



Children Missing from Home and Care Inquiry Background Papers

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Work Outline / Terms of Reference (TOR)

Short Inquiry: Children Missing from Home and Care

Education and Vulnerable Children Overview and Scrutiny Committee (O&S)

Lead Member:	Cllr Susan Barnett
Inquiry Members:	All Members of the Education and Vulnerable Children O&S Committee: Cllrs: Uzma Ahmed, Sue Anderson, Matt Bennett, Barry Bowles, Debbie Clancy, Barbara Dring, Chauhdry Rashid, Valerie Seabright, Mike Sharpe, Martin Straker Welds and Alex Yip Other Reps: Samera Ali, Richard Potter and Sarah Smith
Lead Officer:	Benita Wishart & Amanda Simcox, Scrutiny Office
Our key question:	What safeguards does the City Council, working with partners, need to implement to effectively and comprehensively reduce the number of children who are missing from home and care and minimise the risks they are exposed to?
1. How is O&S adding value through this work?	Improving safeguarding is a priority for the City Council. This complements the work undertaken as part of the Committee's previous Inquiry, We Need to Get it Right: A Health Check into the Council's Role in Tackling Child Sexual Exploitation (CSE).
2. What needs to be done?	Key issues to explore will include: <ul style="list-style-type: none">• What role should and does the City Council play?• What roles can we expect from partners, such as the Police etc to play?• Is there effective collaboration to keep children safe, including data sharing; and policy and practice?• Are sufficient steps taken to reduce numbers of missing children / episodes?• Does the City Council manage the risks to children appropriately? Possible issues, concerns and risks to be explored: <ul style="list-style-type: none">• Costs to the Council and other partners when a child is missing, possible savings through different ways of working• Collaborative working• Joined up working between education and social care• Return interviews – resources and priorities



	<ul style="list-style-type: none"> • Young person's voice, Children in Care Council <p>Issues which may make children more at risk or impact on missing:</p> <ul style="list-style-type: none"> • CSE and exploitation • Unmet mental ill-health • Special Educational Needs and Disability (SEND) • Familial / other abuse / neglect • Domestic violence / Homelessness / Emergency accommodation • Criminal activity, youth justice • Unaccompanied asylum seekers, trafficked children • Children not registered at Border control • Abduction / residency disputes <p>Evidence Gathering includes:</p> <ul style="list-style-type: none"> • Call for evidence and written evidence • Evidence gathering session on the 21st October 2015 • Witnesses / Written evidence to include: <ul style="list-style-type: none"> ○ West Midlands Police ○ Birmingham Safeguarding Children Board ○ Children's Society
<p>3. What timescale do we propose to do this in?</p>	<ul style="list-style-type: none"> • September 2015: Terms of Reference Agreed • October 2015: Call for evidence • 21 October 2015: Evidence gathering Session • Additional evidence gathering and visits to be arranged • 25 November 2015: Committee agree draft report • Before 7 December 2015: report to Executive (8 day rule) • 17 December 2015: Committee agree final report • 22 Dec: Print & 23 Dec 2015: Report to be sent out • 12 January 2016: Report is presented to City Council
<p>4. What outcomes are we looking to achieve?</p>	<p>To ensure that partners are working together to prevent and support children missing from home and care and make recommendations where this can be improved.</p>
<p>5. Relevant Background Information / Evidence</p>	<ul style="list-style-type: none"> • Ofsted, Missing Children, February 2013 • DFE, Statutory guidance on children who run away or go missing from home or care, January 2014



Definitions

Missing from care: a looked after child who is not at their placement or the place they are expected to be (eg, school) and their whereabouts is not known.

Away from placement without authorisation: a looked after child whose whereabouts is known but who is not at their placement or place they are expected to be and the carer has concerns or the incident has been notified to the local authority or the police.

Police Definitions

Since April 2013 police forces have been rolling out new definitions of 'missing' and 'absent' in relation to children and adults reported as missing to the police. These are:

- *Missing:* anyone whose whereabouts cannot be established and where the circumstances are out of character, or the context suggests the person may be subject of crime or at risk of harm to themselves or another; and
- *absent:* a person not at a place where they are expected or required to be.

