess and co-ordinate multi-agency activity to safeguard children effectively;
    - background checks, initial assessments and strategy discussions between agencies take place in good time and do not leave children at risk; and
    - there is supervisory oversight at a senior level to ensure that the unit is working properly and that any problems are speedily resolved.

- We recommend that, within three months, West Midlands Police takes steps to improve practice in cases of children who go missing from home and those who are assessed as absent. As a minimum, this should include:
    - improving staff awareness of their responsibilities for protecting children who are reported missing from home and assessed as absent – in particular, in those cases where absences are a regular occurrence;
    - improving staff awareness of the significance of drawing together all available information from police systems better to inform their risk assessment;
    - improving senior management oversight to ensure that supervisors are fulfilling their responsibilities;
    - identifying the range of responses and actions that the police can contribute to multi-agency plans for protecting children in these cases;
    - ensuring that, when police officers and staff recognise a risk and consider that other agencies are not meeting their responsibilities, they raise the issue with managers to ensure that the risk is addressed and know how to escalate their concerns; and
    - at a senior level, initiating discussions with the local authorities and children's home providers so that risks to children who are looked after are properly addressed.
- We recommend that, within three months, West Midlands Police:
    - ensures that MARACs record what safeguarding action has been taken, and what actions are planned for the future;
    - provides information (e.g. history of abuse, number of children in the family) to other agencies before the MARAC takes place;
    - identifies the range of responses and actions that the police can contribute to multi-agency plans for protecting victims and children in high-risk domestic abuse cases; and
    - improves the timeliness for screening domestic abuse cases in Birmingham.

## Re-inspection findings

West Midlands Police was in the process of making changes to the way information is referred to and exchanged with partners and, as noted earlier the force is working with partners to establish MASHs across all ten LPUs using a consistent safeguarding model to improve decision making and protective plans. At present the central referral unit and the recently developed MASHs in Birmingham, Coventry and Sandwell are the focal points for information exchange and inter-agency planning. They manage large volumes of information, and for the most part they do so quickly and efficiently. Although some inconsistency was evident in how referrals were processed, HMIC acknowledges that the force is in transition and recognises that a single safeguarding model is likely to result in more effective and efficient referral processes in future.

Generally, the force responded well in cases where the concern was clear, and particularly when the situation required immediate action. Contact with children's social care services was made promptly and there was evidence of agencies working well together – identifying risks, making plans to reduce them and supporting children and their families. The force had invested time and resources in reducing backlogs within the CRU and MASHs and child protection referrals were now dealt with on the day they were received.

While the majority of initial enquiries were timely and thorough with specific investigation and safeguarding plans agreed, inspectors were concerned that recording on police systems was frequently poor. Inspectors examined twenty cases where safeguarding referrals were made and found eight to be inadequate and seven to require improvement. The details of action taken to protect the child, such as strategy discussions and longer-term safeguarding plans to inform future decision making, were often absent. For example:

- a 16-year-old girl told her teacher that her life was being threatened by members of a gang. The girl was concerned in particular about the imminent release from prison of one member of the gang. The girl was subsequently reported as missing and police attended promptly. She was later seen and spoken to by patrolling officers who ensured her immediate safety. The officers completed a referral to children's social care highlighting their safeguarding concerns (including possible sexual exploitation). However, there was no record of a strategy discussion taking place or of any further joint working with children's social care services to determine the appropriate safeguarding response. There was limited evidence of supervision and at the time of the inspection (some six weeks after the initial incident), a strategy discussion had still not taken place, nor had the child been spoken to; and

- an officer executed a search warrant and was concerned about the living conditions of a four-year-old-girl (and the unborn child of the girl's mother) at the address. There were two large dogs present at the address on the backs of which the child apparently rode. Excrement from the dogs was also evident throughout the house. A referral was made to children's social care services but no strategy discussion took place for 16 days. When it did, no consideration was given to the safety unborn child. There was no evidence of any ongoing safeguarding support for the girl or any evidence that the matter had been investigated.

In part, a lack of effective supervision contributed to the failings identified in these cases. Inspectors were also concerned to find that the supervision of cases referred to the central referral unit and the MASH by trained and experienced child protection supervisors was inconsistent. For the most part, child abuse concerns were quickly identified, but records of the early investigative and safeguarding response were sometimes poor, with little evidence of effective supervision. As noted earlier, the force had deployed significant additional resources to the PPU and backlogs had reduced. However, this had not yet translated into consistently improved assessments (and therefore outcomes) for children at risk of harm.

Within the PPU, the force had created dedicated teams of child protection staff whose role it was to attend initial child protection case conferences. Inspectors were pleased to find that police attendance at case conferences across the force area was consistently high. Inspectors were also told by partner agencies that the contribution made by these dedicated teams was of a high standard.

The force had taken some important steps to identify and protect children at risk of sexual exploitation. Bespoke trigger[12] and safeguarding plans were in place to protect the 720 children identified as being at risk across the force area. Inspectors were pleased to find that the implementation of plans was well supervised and trigger plans were regularly updated with details of the safeguarding plans in place. The number of children identified by the force as being at risk through a quarterly child sexual exploitation (CSE) assessment had increased consistently as the process evolved.

Nevertheless, inspectors were concerned to find that in some other cases, officers did not display a thorough awareness of the factors associated with identifying children at risk of sexual exploitation. This resulted in poor investigations. For example:

[12] A plan that directs initial decision making, ensuring that protective plans are put in place at the earliest opportunity and reflect the specific circumstances of an individual child.

- a 12-year-old girl had been sent explicit images of an older man over the internet and had made an arrangement to meet him for sex. Whilst a referral to children's social care services was made, and a strategy discussion took place, this was not until five days after the information had been received by police and after the meeting between the girl and the man was supposed to have occurred. The girl was spoken to by police in the presence of her parents, however the investigation was closed without enquiries to identify the suspect being completed. The victim's phone was not seized despite images having been viewed on the device and no consideration was given to the likelihood of the suspect attending the meeting and whether this presented an opportunity to effect his arrest; and

- children's social care services contacted police after concerns were raised about two girls aged 11 and 13 who had engaged in sexualised communications with older men and exchanged indecent images with them. There was an eight day delay in holding a strategy discussion and inspectors found no evidence of a longer-term joint safeguarding plan to protect the girls from further exploitation. There was some evidence of supervision of the case by police, however there was a failure to identify and investigate criminal offences properly.

