

National child protection inspections

**Staffordshire Police
12–23 May 2025**

Contents

Overall summary	1
Our judgments	1
HM Inspector's summary	1
Introduction	3
About us	3
Child protection and our inspections	3
Terminology in this report	4
Leadership of child protection arrangements	5
Areas for improvement	5
Main findings	6
Working with safeguarding partners	10
Innovative practice	10
Main findings	11
Responding to children at risk of harm	14
Areas for improvement	14
Main findings	16
Assessing risk to children and making appropriate referrals	18
Area for improvement	18
Main findings	18
Investigating reports of abuse, neglect and exploitation of children	22
Areas for improvement	22
Main findings	24
Next steps	28

Overall summary

Our judgments

Our inspection assessed how good Staffordshire Police is at safeguarding children who are at risk. Our graded judgments are as follows:

Outstanding	Good	Adequate	Requires improvement	Inadequate
	Working with safeguarding partners	Leadership of child protection arrangements	Responding to children at risk of harm	
		Risk assessment and referrals	Investigating child abuse, neglect and exploitation	

HM Inspector's summary

I am pleased with some aspects of the performance of Staffordshire Police in [safeguarding children](#) at risk, but there are some areas in which it needs to improve.

[Chief officers](#) and senior leaders make sure there are enough [officers](#) and [staff](#) to provide effective safeguarding services for children and their families.

The force has a range of measures to support the well-being of its officers and staff who work in child protection roles.

It contributes well to multi-agency child protection arrangements and works productively with its [statutory safeguarding partners](#). The force also works well with partner agencies to carry out prompt and regular [risk assessments](#) of children at risk of, or harmed by, exploitation.

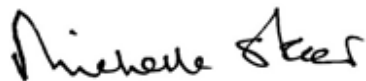
Staffordshire Police needs to improve in several areas. These include how it investigates online [child sexual exploitation](#) and its out-of-hours response to [the sudden and unexpected death of a child](#). It should also make sure its officers and staff record children's demographic information, such as ethnicity, so it can better assess risks.

Senior leaders and managers need to improve the quality of the force's performance data to understand what is working well and where it needs to improve.

The force must correctly record children who are [missing](#) to make sure it deploys the appropriate policing response. It needs to reduce delays when responding to incidents where it is likely to use [police protection powers](#).

The force also needs to use warning [flags](#) on records more effectively to improve its risk assessment of children. Flags are used inconsistently and not managed well. Better use of flags will make sure that responding officers receive accurate information about risk and [vulnerability](#) of children.

I was reassured that the force responded promptly and comprehensively to our feedback during this inspection. It has already put some plans in place to address the areas in which it needs to improve. I will continue to monitor its progress.



Michelle Skeer OBE QPM

His Majesty's Inspector of Constabulary

Introduction

About us

His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) independently assesses the effectiveness and efficiency of police forces and fire and rescue services, to make communities safer. In preparing our reports, we ask the questions that the public would ask, and publish the answers in an accessible form. We use our expertise to interpret the evidence and make recommendations for improvement.

Child protection and our inspections

[Children](#) are among the most [vulnerable](#) in society. Most children grow up in loving, caring families and reach adulthood unharmed. But some don't – they fall prey to people who coerce them into [criminal enterprises](#) or [exploit them for sexual gratification](#). Children who don't grow up in loving, caring families face heightened risks, as do [children who go missing from home](#).

These things are well known. Public services, including the police, have a shared responsibility to look for the warning signs, be alert to the risks and act quickly to protect children.

In February 2024, we introduced a new child protection rolling inspection programme. For each police force in England and Wales, we make five judgments on how effectively the force [safeguards](#) children at risk.

Our inspection findings are intended to provide information for the police, [police and crime commissioners](#) (and mayoral equivalents) and the public. The expectations of agencies to safeguard and promote the welfare of children are set out in statutory guidance: '[Working together to safeguard children 2023](#)' and '[Wales safeguarding procedures](#)'.

In each inspection, we focus on the experiences of children who come into contact with the police when there are concerns about their safety or well-being.

Terminology in this report

Our reports contain references to, among other things, 'national' definitions, priorities, policies, systems, responsibilities and processes.

In some instances, 'national' means applying to England and Wales. In others, it means applying to England, Wales and Scotland, or the whole of the United Kingdom.

Leadership of child protection arrangements

Adequate

Staffordshire Police's leadership of its child protection arrangements is adequate.

Areas for improvement

The force should improve the quality and management of its child protection performance data

Senior leaders and managers still need to improve the quality of the force's performance data to understand what is working well and where it needs to improve. This was a finding when [we inspected the force in 2022](#) and [re-inspected it in 2023](#).

