

National Child Protection Inspections

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

Police officers are often the eyes and ears of the community as they go about their daily tasks and come across children who may be being 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.

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1. Introduction

This report is a summary of the findings of an inspection of child protection services in West Midlands Police, which took place in June 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 practice.

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 audits¹ carried out by the force, and case audits and interviews with police officers and staff and representatives from partner agencies, conducted by HMIC.

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

3. Context for the force

West Midlands Police is the largest police force outside London with an establishment of approximately 7,288 police officers, 2,907 police staff and 676 police community support officers.² It provides policing services to 2.74 million people. It serves a densely populated, predominantly urban area, with diverse needs. 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)³. The seven local authorities within the West Midlands Police force area are:

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

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

² *Police workforce, England and Wales, 31 March 2014*. Home Office, www.gov.uk/government/statistics/police-workforce-england-and-wales-31-march-2014

³ LSCBs have a statutory duty, under the Children's 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	Inspection framework
Birmingham	Inadequate	March 2014	Framework for inspection of children in need of help and protection and children looked after and care leavers
Coventry	Inadequate	January 2014	Framework for inspection of children in need of help and protection and children looked after and care leavers
Dudley	Adequate	November 2011	Safeguarding and looked after children inspection
Sandwell	Inadequate	February 2013	Arrangements for children in need of help and protection
Solihull	Adequate	November 2011	Safeguarding and looked after children inspection
Walsall	Adequate	June 2013	Arrangements for children in need of help and protection
Wolverhampton	Adequate	June 2011	Safeguarding and looked after children inspection

The West Midlands Police public protection unit (PPU) was formed in April 2010. The model comprises a central department with responsibility for the delivery of services relating to child protection (including child sexual exploitation), domestic abuse, registered sex offender management, the investigation of rape and serious sexual offences and missing persons. The PPU is also responsible for:

- multi-agency public protection arrangements (MAPPA) ⁴;
- the online child sexual exploitation team;
- the vulnerable adults unit; and
- the central referral unit (CRU).

A detective chief superintendent is responsible for the PPU, supported by three superintendents and two detective chief inspectors.

The current establishment of officers in child protection posts is set out in the table below.

1 superintendent	8 chief inspectors
11 inspectors	22 sergeants
142 constables	32 police staff

There are eight child abuse investigation teams (CAITs) in the local policing areas, led by four detective chief inspectors who report to the PPU

Following a review of the force's structure for public protection, a programme of changes began in June 2014. This includes the introduction of specialist domestic abuse teams in each LPU.

At the time of the inspection, in June 2014, the force was actively negotiating with partner agencies to establish multi-agency safeguarding hubs (MASHs)⁵ across the force area and one such hub was operating in Sandwell.

⁴ The Criminal Justice and Court Services Act 2000 requires the police and probation services to act jointly as the 'Responsible Authority', make arrangements to assess the level of risk individuals pose and manage individuals who may cause serious harm to the public. These arrangements are known as multi-agency public protection arrangements. The Criminal Justice Act 2003 includes Her Majesty's Prison Service as a 'Responsible Authority' and places a duty on other agencies to co-operate with the named authorities.

⁵ This is an 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.

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.⁶ The police are duty-bound to refer to the local authority those children in need they find in the course of their work.⁷ Government guidance⁸ outlines how these duties and responsibilities should be exercised.

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

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

Every officer and member of police staff should understand their duty to protect children as part of their day-to-day business. It is essential that officers going into people's homes regarding 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 the police service 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.

⁶ Section 47 of the Children Act 1989.

⁷ 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 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.

⁸ *Working Together To Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2013.

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 audited 30 cases in accordance with criteria provided by HMIC. Although the force was not asked formally to rate each of the 30 self-assessed cases individually, practice was viewed as good by the force assessors in about two thirds of the cases. Inspectors reviewed all 30 cases that had been self-assessed. They considered one case to be excellent, six good, thirteen adequate, one requiring improvement and nine inadequate. Among the cases there were some differences between the views of the inspectors and those of the self-assessors, and in four cases the inspectors' assessments differed significantly.⁹ Overall, the inspectors identified more weaknesses in practice than the self-assessors. However, the inspectors found some good examples of critical analysis. The assessors not only identified areas for improvement, but also intervened directly or arranged an immediate management review of those cases that were a cause for concern.