West Midlands Police had reviewed its processes for safeguarding children who regularly go missing from home (including those in the care of the local authority and those vulnerable to CSE). New strategic partnerships and oversight arrangements with key stakeholders had been developed and inspectors were pleased to see better engagement with local care home managers. However, concerns remained about the protection of some children who regularly go missing from home. Inspectors assessed eleven cases and judged two as inadequate and seven as requiring improvement. Two were adequate while none were found to be good. Although the initial response to locate the child was often prioritised, opportunities for early intervention and longer-term inter-agency planning to protect children had not been considered.

In some cases, children, most notably those in the care of the local authority, were reported missing over ten times without any action being taken to protect them. In the majority of cases examined, officers conducted 'safe and well' checks promptly (to check their immediate safety) after a missing child was located, although some records contained scant information. Inspectors found that independent return interviews[13] for children missing from home were available across all local authority

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

areas, although the details of whether they were conducted and what was said were not always recorded on police systems. Interviews with children at this stage can provide a wealth of information about the reasons why they are running away, particularly where this is becoming more frequent and the child is reluctant to speak to police or other agencies. A better understanding of why a child has run away can provide vital information to partners and support more effective risk management and it should inform planning and decision making about future safeguarding action.

Inspectors were pleased to see that the force's revised processes for monitoring the risks of CSE to specific children had improved the awareness of officers that children who regularly go missing from home may be at risk of being groomed for sexual abuse. In five of the eleven missing from home cases examined by inspectors, there were signs that the children involved could be at risk of sexual exploitation and in all but one this risk had been recognised, and there was some evidence of longer-term safeguarding. However, inspectors found that in some of these cases, when making an assessment of risk, officers continued to focus principally on the most recent episode rather than taking account of information held by police about previous occurrences. For example:

- a 15-year-old girl had been reported missing on numerous occasions from her home. She had previously been known to associate with older men and smoke drugs. While some multi-agency work took place and the girl was 'flagged' as being at risk of sexual exploitation, there was little evidence of this being given proper consideration by police when assessing her vulnerability when she was reported missing again A 'missing person report[14]' was not created until the morning after her disappearance and police received, but did not properly consider, information that she intended to travel to France; and

- a 14-year-old girl in local authority care had been reported missing on over 20 previous occasions. Police records indicated a risk of sexual exploitation and a history of self-harm but this did not feature as part of the risk assessment or the response in the most recent episode. When the child was located there was no evidence of a referral being submitted to children's social care services. An investigation did not take place when she alleged that she had been held by her boyfriend against her will and had to escape by climbing out of a window. No further assessment was undertaken of the wider risks to the girl and there was no evidence of longer-term safeguarding measures being considered.

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www.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf

[14] A report created when someone goes missing that details the circumstances of the disappearance and the actions taken by the police to locate them.

Overall, inspectors' assessments of cases of children who go missing from home did indicate some improvement in practice since the previous inspection (when nine of the eleven cases of children missing from home were graded as inadequate). Nevertheless, there is more to do before West Midlands Police can be confident that those to children who regularly go missing are adequately safeguarded.

West Midlands Police refers domestic abuse cases that are assessed as 'high risk' to a multi-agency risk assessment conference (MARAC) for longer-term safeguarding plans to be put in place. Inspectors examined minutes of MARACs and assessed ten cases involving children: six were inadequate and four required improvement. Following a review of MARAC arrangements, the force had made supporting the process a priority in its force-wide domestic abuse action plan and some improvements were evident. MARACs were well attended by representatives from the force and a wide range of partner agencies. Information was shared to protect both victims and any children affected by domestic abuse and the force had implemented a joint screening process to undertake prompt safeguarding assessments for children living in homes where there was a risk of domestic abuse. However, inspectors found that record-keeping was inconsistent in respect of the immediate safeguarding measures put in place for children living in families at high risk of domestic abuse. In some of the cases examined, DASH risk assessments were not completed consistently and inspectors found that significant backlogs in the joint screening process across the force area meant that strategy discussions often did not take place prior to the MARAC meeting (or if they did no record was made). This could leave children at risk because information was not shared and possible joint action was delayed as a result.

# Investigation

**Recommendation from the October 2014 inspection report**

- We recommend that West Midlands Police immediately:
    - takes steps to ensure that children receive the right level of service irrespective of the team to which the case is allocated;
    - develops a force-wide good practice regime aimed at improving the standards of investigation;
    - takes steps to improve staff awareness, knowledge and skills in these types of investigations;
    - takes steps to reduce the delays in analysis of material sent to the high-tech crime unit; and
    - initiates discussions at a senior level with the Crown Prosecution Service (CPS) to address the delays in charging decisions.

## Re-inspection findings

As a result of the Service Transformation programme most cases of child abuse were allocated to the CAITs. All officers in these teams had received specialist training in the investigation of child abuse that occurs primarily within the family. However, some officers told inspectors that this training did not always equip them to investigate properly some offences with child victims (such as sexual offences) which occur outside of the family structure. The force had also begun to establish specialist child sexual exploitation co-ordinator posts and teams to be deployed in each CAIT. At the time of our inspection, implementation was at an early stage and the investigation of cases of sexual exploitation was not always of the required standard.

Nevertheless, inspectors were encouraged by the force's commitment to improving child protection practice through its investment in a new service improvement team. The team had recently developed a child-focused performance framework but its focus was on the volume of child protection incidents and cases, rather than the quality of decision-making or investigations and outcomes for children. Management information on the volume of incidents is important and will better enable the force to understand demand and manage workflow. However, inspectors consider that the force should include an unambiguous focus on quality and outcomes for children within the framework and use this information to inform training and improve practice.