The force produces general performance data about crime and incident demand. At a monthly [public protection unit](#) performance board, the chief superintendent tells unit managers about demand related to [vulnerability](#). Detective inspectors bring their own data from different systems to this board.

The unit's superintendent also chairs a monthly [child](#) protection governance meeting. We found that meeting attendees didn't always discuss performance data. Just before our inspection, we reviewed a performance presentation from the December 2024 meeting. It was rich with quantitative data but lacked qualitative analysis of child protection themes and trends.

We were told that individual [officers](#), [staff](#) and leaders working in child protection couldn't directly access up-to-date performance data to assess individuals and teams. Without detailed information, [chief officers](#) can't see if their child protection services are effective.

Chief officers recognise that the force's performance analysis has mostly been about measuring data. The force's central insight team told us that it was working to include child protection performance data in the force's policing plan and annual delivery plan.

The force has developed its Microsoft Power BI reporting tools. However, it hasn't prioritised producing a [protecting vulnerable people](#) data dashboard. Senior leaders told us that the force planned to introduce this dashboard within the next 12 months. At the time of our inspection, the force couldn't confirm a date.

The force needs to record children's demographic information more consistently

In 17 of our 48 case file reviews, we found that [officers](#) and [staff](#) hadn't recorded the [child's](#) ethnicity. This makes it more difficult for the force to assess risk in cases where a child's ethnicity may be a factor. The force also can't fully understand potential risk factors affecting people because of their cultural heritage.

The force's IT system allows officers and staff to record whether a child has a disability or if that information isn't known. In 27 of the 48 case files we reviewed, officers and staff hadn't recorded disability information.

It may be that officers and staff leave the field blank when they don't have the information. But better recording would allow the force to identify when a child is at higher risk and respond accordingly. All six of the online [child sexual exploitation](#) cases we reviewed had no disability [flags](#), even though some involved children with special educational needs.

We know that the recording of ethnicity of [victims](#) and suspects is a challenge for forces nationally. However, this was an [area for improvement](#) identified in [our child protection re-inspection of Staffordshire Police in 2023](#). The force needs to make sure it collects this information to protect children.

Main findings

In this section, we set out our main findings that relate to the force's leadership of its [child](#) protection arrangements.

The force's governance arrangements provide some oversight of child protection performance and practice

The deputy chief constable chairs a monthly force performance board that considers child protection performance.

A strategic vulnerability board, chaired by the assistant chief constable, discusses child protection priorities. Senior leaders and representatives from local policing areas attend.

A chief superintendent leads the force's child protection strategy and is responsible for implementing it. A detective superintendent chairs a monthly child protection governance meeting, which is well attended by managers from local policing areas.

The deputy chief constable commissions thematic reviews. These have included a review of child protection investigations and cases where children are [missing from home](#). The reviews aim to help the force understand changes in performance and their causes. The force told us that learning from these reviews was fed into a new [organisational learning](#) board chaired by the deputy chief constable.

The deputy chief constable is also the [National Police Chiefs' Council](#) lead for child protection.

The force recognises that child protection is a priority, but progress on improvements is slow

The force has three priorities in its [control strategy](#): child protection, [domestic abuse](#) and [serious and organised crime](#). To help it focus on these priorities, the force has a vulnerability strategy and a child protection strategy.

The force has invested in improving its public protection unit. In March 2023, it created an additional 100 posts, 41 of which were allocated to child protection.

Despite this investment, progress since our recent inspections has been disappointing and slow, particularly in relation to:

- investigations and the appropriate allocation of investigations;
- managing online [child sexual exploitation](#); and
- recognising children affected by domestic abuse.

We discuss this in detail in [our section on 'Investigating reports of abuse, neglect and exploitation of children'](#).

The force should make sure it is making enough progress and that it increases the pace of improvements. We will monitor this through the force's action plan.

The force doesn't always adopt a child-centred approach

The force uses daily management meetings and its 'pacesetter' meeting to make sure it deploys adequate resources to address current incidents and priorities. During our inspection, we found that these meetings sometimes prioritised incidents relating to children. However, officers and staff didn't always identify risks relating to children. And worryingly, we found that children were sometimes treated as adults.

We also found that meeting attendees didn't always discuss serious incidents that might involve children. For example, during a pacesetter meeting, officers discussing a firearms incident didn't appear to consider whether children were involved.

The force makes sure there are enough officers and staff to provide safeguarding services for children and their families

In March 2023, the force adopted a new operating model for its public protection unit to improve its ability to keep vulnerable people safe. It introduced specialist teams for areas such as child protection and missing people.

It set out the number of investigators the teams needed and the training they should have. It implemented a plan to achieve this. In January 2024, it introduced child exploitation teams.

We found that the force had enough officers in its child protection and exploitation teams. They deal with the most complex and serious offences against children and require specialist training and skills to get the best outcomes. The force monitors how many have achieved [professional investigation](#) accreditation and knows it doesn't have enough officers trained to this level.

