

# **National child protection inspections**

**West Midlands Police  
31 March–11 April 2025**

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# Overall summary

## Our judgments

Our inspection assessed how good West Midlands 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 West Midlands Police in [safeguarding children](#) at risk, but there are several areas in which it needs to improve.

We found [chief officers](#) and senior leaders make sure there are enough [officers](#) and [staff](#) to provide effective safeguarding services for children and their families. And the force has a range of measures to support the well-being of its officers and staff who work in child protection roles.

The force contributes well to multi-agency child protection arrangements and works productively with its [statutory safeguarding partners](#). And it has good arrangements to share information and contribute to joint plans to prevent harm to children.

The force also works well with local and national partner organisations to understand and improve the effectiveness of its arrangements to safeguard children.

But there are several areas in which the force needs to improve.

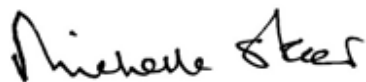
When incidents involving children at risk of harm are dealt with by scheduled appointment rather than emergency response, the force should make sure its officers and staff assess the children's ongoing risk.

It should make sure that its officers and staff consistently speak with children and record the [voice of the child](#). It should also make sure it makes referrals to statutory safeguarding partners for every child in need of help and support, and that those referrals contain all relevant information.

The force also needs to make sure its officers and staff correctly [flag](#) children who are at risk of, or harmed by, exploitation, as well as perpetrators who pose a risk to children.

When investigating reports of abuse, neglect and the exploitation of children, the force needs to make sure it does so jointly with statutory safeguarding partners. And it should make sure all officers and staff investigating [child sexual exploitation](#) have the right knowledge and skills to get the best outcomes for children.

I was reassured that the force responded promptly and comprehensively to our ongoing 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

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

### Area for improvement

#### **The force should make sure its officers and staff accurately record children's demographic information to better assess risks to children**

In 30 of the 48 child protection cases we reviewed, we found the force hadn't recorded the [child's](#) ethnicity. This makes [risk assessment](#) harder in cases where a child's ethnicity may be a factor. It also makes it more difficult for the force to analyse how risks differ for certain groups of children, based on their cultural heritage.

The force's IT system allows [officers](#) and [staff](#) to record whether a child has a disability or a special educational need, or whether that information isn't known. But we found that in 17 of the 48 cases we reviewed, officers and staff hadn't recorded this information.

We also found officers and staff weren't always recording the children's gender.

We found [chief officers](#) were already aware of issues relating to the recording of ethnicity through other work taking place in the force. The force told us addressing poor data recording is a priority and that it has plans for an education campaign for officers and staff.

### 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 strong oversight of performance and practice**

The force prioritises child protection in its [control strategy](#). This strategy outlines the force's operational priorities, which include violence against women and girls, [serious and organised crime](#) and exploitation, and [vulnerable persons](#), including children. It also recognises child [sexual abuse](#) as a priority. This is important as it is one of the national [strategic policing requirements](#). As such, the force has both a vulnerability strategy and a child protection strategy.

Each month, the force's deputy chief constable chairs what the force calls a 'force performance day'. This day-long meeting focuses on the quality of the force's practice, as well as quantitative performance data, including child protection priorities. Information and analysis from audit and [dip sampling](#) activity is presented, to provide assurance to the chief officers that their expectations are being met.

The force has a rolling programme of audits of different case types, including child protection investigations. The force reviews and reports to chief officers on the 1,000 cases it audits per month.

The force told us the deputy chief constable commissions monthly thematic audits. Previous thematic audits have included:

- reviewing child protection investigations where [victims](#) have withdrawn their support;
- reviewing officers' recordings of the [voice of the child](#);
- use of [victim-blaming](#) language; and
- the quality of [multi-agency referral forms](#).

The force uses the results of these audits to help it understand how well it is protecting children.

The [safeguarding](#) and vulnerability board, the vulnerability and investigation improvement board, and the child protection executive oversight board meet every month. An assistant chief constable chairs the meetings. These boards also assess performance and inform the force performance day. Senior leaders from across the force attend these meetings.

The [public protection unit](#) has oversight meetings with its specialist child protection senior leaders. Local policing commanders have similar oversight meetings in their local policing areas. All the local policing commanders we spoke to had a thorough understanding of the performance in their area relating to the protection of children.

These senior leader oversight meetings report to relevant chief officer boards and inform the force's performance.

## **The force understands and prioritises risk to children in daily operational incidents**

The force has good oversight of ongoing issues through its daily threat and risk meetings. These take place with the force's public protection unit, and in each local policing area. This is followed by a force-wide meeting, which is chaired by a senior or chief officer.

We were pleased to see that the meetings prioritise matters relating to children, including crimes against children, officers' use of [police protection](#) powers, and the progress of investigations into [missing children](#). Senior leaders chairing the meetings make sure that officers and staff have completed work from the previous day, or that the work is continuing to move forward.

### **Case study: The force senior leaders have good daily oversight of serious incidents involving children**

We observed a force-wide threat and harm meeting where senior leaders discussed a serious incident in which a [child](#) had fallen through the roof of an abandoned building, resulting in injury.