The police classification of a person as 'missing' or 'absent' will be based on on-going risk assessment. Note that 'absent' within this definition would not include those defined as "away from placement without authorisation" above: a child whose whereabouts are known would not be treated as either 'missing' or 'absent' under the police definitions. Guidance on how police forces will apply these definitions to children was issued by ACPO in April 2013. Paragraph 20 makes a requirement that 'Local authorities should agree with local police and other partners a protocol for dealing with children who run away or go missing in their area. Where appropriate, they should also have agreed protocols with neighbouring authorities or administrations'.¹

¹ DFE, Statutory guidance on children who run away or go missing from home or care, January 2014

Definitions currently used by West Midlands Police:-

As at September 2015

Missing: - Anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be subject of crime or at risk of harm to themselves or others.

Absent: - A person who is not at a place where they are expected or required to be.

The decision as to whether a person is missing or absent is made by West Midlands Police (usually by the duty inspector). In order to assist in their decision making process 16 questions are asked as a prompt.

The 16 Questions

1. Is this event significantly out of character?
2. Is the person likely to be subjected to harm or a crime?
3. Is the person a danger to themselves or others?
4. Is the person likely to attempt suicide?
5. Is the person a victim of abuse?
6. Does the person have any specific medical needs?
7. Is there a specific concern?
8. Do you know the person's whereabouts?

9. Have they done this before?
10. Have you been in contact with this person?
11. Who are they with?
12. Do you believe them to be involved in crime?
13. What were their intended actions when last seen?
14. What have you done to locate this person?
15. Is there a time you expect them to return?
16. Is there any other significant information you can give?

The first 8 questions are the risk-based questions. The remaining questions are the fact-finding questions.

Children Missing from Care, Home and Education



Quick Links:

[Introduction and Definitions](#)

[Agency Roles and Responsibilities](#)

[Specific Risks](#)

[Children Missing from Care and Care Leavers](#)

[Children Missing from Home](#)

[Children Missing from Education \(CME\)](#)

[Children who are Foreign Nationals and go Missing](#)

Links to Further Information

[Flowchart: Statutory Guidance on Children who Run Away or go Missing from Home or Care](#)

[Relevant Legislation and Statutory Guidance](#)

[Amendments to this Chapter](#)

Introduction and Definitions

Introduction

Children running away and going missing from care, home and education is a central issue for Birmingham safeguarding children board. Current research findings estimate that 25 per cent of children and young people, who go missing are likely to suffer significant harm. There are specific concerns about the links between children running away and the risks of sexual exploitation. Many looked after children (LAC) missing from their placements are vulnerable to sexual and other exploitation, especially children in residential care.

This chapter is based on guidance issued under Section 7 of the Local Authority Social Services Act 1970 which requires local authorities in exercising their social services functions, to act under the general guidance of the Secretary of State. Local authorities must comply with this guidance when exercising these functions, unless local circumstances indicate exceptional reasons that justify a variation.

This guidance complements Working Together to Safeguard Children and related statutory guidance (2015) and the Children Act 1989 guidance and regulation volumes in respect of Care planning and review.

Acknowledgement: This guidance has taken account of the DfE Statutory Guidance on 'Children who run away or go missing from home or care', January 2014.

Definitions

Based on the 'Statutory guidance on children who run away or go missing from home or care' (DfE 2014) the definitions which should be used when working with children, young people and their families are set out as follows:

- **Child:** anyone who has not yet reached their 18th birthday. 'Children' and 'young people' are used throughout this guidance to refer to anyone under the age of 18;
- **Young runaway:** a child who has run away from their home or care placement, or feels they have been forced or lured to leave;
- **Missing child:** a child reported as missing to the police by their family or carers;
- **Looked after child:** a child who is looked after by a local authority by reason of a care order, or being accommodated under section 20 of the Children Act 1989;
- **Responsible local authority:** the local authority that is responsible for a looked after child's care and care planning;
- **Host local authority:** the local authority in which a looked after child is placed when placed out of the responsible local authority's area;
- **Care leaver:** an eligible, relevant or former relevant child as defined by the Children Act 1989;

- **Missing from care:** a looked after child who is not at their placement or the place they are expected to be (e.g., school) and their whereabouts is not known;
- **Away from placement without authorisation:** a looked after child whose whereabouts is known but who is not at their placement or place they are expected to be and the carer has concerns or the incident has been notified to the local authority or the police;
- Care leavers cover young people from aged 16-24;
- For Police definitions of missing and absent, and responses, see below.