Inspectors found some good examples of police child protection work with child abuse investigators displaying a mix of investigative and protective approaches. This ensured that the safeguarding of children remained central to their efforts while criminal investigative opportunities were pursued. There were good examples of investigations by the force, particularly when children were identified as being at further risk of immediate harm. Officers considered the best approach for interviewing children, sought evidence from a range of sources and made good arrangements to pursue and apprehend those who were responsible for causing harm. For example:

- police were contacted by a father whose 9-year-old son had called him to say that his mother was drunk and falling over and his 11-year-old sister was scared. Officers attended promptly and the children were spoken to sensitively and looked after well while the matter was investigated. When it became clear the mother was too intoxicated to look after the children officers consulted with children's social care services and the children were left with their father. Officers considered whether to arrest the mother, but chose not to after careful consideration of all the relevant factors (such as the views and demeanour of the children and information held by the police and other agencies). The appropriate referrals were made and there was effective joint

working with long-term plans developed with other agencies to support both the children and their mother.

Since June 2014, the force had deployed an additional 370 staff to the PPU and extended the remit of the unit to include most offences with a child victim. Inspectors found that in some areas of the force the work of child protection officers in the PPUs was difficult to manage because of high workloads. Whilst inspectors did see some evidence of good supervisory oversight, this was inconsistent because of the heavy workloads of supervisors. In a number of cases examined by inspectors, lack of supervision had contributed to delays in the investigation. Staff reported difficulties in managing the expectations of victims: their capacity to provide families and children with information and guidance on what would happen next was constrained. Officers told inspectors that delays adversely affected the confidence of children and families in the police. For example:

- a mother contacted police and stated that the father of her three-year-old daughter had picked her up by the neck, and that this had been witnessed by the girl's seven- year-old sister. The initial police response was good, an investigative plan was put in place by a supervisor and the father was quickly arrested and interviewed. The suspect was bailed and the investigation was then allowed to drift, with limited evidence of action or protective measures having been put in place. The child was not medically examined, her sister was not interviewed by a specialist child protection officer and there was no evidence that a strategy discussion had taken place. At the time of the inspection, this investigation was still ongoing some two months after the initial allegation; and

- police were called to reports of a three-year-old boy seen wandering alone in the street with no shoes. The initial response was good, with police attending promptly, locating the child and arresting his grandfather who was caring for him (he had known the boy was lost but had not contacted police). Police also ensured that the boy's two siblings were seen and safeguarded. However, following the initial interview of the suspect there was no supervisory input to the case until 16 days after the initial incident. Although a strategy discussion did take place and a joint investigation was agreed, there was no evidence that either the other children or their mother had been spoken to since the original incident. At the time of the inspection, two months after the incident, there were no further updates on this case.

West Midlands Police had recognised the need to improve its response to CSE, and at the time of the inspection the force's response was evolving. Dedicated specialist teams were being established to manage CSE investigations and inspectors found some good evidence of staff within these teams working proactively to protect and monitor children identified as being at risk.

In these cases, safeguarding plans were both bespoke and comprehensive, and there was evidence of regular review and supervision. For example:

- a case concerning a 16-year-old boy who was offering himself for sex on the internet and frequently going missing. He was suspected of using alcohol and drugs and of being in an inappropriate relationship with a 72 year-old man (he was also on bail for stealing from this man). The boy had been identified as being at risk of CSE at an early stage and was engaging with a specialist CSE officer. A comprehensive multi-agency safeguarding plan was in place with regular oversight provided by supervisors. Criminal matters were properly investigated, but the wider vulnerability of the boy was always recognised. The police file was closed once there was evidence that the risk had been reduced; and

- a 14-year-old girl disclosed to her school that she and two other girls of the same age had been sexually exploited by a 19-year-old man who had taken them to a hotel where they were made to engage in and watch sexual activity. Police attended promptly and completed a thorough initial investigation. An investigation plan was developed and the suspect was identified and arrested. There was clear evidence of effective supervision and good multi-agency working to develop appropriate safeguarding plans to support the victims and reduce the risks they faced.

These cases illustrate that the force is making some progress but inspectors were concerned that, in a number of other cases, children at risk had not been identified through the CSE profiling process (described in the previous section): risk was still not being recognised despite clear warning signs. Inspectors examined 21 cases involving CSE and found 10 to be inadequate while 7 required improvement. Signs of risk were missed, lines of enquiry were either not followed up or took too long, and there were failures to respond to information and intelligence and to pursue offenders. In most (though not all) of the cases assessed, the immediate safeguarding measures were adequate but there was often a failure to identify wider risks. For example:

- a case concerning a 16-year-old girl found drunk and unconscious in the street after she was seen being thrown out of a car by a group of men. A month later a member of the public called the police, having seen a group of men having sex with the same girl in the front garden of a house (the caller believed they were raping her). In each case, the initial response and investigation were poor with little consideration or awareness of the CSE risk. No referrals were made to children's social care services and the risk of CSE was only identified after the intervention of a senior officer a week after the initial incident. Record keeping was poor and the matter was allowed to drift, with no indication of any of the incidents being investigated as crimes, despite the girl later alleging she had been raped by the men. The suspects were not

traced and arrested, although their identities were known and they had previously been identified as CSE suspects.

- a case concerning a 13-year-old girl who had been enticed to perform sexual acts and engage in sexualised chat by an older man who was also in contact with other girls. The case was allocated to a CAIT officer but there was little evidence of any investigation taking place. The girl's computer was not seized, nor was she spoken to by specialist officers. There was some evidence of supervision, but the case was allowed to drift (a month passed before the investigating officer responded to the actions set by their supervisor) and there was no evidence of this matter being referred for a strategy discussion.

To reduce delays in the examination and analysis of computers and other media undertaken by the high-tech crime unit (HTCU), the force had allocated additional funding (to send some devices to an external provider) and developed more sophisticated prioritisation processes to clear the backlog. Inspectors saw evidence of some improvements in the timeliness of examinations but delays remained. At the time of the inspection there were 250 electronic devices awaiting assessment: in some cases examinations were taking over 12 months.

We saw evidence that the force was working with the CPS to improve the timeliness of decision making, but this had yet to result in improved performance. Inspectors were told by staff that delays of up to six months were common in cases sent to the CPS for review and charging decisions.