The assistant chief constable chairing the meeting made sure the focus of the investigation was on [safeguarding](#), and that [officers](#) completed a multi-agency referral form so children's social care services could give the necessary support to the child and their family.

## **Chief officers and senior leaders make sure there are enough officers and staff to provide safeguarding services for children and their families**

The force is clear about the resourcing and training needs for roles connected to the protection of children.

We found that the numbers of officers in the child abuse investigation team (CAIT) and complex CAIT were sufficient. These officers deal with the most complex and serious offences against children. They require specialist training and skills to get the best outcomes for children.

The force knows how many officers in these specialist roles have achieved professional accreditation and it knows it doesn't have enough. We discuss this in the ['Investigating reports of abuse, neglect and exploitation of children' section](#) of this report.

At the time of our inspection, the teams in the force responsible for sharing information with its safeguarding partners, such as the [multi-agency safeguarding hubs](#) and the central referral units had enough [personnel](#). But chief officers told us that the introduction of a new multi-agency referral form (similar to a [public protection notice](#)) has increased demand on these teams. They told us they are monitoring the levels of

demand, and that they have a plan to increase the number of officers and staff should they need to.

### **The force has some understanding of risks affecting children, but poor data recording limits the usefulness of its problem profiles**

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

However, due to the data quality issues we found in relation to the force's recording of children's gender, ethnicity and disability, these profiles have limited value. They aren't detailed enough to help the force understand the nature and scale of the crimes and safeguarding concerns affecting children.

The force only uses limited data from its safeguarding partners to inform the profiles. Such data would improve the safeguarding partnerships' joint understanding of risk.

The force supports officers and staff to provide a [child-centred](#) service. New recruits receive training in a full range of topics relevant to child safeguarding, supporting them to provide a child-centred service. The topics include:

- trauma-informed training;
- understanding the impact on children of using victim-blaming language; and
- recording the voice of the child.

The force has also mandated that all frontline officers and staff complete six child safeguarding-related training packages. These include:

- the use of the AWARE (appearance, words, activity and behaviour, relationships and dynamics, and environment) mnemonic to help them better understand and record the voice of the child and their lived experience;
- victim-blaming language training; and
- dealing with child sexual abuse images with the support of victim identification tools and the [child abuse image database](#).

During our inspection, the force told us that between 50 and 70 percent of officers and staff had completed each training package.

The force also has internal communications campaigns relating to child protection matters. These include, but aren't limited to:

- the use of the AWARE mnemonic;
- recording the voice of the child;
- the need for [professional curiosity](#); and
- understanding the impact of victim-blaming language on children.

## **The force is working to eradicate victim-blaming language, but it still needs to do more**

Officers told us that force-provided training had increased their confidence to deal with children, and they better understood the consequences of victim-blaming language when speaking to children.

In 5 of 48 cases we reviewed, we found use of victim-blaming language. In three of the five cases, officers and staff used inappropriate language about children who were missing from home.

When we spoke to force personnel, we heard isolated incidents of officers and staff using victim-blaming language. In each incident, they were referring to children who were missing. The force must keep educating its officers and staff to make sure they no longer use victim-blaming language.

## **The force has measures to support the well-being of its workforce, but could do more to make sure its personnel understand what is available**

The force has a well-being portal that all officers and staff can access. It provides details of the trauma and incident support, the employee assistance programme, peer support, and other types of available support. Supervisors can refer members of their team to the support services, or personnel can self-refer. The force also offers all officers and staff [trauma risk management](#) when they have been exposed to potentially traumatic incidents.

The force's public protection unit has a health and well-being strategy that aims to promote a culture of support to enhance the well-being of its officers and staff. It recognises the effect of trauma on personnel working in public protection. Senior leaders and chief officers attend meetings to monitor performance measures relating to officer and staff well-being in public protection and across the force.

The force has designated some roles as being high risk. These include roles in the CAIT and complex CAIT teams, and those in the child death team. The force provides additional services to those affected by trauma in these roles. It also told us that in future these personnel will have access to an annual psychological assessment, which should help it identify officers and staff who have experienced trauma.

However, we found that many people in these high-risk roles didn't know about the support already available to them.

The force should make sure all officers and staff understand what support they can access.

# Working with safeguarding partners

## Good

West Midlands 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.

West Midlands Police is a partner in seven [safeguarding children partnerships](#):

- Birmingham Safeguarding Children Partnership
- Coventry Safeguarding Children Partnership
- Solihull Safeguarding Children Partnership
- Walsall Safeguarding Partnership
- Wolverhampton Safeguarding Together Partnership
- Dudley Safeguarding People Partnership
- Sandwell Children's Safeguarding Partnership.

Within these partnerships, the force is an equal partner with the seven local authorities and with three integrated care boards:

- NHS Birmingham and Solihull Integrated Care Board
- NHS Black Country Integrated Care Board
- NHS Coventry and Warwickshire Integrated Care Board.