The inspectors examined a further 85 cases where children were identified as being at risk. Overall, 17 were assessed as good, 21 adequate, 7 requiring improvement and 40 inadequate.

Initial contact

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 considering a course of action that was in the child's best interest. For example, in one case where children had been left alone at home, officers fully engaged with the children, explored the circumstances, contacted social workers and considered the best course of action to minimise distress.

Although most officers routinely checked on the welfare of children when attending a domestic abuse incident, this was not always the case. Some children were not seen or spoken to alone when this would have been appropriate (i.e. if the presence of a parent might inhibit a child expressing their view). The behaviour and demeanour of a child was often not recorded. A child's demeanour, especially in those cases where a child is too young to speak to officers, or where to do so with a parent present might present a risk, provides important information about the impact of the incident

⁹ The case types and inspection methodology are set out in Annex A.

on the child. It should inform both the initial assessment of need and any referral to children's social care services.

Inspectors found that the force's initial response to concerns about those who may pose an immediate and obvious risk to children was often good. Officers undertook prompt and thorough enquiries and searched for suspects. However, there were some calls from the public about children where the assessed level of threat was reduced without checking the safety of the child. For example, a passer-by saw a man hitting a small child in a car. It was graded as a 'priority' incident, but control room staff recorded that no officer was available to attend at the time of the call. Several hours later, control room staff recorded that the incident had passed and downgraded the call to 'routine' but no checks had been made to justify this, nor was there a check on the child's safety.

When there was an immediate child protection concern, there were good examples of police co-ordinating an effective inter-agency response. For example, police received a referral from a school that a nine-year-old pupil had been assaulted by his father. Police promptly contacted children's social care services, held a strategy meeting (a meeting to assess risk and decide what action to take) and arranged for a joint visit to take place at school before the boy left for the day. His best interests were central both to police actions and the arrangements to support the family.

Generally, initial contact and interviews with children and their families were undertaken sensitively. In one case, health services raised concerns that children in a family could be at risk of female genital mutilation. Careful attention was paid to how enquiries would be conducted and, with the use of an interpreter, a joint visit with children's social care services was made to the family home. Police engaged well with the family and agencies concluded that the girls were not at risk of harm.

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.

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.**

Assessment and help

The CRU is the hub for information exchange in cases of child protection and it receives referrals from agencies concerned with children's social care or health. Generally, the force responded well in cases where the concern was clear, and particularly so 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.

However, inspectors found the response to some concerns was not sufficiently prompt. For example, a health visitor referred a case involving neglect of young children who were on a child protection plan (i.e. they had already been identified as being at risk and had been placed on a plan to protect them). On this occasion, it took over 24 hours for the CRU to carry out background checks on police systems and then make contact with children's social care services to hold a telephone 'strategy discussion' to determine next steps. There were also considerable delays in other cases, sometimes due to a backlog of work and at other times because no social worker was available. In some local authority areas, children's social care staff and police managers in CAITs told inspectors that they were not confident that the CRU system was working well. On occasion, children's social care staff bypassed the CRU by contacting local child abuse officers directly to protect a child more quickly.

Inspectors found examples of good practice at domestic abuse joint screening panels (where partner agencies meet to share information and agree the level of risk), particularly in Coventry. Panels were held regularly and were well attended by agencies, with children kept at the heart of decision making. However, this was not consistent across the force. In Birmingham there were significant delays in discussing cases; this could leave victims and children vulnerable to further harm. West Midlands Police, children's social care and health services have recognised the problem and are working together to make improvements.

The force 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. The standard of these arrangements across the force area was very mixed. In Wolverhampton, minutes were not recorded and in some other areas recorded information was poor. Agencies did not always share information before the meeting (for example, police did not pass on relevant information about a five-month-old baby). Inspectors also found that protective measures relied on a single agency (usually children's social care services), rather than all agencies making a contribution to the multi-agency plan. In the domestic abuse cases examined, there was no evidence of joint visits or strategy discussions concerning the children. As a result, there were few actions taken by the police following MARAC discussions.