Agency Roles and Responsibilities

- [The West Midlands Police Force](#)
- [Legal Powers: the Birmingham City Council and the West Midlands Police](#)
- [Birmingham City Council](#)
- [Ofsted: Disclosure to Police](#)
- [Healthcare Professionals](#)

The West Midlands Police Force

The West Midlands Police Force, as the lead agency for investigating and finding missing children, will respond to children and young people going **missing** or being **absent** based on on-going risk assessments in line with current guidance. The police will prioritise all incidents of missing children as medium or high risk.

The police definitions of 'missing' and 'absent' are:

Missing

Anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be subject of crime or at risk of harm to themselves or another'.

and

Absent

A person is not at a place where they are expected or required to be'.

The police classification of a person as 'missing' or 'absent' will be based on on-going risk assessment. A child whose whereabouts are known would not be treated as either 'missing' or 'absent' under the police definitions.

It is important to note that professionals or others reporting a child missing to the police, should not make the judgement themselves as to whether a child is missing or absent – this decision will be made by the police on the basis of the information provided.

Where a child is recorded by police as being absent, they will agree review times and any on-going actions with the person reporting the absence. All persons recorded by police as absent are monitored on the police system. Monitoring is ongoing and subject to regular reviews to ensure risk levels do not change. Where information comes to light which introduces any risk to that person, then the case may be re-categorised as 'missing' and a police investigation started.

One of the overriding principles of 'Absent' is that police are able to focus resources more effectively, in accordance with the police risk assessments of 'absent' and 'missing' incidents.

The Police will carry out a 'Safe and Well' check with a 'missing' child who returns and will also carry out an independent "Return Review" interview in exceptional circumstances.

Risk Assessment

The police will prioritise all incidents of missing children as medium or high risk. Where a child is recorded as being absent, the details will be recorded by the police, who will also agree review times and any on-going actions with the person reporting.

A missing child incident would be prioritised as 'high risk' where:

- The risk posed is immediate and there are substantial grounds for believing that the child is in danger through their own vulnerability; or
- The child may have been the victim of a serious crime; or
- The risk posed is immediate and there are substantial grounds for believing that the public is in danger.

The high risk category requires the immediate deployment of police resources. Police guidance makes clear that a member of the senior

management team or similar command level must be involved in the examination of initial enquiry lines and approval of appropriate staffing levels. Such cases should lead to the appointment of an Investigating Officer and possibly a Senior Investigating Officer and a Police Search Advisor. There should be a media strategy and / or close contact with outside agencies. Family support should be put in place. The UK Missing Persons Bureau should be notified of the case immediately. **CEOP (National Crime Agency)** and local authority children's services should also be notified.

A missing child incident would be prioritised as '*medium risk*' where the risk posed is likely to place the subject in danger or they are a threat to themselves or others. This category requires an active and measured response by police and other agencies in order to trace the missing person and support the person reporting. This will involve a proactive investigation and search in accordance with the circumstances to locate the missing child as soon as possible.

Legal Powers: Birmingham City Council and the West Midlands Police

The police can use the powers under Section 46(1) of the Children Act 1989 to remove a child into police protection if they are likely to suffer significant harm. Police Protection lasts up to 72 hours.

Section 17 of the Police and Criminal Evidence Act 1984 provides police with powers to enter and search a premises in certain circumstances, notably, with regard to this guidance, for the purposes of saving life and limb or to arrest without warrant a person who has committed an indictable offence or certain other listed offences under the section.

Section 24 of the Police and Criminal Evidence Act 1984 provides police the power of summary arrest for any offence subject to certain provisions notably, for the purposes of this guidance, under S.24(5)(d) to protect a child or other vulnerable person from the person in question.

Should it be necessary to take the child into police protection, the child must be moved as soon as possible into local authority accommodation. The local authority should consider what type of accommodation is appropriate in each individual case. It is important that young people are not placed in accommodation that leaves them vulnerable to exploitation or trafficking.