## 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**

'[Working together to safeguard children 2023](#)' introduced changes to how forces should work with their statutory safeguarding partners as part of their [local child safeguarding partnership](#) arrangements.

The force's chief constable is its lead safeguarding partner under the guidance. They have appointed seven local policing area commanders (all chief superintendent rank) as their delegated safeguarding leads. The seven local policing areas are geographically the same as the seven local authority areas. They are the force representatives for the local children's safeguarding arrangements.

We found that all the local area commanders understand their role in the statutory partnership. Several of them have experience of child protection work. We found they are active in the chairing and partnership meeting arrangements in their areas.

### **The force has strong arrangements in local areas to meet its statutory responsibilities to safeguard children**

We spoke to senior leaders from the force's statutory safeguarding partners. All of them spoke positively about the force's commitment to working with them to achieve better outcomes for children in their communities. They described strong working relationships.

All of them know, and have regular contact with, senior police leaders in their area. They described being able to easily contact the force to resolve issues if necessary.

We found that those senior leaders, [officers](#) and [staff](#) who represent the force in the partnership arrangements are sufficiently experienced and knowledgeable to contribute to discussions and make decisions.

This includes safeguarding partnership subgroups and forums, multi-agency meetings to risk assess and support children exploited or missing (similar to a [multi-agency child exploitation meeting](#)), and [multi-agency risk assessment conferences](#) to help protect children and families.

### **The force works well with local and national partner organisations to understand and improve the effectiveness of its arrangements to safeguard children**

The major crime review team is responsible when the force needs to contribute to joint practice reviews, such as those on adult safeguarding, domestic homicide, or child safeguarding. Officers and staff responsible for joint reviews relating to children are experienced child protection investigators.

The team monitors incidents and investigations for any that might require the local authority to make a referral to the [Child Safeguarding Practice Review Panel](#). When a case fits the criteria, the team formally reports it to the relevant local authority.

The team is then responsible for contributing to the partnership decision to make a referral, carry out a rapid review, and jointly analyse the findings. Safeguarding partners spoke favourably about the team's contribution.

The review team records [organisational learning](#) for the force and presents it at the force's organisational learning board. This board co-ordinates and influences future practice through training, guidance and communications to officers and staff.

We also found the force carried out quality assurance analysis with its safeguarding partners in each of the local policing areas. This has included multi-agency reviews of the force's use of [section 46 protection powers](#) and regular reviews of the force's safeguarding referrals to statutory partner agencies.

### **The force has good arrangements to share information and contribute to joint plans to prevent harm to children**

The force provides [personnel](#) to [multi-agency safeguarding hubs](#) in every local policing area where staff from different agencies work in the same location. It also has two central referral units. These teams allow it to quickly share information to safeguard and promote the welfare of children.

Each local partnership is expected to produce a [threshold](#) document to promote consistent understanding and application of referral and intervention thresholds. This helps them to make sure children receive the right support at the right time. Each area may have a slightly different threshold and different services available.

The force provides bespoke training to help its multi-agency safeguarding hub officers and staff understand their roles and their contributions to the partnership. Each team member also receives further training about local processes and services. This gives them a good understanding of their local thresholds, what information they should share, and how that information will be used.

### **The force works with local multi-agency partner organisations to make sure children receive protection and support**

[Neighbourhood policing teams](#) work with local children's homes to build links with the staff and children. They have agreed working practices under the [Philomena protocol](#) to make sure the force and the care providers understand each other's responsibilities when a child goes missing.

The force also carries out activity in line with [Operation Makesafe](#), with officers and staff working with hotels, taxi companies, vape shops and large events venues in the force area to make sure their personnel can spot signs of child exploitation and report it.

### **Case study: Hotel staff member recognises signs of child sexual exploitation and protects two young girls**

Early one morning, a hotel staff member noticed two girls, who they believed to be around 13 years old, enter a hotel room with an older man. The staff member spoke to the man, who told them the girls had “sneaked” into his room.

Concerned for the girls’ safety, the staff member called 999 and reported the incident to the police. The man left the hotel within minutes, before the police arrived.

The staff member told the attending [officers](#) that the girls kept running off, so the officers used their [police protection](#) powers to keep the girls with them to make sure they were safe.

Hotel staff provided the police with the man’s details from his hotel room booking. Officers then started the investigation by speaking with the children to understand what had happened. The suspect was arrested.

This investigation was ongoing at the time of our inspection.

The force also works with partners to encourage the submission of [intelligence](#) related to child protection. Force intelligence bureau staff have trained staff in other partner agencies, including:

- local authorities
- Barnardo’s
- children’s homes
- children’s social care services.

This helps partner agency staff to understand what intelligence is, and how to complete the intelligence form and send it into the force.

The force told us that, in March 2025, it received 229 intelligence submissions from partner agencies. But senior leaders told us they could do more to increase this number.

The force has also worked closely with schools in the Walsall local policing area. This is because of shared learning following an incident involving an intruder on a school premises during the school day. The result of this collaborative working is a presentation that helps school staff make decisions based on the [national decision-making model](#). This means that in the event of a similar incident in the future, the school staff and police should be better able to co-ordinate their responses.