Inspectors were told that a recent review with partner agencies of MARAC arrangements would improve consistency across local authority areas.

Inspectors saw examples of good practice in cases of missing children when the child was assessed as being at high risk of child sexual exploitation. In these cases, there was a 'trigger plan' (a plan of action attached to the police record in order to locate the child quickly) and the police response was generally prompt and the child actively sought. However, inspectors had significant concerns about some children who were reported missing from home, some of whom were at high risk of sexual exploitation but not assessed by the police as such.

Inspectors assessed the handling of 9 of the 11 cases of children missing from home as inadequate. In each of these cases, officers failed to gather further information and as a result there was poor assessment of the overall risk. Inspectors found that in some cases children who were among the most vulnerable were classified as absent (a child deemed to be 'absent' rather than 'missing' is viewed as most likely to return of their own accord and would not be actively sought). For example, care home staff called police when a 15-year-old girl left the home at night, in her pyjamas, and got into a car with an older man. Although the girl was known to be at risk of sexual exploitation, her location was not immediately sought. When she returned home at 6 o'clock the following morning, police did not check on her welfare or seek information about risk or exploitation. In such cases, a child could be recorded as absent on any number of occasions without consideration being given to protective measures, in contrast to the way that they would be considered for a child who was recorded as missing.

In another case, supervisors recorded that a 13-year-old girl who frequently went missing was making 'a lifestyle choice', although it was clear from police systems that she was being, or was at high risk of being, sexually exploited. Some officers were frustrated by care homes reporting children as missing, and considered that the homes were failing to protect children and passing responsibility for this to the police. This assessment of 'lifestyle choice' should not negate police responsibilities towards vulnerable children. Inspectors also found that visits by the police (or another organisation in which the young person might have more confidence – for example, Barnardo's or the Children's Society) to check if a child was 'safe and well', and to establish what might be done to prevent a recurrence, did not always take place.

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 coordinate 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:

- **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.**

We recommend that, within three months, 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.**

Investigation

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, seeking evidence from a range of sources and making good arrangements to pursue and apprehend those who were responsible for causing harm. For example, police received a referral from children's social care that an eight-year-old boy had been assaulted by his stepfather. They quickly gathered and assessed information, promptly undertook a joint visit (with children's social care), interviewed the child sensitively and arranged a medical examination. The stepfather was immediately arrested, thereby preventing further harm to the children in the family.

When officers were called to domestic abuse incidents, we found examples where the initial investigation was good. In most of the cases examined, there was a prompt response and a thorough investigation. Officers considered language barriers and where necessary requested the service of an interpreter to make sure that they fully understood the needs of the victim and the children.

Inspectors were concerned about the high number of 'open' cases in some of the CAITs. There were often good initial safeguarding plans to protect a child from immediate harm. However, in some cases, if the investigators had more to do, such as gathering further evidence and interviewing other witnesses, there was significant drift in investigations. This was particularly noticeable when an officer had a high workload. Inspectors assessed 14 sexual abuse cases and found half of them to be inadequate. Most investigations needed further enquiries and there were unnecessary and long delays. Officers recognised that an investigation needed more action, but commented on police records that they could not carry out the necessary enquiries because of high workloads. Records indicated a lack of supervisory oversight and there was a perception among officers that no support from senior officers was available.

In other investigations, staff spent too much time discussing the type of crime and who should investigate it. Cases were moved around the system to different units and the needs of the victim were lost.

For example, a 14-year-old boy coerced a 14-year-old girl to pose for sexually explicit photographs. Without her knowledge he distributed the images via social media, causing her serious emotional harm. Nobody took responsibility for this investigation for far too long. As a consequence, no action was taken to protect or help the girl, or to consider the continuing risk from the boy.