Children's Social Care may need to obtain an Emergency Protection Order under Section 44 of the Children Act 1989, before expiration of the Police Protection.

The Local Authority may apply to the Court for a Recovery Order under Section 50 of the Children Act 1989. A Recovery Order can only be sought when the child is subject to an Interim or Full Care Order and it is clear that the child is in no immediate danger of significant harm.

Birmingham City Council

Section 13 of the Children Act 2004 requires local authorities and other named statutory partners to make arrangements to ensure that their functions are discharged with a view to safeguarding and promoting the welfare of children. This includes planning to prevent children from going missing and to do everything possible to ensure their safe return when they do go missing. Through their inspections of local authority children's services, Ofsted will include an assessment of measures with regard to missing children as part of their key judgement on the experiences and progress of children who need help and protection.

Birmingham City Council should name a senior children's service manager as responsible for monitoring policies and performance relating to children who go missing from home or care. The responsible manager should look beyond this guidance to understand the risks and issues facing children missing from home or care and to review best practice in dealing with the issue.

Birmingham City Council must ensure that all incidents where children go missing are appropriately risk assessed, and should record all incidents of looked after children who are missing or away from placement without authorisation.

Even with strong systems and services that minimise the likelihood of young people running away, some young people will still feel that they have to run away. In all circumstances local safeguarding procedures should be followed. If there is concern that the child may be at risk if returned home, the child should be referred to children's social care to assess their needs and make appropriate arrangements for their accommodation.

Children, who are looked after should have information about, and easy access to, help lines and support services including emergency accommodation. Support should also be made available to families to help them understand why the child has run away and how they can support them on their return.

It is important that emergency accommodation can be accessed directly at any time of the day or night. Bed and breakfast (B&B) accommodation is not an appropriate place for any child or young person under the age of 18 and should only be used in exceptional circumstances.

Sharing information to locate a child who is looked after, subject to a child protection plan or a child in need.

The local authority should consult with the police regarding what action should be taken to share information about a missing child who is looked after, subject to a child protection plan or a child in need. This should include an assessment of whether to release information to the media. The local authority should also notify other local authorities according to degree of concern. Consideration should also be given to whether the child or their family has links to other areas in the United Kingdom.

On receipt of a notification from another local authority, a flag should be added to the electronic record system for children's social care and consideration should be given to notifying health and other relevant partners.

Data on looked after children who go missing or are away from placement without authorisation.

The Department of Education Statutory guidance on children who run away or go missing from home or care (January 2014) states the following:

"Looked after children who go missing, or who are away from placement without authorisation, can be at increased risk of sexual or other forms of exploitation or of involvement in drugs, gangs, criminal activity or trafficking. Particular attention should be paid to repeat episodes. Data on these episodes should be analysed regularly in order to map problems and patterns. Regular reports on this data should be provided to council members and the LSCB."

Data for children missing or away from placement without authorisation should be reported to the Department for Education by the responsible authority (through their annual data returns on looked after children as part of the annual SSDA903 data collection)."

Local authorities collect information about children missing from education and educational establishments and about children who access other local authority services, such as youth services and children who are looked after.

As the guidance says, early and effective sharing of information between professionals and local agencies is essential for the identification of patterns of risky behaviour. This may be used to identify areas of concern for an individual child, or to identify 'hotspots' of activity in a local area.

Local authorities should collect data on children reported missing from care including repeat episodes of missing from care, unauthorised absences from care placements, and other relevant data and should regularly analyse this in order to map problems and patterns. This should include identifying patterns of sexual and other exploitation.

Good practice suggests that the following data should be collected and analysed by a multi professional group:

- Demographics of all children who are missing, absent or away from placement without authorisation;
- Associates of the above;
- The legal status of the children;
- Episodes, and length of episode by child;
- Numbers and themes from safe and well checks;
- Numbers and themes from return interviews;
- Cross match data with local information about gangs, CSE lists, home educated and missing from education lists, including information about children who go missing for part of the school day;
- Consideration should be given to analysing where the child is found as this information could help identify links between missing children and criminal groups.
- Analyse data by establishment and geographical area.