Partnership leaders spoke positively of the force's work with schools. They told us they hoped this presentation would be rolled out across all local schools and the wider force area.

# Responding to children at risk of harm

Requires  
improvement

West Midlands Police requires improvement at responding to children at risk of harm.

## Areas for improvement

### **The force should make sure it assesses children's ongoing risk when incidents involving them are dealt with by scheduled appointment**

When the force contact centre receives a call, it uses the [threat, harm, risk, investigation, vulnerability and engagement assessment \(THRIVE\)](#) model to assess risk. If neither an emergency response (meaning an [officer](#) must attend within 15 minutes) or a priority response (meaning an officer must attend within 60 minutes) is needed, the contact centre staff schedule an appointment for the [victim](#) with an officer. Once an appointment is made, the contact centre no longer actively monitors these incidents.

Senior leaders told us each local policing area is responsible for managing its own appointments. Officers from across local policing teams, including neighbourhood officers, detectives and offender managers, deal with the appointments.

This process meant incidents assessed as suitable for an appointment weren't always subject to further [risk assessment](#) or management until the officer met with the caller. They would then then carry out another assessment.

We [dip sampled](#) ten cases where [children](#) were involved and calls had been scheduled for appointment. We found several offences against children, including physical assaults on child victims who attend the same school as the child suspects. In eight cases, children were subsequently recorded as victims of crime. Five cases were violent offences, and one included the sexual assault of a 13-year-old boy by a 16-year-old child. The appointments were scheduled between two and five days after the incidents.

The lack of risk assessment and suspect management between the initial call and the appointment with an officer means the force isn't always protecting child victims and other children.

We also found the force wasn't always creating [multi-agency referral forms](#) at the earliest opportunity. They should do this to share information about the child with [statutory safeguarding partners](#) to get them additional support.

**The force needs to make sure that its officers and staff speak with the children they meet, record their voices of the child, and effectively share the information with its safeguarding partners**

The force has worked to encourage its [personnel](#) to speak with the [children](#) they meet and record their views, concerns, and experiences. But in 26 of 47 applicable cases we reviewed, we found [officers](#) and [staff](#) didn't always speak to the children and often didn't record the [voice of the child](#).

In five of the six cases where children had been reported [missing](#), officers didn't speak with the children to effectively understand their experience.

In all six of the online [child sexual exploitation](#) cases, and four of the six contact child sexual exploitation cases, officers didn't demonstrate that they understood the child's experience or their wishes, even when the children were [victims](#) of crime.

In the cases of [domestic abuse](#) we reviewed, when officers attended and children were present, they did check the children were safe. But we found officers didn't routinely record the children's lived experience in relation to the effect of domestic abuse on them.

Some officers and staff we spoke to were positive about the training they had completed on voice of the child, and about using the AWARE mnemonic (appearance, words, activity and behaviour, relationships and dynamics, and environment). They told us it had improved their confidence in and understanding of why they need to speak with children.

## 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.

## **Children and people acting on their behalf can easily contact the force**

The force's website explains how people can make reports to the police, including about crimes or concerns affecting children. It has a section on child abuse that gives specific advice for children to help them report matters to the police. It also signposts them to children's services or support organisations.

The [force contact centre](#) has an online reporting portal, and a live chat service that it monitors 24 hours a day. This is positive because we believe children may be more likely to contact the police this way.

## **Officers and staff can usually identify vulnerable children and know how to safeguard them**

During initial training, the force gives contact centre officers and staff information and guidance to help them understand risks to children. We found that, overall, staff had a good understanding of these risks when considering their response and use [threat, harm, risk, investigation, vulnerability and engagement \(THRIVE\)](#) assessments to better understand them.

When a call relates to concerns about a child, such as a child reported missing or the [sudden death of a child](#), the force has developed a series of questions to help call handlers guide the conversation. The detailed information collected using these questions helps call handlers to carry out [risk assessments](#) to correctly prioritise the force's response.

An [intelligence](#) team supports officers and staff in the contact centre. The team carries out research to help officers and staff have a detailed understanding of risks when it responds to incidents. Control room staff can assign the team incidents to review and research, such as when a child at high risk of harm is reported missing. The team also monitors incidents to identify cases it can help with.

We also found the force contact centre has good supervisory oversight of emergency and priority incidents. And staff appropriately escalate incidents involving children to supervisors to review when no resources are available. This helps manage risk and prioritisation of police attendance.

## **The force has good oversight of its initial response to children reported missing**

We found the force has good oversight of its response to children who are reported missing from home. This includes senior leadership oversight of all missing children at the daily threat and risk meetings. Force response times to missing children are monitored in performance meetings.

We saw contact centre officers and staff use police systems well to inform the risk assessment for children who were reported missing. And its [trigger plans](#), which help inform priority actions to find the child, were easily accessible.

We also found the force uses the [Philomena protocol](#) across all local policing areas. Force contact centre officers and staff recorded that care staff had followed the protocol to find children before reporting them as missing to the police.