At the time of our inspection, the force told us it was planning to review its public protection unit. This should help the force assess if it has allocated enough resource for child protection.

The force has some understanding of risks affecting children, but poor-quality data limits the usefulness of its problem profiles

The force has [problem profiles](#) to help it understand the nature and scale of crimes and issues affecting children. These include missing people and child sexual exploitation.

However, due to the poor recording of children's ethnicity and disability, these profiles are less able to help the force to understand the nature and scale of crimes and [safeguarding](#) concerns affecting children.

We found that the force didn't effectively put [flags](#) on records to identify children at risk of, or harmed by, exploitation or to identify people who posed harm to children. More effective flagging would support greater understanding of area and force-level risks of [criminal](#) and sexual exploitation of children.

We found cases of officers using victim-blaming language despite training

The force provides a range of training to new recruits, officers and staff in the public protection unit. This includes training on understanding [adverse childhood experiences](#), avoiding [victim-blaming](#) language and recording the [voice of the child](#).

The force recognises that there is a victim-blaming culture among some frontline officers and is working to address this. In January 2025, it reviewed missing person investigations and identified officers who had used victim-blaming language about missing children.

In 4 of the 48 cases we reviewed, we found victim-blaming language. This related to children reported missing and the text of a [public protection notice](#). Officers told us that online training had increased their confidence to support children and they better understood the consequences of using victim-blaming language.

The force should continue to train officers and staff to make sure they never use victim-blaming language.

The force should do more to make its well-being support available to all officers and staff in child protection roles

The force provides support services for most officers and staff. It has a well-being strategy for members of its child protection teams.

It has designated some officer and staff roles as high-risk, including some in child protection. The force schedules counselling appointments for these officers and staff every six months so they can discuss the effect of their work on their well-being. Most [police personnel](#) we spoke to told us that they discussed their welfare during regular meetings with supervisors.

But officers and staff in child sexual exploitation teams told us that they weren't referred for counselling every six months. This is a concern because they are regularly exposed to traumatic material. The force should make sure these officers and staff have the same well-being support as other child protection teams.

The force offers [trauma risk management](#) when officers and staff have been exposed to potentially traumatic incidents, such as [the sudden or unexpected death of a child](#).

Regular well-being bulletins and a toolkit are among the extensive resources available on the force's intranet. Some public protection unit officers and staff we spoke to were aware of and happy with the well-being support provided.

Working with safeguarding partners

Good

Staffordshire Police is good at working with safeguarding partners.

The expectations of agencies to [safeguard children](#) are set out in statutory guidance: '[Working together to safeguard children 2023](#)' and '[Wales safeguarding procedures](#)'.

The framework for how forces and [statutory safeguarding partners](#) should effectively protect children is set out in the following primary legislation:

- [Children Act 1989](#)
- [Children Act 2004](#)
- [Social Services and Well-being \(Wales\) Act 2014](#)
- [Children and Social Work Act 2017](#).

Statutory safeguarding partners have a legal duty to work together, and with other local partners, to safeguard and promote the welfare of all children in their area.

Staffordshire Police is a partner in two [safeguarding children partnerships](#):

- Staffordshire Safeguarding Children Partnership
- Stoke-on-Trent Safeguarding Children Partnership.

Within these partnerships, the force is an equal partner with the two local authorities and with one integrated care board:

- NHS Staffordshire and Stoke Integrated Care Board.

Innovative practice

The force, with its partners, has invested in specialist training for sudden or unexpected death in childhood

The force, working with the Stoke-on-Trent and Staffordshire Child Death Overview Panel, is funding an interactive training course to improve the multi-agency response to [the sudden or unexpected death of a child](#).

The simulation training is for:

- [child](#) protection [officers](#);
- children's emergency department staff;
- county council [safeguarding](#) teams;
- ambulance service safeguarding leads; and
- anyone involved as part of the multi-agency response to a child death.

Officers we interviewed spoke highly of the course, which was held in June 2024 and June 2025. NHS and other police force representatives observed the training. This [innovative practice](#) is likely to have the potential to improve the multi-agency response to the sudden or unexpected death of a child.

Main findings

In this section, we set out our main findings that relate to how well the force works with safeguarding partners to help safeguard, protect and promote the welfare of children.

The force understands its statutory responsibilities to safeguard children

When 'Working together to safeguard children 2023' introduced changes to how forces should work with statutory safeguarding partners, Staffordshire Police asked for advice from the [College of Policing's Vulnerability Knowledge and Practice Programme](#). This helped the force to understand its obligations and respond in line with them.

The chief constable is the designated safeguarding lead. The force has delegated this role to a detective chief superintendent, who chairs one of the two designated safeguarding partnership groups.