Data about children and young people who go missing from home, education or care should be included in regular reports to Council members, especially to the Lead Member for Children's Services and in regular reports by the local authority to Birmingham Safeguarding Children Board.

Ofsted: Disclosure to Police

On 1 April 2013 regulations came into force requiring Ofsted to disclose details of the locations of children's homes to local police services to support the police in taking a strategic and operational approach to safeguarding children particularly in relation to sexual exploitation and trafficking.

It should be noted that disclosure of this information to police services does not happen automatically and police services will need to request to receive this information on an on-going basis.

This duty is in addition to the existing obligation for Ofsted to disclose this information to local authorities. A protocol published alongside the regulations sets out the responsibilities of the public authorities to use information about the location of children's homes only for the purposes for which it was disclosed; and to share it onward only where this is compatible with safeguarding children and promoting their welfare.

Department for Education: Joint protocol: children's homes - procedure for disclosing names and addresses (2013).

Healthcare Professionals

Healthcare professionals have a key role in identifying and reporting children who may be missing from care, home and school.

- Missing children access a number of services provided by a range of health providers, for example:
- Urgent Care Units;
- Accident and Emergency Departments;
- Genito-Urinary Medicine Clinics (GaUM);
- Community Sexual Health Services; and
- Pharmacy Services.

Health professionals should have an understanding of the vulnerabilities and risks associated with children that go missing. Staff working in health settings should be aware of their professional responsibilities and the responses undertaken by the multi-agency partnership. Risks include sexual exploitation, trafficking, forced marriage and female genital mutilation. Radicalisation, also a risk factor for vulnerable young people, is managed via the national 'Prevent' strategy.

All health providers should provide a comprehensive service for Looked after Children (LAC). A Designated Nurse and Doctor for Looked after Children are located in each Clinical Commissioning Group (CCG). They are statutory appointments and are responsible for the commissioning and delivery of appropriate healthcare, assessments and services. Designated health professionals for LAC should share relevant information and intelligence relating to high risk individuals or emerging themes and patterns indicative of organised and targeted abuse, to the NHS Patch

Safeguarding Children Forum. They should also ensure that all health staff within their locality know how to identify, report and respond to a child who is missing from care.

Specific Risks

- [Homeless 16 / 17 year olds](#)
- [Trafficking](#)
- [Grooming](#)
- [Radicalisation](#)
- [Sexual Exploitation](#)
- [Criminal Behaviour](#)

Homeless 16 / 17 year olds

When a 16 or 17 year old runs away or goes missing they are no less vulnerable than younger children and are equally at risk, particularly of sexual exploitation or involvement with gangs.

When a 16 -17 year old presents as homeless, local authority children's services must assess their needs as for any other child. Where this assessment indicates that the young person is in need and requires accommodation under [Section 20 of the Children Act 1989](#), they will usually become looked after.

The accommodation provided must be suitable, risk assessed and meet the full range of the young person's needs. The sustainability of the placement must be considered. Young people who have run away and are at risk of homelessness may be placed in supported accommodation, with the provision of specialist support. For example, a specialist service might be provided for those who have been sexually exploited, or at risk of sexual exploitation.

Local authorities should have regard to statutory guidance issued in April 2010 to children's services authorities and local housing authorities about their duties under Part 3 of the Children Act 1989 and Part 7 of the Housing Act 1996 to secure or provide accommodation for homeless 16 and 17 year olds.

Trafficking

Some of the children who local authorities look after may be unaccompanied asylum seeking children or other migrant children. Some children in this group may have been trafficked into the UK and may remain under the influence of their traffickers even while they are looked after. Trafficked children are at high risk of going missing, with most going missing within one week of becoming looked after and many within 48 hours. Unaccompanied migrant or asylum seeking children, who go missing immediately after becoming looked after, should be treated as children who may be victims of trafficking. Children who have been trafficked may be exploited for sexual purposes and the link to sexual exploitation should be addressed in conjunction with [Trafficked Children](#) and [Child Sexual Exploitation](#).

The assessment of need to inform the care plan will be particularly critical in these circumstances and should be done immediately as the window for intervention is very narrow. The assessment must seek to establish:

- Relevant details about the child's background before they came to the UK;
- An understanding of the reasons why the child came to the UK; and
- An analysis of the child's vulnerability to remaining under the influence of traffickers.