### **Specialist officers and staff work effectively to find and protect children who are reported missing**

The force told us that, following the initial report of a child being missing, frontline response officers carry out all initial actions to quickly find the child, such as visiting the child's friends and family. Once their inspector is satisfied these actions are complete, the missing child investigation is handed over to the specialist missing person team.

This team has officers and staff trained in financial investigation, digital media investigation, and intelligence. All these skills support enquiries to find missing children. The team also has some qualified detectives. It is on duty from 7am to 11pm every day.

We found the missing person team acted promptly to find children and worked closely with other teams (such as the criminal investigations department, the [neighbourhood policing teams](#), and response teams) to complete the investigative actions.

As well as finding the missing children, the team also collaborates with other teams to support the child and help prevent them from going missing again, such as the force's exploitation team, and school officers. The force told us that other partner organisations include local early help teams, the wider local authority, charities, and community groups.

### **To help keep children safe the force needs to improve its understanding of why children are going missing**

We found that in all six of the missing children cases we reviewed, the force had recorded the children on its missing person system. But the force hadn't routinely carried out [prevention interviews](#) and [return home interviews](#) with children once they were found or had returned home.

This means the force doesn't understand the reasons why the children were missing, or what had happened to them. This information is important when assessing the risks that children face and the support they may need to prevent them going missing in future.

Also, although the force has meetings with statutory safeguarding partners to discuss children who were or had been missing, we found [strategy meetings](#) about individual children didn't always take place when they should.

### **Case study: Officers failed to visit a child at high risk of harm to understand what had happened to him while he was missing from home**

A 15-year-old [child](#) was reported [missing](#) to the police by staff at his children's home when the boy didn't come home by his curfew.

The [force's contact centre](#) staff recognised that the child was at risk of harm from gangs, child exploitation and possible involvement with drugs. He had ADHD, and records stated he was taking medication for it. His records showed he had been reported missing 117 times before. On one occasion, while missing from home, he had been stabbed.

The contact centre staff recorded the boy as being at high risk of harm. [Officers](#) were deployed to look for him.

In the early hours of the morning, four hours after the report had been made, the boy returned home in a taxi.

Care staff spoke to him on his return, and he told them he had been out with friends.

Officers didn't attend the child's home. Nor did they speak with him to check his welfare and understand where he had been. Neither the force nor its partner agencies completed a [return home interview](#) with him.

### **Officers and staff carefully consider when to use their protective powers to safeguard children, but the force needs to provide better oversight**

The force recognises that it is a very serious step for it to use its emergency power to take a child into police protection. Senior leaders told us they have done a great deal of work to make sure officers use [police protection](#) powers appropriately.

In two of the six cases we reviewed, we found the force contact staff didn't understand how police protection powers could be used to safeguard children.

Where attending officers found they needed to take immediate action, they used their powers appropriately to remove children from harm's way. In all six cases, officers made well-considered decisions to take a child to a place of safety. Officers also quickly contacted children's social care services to begin joint planning, which helps better joint decision-making in the best interests of the child.

This power should be overseen by a [designated officer](#), who should be an inspector or above. The designated officer should do what is reasonable for the purpose of safeguarding or promoting the child's welfare. This includes making sure they are aware of the wishes and feelings of the child. They should consider and allow contact between the child and their parents or carers when it is reasonable and in the best

interests of the child. They should also consider the length of the time the child is under police protection.

We found the designated officers' records weren't always of a sufficiently high standard. Important details were missing or incomplete, such as when the police protection had ended or been rescinded. In some records, there were no details of who the designated officer was.

**Case study: Officers protected young children from harm by using their powers, but the force didn't record what happened to the children afterwards**

A member of the public reported to the police that a young [child](#) was walking up and down a street on their own. The child was naked.

The force contact centre deployed [officers](#) as an emergency response to find the child. Within a few minutes another member of the public contacted the police to say they had taken the child back to the child's home. They had found a man there who was very drunk.

Officers arrived quickly and found two young brothers, aged two and five years old. The home was in poor condition. The officers used their [police protection](#) powers to remove the children.

The children's mother and her boyfriend were arrested for child neglect.

The officers took the children to the police station and informed the [designated officer](#) of their actions. They recorded initial details of the use of police protection powers on the force system.

They contacted children's social care services, who started looking for a placement for the brothers. A social worker took the children to the hospital for child protection medical examinations. A police investigation was opened.

But there is no designated officer update on the force's police systems showing when the police protection power was ended, what happened to the children, or where they were taken after their medical examinations.

# Assessing risk to children and making appropriate referrals

## Requires improvement

West Midlands Police requires improvement at assessing risk to children and making appropriate referrals.

### Areas for improvement

**The force needs to make sure it shares good quality referrals with safeguarding partners for all children in need of help and support, and record them on force IT systems**

In March 2025, the force introduced the [multi-agency referral form \(MARF\)](#) process to share [safeguarding](#) concerns about children with its [statutory partner agencies](#).