There were other causes of delays in investigations:

- Officers reported that analysis of computers and other media submitted to the high-tech crime unit took too long to complete and inspectors found some cases with significant delays. For example, a computer belonging to a man arrested for grooming children on social media was submitted in December 2013 and had not been dealt with at the time of the inspection in June 2014. While inspectors were encouraged to find that there were plans to improve timeliness, the increasing volume of work from the specialist online child sexual exploitation team and the PPU requires further review to ensure how best to meet those demands.
- There were also delays in some cases sent to the Crown Prosecution Service (CPS) for review – sometimes 3 months or more. For example, a 12-year-old girl was assaulted by her mother. The police investigation was thorough, there were witnesses and photographic evidence and the case was sent to the CPS for a decision to charge in August 2013. However, the mother had been re-bailed on numerous occasions and a decision had still not been reached at the time of the inspection in June 2014. The CPS prosecutor recorded the reason for the delay as an 'excessive workload'.

Although West Midlands Police has a small central team, it does not have dedicated local specialist teams to investigate child sexual exploitation. Child sexual exploitation is investigated by officers in the CAIT. In the cases examined by inspectors, the police response was mixed. The service was generally good if the risk was clearly identified by another agency – for example, a referral from the health service relating to a 15-year-old boy who was having sex with older men. In this case a joint visit took place promptly and intelligence was followed up to make sure the boy was protected from suspected offenders.

However, five of the nine cases of child sexual exploitation examined were assessed as inadequate. Signs of risk were missed, lines of enquiries were either not followed up or took too long, and there were failures to respond to information and intelligence and to pursue offenders. In one case, staff from a children's home called police with concerns about texts on the phone of an 11-year-old girl. An officer attended and found that the texts were of a sexual nature from an older man. This was a straightforward case.

The police should have submitted the phone for examination to identify the man and considered safeguarding measures to protect the girl. However, there was little activity for over two months and police failed to attend a multi-agency meeting to discuss protective measures. In another case, a 17-year-old girl revealed that she did not want to return home because she was being approached by older men for sex. Information gathered from her and sent to the force's intelligence unit indicated that the men may still be having sex with, and sometimes raping, younger girls. No follow-up action took place and she was not spoken to by police because she had turned 18. There was no apparent consideration that the men would continue to pose a risk to other vulnerable girls, or that she was a victim of crime and may need help and protection.

Overall, inspectors concluded that too many investigations took too long to progress, resulting in a lack of protection for victims, reduced victim confidence, loss of evidence and a continuing risk from offenders. Although the force has transferred more staff into the CAITs, it still has much more to do.

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 CPS to address the delays in charging decisions.**

Decision making

There were 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 attended incidents promptly when there were significant concerns about the 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 protection¹⁰ and, in the cases examined, initial decisions to take a child to a place of safety were well considered and in the best interests of the child.

Inspectors found a lack of understanding about, and guidance for recording information that had come to the attention of the police. 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. This record outlines the incident, risks to the child and any action taken. An incident may be minor and require no further police action, but the form is important because it is through these records that patterns of abuse are identified. Inspectors found cases where vital information had not been recorded – for example, children who were found living in chaos because of their parents' involvement in criminality, and the sexual exploitation of a 13-year-old girl. Inspectors found a lack of general child protection awareness in some frontline teams and inconsistent supervisory oversight, which may account for the poor recording and quality of information in some cases. In other cases, inspectors found that officers were submitting information about a child through other routes such as the CAITs or directly to children's social care services. Although it may be necessary to speak to other agencies in urgent cases, this was common practice that bypassed the CRU, making it difficult to draw information together.

The slow processes for receiving and passing on information in the CRU, coupled with the heavy workload of officers in the CAITs, caused unnecessary delays in decision making and were frustrating officers on the ground. For example, a response officer attended an incident of alleged child abuse and, while at the home, sought the advice of the CAIT. He was advised to fill in a non-crime incident form and told they would get round to dealing with it later. When inspectors spoke to the officers in the CAIT about this poor response, they explained that they did not have the time to support the officer because they were engaged with other urgent work. These difficulties created an environment in which the outcome is identified as the completion of the process rather than securing the best interest of the child. Delays in decision making leave children and parents not knowing what will happen next.