In conducting this assessment it will be necessary for the local authority to work in close co-operation with the [UK Human Trafficking Centre \(UKHTC\)](#) and immigration staff who will be familiar with patterns of trafficking into the UK. Immigration staff should be able to advise on whether information about the individual child suggests that they fit the profile of a potentially trafficked child.

Provision may need to be made for the child to be in a safe place before any assessment takes place and for the possibility that they may not be able to disclose full information about their circumstances immediately. The location of the child should not be divulged to any enquirers until their identity and relationship with the child has been established, if necessary with the help of police and immigration services. In these situations the roles and responsibilities of care providers must be fully understood and recorded in the placement plan. Proportionate safety measures that keep the child safe and take into account their best interests should also be put in place to safeguard the child from going missing from care or from being re-trafficked.

It will be essential that the local authority continues to share information with the police and immigration staff, concerning potential crimes against the child, the risk to other children, or other relevant immigration matters.

'Safeguarding Children Who May Have Been Trafficked: Practice Guidance (2011) contains practical guidance for agencies which are likely to encounter, or have referred to them, children and young people who may have been trafficked. Where it is suspected that a child has been trafficked, they should be referred by the local authority into the UK's victim identification framework, the [National Referral Mechanism \(NRM\)](#).

The Trafficked Children Toolkit, developed by the London Safeguarding Children Board, has been made available to all local authorities to help professionals assess the needs of these children and to refer them to the NRM.

The NSPCC Child Trafficking Advice Centre (CTAC) provides specialist advice and information to professionals who have concerns that a child or young person may have been trafficked. CTAC can be contacted at free phone number: 0808 800 5000, Monday to Friday 9.30am to 4.30pm or email help@nspcc.org.uk

Grooming

Grooming is when someone builds an emotional connection with a child to gain their trust for the purposes of abuse or exploitation. Children and young people can be groomed online or in the real world, by a stranger or by someone they know - for example a family member, friend or professional. Groomers may be male or female. They could be any age. Many children and young people don't understand that they have been groomed, or that what has happened is abuse.

Children can be groomed for the purpose of sexual abuse as well as other forms of exploitation including involvement in criminal and extremist activity. Children who are missing are more vulnerable to being groomed and may also go missing as a result of being groomed.

Protecting Children at Risk of Radicalisation

Children and young people can suffer harm when exposed to extremist ideology. This harm can range from a child adopting or complying with extreme views which limit their social interaction and full engagement with their education, to children being groomed for involvement in violent attacks.

Children can be exposed to harmful, extremist ideology in the immediate or extended family, or relatives/family friends who live outside the family home but have influence over the child's life. Older children or young people might self-radicalise over the internet or through the influence of their peer network – in this instance their parents might not know about this or feel powerless to stop their child's radicalisation.

Going missing is a risk factor in relation to radicalisation:

- A child may go missing because they have already been radicalised;
- A child's risk of being radicalised might increase because they are missing and are spending time with people who may seek to involve them in radical/extreme activities. The risk is heightened whilst they are missing, because the protective factors of family or care are not available to them.

Professionals should always assess whether a child who has gone missing is at risk of radicalisation.

Children at Risk of Sexual Exploitation (CSE)

The sexual exploitation of children involves exploitative situations, contexts and relationships where the young person (or third person/s) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Violence, coercion and intimidation are common.

Involvement in exploitative relationships is characterised by the child's or young person's limited availability of choice as a result of their social, economic or emotional vulnerability.

A common feature of CSE is that the child or young person does not recognise the coercive nature of the relationship and does not see themselves as a victim of exploitation.

Going missing is a significant risk factor in relation to sexual exploitation:

- A child may go missing because they are being sexually exploited;
- A child's risk of being sexually exploited might increase because they are missing and are spending time with people who may seek to involve them in sexual exploitation. The risk is heightened whilst they are missing because the protective factors of family or care are not available to them.

Because there is such a strong link between children going missing and risk of sexual exploitation, professionals should always assess whether a child who has gone missing is being sexually exploited or at risk of being sexually exploited.