Delays are not in the best interests of children who are unable to put the incident behind them, nor do they serve the suspect who may be on bail or in custody. When delays occur in evidence-gathering, media analysis and receipt of charging decisions from CPS, as was seen in cases in this inspection, the length of time between the first call to police or children's social care services and a criminal justice outcome can be considerable.

**Recommendations**

- We recommend that West Midlands Police takes immediate steps to ensure that officers and staff within specialist child protection teams have received the necessary training to enable them to investigate the full range of child abuse offences.

- We recommend that, within three months, West Midlands Police takes steps to eradicate the backlog in the HTCU and continues to work with the CPS to reduce timescales for charging decisions.

# Decision making

### Recommendation from October 2014 inspection report

- We recommend that West Midlands Police takes immediate steps to:
    - ensure that police officers and staff understand the significance of drawing together all available information from police systems to improve their risk assessments;
    - ensure that all relevant information is properly recorded and readily accessible in all cases where there are concerns about the welfare of children and, as a minimum, provides guidance to staff on:
        - what information (and in what form) should be recorded on systems to enable good quality decisions;
        - the importance of sending the information to the correct police department and/or relevant partner agency;
        - the value and relevance of ensuring that records are made promptly and kept up to date; and
    - ensure that managers carry out quality assurance checks on records and provide feedback to police officers and staff.

### Re-inspection findings

As noted earlier, the force had reviewed its processes and issued updated guidance through the Operation Sentinel training programme.

During the re-inspection, inspectors found some good examples of effective decision-making to protect children. This was particularly noticeable in those cases where the concern was identified as a child protection matter from the outset. Officers handled incidents well when there were significant concerns about the immediate safety of children, such as parents leaving children home alone or being drunk while looking after them. It is a very serious step to remove a child from their family by way of police protection.[15] In the cases examined, decisions to take a child to a place of safety were well considered and in the best interests of the child.

[15] Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to (a) remove the child to suitable accommodation and keep the child there, or (b) take such steps as are reasonable to ensure that the child's removal from any hospital, or other place, in which the child is then being accommodated is prevented.

There was evidence that frontline staff made effective decisions in the early stages of child protection matters. Inspectors found a good level of understanding among frontline staff of the need to record and report information that had come to their attention when attending an incident involving concern for a child. Many staff told inspectors of the force's increasing emphasis on safeguarding children. In addition, staff understanding about the importance of recording information about children that had come to the attention of the police and related guidance had also improved, but this had yet to lead to consistent improvements in recording practice.

While there were examples of officers taking appropriate protective action, inspectors were concerned about the inconsistent quality of recording on police systems across the force. Accurate and timely recording of information is essential for good decision-making in child protection matters. When officers attend an incident where there is concern for a child, as well as taking any necessary action to protect the child, they should initiate an electronic non-crime incident form. In a number of cases examined by inspectors important information was missing and there were delays in recording it on the system. This included delays in recording the outcome of strategy meetings (minutes were often not taken), delays in updating records about the progress of an investigation and delays in recording details about contact with children and families.

Inspectors found consistently good practice across the force in relation to the daily management of risk for immediate and urgent child protection matters, including for those children detained in police custody suites. The daily management meeting in particular was effective and supported good decision-making.

## Trusted adult

**Recommendation from October 2014 inspection report**

- We recommend that, within six months, West Midlands Police:
    - records the views and concerns of children;
    - records any available outcomes at the end of police involvement in a case;
    - informs children, as appropriate, of decisions made about them; and
    - ensures that information about children's needs and views are made available on a regular basis for consideration by the police and crime commissioner.

### Re-inspection findings

West Midlands Police had provided revised guidance to officers about the need to record the views of children (through Operation Sentinel). However, inspectors found that this had not yet resulted in consistently improved practice. Inspectors found that in a significant number of cases, particularly those of domestic abuse, the views of children were either not sought or not recorded and the impact on the child was not reflected in sufficient detail. Inspectors were told that the force was committed to improving the recording of outcomes for children, but at the time of the inspection this work had not started and, as noted earlier, there was a lack of qualitative data incorporated in the new child focused performance framework. Nor were inspectors able to find evidence that the force was developing arrangements for regularly sharing information about children's needs and views with the police and crime commissioner.

Nonetheless, in some cases, though not all, it was clear that when the concern was serious and immediately recognised as a child protection matter, the approach to the child or parents was carefully considered, and the best ways to engage with the child were explored. This sensitive approach resulted in stronger relationships between the child and police. For example:

- in the case of a referral from a school that an eight-year-old boy had disclosed that he and his sister were hit with a stick by their father if they misbehaved. A joint visit was made to the children by police and children's social care services. The boy and his sister were spoken to and safeguarding actions were agreed. The parents were interviewed, and the father was issued with a caution and agreed to accept support from social services. Throughout the case there was support from children's social care services and the school; and

- in the response to an emergency call to an incident involving a two-year-old boy alone in the street. Officers attended promptly and located the boy and, following some initial enquiries, identified his home address. The officers spoke with the child and his mother and made a detailed record of his demeanour and living conditions. Officers were not concerned for the child's immediate safety as this appeared to be an isolated, and accidental, incident. However, they made a referral to children's social care and a strategy discussion took place. The views and demeanour of the child were the main consideration when this decision was taken.

## Managing those posing a risk to children

### Recommendation from October 2014 inspection report

- We recommend that West Midlands Police takes immediate action to review its plans for identifying, disrupting and prosecuting perpetrators involved in child sexual exploitation.

### Re-inspection findings

As noted earlier, the force had created specialist teams to manage CSE investigations and established a unit dedicated to the identification of perpetrators. It was clear that this had resulted in some meaningful progress and the arrest of a number of CSE suspects, reducing the risk to children across the force area. HMIC welcomes these developments. However, as the earlier case examples illustrate, risks to vulnerable children of CSE continued to be missed.

Those responsible for managing registered sex offenders were clear about their responsibilities. Inspectors found that plans to manage risks were in place and considered these plans to be proportionate, but monitoring visits to check that registered sex offenders were keeping to their registration requirements were not always undertaken in a timely manner. At the time of the inspection 250 such visits were outstanding.