The force has good arrangements to meet its statutory responsibilities to safeguard children

Throughout the year, the chief superintendent meets the leads from both Staffordshire and Stoke-on-Trent's safeguarding children partnerships. The Staffordshire designated partnership board meets monthly. The Stoke-on-Trent designated partnership board meets every two months.

These partnership meetings help build a shared understanding of local needs and how services work together to safeguard and promote the welfare of children. It shows the force's understanding of its obligations as set out in 'Working together to safeguard children 2023'.

During our inspection, senior leaders from both safeguarding children partnerships told us that joint working had been strengthened since the force improved its [public protection unit](#). They told us that officers and [staff](#) participated in discussions, challenged appropriately and were committed to achieving better outcomes for children.

Each local partnership produces a document to promote consistent understanding and application of referral and intervention [thresholds](#). These documents aim to help make sure children receive the right support at the right time. Senior leaders, officers, staff and partners have a good understanding of them, even though different areas have different thresholds and services.

All the partners that we spoke to had regular contact with senior police leaders. They told us that they found it easy to contact the force to resolve or escalate issues if necessary.

The force works with local and national partners to identify and share learning

The force has a team, comprised of two review officers led by a detective inspector, that contributes to joint practice reviews, such as those on adult safeguarding, domestic homicide or child safeguarding. The review officers are also responsible for reviews of areas of child protection and [domestic abuse](#).

The review officers monitor for incidents and investigations that may require the local authority to make a referral to the [Child Safeguarding Practice Review Panel](#). When they see cases that fit the criteria, they formally report them to the relevant local authority.

They track the cases through the review process. The team is then responsible for contributing to the partnership decision to make a referral, carrying out a rapid review and jointly analysing the findings. Leaders in the partnerships spoke favourably about the team's contribution.

The review officers record learning and improvements and track them through the force's new [organisational learning](#) board. The deputy chief constable is responsible for making sure that learning improves the force's performance.

The force completes quality assurance analysis with its safeguarding partners. For example, together they audit ten [public protection notices](#) every month. This helps to achieve a shared focus on improvement, with particular emphasis on including the [voice of the child](#).

The force shares information promptly with schools so they can make sure children at risk get support

When school-aged children are exposed to domestic abuse, the force shares information with the child's school through [Operation Encompass](#). The automated process means that schools receive the information before the next school day begins. This should help to make sure that children receive support when they need it.

During our inspection, we found that clear guidance was given to officers and staff on how to complete the necessary information for an Operation Encompass referral. We found good referrals in all relevant cases.

The force must make sure the most appropriate officers and staff attend partnership meetings

The force contributes to [multi-agency risk assessment conferences](#) and chairs many of the meetings. We reviewed recent meeting minutes and found effective activity to mitigate risks to children and adult [victims](#).

We attended one [multi-agency child exploitation panel meeting](#) and reviewed the minutes of five others. We found that there was a good understanding of the children discussed. Actions and reviews were documented.

But some police representatives weren't senior enough to make decisions. The force must make sure that officers and staff have the right knowledge and seniority to represent it at these meetings.

Responding to children at risk of harm

Requires
improvement

Staffordshire Police requires improvement at responding to children at risk of harm.

Areas for improvement

The force must record missing children correctly to make sure it responds appropriately to keep them safe

The force should treat [children](#) that go missing as at risk of harm. It should complete a [missing person](#) report so it can address any risks.

We reviewed ten ‘concern for safety’ incidents involving children. We found that in two of those cases, the force had closed the incident as a ‘concern for safety’ when it should have been recorded as a missing person case.

We also found information incorrectly recorded on [COMPACT](#), the missing person case management computer system that brings together all information about a missing child.

Children who go missing on repeated occasions are sometimes in a local authority setting and at a higher risk of exploitation. So even if [officers](#) and [staff](#) have knowledge about a child, the force must make sure they record all incidents in the same way. If it doesn’t record incidents consistently, the force may not identify cumulative risk to a child.

The force needs to respond more quickly to incidents where it may need to use police protection powers

A [designated officer](#) of rank inspector or above should oversee [police protection powers](#). They should consider the length of time the [child](#) is under police protection. In the six cases we reviewed, the force recorded this information.

In four of the cases, the force was too slow to deploy officers to incidents where a child may have been at risk. Some involved more than one child. In all four cases, police used protection powers, which shows that the delay had left children at risk.

When they attended, [officers](#) often made well-considered decisions to take a child to a place of safety. They did this in the best interests of the child.

The force needs to make sure that it records risk to children when responding to domestic abuse incidents

[Section 3 of the Domestic Abuse Act 2021](#) requires [children](#) to be treated as [victims](#) of [domestic abuse](#) in their own right when they see, hear or experience the effects of domestic abuse and they are related to the [abuser](#) or the abused person.