When officers attend a domestic abuse incident, they must complete a risk assessment form if a crime has been committed. However, this is not the case for incidents classed as 'non-crime' – for example, a heated argument. In these cases, completion of the form is discretionary, based on the officer's professional judgement. Some staff were unsure about where to record information if the incident was 'non-crime'. In one control room, further incidents would be added to the original

¹⁰ 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, (a) remove the child to suitable accommodation and keep him/her there or (b) take such steps as are reasonable to ensure that the child's removal from any hospital, or other place, in which he/she is then being accommodated is prevented.

non-crime report but, because non-crime incidents were not always included in the assessment undertaken by the domestic abuse screening team, cumulative risk could be missed. In one case, six children were living in a chronic domestic abuse setting. In the latest incident, the father was arrested for assault and assessed as posing a 'standard risk'. However, there had been three incidents in a short time and the children had been on a child protection plan a year previously. This information had not been drawn together sufficiently well for police to understand the cumulative risk to the children.

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.**

Trusted adult

There were examples where good engagement with other agencies and individuals enhanced a child's protection and resulted in a stronger relationship with the police. In one case, a 13-year-old boy told a teacher at his school that he had been sexually abused by a family member. Police and social workers determined together how best to engage with the child and family. Enquiries were undertaken sensitively and good evidence was obtained that also revealed abuse against other children in the family.

However, there is much more to do to demonstrate that staff are listening to children. In most of the cases assessed, officers said little about the views of children, the impact of an offender's behaviour on a child or the outcomes for children.

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

next. In one case, a mother reported concerns that her daughter was being groomed by an older man. After the initial report was sent to the PPU, no further contact was made for a month, by which time the mother had lost confidence in the police and would no longer agree for her daughter to be interviewed. A supervisor recognised that the child and mother had been let down, and attempted further contact. This was unsuccessful and the case was closed.

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.**

Management of those posing a risk to children

Those working with known registered sex offenders were clear about their responsibilities, assessed risk and took action to reduce it. Risk management plans were good and staff maintained contact and oversight appropriately and challenged offenders about their activities and contacts. They communicated and worked well with other agencies – for example, by carrying out joint visits with probation officers. They also identified children who might be at risk and informed potential victims about concerns for their safety.

Inspectors were concerned, however, about delays in the arrest of offenders, and prolonged investigations which officers attributed to heavy workloads. They found examples where officers did not follow up enquiries, and closed cases without sufficient consideration of the risk the offender posed to other potential victims.

Recognising the need for better arrangements to deal with information and intelligence concerning risks to children and other vulnerable people, West Midlands Police has restructured its intelligence-gathering and established local policing intelligence units. This provides the capability to draw intelligence together and to identify the risks posed by individuals and those who operate in groups and gangs to target children.

Inspectors also found good examples of multi-agency work. For example, in Coventry concerns were raised about exploitation in a 'shisha' bar (i.e. a bar where hookah pipes were smoked). An operation with the local authority and the LPU successfully tackled the problem. However, overall, inspectors were concerned

about the management of those who sexually exploit children. In 13 of the 18 cases involving child sexual exploitation (including internet grooming), inspectors found poor risk management of known suspects, significant delays in arrest and a failure to identify suspects even though there were lines of enquiry that could have been followed and were not. Inspectors also found indications of a wider network of men offending in groups and gangs that had not been identified and therefore not followed up.

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

Police detention

Inspectors looked at 15 cases of children in detention. The youngest was 13 years old and the oldest 17. Three of the detainees were girls, two of whom were 13 and the other, 15. Five of the children lived in care homes. Offences included robbery, assault and breach of bail conditions.

Inspectors judged that only six of the cases had been handled adequately. West Midlands Police self-assessed three cases, all featuring boys. Two were assessed as adequate and one inadequate.