Across the force, the violent and sex offender units were dealing with caseloads in excess of the ratio recommended for sex offender managers by national guidance[16], with approximately 80-90 offenders being managed by each manager. Consequently, there was limited capacity for proactive work within these units because of the large number of sex offenders requiring supervision.

Inspectors were concerned that in the cases they examined involving sex offenders, wider safeguarding planning for the child or children at risk was often of a poor standard, with inconsistent recording and some drift in decision making. Inspectors reviewed seven such cases and found six to be inadequate. There were delays in the arrest of offenders, drift in investigations where officers did not follow up enquiries, and cases closed without sufficient consideration of the risk the offender posed to potential victims. For example:

- a registered sex offender who had been in a relationship with a 15-year old girl and in possession of indecent images of children was found to be living with his three younger siblings. A referral was made but there was a delay of two weeks before an assessment and strategy discussion took place in the

[16] *MAPPA Guidance 2012 version 4*, Ministry of Justice National Offender Management Service, February 2015 (latest update), available at: www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2.

MASH. There was no evidence of any police investigation taking place to identify whether criminal offences had been committed, nor was there any record of what consideration had been given to safeguarding for the three young children; and

- a referral was made by a police offender manager about a registered sex offender who was due to be released from prison, and who had stated that he intended to have contact with his four children. While the referral was made on the same day that the information became known, there was a delay of six days before an initial assessment was completed and the mother of the children informed. This was after the man had been released from prison.

We found that links between the sex offender management teams and neighbourhood policing teams[17] varied across the force area. Officers were not routinely made aware of registered sex offenders living in their area who posed a risk to children. As a result, information from local units about these individuals was not regularly submitted limiting the supply of potentially valuable information. .

## Police detention

### Recommendation from the October 2014 inspection report

- We recommend that, within three months, West Midlands Police undertakes a review (jointly with children's social care services and other relevant agencies) of how it manages the detention of children. This review should include, as a minimum, how best to:

    - improve custody staff awareness of child protection and of the standard of risk assessment required to reflect the needs of children and the support they require at the time of detention and on release;

    - assess at an early stage the likely need for secure or other accommodation and work with children's social care services to achieve the best option for the child;

    - ensure that custody staff comply with statutory duties and complete child detention certificates if children are detained in police custody for any reason;

    - ensure that custody staff make a record of all actions and decisions on the relevant documentation; and

[17] A team of police officers and police community support officers who predominantly patrol and are assigned to police a particular local community. Teams often comprise specialist officers and staff with expertise in crime prevention, community safety, licensing, restorative justice and schools liaison.

- work with local authorities to ensure that no child who is looked after by the local authority is refused accommodation by them.

**Re-inspection findings**

West Midlands Police had reviewed its management of the detention of children and revised guidelines for staff were being developed. However, inspectors found no evidence that this review had involved children's social care services and other agencies - in line with HMIC's earlier recommendation.

West Midlands Police undertook reviews of children being detained at the force-wide daily management meetings. Inspectors were told by custody staff that they had received training in child protection, and it was clear that the force had taken steps to raise awareness among custody staff of the need for alternative (secure and non-secure) accommodation for children detained in police custody. Inspectors did note some confusion amongst custody staff about the minimum thresholds for secure and non-secure accommodation, and record keeping was sometimes inconsistent (particularly in respect of detention certificates). Although it was clear that staff awareness of the importance of these matters had improved, this had not resulted in consistent improvements in practice.

Inspectors examined 13 cases of children in detention. The youngest was 13-years-old and the oldest, 16. Twelve of the children were boys and one was a girl. They had been detained on suspicion of offences that included robbery, serious assault and burglary. Inspectors judged one of the cases as good, seven as adequate, three as requiring improvement and two as inadequate.

West Midlands Police self-assessed three of these cases, two featuring boys and a single case involving a girl. The force assessed all three cases as good. Inspectors assessed them as adequate.

In the cases examined by inspectors, twelve of the children, all under 17-years-old, were charged and refused bail by the custody sergeant. In these circumstances the local authority is responsible for providing appropriate accommodation if a child is to be detained[18]. It should only be in exceptional circumstances (such as during extreme weather) that the transfer of the child to alternative accommodation would not be in their best interests. In rare cases – for example, if a child presented a high risk of serious harm to others – secure accommodation might be needed.

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

In the cases examined by inspectors, only two of the children detained overnight were transferred to the care of the local authority. In three of the cases, custody records showed that no request had been made to the local authority for accommodation after a decision to refuse bail.

Detention certificates, which outline to a court the reason for a custodial remand, are essential for police accountability and enable forces to monitor how well they are discharging their responsibilities under the Police and Criminal Evidence Act 1984. Inspectors found just two records where this form had been completed.

Section 136 of the Mental Health Act 1983 allows a police officer to remove an apparently mentally disordered person from a public place to a place of safety. Although a place of safety can include a police custody suite, these should only be used in exceptional circumstances and it is preferable for the person to be taken directly to healthcare facilities such as a hospital.[19] Inspectors were pleased to find that West Midlands Police, in conjunction with partner agencies, had invested time and resources to create multi-agency 'street triage' teams to provide immediate support and assessment for children suffering from mental health issues. Alternative places of safety for children, where appropriate support and accommodation could be provided for those suffering with mental health problems were also available. As a result the force had not detained a child under section 136 since 2011. This is clearly evidence of effective practice.

[19] *Code of Practice: Mental Health Act 1983*, Department of Health, 2008, paragraph 10.21. http://webarchive.nationalarchives.gov.uk/20130123193537/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597

# 6. Findings: leadership, management and governance

Protecting vulnerable people is a priority for the force and the PCC and is reflected as such in the police and crime plan[20]. The chief constable, his chief officer team and the PCC all have a strong commitment to child protection and there was clear evidence of work progressing at a strategic level to improve the force's ability to manage identified risks concerning the safeguarding of children.