[Authorised professional practice](#) sets out what this means for police forces and how they should act. For example, the police need to consider the full range of existing legislation (including relevant offences) and [safeguarding](#) procedures to protect children.

Staffordshire Police encourages its workforce to take a robust approach when tackling domestic abuse. We reviewed six domestic abuse cases. We found that [officers](#) and [staff](#) had completed [public protection notices](#) and took positive action, such as making arrests, in all of them. We found that some officers had made effective use of [body-worn video](#), except in two of the six cases where it hadn't been used.

In four cases, officers who visited the homes didn't record [the voice of the child](#) in enough detail. They asked questions about the child's welfare but didn't comment on the child's demeanour or appearance. Officers didn't record an assessment of the child's living conditions in any of the cases.

In September 2023, the force reviewed its response to domestic abuse following [our inspection in 2022](#). The force told us that in 304 of 720 incidents (42 percent) reviewed, it hadn't recorded the voice of the child. This means that it missed opportunities to safeguard children.

At the time of our inspection, supervisors on response teams and in harm reduction hubs told us that officers didn't routinely speak with children who were present when they attended domestic abuse incidents. This means they were unlikely to fully understand the children's experiences.

The force has been training officers to help them have conversations with children at domestic abuse incidents. At the time of our inspection, it was starting to see improvements in how officers were recording the voice of the child. It should continually monitor that officers are recording it in enough detail.

Main findings

In this section, we set out our main findings that relate to how well the force responds to help [safeguard children](#) at risk.

The force's website provides advice and information that is beneficial for children and those who care for them

The force's website lists several ways for members of the public to contact the police in both emergency and non-emergency situations. Children and their carers can report crimes online. But there isn't a live chat option, which children may find more accessible.

The website has information on topics that may affect children, such as [vulnerability](#) and forms of exploitation. There is also information about support organisations and how to contact them. This is helpful for families or professionals acting on behalf of children.

The force's control centre is using research to identify and highlight risks to children

Staff in the [force's control centre](#) can use an [intelligence](#) development function to carry out research, provide context and add to the force's understanding when responding to incidents.

Officers and staff in the control centre showed a good understanding of risks to children when considering their response. Call handlers use the [threat, harm, risk, investigation, vulnerability and engagement model](#) to assess risk.

When research indicates that a child is at high risk of harm, the force uses tactical options and resources at its disposal over and above traditional policing methods, such as telecoms analysis and police search advisors.

Case study: The force made good use of its resources to locate a high-risk missing child

A care home reported a 14-year-old girl [missing](#). She had ADHD and autism, and was assessed as being at high-risk of [child sexual exploitation](#).

The force worked quickly to locate the [child](#). [Officers](#) were deployed within three minutes to look for her. The force's [control room](#) completed a thorough [risk assessment](#) recording the child's vulnerabilities.

The [intelligence](#) development team promptly searched police systems and identified that she had previously tried to jump from bridges. Earlier records on the police missing person system also identified the child as being at high risk of harm.

The force used tactical resources, including a police search advisor, police dogs and drones. And it used the [Philomena protocol](#) to share information about the missing child with social care. It kept officers informed with physical descriptions and known locations the child frequented. This led officers to locate the child safe and well at a local shop. They carried out a detailed debrief and recorded relevant information about why the child had gone missing and where she had been.

[As described in the area for improvement](#), during our inspection, we found that the force was too slow in deploying officers to incidents where it may need to use [police protection powers](#).

Case study: Officers took 40 hours to locate a child at risk of sexual exploitation

West Midlands Police asked the force to visit an address to check the safety of a 12-year-old girl believed to be [missing](#) with her mother.

The mother, a drug user and sex worker, was the subject of a court order and only allowed supervised access to the girl. The [child](#) was at risk of [sexual exploitation](#).

A social worker also called the police to report that the girl wasn't at the mother's address, where there was evidence of drug-taking. The force received a further report that the mother had been leaving the child alone in a guest house room that men had been entering.

It took [officers](#) 40 hours from the initial call to find the child. The force should have responded more quickly and made greater efforts to locate the child. The delay left the child at risk for a long period of time.

On locating the child, officers arrested the mother for child neglect. They used their powers to remove the child to a place of safety.

Assessing risk to children and making appropriate referrals

Adequate

Staffordshire Police is adequate at assessing risk to children and making appropriate referrals.

Area for improvement

The force needs to use warning flags on records to improve its risk assessment of children

We reviewed eight [child sexual exploitation](#) investigations. We found that the force didn't routinely use [flags](#) on its record management system, [Niche](#), to identify [children](#) at risk of harm. This reduces its ability to immediately recognise risk, effectively grade calls and share information about the child's [vulnerability](#) with responding [officers](#).