In the 15 cases reviewed by inspectors, all offenders were charged and were refused bail by the custody sergeant. In such cases, the local authority has responsibility for providing appropriate accommodation if the child is to be detained overnight. It should only be in certain circumstances (such as in the middle of the night) that transfer to alternative accommodation is unlikely to be in the best interests of the child. In rare cases, 'secure' (locked) accommodation might be needed if the child represents a high risk to themselves or others. In only one case was the child transferred into the care of the local authority. In another case, care home staff refused to allow a 13-year-old girl to return after she had caused damage and assaulted a member of staff. The social worker was unable to find her alternative accommodation and she remained in custody overnight.

It was apparent that custody officers did not always contact children's social care services. Only five custody records indicated a request had been made to the local authority after a decision to refuse bail. When a child is held overnight in police cells, the custody officer should complete a 'child detention certificate'¹¹ to present to the

¹¹ Section 38(7) of the Police and Criminal Evidence Act 1984 states when a child continues to be detained in police custody after charge, because there is no alternative accommodation, a certificate has to be completed by the custody officer. This is to certify that the continued detention was necessary and to explain the circumstances.

court giving an explanation for the reason for the refusal. Inspectors found just two records where this form had been completed.

Inspectors asked several senior managers from children's social care services about the provision of accommodation for children who were refused bail. All claimed that there was provision for children refused bail to be accommodated and that this issue had not been brought to their attention as a problem.

Inspectors found that some custody staff lacked awareness and knowledge about child protection. They told inspectors that they had not received any training. This was evident in some cases examined by inspectors. For example, a risk assessment was completed on the arrival of a 13-year-old girl. She disclosed to a nurse in custody that she had a history of mental health issues, but this new information did not trigger a review of her risk assessment or her needs while in custody or on release.

Inspectors found good practice in the care of children detained for their own protection. 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, it is preferable for the person to be taken directly to health facilities such as a hospital. Children in the West Midlands who were detained under this power were taken to health facilities for an assessment.

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

6. Findings: leadership, management and governance

The chief constable and his command team are strongly committed to child protection and have a clear vision of how to develop child protection services across West Midlands Police.

Following a force review, an additional 370 staff will be moved to the public protection unit (increasing staffing from 430 to 800) and new specialist domestic abuse teams will be established. A further 16 police staff have been recruited to improve attendance at initial child protection case conferences.

Throughout the inspection, it was apparent that many staff responsible for managing child abuse investigations were knowledgeable, committed and dedicated to providing good outcomes for children identified as being at risk of harm. Inspectors witnessed good individual examples of police child protection work with officers displaying a mix of investigative and protective approaches.

Many staff knew to whom they were accountable and most staff were supported by their immediate line managers and heads of unit. However, this was not always the case in CAITs, where many staff reported that they were unable to manage their investigations effectively because of heavy workloads. There was inconsistent practice in the oversight and supervision of work and checking of standards in these units. As noted above, supervisory weaknesses are a contributory factor in many poor-quality investigations. In some areas, detectives said that their concerns about workloads were not being heard or acted upon, leading to the recording of inappropriate remarks about workloads on police records.

Inspectors found that officers did not always understand when a referral to another agency was required, how to submit the information or where to submit it. They also noted a lack of oversight by supervisors. Some police staff and partner agencies lacked confidence in the effectiveness of the CRU, leading to local deviations from agreed protocols. Inspectors consider that the force should undertake an immediate review of the CRU.

West Midlands Police serves diverse, multi-cultural communities. However, data on ethnicity did not appear to be used to improve services. Nevertheless, inspectors saw some evidence of culturally sensitive practice, for example, the response to children who were at risk of female genital mutilation.

Performance data and other information, such as that about children's views and needs, were limited. This restricts the ability of the force, partner agencies and LSCBs to meet needs and improve services and outcomes for children. Inspectors noted that a performance framework was under development.

The force's use of audits – both its own and the LSCBs' – was mixed. Inspectors were told that no case audits had been completed in the PPU to identify good practice and areas for improvement. Some staff reported that audits for the LSCBs were delayed because there was a lack of staff to complete them. However, multi-agency case audits in some areas were good. For example, the Sandwell MASH regularly conducted audits and had developed a good understanding of practice that achieves good outcomes for children.