The recent review of public protection (and associated significant uplift in resources), the ongoing improvement programme and the development of MASHs all demonstrate the force's continued commitment to improving child protection. However inspectors found that the current structure had created some inconsistencies in standards of practice and delays in investigations and decision making across the force area. This was exacerbated by resource and workload pressures in child abuse teams. Inspectors were unable to establish how the force intended to evaluate the effectiveness of its evolving improvement programme. As such, it was difficult to assess whether the programme would provide the force with a more consistent framework to meet the needs of children effectively.

There was visible leadership of child protection in the force, including in LPU senior teams where child protection was recognised as a priority. This had a positive impact on operational staff. Inspectors found some good examples of officers demonstrating awareness of safeguarding. But in many cases this was undermined by poor record keeping — we saw only modest improvement since our inspection in June 2014. It was also apparent that the supervision of decision-making was not always robust, and there was limited oversight of whether outcomes for children were improving.

Throughout the inspection it was apparent that all the staff spoken to who were responsible for managing child abuse investigations were committed and dedicated to providing good outcomes for children identified as being at risk of harm. However, as noted above, in a number of cases poor record keeping and a lack of visible supervision meant that child protection investigations were undermined. All child protection staff were trained in, or in the process of completing, the specialist child abuse investigator development programme, and all police officers in the CAITs were detectives or were working towards full detective status. That said, inspectors were told that the expanding remit of the CAITs had led to some officers feeling they lacked all of the relevant training and expertise necessary to cope with their expanded role.

[20] The West Midlands police and crime plan for 2015-16 is available at: www.westmidlands-pcc.gov.uk/your-commissioner/police-and-crime-plan

Arrangements for managing high-risk sex offenders were inconsistent across the force and there was insufficient capacity for proactive work within the sex offender management teams.

Senior leaders took an active role in partnership working across the force area to build more effective joint safeguarding arrangements. The assistant chief constable responsible for public protection chaired the multi- agency strategic child abuse partnership board which coordinated force-wide child protection improvement activity, ensuring strong strategic oversight and impetus. Key information and details of activity were shared at senior management meetings with divisional commanders to ensure they were kept informed of developments in policy and practice.

The force had established a service improvement team within the PPU to support its drive to improve safeguarding practice. Although a recent development, the team was producing regular performance information relating to child protection. This is a positive step. However, information on the quality of service and outcomes for children (to aid quality assurance and support effective decision making) was under-developed and inconsistent across the force area.

West Midlands Police serves diverse, multi-cultural communities. Inspectors were pleased to see that data on the ethnicity of victims and suspects was included in the CSE profiling undertaken by the force and was being used improve services. While this is positive, the force needs to do more to understand better the needs of vulnerable children across the range of child protection services and collect the information necessary to shape services to meet the needs of such children.

Inspectors recognise that achieving a consistent approach to child protection across seven local authority areas and ten LPUs constitutes a considerable challenge for West Midlands Police. The development of the MASH model across the force area, and the agreement to implement a consistent safeguarding model, are good examples of the force's commitment to working with partners to improve services. Chairs of LSCBs and directors of children's services to whom we spoke praised the commitment of the force and the consistency of senior representation at safeguarding board meetings. The attendance of LPU commanders alongside PPU leaders was viewed as particularly positive. At executive and sub-group level (where more work to translate strategy into action is progressed), some difficulties with representation were reported due to competing demands on officers. While chairs and directors felt that referral and investigation thresholds were generally understood by the force, some concern was expressed about the effectiveness and timeliness of screening processes within the CRU.

West Midlands Police had developed a CSE problem profile and used it to assess risk more effectively and mitigate harm. However, inspectors were concerned that obvious risks of CSE were still being missed, leaving vulnerable children at risk. Although West Midlands Police had prioritised CSE and had a better understanding

of the extent of offending across the force area, there was limited evidence that frontline staff were aware of how to respond appropriately to sexual exploitation and provide effective safeguarding for those children identified as being vulnerable. As previously noted, at the time of the inspection, the force had created a central team to investigate perpetrators of CSE and was in the process of creating dedicated CSE coordinator posts and investigators with specialist knowledge aligned to each child protection team. Inspectors acknowledge that some improvements had been made and that the new arrangements may improve outcomes for vulnerable children in future, but these changes have not yet translated into consistently improved practice.

Overall, inspectors consider that the force's response to tackling CSE has improved. However, there is still more to do to ensure that all those children who come to the attention of West Midlands Police who are at risk of sexual exploitation are protected.

Inspectors were also concerned about the protection of some children who regularly go missing from home. Again the force's response had improved, but intervention and long-term inter-agency planning were often ineffective. Inspectors also found limited evidence of early diversionary support being considered for some children who had been reported missing multiple times.

As noted earlier, West Midlands Police was implementing a MASH structure using a consistent safeguarding model across the force area. Although in the early stages of development, this approach has the potential to lead to greater consistency of practice and enable police, social workers and health professionals to discuss cases more promptly to determine the best approach for children.

Inspectors were pleased to find that no children were detained in police cells under the Mental Health Act 1983. Alternative places of safety for children, where proper support and accommodation can be offered to those suffering with mental health problems, were also in place. This is a significant achievement. However, children and young people continued to be unnecessarily detained in police custody post-charge when they should be transferred to the care of the local authority. Inspectors were informed that there was a lack of secure and non-secure accommodation available. Although senior officers had taken steps to resolve this with partners, there had been no improvement in the availability of suitable accommodation at the time of our re-inspection. The detention of children was reviewed each day through the daily management meeting process.

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

West Midlands Police demonstrated a strong commitment to improving services for the protection of vulnerable people. The chief constable and the PCC have prioritised child protection and it is clear that there is a force-wide focus on reducing risk and harm to vulnerable children. However, while there were a number of examples of good child protection work, this commitment has not yet resulted in consistently improved outcomes for children.

There was evidence of progress and some improvement since our inspection in June 2014, including in the strength of partnership working. However, inconsistencies remain in the management and supervision of investigations across the force, and in the assessment of risk. This adversely affects the quality and effectiveness of safeguarding practice, ultimately leaving children vulnerable to harm. Inspectors found some good examples of the force protecting children who were most in need of help, with effective multi-agency work and a child-centred approach. However, poor supervision and record-keeping persist, undermining decision-making and safeguarding measures.