The force has no guidance on how officers and [staff](#) should use warning flags on records. Nor does it monitor their use. Officers and staff we spoke to didn't know who could place flags on records.

Main findings

In this section, we set out our main findings that relate to how well the force assesses risk to [children](#), and makes appropriate referrals.

The force provides training, guidance and tools to identify risk and vulnerability, although some officers don't use them

We reviewed the force's [vulnerability](#) toolkit, 'See Me, Hear Me, Protect Me', on its intranet. The toolkit covers all aspects of adult and child [safeguarding](#). It has up-to-date information and offers advice on early intervention and prevention. It links to partner agencies and the integrated [front door](#) (the central point of contact for sending information and referrals related to children and families). Officers and staff can see any changes to policy and procedures.

Officers can access the toolkit on their mobile devices, but some don't. The force needs to make sure that all officers are aware of the toolkit and that they use it.

Officers and staff in child protection and harm reduction hubs have attended multi-agency safeguarding training provided by Keele University. With social workers and paramedics, they observed a joint visit and then together held a debrief of the scenario to identify best practice.

Officers and staff who attend [domestic abuse](#)-related incidents complete a [domestic abuse, stalking, harassment and honour-based violence risk assessment](#).

Most officers we interviewed understood that to make sure they considered the child's perspective and well-being, they should use the mnemonic ARTHUR:

A – Are there children present?

R – Review the circumstances to identify and assess risks.

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

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

U – Understand their wishes, thoughts and feelings.

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

The force works well with partner agencies to carry out prompt and regular risk assessments of children at risk or harmed by exploitation

In January 2024, the force introduced child exploitation teams. They have specialist officers who carry out criminal investigations. The teams carry out prevention and disruption activity to better protect children at risk of or harmed by exploitation. They use [intelligence](#) to identify and arrest suspects when [victims](#) don't recognise they are being exploited.

Using an approach similar to that of [Operation Makesafe](#), officers and staff work with hotels to make sure their employees can spot and report signs of exploitation. Officers visit areas where children frequent, such as vape shops.

At the time of our inspection, the force was piloting a new structure for meetings in Stoke-on-Trent. The child exploitation team, along with [personnel](#) from the harm reduction hubs and violence reduction team, attend a daily multi-agency triage meeting, chaired by the local authority.

Together they review cases, usually three at a time, of children at the highest risk of being exploited over the last 24 hours. They make a joint grading decision about the level and imminence of that risk. The child exploitation team is responsible for children at the highest level of risk.

We attended a [multi-agency child exploitation panel meeting](#) and found that partners shared information well. They held each other to account to make sure that safeguarding activity previously agreed to had been carried out.

Case study: Daily child exploitation meetings support better multi-agency understanding of risk to children

We attended a [child](#) exploitation daily management meeting chaired by a representative of children's social care.

The meeting focused on three main areas:

1. children who had been arrested over the previous 24 hours;
2. children who had been subject to harm over the previous 24 hours; and
3. children who had been reported [missing](#) overnight.

The meeting also reviewed whether cases met the criteria for the [national referral mechanism](#), which makes sure that [victims](#) of [modern slavery](#) are supported.

The partners identified a child who had gone missing three times in three days. They discussed and agreed a plan in the child's best interests. They agreed to hold a joint partnership meeting the following day due to an increase in risk to the child. The missing persons investigation team contacted the child.

This multi-agency meeting's early identification of risk is crucial for preventing harm to [vulnerable](#) children.

The force's harm reduction hubs manage risk to children well

The force has ten harm reduction hubs split over Staffordshire and Stoke-on-Trent. Some are co-located with partner organisations. All four harm reduction hubs that we visited worked well to share information to get the right help for children.

Hub officers and staff promptly carry out a secondary [risk assessment](#) on all domestic abuse cases and review [public protection notices](#). They check that investigators have considered relevant information about children and provide feedback, usually through their supervisors. Hub officers and staff also research whether any children are associated with either the victim or the suspect and check that public protection notices have been submitted.

We found that hub officers and staff promptly exchanged information with social workers. We observed joint daily triage meetings and found that officers and staff used relevant information and asked the right questions to assess risks to children.

Hub officers and staff also attend [multi-agency risk assessment conferences](#) and multi-agency child exploitation panel meetings.

The force contributes to multi-agency meetings, but child protection officers and staff aren't always able to attend joint visits

The force makes sure that officers and staff are available to take part in strategy meetings with partners.

Officers and staff play an active role in multi-agency risk assessment conferences. They chair meetings and contribute positively, which results in clear decision-making about the need for a [joint investigation](#) and what should happen next. The force's representative at these meetings is usually the integrated front door supervisor.

We found that the force was good at recording discussion outcomes on its systems and included detailed information. This means that the officer in the case can be clear about strategy meeting decisions. It also means that those dealing with future incidents will have a good understanding of previous decisions.