Overall, the force's response to tackling child sexual exploitation has been slow, with inconsistent practice across the force area. There was a general lack of understanding of the extent of exploitation. The force developed a child sexual exploitation problem profile in July 2013. The profile identified a number of children at risk from, and perpetrators involved in, exploitation, but there had been little subsequent activity to develop this intelligence further.

A strategic group to tackle child sexual exploitation was developing a set of standards to provide a single approach across the police and local authority areas. This, coupled with co-ordinated plans at a strategic level, may improve future practice but was not yet influencing operations or multi-agency approaches. The force intended that CAITs would manage future investigations. This did not reassure inspectors that there would be sufficient capacity or co-ordination to respond effectively to the problem.

Inspectors recognise the challenge in achieving a consistent approach to child protection across seven local authority areas and ten LPUs. The 'preventing violence against vulnerable people programme' and the development of the MASH model across the West Midlands are good examples of the force's commitment to working with partners across the force area.

Generally, the force worked well with LSCBs but there were some concerns about senior police representation on the boards. Some were attended by the local policing commander and others by PPU detective chief inspectors. Some partners did not consider a detective chief inspector to be sufficiently senior to represent the force at the key meetings – nor does HMIC¹². Although attendance was good, it was difficult for some staff to contribute fully to the work of the board because of other operational commitments. We consider that consistent representation at LSCBs from local command teams sends out a strong signal to partners about the force's commitment to child protection. Involvement of the local command team would give them a better understanding of child protection arrangements, enable them to make better decisions about resources and influence practice in child protection both within

¹² Section 13 of the Children Act 2004 sets out that the police representative on the LSCB must be 'the chief officer of police'.

the force and through the LSCB. Involvement at commander level would also enable detective chief inspectors to prioritise supporting and developing staff and improving the quality and management of investigations.

Concerns were also raised by some LSCBs about police engagement in all of the priorities of the board, such as ensuring that the views of children are incorporated into all aspects of service delivery and how agencies can, collectively, help children and families at a much earlier stage to prevent problems escalating.

Inspectors noted that West Midlands Police has introduced a series of mandatory training packages for officers and staff. Operation Sentinel covers issues of vulnerability such as child sexual exploitation, so-called honour-based violence and female genital mutilation, with concerted campaigns to highlight responsibilities. Initially focused on supervisors, the training will be extended to frontline staff – a necessary step to improve awareness of child protection matters. Inspectors were, however, concerned about the lack of specific child protection training for custody staff and the limited joint agency training to improve practice between police and social workers.

Not all child protection staff had been trained in the specialist child abuse investigator development programme (SCAIDP), although there was a plan in place to achieve this over a 2-year period.

A number of senior officers with responsibility for public protection units had a limited background in child protection. While they brought other valuable experience, inspectors considered that a structured development plan would provide some necessary support for the demands of this new specialist role.

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

West Midlands Police has demonstrated a commitment to improving child protection services. The move to build increased capability and capacity is testament to this as is the focus on child protection within the force's strategic change programme.

However, at the time of the inspection, not all children at risk of harm were sufficiently protected by West Midlands Police and it is too soon to judge whether the changes underway will deliver the level of improvement required. While the first phase of the programme had been implemented at the time of the inspection, inspectors found that the ambition of the leadership team for service transformation had not yet gained traction among officers and staff working on the front line.

Inspectors found good practice in particular cases, but also significant weaknesses. When the matter was clearly one of child protection, the West Midlands Police often responded well. In difficult, complex or prolonged cases, the response was often much weaker.

Many staff were highly committed and knowledgeable, but many of those working in the CAITs showed signs of resignation to poor practice, claiming 'too much work' prevented anything better. They did not have enough support to carry out their role in child protection and this had a direct impact on the quality of service to children. Although the force had moved additional staff to the CAITs, this had not so far led to improved timeliness and quality of investigations.

Some of the attitudes officers held towards potential victims of child sexual exploitation or children who ran away were unacceptable and resulted in poor decision making. Staff need to understand that children do not make a 'lifestyle choice' to be abused, particularly those who are more vulnerable because of the neglect they have already suffered in their life.