We found when a [child](#) was a [victim](#) of crime, [officers](#) and [staff](#) were more likely to refer them. But this wasn't routinely done when children were:

- identified as suspects (whether officers arrested them or not);
- on child protection or child in need plans; or
- [missing](#) from a children's home.

Also, when the force made a disclosure to an adult at risk under [the domestic violence disclosure scheme](#), MARFs weren't being shared if their children were already known to children's social care services.

We also found MARFs didn't routinely contain the [voice of the child](#) and other demographic data, such as the ethnicity of children involved and whether they had disabilities. Some lacked details of the children's gender. This means safeguarding partners might not have all the information they need to assess risk and make decisions in the best interests of the child.

### **The force needs to make sure it correctly flags children who are at risk of, or harmed by, exploitation, and those perpetrators who pose a risk to children**

The use of [flags](#) or markers on police systems is important to help quickly show risk or [vulnerability](#).

We found the force was inconsistent in its use of flags to identify [children](#) who were at risk of and harmed by [criminal](#) and [sexual exploitation](#). It was also inconsistent at flagging perpetrators who pose a risk to children.

We spoke to [officers](#) and [staff](#) in specialist and frontline teams. We found many [personnel](#) had no clear understanding of what flags are available on the force systems in relation to child exploitation. They also weren't sure when flags should be applied to a child's record, or who was responsible for adding and later removing them. This means the officers and staff responsible for [risk assessing](#) incidents and the officers attending incidents may not be able to effectively protect the child involved.

The inconsistent use of flags may also restrict the force's ability to complete analytical work. This can limit its ability to understand the true nature and scale of child criminal and sexual exploitation across the West Midlands area.

## **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 mostly provides effective tools and guidance to its officers and staff so they can assess risk and manage responses to vulnerable children**

The force uses a variety of tools to help its officers and staff to understand risk and respond appropriately, including question sets to support call handlers to obtain good details from the person asking for police support. It uses the [threat, harm, risk, investigation, vulnerability and engagement \(THRIVE\)](#) assessment to help inform the grading decision for deploying officers.

The force's [missing persons](#) policy makes it clear that when a child under 14 years old is reported missing, they should quickly be categorised as high risk.

We found that when officers attend [domestic abuse-related](#) incidents, they consistently complete a [domestic abuse risk assessment](#). Most officers also completed a multi-agency referral form or referred to safeguarding partners when children were present or lived at the address. But in some cases we found these referrals lacked detail, such as the voice of the child.

We found the force has child protection-related guidance material on the force intranet. It is both accessible and informative. This material includes guidance on domestic abuse, missing children, and information sharing in [multi-agency safeguarding hubs](#).

Frontline officers and staff can access this information on handheld devices while out in the community. This supports them to make informed decisions about how they respond to children and incidents affecting children.

But we found the force had limited guidance for frontline personnel on how to recognise and respond to children at risk of or harmed by online sexual exploitation. It should improve its guidance on this topic.

### **The force could do more to make sure children are protected through its multi-agency approach to criminal and sexual exploitation**

We reviewed six cases where children were at risk of [criminal exploitation](#). We found the force generally carried out good multi-agency working with its safeguarding partners.

We found most local policing areas held meetings, similar to [multi-agency child exploitation meetings](#). The minutes we reviewed showed these were well attended by officers and staff from different police teams, including the specialist missing person team.

The frequency of these meetings varies across the force. Some local policing areas hold daily triage meetings to discuss individual children's cases and to map children connected to these cases who may also be at risk. In some areas, they discuss children who have been missing, so that personnel can better understand and assess the risk of exploitation to these children.

We found some areas use screening tools to help identify those children at most risk of harm. And some areas also make use of the Home Office 2019 [child exploitation disruption toolkit](#) to better inform risk and provide a suitable response to the child to prevent future harm. We found children's records were more complete when the information from these meetings was included.

Some areas held more strategic meetings with safeguarding partner organisations, where they discussed, for example, the overall risk of child exploitation in the community. They used tools to identify locations, perpetrators posing a risk to children, and different types of exploitation affecting children in their community.

Senior leaders told us they are aware of the inconsistent approach to multi-agency child exploitation meetings across the force area. They told us they have started a review of their overall approach to protecting and supporting children who are at risk of or being harmed by exploitation.

## **Specialist officers working with youth justice services provide good support to children harmed by criminal exploitation**

We reviewed two child exploitation cases where the children were being managed by local offender managers and supported by [Youth Justice Services](#).

We found the offender managers helped provide consistent child-focused support to the children. Each child had a detailed management plan that showed officers recorded and understood the child's needs and wishes. The plan provided clear details of all contacts with the child and how the force, with safeguarding partners, was working to protect the child and prevent future harm to them.

The force recognises that children harmed by exploitation need additional support, and we found officers made referrals to the [national referral mechanism](#) in these cases.

## **The force specialist child criminal exploitation team works well to get good outcomes for child victims of criminal exploitation**

We found officers and staff in the force's specialist child criminal exploitation teams have a good understanding of children as victims of exploitation. This includes children arrested for offences such as drugs possession.