Harm reduction hub officers and staff told us that child protection officers weren't always available to attend the joint visits agreed. The response officers who attend in their place often don't have child protection experience. The force must make sure that it meets its statutory obligations and resources joint visits with officers or staff who have experience in child protection.

Investigating reports of abuse, neglect and exploitation of children

Requires
improvement

Staffordshire Police requires improvement at investigating reports of abuse, neglect and exploitation of children.

Areas for improvement

The force should make sure investigations are allocated to the most appropriate officers and staff with the necessary skills and training

The force doesn't have a crime allocation policy. This means that crimes may not be allocated to the most appropriate resource or team. This was also a finding in [our 2023–25 Staffordshire Police PEEL inspection report](#).

During our [child](#) protection inspection, we saw [high-risk domestic abuse](#) cases involving children being allocated to response [officers](#) who didn't have the appropriate training.

Without a crime allocation policy, the force can't check if crimes are being allocated to the correct teams. Supervisors aren't routinely using the escalation process to question whether a case should be allocated to their team. We found that crimes were allocated in line with severity and complexity and not risk and vulnerability.

At the time our inspection, the force provided us with a summary of the allocation of high-risk domestic abuse cases. The document showed that there were 2,981 allegations of domestic abuse under investigation. Of the more serious offences (rape, violence with injury and other sexual offences), 57 percent were allocated to the [public protection unit](#) and 4 percent to the criminal investigation department. However, 30 percent were allocated to response teams.

The force is considering several options to improve its access to data and oversight of [vulnerability](#). It also intends to allocate high-risk domestic abuse cases according to risk and not just severity or complexity. The force told us that this work would be prioritised.

The force should make sure that it implements a revised crime allocation policy as soon as possible to reassure itself that appropriately trained officers and staff investigate crimes involving children and high-risk domestic abuse.

The force should improve its arrangements for responding to sudden or unexpected child deaths at night

When a [child](#) dies, it is usually because of illness or accidental injury. A small proportion of child deaths are because of abuse. So when the police respond, they must find a balance between compassion and [professional curiosity](#).

This relies heavily on the knowledge and skill of the lead investigator. They must work closely with health professionals, children's social care services, the coroner and other partner organisations to quickly understand the circumstances leading to the death and decide together how to proceed. How services respond in the early stages can have a substantial effect on the resulting investigation. We assessed the force's preparations for and initial response to these incidents.

The force told us that it had provided training to some but not all [officers](#) who may attend [sudden or unexpected deaths of infants and children](#). Officers told us they didn't get enough training and many were concerned about dealing with these incidents.

We found that when the force received a report of the death of a child during the day, specialist child protection detective inspectors attended and led the investigation. During the night, the [on-call senior investigating officer](#) responded.

But many senior investigating officers don't have child protection expertise or the right training. A child protection officer who is considered the on-call expert in [sudden or unexpected death in childhood](#) supports them. However, this is often a constable with no experience of dealing with child death. It may even be a student officer.

The force should make sure that all officers and staff, and their supervisors, who investigate online child sexual exploitation have the right knowledge and skills

We found that the force didn't prioritise the [safeguarding](#) of [children](#) in all relevant investigative activity.

In the six online [child sexual exploitation](#) cases we reviewed, the force allocated response [officers](#) to investigate. But not all response officers have enough training or guidance in what they should do. We found that they didn't know how to progress cases when offenders incited children to take part in sexual activity, coerced them into sharing [indecent images of themselves](#) or extorted them for money.

This means that the force missed opportunities to trace suspects. Officers didn't always seize mobile devices or arrange for the force to examine them. They didn't explore whether a suspect had [groomed](#) and exploited the child or if the offender was in contact with other children.

Investigating officers completed no research to identify suspects, even where there were clear lines of enquiry from social media usernames or where [victims](#) had provided email addresses to officers.

The force missed opportunities to recover images and upload information to the [child abuse image database](#). This would help to reassure children that if someone uploaded their image to the internet in the future, it could be quickly removed. Some response officers we spoke to weren't aware of the database.

In all six cases, the force didn't recognise the need for joint working with children's social care services. There were no strategy meetings, and officers didn't make the necessary referrals to statutory partners for any of the children.

In [our 2023 report, 'An inspection of how well the police and National Crime Agency tackle the online sexual abuse and exploitation of children'](#), we made a recommendation that all chief constables should make sure their forces make referrals for children at risk of online [child sexual exploitation](#).

Main findings

In this section, we set out our main findings that relate to how well the force investigates reports of abuse, neglect and exploitation of [children](#).

The force doesn't have enough officers and staff trained to investigate reports of child abuse, neglect and exploitation

In March 2023, the force adopted a new operating model for its public protection unit. It created 100 extra posts in the unit, including 41 posts for child protection.