There was insufficient awareness in some areas about the responsibilities police have for protecting children. The response to child sexual exploitation has been slow and the strategic framework will not deliver the desired outcome unless there is a greater commitment to a multi-agency response at an operational level (for example, through specialist multi-agency child sexual exploitation teams and an investment in knowledgeable staff with a commitment to protecting children).

Performance information for child protection was underdeveloped. The force needs to do more to understand and record outcomes in order to improve and develop services further. More oversight is needed of day-to-day work, especially investigations, and the force would benefit from undertaking regular reviews and audits to improve performance.

The force has developed good relationships with partner agencies and LSCBs, but in some areas partner agencies have expressed concerns about police commitment and there is more to do to gain their confidence. There was some co-located multi-agency working, and the plan to develop multi-agency safeguarding hubs is a positive step forward.

8. Recommendations

Immediately

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 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 CPS to address the delays in charging decisions.

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.

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

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.

We recommend that West Midlands Police undertakes a review of the CRU to ensure that:

- the unit is fulfilling its purpose to receive, assess and coordinate 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 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.

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.

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

Within six months

We recommend that 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.

9. Next steps

Within six weeks of the publication of this report, HMIC will require an update on the action being taken to respond to the recommendations that should be acted upon immediately.

West Midlands Police should also provide an action plan within six weeks to specify how it intends to respond to the other recommendations made in this report.

Subject to the responses received, HMIC will re-visit the force no later than six months after the publication of this report 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 practice.

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*, published in March 2013¹³. 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 taking 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 the child's 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.

¹³ *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2013. Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf

The inspections considered how the arrangements for protecting children, and the leadership and management of the service, contributed to and supported effective practice on the ground. The team considered how well management responsibilities for child protection, as set out in 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 exercise 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 within 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
Police protection powers	3
At risk of sexual exploitation	3
Online sexual abuse	3
Child in custody	3

Annex B

Glossary

child	person under the age of 18.
Crown Prosecution Service (CPS)	established in 1986 as an independent body and the principal prosecuting authority in England and Wales; responsible for advising the police on cases for possible prosecution; reviewing cases submitted by the police; determining any charges in more serious or complex cases and preparing and presenting cases for both magistrates and the high courts, including Crown Court and the Court of Appeal.
child protection plan	a written record for parents, carers and professionals which identifies specific concerns about a child and assesses the likelihood of a child suffering harm; sets out what work needs to be done to protect a child from harm, by when and who is responsible for that work; a child is no longer subject to a protection plan when it is judged that he or she is not believed to be suffering or at risk of suffering harm.
high-tech crime unit	a police computer crimes unit that undertakes examination and retrieval of evidence or intelligence from computers, computer-related media and other digital devices.

multi-agency risk assessment conference (MARAC)	locally held meetings 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 who they believe to be at high risk of harm; the aim of meetings is to produce a co-ordinated action plan to increase an adult or child's safety, health and well-being; agencies that attend will vary but are likely to include, for example: the police, probation, children's, health and housing services; over 250 currently in operation across England and Wales.
multi-agency safeguarding hub (MASH)	an entity in which public sector organisations with common or aligned responsibilities in relation to the safety of vulnerable people work; the hubs comprise staff from organisations such as the police and local authority social services; they work alongside one another, sharing information and co-ordinating activities to help protect the most vulnerable children and adults from harm, neglect and abuse.
Office for Standards in Education, Children's Services and Skills (Ofsted)	a non-ministerial department, independent of government, that regulates and inspects schools, colleges, work-based learning and skills training, adult and community learning, education and training in prisons and other secure establishments, and the Children and Family Court Advisory Support Service; assesses children's services in local areas and inspects services for looked-after children, safeguarding and child protection; reports directly to Parliament.

police and crime
commissioner
(PCC)

elected entity for a police area, established under section 1, Police Reform and Social Responsibility Act 2011, responsible for securing the maintenance of the police force for that area and securing that the police force is efficient and effective; holds the relevant chief constable to account for the policing of the area; establishes the budget and police and crime plan for the police force; appoints and may, after due process, remove the chief constable from office.

registered sex offenders

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.