These teams work to build trusting relationships with child victims to find out what support they needed. And we found they work well with safeguarding partners to help and support the children.

In reviewing the two criminal exploitation cases, we found these teams recognise how scared and reluctant children may be to support a police investigation against their exploiters. Officers told us how they work to build evidence-led prosecutions where they can, so that perpetrators can still be held to account.

### **Case study: A child is better protected from exploitation because of good multi-agency working**

The force recognised a 16-year-old boy as being at high risk of harm from [criminal exploitation](#). The boy was living in a children's home. He had been reported [missing](#) 86 times. Officers from the specialist exploitation team had been developing a relationship with him to understand how to better protect him.

One night, the children's home staff reported to the police that the boy hadn't returned home by his curfew. They told the call handler they had spoken to him about being late home, but he had then stopped answering their calls.

The force graded the boy as being at high risk of harm because of exploitation. It started an investigation to find him. The following day, the local hospital contacted the police. The boy had been dropped off at the emergency department with stab wounds. The boy had given the name of the man dropping him off.

[Officers](#) attended the hospital and spoke with the boy. They found he was in possession of Class A drugs.

Officers quickly contacted children's social care services to discuss the boy's situation. To protect him, children's social care services looked for different accommodation for him. But there was nowhere immediately available, so officers used their [police protection](#) powers to keep him safe in the hospital.

The police investigated the boy's stabbing and his criminal exploitation in relation to possessing drugs. They quickly identified that the man who had taken the boy to hospital was a registered sexual offender. They investigated him and his involvement with the child.

Officers worked with safeguarding partners throughout the investigation, along with the specialist exploitation officers, who supported the child.

The boy's level of risk of exploitation has gradually reduced to low risk of harm. He hasn't been reported missing since this incident.

At the time of our inspection, the investigations were ongoing.

### **The force contributes to multi-agency information-sharing arrangements to better protect children exposed to domestic abuse**

Staff in the force's central referral units carry out a daily search of police systems to identify all incidents of domestic abuse involving children that have taken place in the last 24 hours. The staff then share the results with safeguarding partners in the local policing area where the incident took place.

The force also shares this information with schools when the families in the incidents include or are connected to school-aged children, as required by [Operation Encompass](#).

This information is also used in each local policing area's daily domestic abuse triage meeting. Safeguarding partners attend these meetings. The attendees assess risk to adult victims and their children and agree how to support and protect the family.

**The force has good representation at multi-agency risk assessment conferences, but it could share more detail about the voice of the child**

We reviewed the minutes of 95 multi-agency risk assessment conferences from across the force area. We found the force actively contributes to these conferences. Its senior leaders chair some of the meetings.

There were suitable police representatives at all the meetings. There was sufficient information sharing to help attendees understand the risks and agree how to support victims.

Overall, we found the meetings focused on the children, recognising the risks to them and making plans to protect them. We also read examples in the meetings of children in extended family groups being identified, and the risks posed to them being discussed.

But we found that the police contributed little information about the voice of the child to help inform the decision-making and plans to better support the children.

# Investigating reports of abuse, neglect and exploitation of children

## Requires improvement

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

### Areas for improvement

#### **The force should make sure all officers, staff and supervisors investigating child sexual exploitation have the right knowledge and skills**

In all 12 of the [child sexual exploitation](#) cases we reviewed, the force had allocated a response [officer](#). But not all response officers have enough training or guidance to help them understand what they should do. The force provides training, but this isn't always resulting in officers carrying out joint working or good quality investigations for [children](#) who are [victims](#) of online child sexual exploitation.

In all six online child sexual exploitation cases we reviewed, the force didn't recognise the need for joint working with children's social care services. No strategy meetings were held, and officers didn't make the necessary referrals to [statutory safeguarding 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 clear recommendation to all chief constables that they should make sure they are making referrals for children who are at risk of online child sexual exploitation.

We also found officers didn't always seize media devices from child victims. Nor did they always arrange for specialist officers or staff to examine the devices that had been seized. This means opportunities to recover images and upload information to the [child abuse image database](#) were missed.

Investigating officers completed no research to identify suspects, even when there were clear lines of enquiry from social media usernames or email addresses provided to officers by victims.

When contact child sexual exploitation crimes were reported, the force correctly allocated specialist officers. But in four of the six cases we reviewed, we found poor suspect management by officers, with delays in arresting identified suspects. In one case, it took officers three months to arrest a 21-year-old male who had been identified as having sexually exploited a 13-year-old girl in a hotel room.

**The force should make sure all officers and staff responsible for making decisions and investigating child abuse work jointly with statutory safeguarding partners to improve outcomes for children**

The supervisors in the [multi-agency safeguarding hubs](#) review all crime and non-crime reports involving [child victims](#) recorded on force IT systems. This includes supervisors deciding whether police will investigate the crime.