Most officers came from uniform policing teams. But it takes at least a year to become an accredited investigator and even longer to become an accredited specialist child abuse investigator.

So at the time of our inspection, many investigators were still working towards their accreditation. The force provided the following data, detailing the number of accredited officers by role as follows:

- Of 82 [professionalising investigation programme \(PIP\)](#) level 2 investigator posts, 29 percent had completed their training.
- Of 27 PIP level 2 supervisor posts, 4 percent had completed their training.
- Of 8 PIP level 2 manager posts, 13 percent had completed their training.
- Of 117 [specialist child abuse investigation development programme](#) posts, 9 percent had completed their training.

There were no PIP level 3 senior manager posts.

We found that the force had a good understanding of how many trained investigators it has in all teams and had a comprehensive training plan. It closely monitors vacancies. The chief superintendent scrutinises these figures each month at the public protection unit performance board. This allows the force to monitor its training requirements and mitigate any risks that a lack of experience can bring.

Some supervisors aren't giving officers and staff the support they need to carry out high-quality investigations

The force expects sergeants to review crime reports they receive and allocate them to their team's most appropriate investigator. The sergeant should review the investigation within 7 days and then every 28 days. The detective inspector should review the investigation after 56 days.

We found that some sergeants reviewed crimes and provided investigation plans in a timely manner, but other sergeants we spoke to struggled to meet the deadlines due to demand.

We found examples of sergeants leading good, [child-centred](#) investigations. Detective sergeants in child protection teams showed a good understanding of how they should work with their [safeguarding](#) partners. They considered children's needs, their teams' skills and the resources available to help get the best outcome for children.

The force has a triage process to prioritise which mobile phones its [digital forensic unit](#) examines. At the time of our inspection, we were told that there was a nine-month delay in examining mobile devices, which had sometimes led to [victims](#) withdrawing from investigations.

The force makes good use of its specialist resources to carry out or help investigations

We reviewed eight investigations carried out by the child exploitation teams. In every case, the teams held strategy meetings with the local authority and carried out [joint investigations](#) where appropriate.

There was good supervisory oversight and direction in every case, and all were investigated in a timely manner. We found that evidence officers worked with victims and continued to support them when they were reluctant for a police investigation to progress. We also saw evidence that the force used disruption tactics, such as [child abduction warning notices](#), during investigations.

Children have specific rights under the [Code of Practice for Victims of Crime](#). The force must complete a victim needs assessment to establish what support a child needs. We were pleased to find that the force usually carried out these assessments, meaning that investigators could keep the child's needs at the centre of the investigation. The force has victim liaison officers in its exploitation teams who work with victims to help them feel confident in supporting an investigation.

We also found that the force used its specialist [serious and organised crime](#) resources to support local investigations into exploitation. During our inspection, the force was working to break up a network of people suspected of [criminally exploiting children](#), and the investigation was in the final stages of the court process.

Case study: The force provided a good service to a child at risk of sexual exploitation

A mother reported to police that a man had sexually assaulted her 14-year-old daughter. Criminal investigations department [officers](#) visited the [child](#) and her mother. The child said that the man had been sexually assaulting her. He had supplied her with alcohol, clothing and money.

Both the [victim](#) and her mother supported the police investigation. And officers recorded the [voice of the child](#).

They arrested the suspect immediately to secure evidence and minimise the risk of further harm to children. He was given conditional [bail](#).

Officers viewed and obtained relevant evidence from the child's mobile phone. The force identified other children who may have been at risk from the suspect and spoke with them. The force supported the victim and referred her to support agencies.

As we stated in [our section on 'Investigating reports of abuse, neglect and exploitation of children'](#), the force should make sure that all officers and staff, and their supervisors, who investigate online child sexual exploitation have the right knowledge and skills.

Case study: The force failed to recognise online child sexual exploitation risks resulting in a poor safeguarding response

A 17-year-old [child](#) contacted the police using an online form. He reported being extorted after being coerced into sending naked pictures of himself. [Officers](#) didn't see the [victim](#) for seven days.

In the records we reviewed, we found evidence that the force had closed the case despite outstanding lines of enquiry. This included potentially identifying the suspect through social media accounts, email addresses and banking details.

The failure to complete all enquiries to trace the suspect shows a lack of understanding of the wider risk the suspect may pose to children.

The force missed potential opportunities to protect children. We raised our concerns regarding this case, and in response, the force reopened the investigation.

Next steps

Within eight weeks of this report's publication, Staffordshire Police should tell us in writing how it has addressed or intends to address the [areas for improvement](#) we have specified. It would be helpful for this information to be contained in an action plan.

December 2025 | © HMICFRS 2025

hmicfrs.justiceinspectorates.gov.uk