The force has identified CSE as a critical issue and has made some progress to improve its response, but there is still more to do to recognise and respond effectively to all children at risk of sexual exploitation.

The response to children who regularly go missing from home also requires further improvement, although inspectors were pleased to see that in most cases officers and staff understood the link between children who regularly go missing and sexual exploitation.

West Midlands Police has good working relationships with the seven local authorities and other services that operate within the force area. The force is to be commended for its partnership working to provide 'street triage' services and alternative places of safety for children with mental health problems who might otherwise be detained in police custody. However, more needs to be done through joint working to deliver better services, particularly for children detained in police custody in need of alternative accommodation.

If the force is to be confident that it is adequately protecting vulnerable children, safeguarding arrangements require improvement. The recent review and ongoing work to improve and standardise safeguarding processes provide an opportunity for services to be brigaded so as to ensure that consistently good standards of practice are applied across the force area to improve outcomes for children.

Alongside this, a performance framework that focuses more on outcomes for children who need protection (rather than the number of cases processed) should be developed and introduced to enable the force to monitor and improve its child protection work continuously.

### Initial contact

West Midlands Police had delivered training to frontline staff on their role in safeguarding children and this had resulted in better awareness and improved processes for the assessment and escalation of child protection matters. However, inspectors found that the quality and supervision of some assessments (particularly when it was not obviously a child protection matter) required further improvement. Inspectors were pleased to find that in most domestic abuse cases that were assessed, the officers attending had recorded their observations about the behaviour and demeanour of any children present.

### Assessment and help

West Midlands Police had taken steps to review the processes for assessing children at risk within the CRU and there was some evidence of improved decision making to safeguard children. However, inspectors were concerned that the recording and supervision of the action taken to protect children was of a poorer standard. The force had also reviewed its approach to safeguarding those children who go missing from home and those at risk of CSE. This had resulted in improved partnership arrangements (in particular with local care homes) and a better understanding of the particular risks of CSE faced by children who go missing. However, whilst there was some evidence of improved protective plans being developed, inspectors remained concerned about the protection of some children who regularly go missing from home (in particular those in the care of the local authority) and those at risk of CSE. Opportunities for early intervention were missed and longer term safeguarding plans were not implemented at the earliest opportunity.

West Midlands Police had reviewed its MARAC arrangements and had prioritised supporting the process. There was evidence of some improvements in the way information was being shared and the representation at panels, although inspectors found that record keeping was inconsistent and the development of safeguarding plans was not always timely.

### Investigation

West Midlands Police had taken action to improve child protection investigations, including CSE. A new performance framework had been established and all child abuse investigations were allocated to specialist teams. However, whilst there was evidence of some improvement, we were also concerned that the performance framework lacked focus on the quality of outcomes for children, signs of risk were still being missed, officers expressed concerns about a lack of additional training and supervision was inconsistent due to heavy workloads, meaning that some investigations were delayed unnecessarily. Efforts had been made at a strategic level to improve the timeliness of charging decisions and the examination of computers and other media, however at the time of the re-inspection significant delays were still occurring.

### Decision making

The force had reviewed and updated its guidance to officers and staff regarding their responsibilities to safeguard children. Inspectors found good examples of officers making effective decisions that were in the best interests of children. However, while some improvements were apparent inspectors found the quality and timeliness of recording on police systems was inconsistent which undermined the decision making process.

### Trusted adult

West Midlands Police had provided updated guidance to officers and staff about the need to record the views of children. However, while in some serious cases protective plans were carefully considered there was limited evidence of the views of children being regularly recorded.

### Managing those who pose a risk to children

West Midlands Police had created a specialist unit dedicated to the identification of perpetrators and had arrested a number of CSE suspects reducing the risk to children across the force area. However, as noted in other sections, inspectors were concerned that CSE risk was still being missed and in the cases examined relating to RSOs safeguarding planning for the child or children at risk was poor.

### Police detention

West Midlands Police had reviewed its management of the detention of children and revised guidelines for staff were being developed. Inspectors found no evidence that this review had involved children's social care services and other agencies - in line with HMIC's earlier recommendation. We were pleased to find that the force had worked with partners to develop alternative support and assessment processes for children suffering from mental health issues and as a result no children had been detained in police custody for this reason since 2011.

However, inspectors did find that children were still being detained unnecessarily in police custody after charge rather than being transferred to the care of the local authority.

In summary, HMIC acknowledges that the force had created a comprehensive improvement framework to progress and monitor the implementation of the recommendations from our inspection report in October 2014. Inspectors also recognise the scale of the challenge faced by the force. Mindful of this, West Midlands Police needs to do more to evaluate the impact of its change programme and improvement framework in order to ensure that it is resulting in better outcomes for children.

# 8. Progress towards October 2014 Recommendations

## Immediately

| We recommend that West Midlands Police immediately ensures that there are procedures in place to:<br><br>• escalate any concerns about an incident involving children at risk if, for whatever reason, police have been delayed in attending the incident or alleged crime; and<br><br>• ensure that the incident is not downgraded without proper justification, and the appropriate checks have been made on the welfare of the child. | |
|---|---|
| Partially Achieved | Revised guidance had resulted in improved awareness and processes however the quality and supervision of some assessments required improvement. |

| We recommend that West Midlands Police immediately:<br><br>• takes steps to ensure that children receive the right level of service irrespective of the team to which the case is allocated;<br><br>• develops a force-wide good practice regime aimed at improving the standards of investigation;<br><br>• takes steps to improve staff awareness, knowledge and skills in these types of investigations;<br><br>• takes steps to reduce the delays in analysis of material sent to the high-tech crime unit; and<br><br>• initiates discussions at a senior level with the CPS to address the delays in charging decisions. | |
|---|---|
| Partially Achieved | Almost all child abuse allegations are now investigated by specialist officers and some improvements were apparent. However, supervision was inconsistent and staff expressed concern about a lack of further specialist training. The service improvement framework was a positive development but an explicit focus on quality and outcomes is required. Work to reduce backlogs and improve timeliness had begun but little evidence of improvement could be found. |