The force has procedural guidance to support supervisors in the correct allocation of crimes for investigation. But in the co-located Birmingham central referral unit and multi-agency safeguarding hub team, we found that supervisors were routinely using a procedure that wasn't in the force's guidance. This procedure directed that child assaults with what the force described as a "transitory or low-level injury" (regardless of who the perpetrator was), "low-level neglect" and child "peer-on-peer sexual assaults" should all be recorded as crimes of "child cruelty". The procedure recommended no police investigation in these cases.

This approach wasn't [victim](#) or child focused. The force should always work with children's social care services to decide whether a [joint investigation](#) is needed in cases where a crime against a child is suspected to have been committed.

We also found the force wasn't always holding strategy meetings when it should have, including in two of the six cases where the force took children into [police protection](#) to remove them from harm.

When strategy meetings did take place, it wasn't always as promptly as it should have been. We found, and [police personnel](#) told us, that meetings about non-urgent cases were routinely held between three to seven days after the force received the initial request for a meeting.

We also found poor police decision-making in some strategy meetings where joint investigations weren't agreed when they should have been. This includes decisions made in meetings attended by child protection specialist officers.

## 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 responds effectively to the sudden and unexpected death of children**

When a child dies unexpectedly it is a challenging incident for the police to deal with. They must balance compassion with [professional curiosity](#).

The lead investigator must work closely with health professionals, children's social care services, the local coroner and other partner organisations to quickly understand the circumstances leading to the death of the child. They must decide together how to continue. How services respond in the initial stages can affect the resulting investigation.

We found the force has an established team of child death [senior investigating officers \(SIOs\)](#) who attend such cases as lead investigators. All officers on the team are detective inspectors who have had specialist child death training. The team is available to attend 24 hours a day, 7 days a week.

When the initial call about a child death is made to the police, a senior detective officer is quickly informed. They have oversight of the investigation from that point. They can support the child death SIO by advising, or they can provide them with extra staff if needed.

We found the team has good governance arrangements, including recording how many deaths they attend, and the circumstances of each. This means the force can better understand the welfare and development needs of the SIOs.

Force contact officers and staff told us they felt supported by their supervisors when they dealt with reports of child deaths. They said they were aware of the welfare support available to them, including the [trauma risk management](#) process.

### **The force needs to continue its efforts to have enough specialist child protection personnel trained**

Through direct recruitment and by developing existing officers and staff, the force now has the number of investigators it needs. A reduction in police numbers over several years, and problems we see nationally in recruiting and retaining detectives, means reinstating those units with trained, experienced personnel is difficult. It takes a minimum of a year to train to be an accredited investigator, and even longer to become an accredited specialist child abuse investigator.

This means, at the time of our inspection, many investigators were still working towards their accreditation. We found the force had a good understanding of the level of training investigators have had in all teams across the force. It also closely monitors vacancies in those teams. The deputy chief constable scrutinises these figures each month at the workforce strategy board.

The force has identified that roles at both detective constable and detective sergeant rank in the child abuse investigation team (CAIT), complex CAIT and online child sexual exploitation team require the [specialist child abuse investigation development programme \(SCAIDP\)](#) accreditation. It monitors which officers are accredited and which are working towards accreditation.

Some of the CAIT are police constables working towards their [professionalising investigations programme](#) Level 2 (PIP 2) investigator accreditation.

The force told us it provides additional support to newer inexperienced officers. It said it allocates them fewer complex investigations as they work towards their accreditation. This is reassuring.

The force told us that it projects that all officers in these teams will be PIP 2 and SCAIDP trained by December 2026. It explained it is prioritising specialist child protection officer training at every opportunity to try and reduce this time.

The force needs to make sure it has trained and accredited officers investigating the most serious and complex child protection investigations so it can provide better outcomes for children.

### **The force makes effective use of its specialist resources to support child focused investigations**

The force has specialist child rape and serious sexual offence teams. We found these teams had detectives who were SCAIDP accredited or trained and working towards their accreditation. The force allocation process was clear about the nature of the investigations these teams were responsible for, and we found there were enough officers to deal with the demand. Having child protection-trained officers dealing with such serious offences against children supports a child-focused response.

The force also has multi-agency enquiry teams linked to the multi-agency safeguarding hub in each local policing area. We found these teams consist of detectives, many of them either SCAIDP accredited, or trained and with previous child protection experience. This team is responsible for completing joint investigations with children's social care services in cases where the most appropriate outcome is believed to be an [out-of-court resolution](#).

The joint-working approach taken by this team involves the child's school and family and supports a child-focused investigation and outcome in most cases.

## **Supervisors support officers and staff to carry out more effective domestic abuse and child criminal exploitation investigations**

We found effective supervision in 23 of the 48 cases we reviewed. In five out of six domestic abuse cases and five out of six child criminal exploitation cases we found good supervision of the investigations.

In these cases, supervisors supported officers to record clear investigation plans. They made sure officers completed all necessary lines of enquiry and dealt with the suspect effectively to make sure the child was protected from further harm.

In domestic abuse cases we saw good use of police powers, such as [bail](#) and [domestic violence protection notices](#), to protect both adult victims and children.

## Next steps

Within eight weeks of this report's publication, West Midlands 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.

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