<table>
<tr><td colspan="2">We recommend that West Midlands Police takes immediate steps to:<ul><li>ensure that police officers and staff understand the significance of drawing together all available information from police systems to improve their risk assessments;</li><li>ensure that all relevant information is properly recorded and readily accessible in all cases where there are concerns about the welfare of children and, as a minimum, provides guidance to staff on:<ul><li>what information (and in what form) should be recorded on systems to enable good quality decisions;</li><li>the importance of sending the information to the correct police department and/or relevant partner agency;</li><li>the value and relevance of ensuring that records are made promptly and kept up to date; and</li></ul></li><li>ensure that managers carry out quality assurance checks on records and provide feedback to police officers and staff.</li></ul></td></tr>
<tr><td>Partially Achieved</td><td>Reviewed guidance had been issued to all staff about their responsibilities to safeguard children. However, while there was evidence of effective decision making this was undermined by inconsistencies in the quality and timeliness of recording.</td></tr>
</table>

<table>
<tr><td colspan="2">We recommend that West Midlands Police takes immediate action to review its plans for identifying, disrupting and prosecuting perpetrators involved in child sexual exploitation.</td></tr>
<tr><td>Partially Achieved</td><td>The force had created a dedicated team to identify perpetrators and a number of CSE suspects had been arrested. However, safeguarding plans for those children linked to or at risk from RSOs were often poor.</td></tr>
</table>

## Within three months

| We recommend that West Midlands Police ensures that officers always record their observations of a child's behaviour and demeanour in domestic abuse incident records, so that a better assessment of a child's needs can be made. | |
|---|---|
| Achieved | Inspectors found that in most cases assessed the behaviour and demeanour of children had been recorded allowing for better assessments. |

| We recommend that West Midlands Police undertakes a review of the CRU to ensure that:<br>• the unit is fulfilling its purpose to receive, assess and coordinate multi-agency activity to safeguard children effectively;<br>• background checks, initial assessments and strategy discussions between agencies take place in good time and do not leave children at risk; and<br>• there is supervisory oversight at a senior level to ensure that the unit is working properly and that any problems are speedily resolved. | |
|---|---|
| Partially Achieved | There was some evidence of improved processes and assessments however the quality of recording and supervision was of a poorer standard. |

| We recommend that West Midlands Police:<br>• ensures that MARACs record what safeguarding action has been taken, and what actions are planned for the future;<br>• provides information (e.g. history of abuse, number of children in the family) to other agencies before the MARAC takes place;<br>• identifies the range of responses and actions that the police can contribute to multi-agency plans for protecting victims and children in high-risk domestic abuse cases; and<br>• improves the timeliness for screening domestic abuse cases in Birmingham. | |
|---|---|
| Partially Achieved | There was some evidence of improved information sharing however recording was inconsistent and the development of safeguarding plans was not always timely. |

We recommend that West Midland Police takes steps to improve practice in cases of children who go missing from home and those who are assessed as absent. As a minimum, this should include:

- improving staff awareness of their responsibilities for protecting children who are reported missing from home and assessed as absent – in particular, in those cases where absences are a regular occurrence;
- improving staff awareness of the significance of drawing together all available information from police systems better to inform their risk assessment;
- improving senior management oversight to ensure that supervisors are fulfilling their responsibilities;
- identifying the range of responses and actions that the police can contribute to multi-agency plans for protecting children in these cases;
- ensuring that, when police officers and staff recognise a risk and consider that other agencies are not meeting their responsibilities, they raise the issue with managers to ensure that the risk is addressed and know how to escalate their concerns; and
- at a senior level, initiating discussions with the local authorities and children's home providers so that risks to children who are looked after are properly addressed.

| | |
|---|---|
| Partially Achieved | There was some evidence of improved decision making and better partnership arrangements however clear signs of risk and opportunities to intervene were still being missed. |

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

- improve custody staff awareness of child protection and of the standard of risk assessment required to reflect the needs of children and the support they require at the time of detention and on release;
- assess at an early stage the likely need for secure or other accommodation and work with children's social care services to achieve the best option for the child;
- ensure that custody staff comply with statutory duties and complete child detention certificates if children are detained in police custody for any reason;

| | |
|---|---|
| • ensure that custody staff make a record of all actions and decisions on the relevant documentation; and<br>• work with local authorities to ensure that no child who is looked after by the local authority is refused accommodation by them. | |
| Not Achieved | The force had undertaken an internal review however there was no evidence of the involvement of other agencies and children were still being unnecessarily detained in police custody overnight. |

## Within six months

| | |
|---|---|
| We recommend that West Midlands Police:<br>• records the views and concerns of children;<br>• records any available outcomes at the end of police involvement in a case;<br>• informs children, as appropriate, of decisions made about them; and<br>• ensures that information about children's needs and views are made available on a regular basis for consideration by the police and crime commissioner. | |
| Not Achieved | While inspectors found examples of sensitive decision making that took account of the needs of the child no evidence could be found of the views of children being routinely recorded. |

# 9. Further Recommendations and Next steps

We recommend that West Midlands Police continues to work to implement the recommendations made by HMIC following the child protection inspection in report in October 2014 and ensures that the recommendations are implemented in full.

We also recommend that West Midlands Police takes immediate steps to ensure that officers and staff within specialist child protection teams have received the necessary training to enable them to investigate the full range of child abuse offences.

We further recommend that, within three months, West Midlands Police takes steps to eradicate the backlog in the HTCU and continues to work with the CPS to reduce timescales for charging decisions.

Within six weeks of the publication of this report HMIC will require an updated action plan in which West Midlands Police should set out how it intends to incorporate the findings of this re-inspection into the work described above.

Subject to the response received, HMIC may revisit the force to assess how it is managing the implementation of all of the recommendations.

# Annex A
# Child protection inspection methodology

## Objectives

The objectives of the inspection are:

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

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

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

These areas of practice are the focus of the inspection.

## Inspection approach

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

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

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

## Methods

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

## The purpose of the self-assessment is to:

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

## Self-assessment and case inspection

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

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

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

Below is a breakdown of the type of self-assessed cases we examined in West Midlands Police

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

# Annex B
# Glossary

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

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

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