Children at Risk of being Drawn into Offending Behaviour

Children and young people who go missing from care, home and education also need safeguarding against the risk of being drawn into offending behaviour by gangs or criminal groups.

Children Missing from Care and Care Leavers

- [Care Leavers](#)
- [Out of Area Placements](#)
- [Looked after Children who are away from Placement without Authorisation](#)
- [Prevention and Planning – Risk Assessment](#)
- [Actions when the whereabouts of a Looked after Child is not known](#)

- [Actions when a Child has been found](#)
- [Repeat Running Away](#)

Care Leavers

From the age of 16 young people in care are referred to as care leavers, however, it is important to note that local authorities have very similar duties and responsibilities towards 16 and 17 year old care leavers as they do to children in care and for the purposes of this guidance, the response to a missing care leaver age 16 and 17 year old should be the same.

Local authorities continue to have a range of responsibilities towards children leaving care until the young person's 21st and in some instances their 25th birthday. It is good practice to follow the guidance set out below whilst a young person remains 'leaving care'.

Care leavers, particularly 16 and 17 year olds, are vulnerable to sexual exploitation and may go missing from their home or accommodation. Local authorities must ensure that care leavers under the age of 18 live in "suitable accommodation" as defined in Section 23B (10) of the Children Act 1989 and Regulations 9(2) of the Care Leavers Regulations, [The Care Leavers \(England\) Regulations 2010](#).

In particular young people should feel safe in their accommodation and the areas where it is located. Local authorities should ensure that pathway plans set out where a young person may be vulnerable to exploitation, trafficking or going missing, and put in place support services to minimise this risk.

Out of Area Placements

When a child is placed out of their local authority area, the responsible authority must make sure that the child has access to the services they need in advance of placement. Notification of the placement must be made to the host authority and other specified services.

If children placed out of their local authority run away, this protocol should be followed, in addition to complying with other processes that are specified in the policy of the host local authority. It is possible that the child will return to the area of the responsible authority so it is essential that liaison between the police and professionals in both authorities is well managed and coordinated. A notification process for missing/ absent episodes should be agreed between responsible and host local authorities as a part of the care plan and the placement plan.

Looked after Children who are away from Placement without Authorisation

Sometimes a looked after child may be away from their placement without authorisation. While they are not missing, they may still be placing themselves at risk (e.g. they may be at the house of friends where there are concerns about risks of sexual exploitation). The carer or social worker should take reasonable steps to ascertain the wellbeing of the child including, when appropriate, visiting the location. However, if there is a concern the child may be at significant risk of harm to themselves or to others then police should also be notified in order that appropriate safeguarding measures can be taken. This should not be confused with reporting a child missing.

Prevention and Planning – Risk Assessment

Local authorities have a duty to place a looked after child in the most appropriate placement to safeguard the child and minimise the risk of the child running away. The care plan and the placement plan should include details of the arrangements that will need to be in place to keep the child safe and minimise the risk of the child going missing from their placement.

Remember:

- The **Care Plan** – should include strategies to avoid unauthorised absences and/or a child going missing. It should also include strategies to reduce the duration and risks associated if the child does have unauthorised absences/go missing;
- The **Placement Plan** – should include strategies for preventing the child from taking unauthorised absences/going missing;
- A risk assessment should be completed for all children for whom there is concern that they may run away. Distance from home, family and friends should be considered as a risk factor;
- Provide the child with advice about an independent advocate and take the child's views in to account;
- Statutory reviews should consider any absences and revise strategies to prevent repeat absences and/or missing incidents and the care plan should be revised accordingly.

Where a child already has an established pattern of running away, the Care Plan should include a strategy to keep the child safe and minimising the likelihood of the child running away in the future. This should be discussed and agreed as far as possible with the child and with the child's carers and should include detailed information about the responsibilities of all services, the child's parents and other adults involved in the family network.

Independent Reviewing Officers (IROs) should be informed about missing/ absent episodes and they should address these in statutory reviews. The pre incident risk assessment should be updated after missing incident and should be regularly reviewed.

Designated health professionals for **Looked After Children (LAC)** should be informed of children missing from care who are deemed to be 'high risk'. They should be included in any multiagency strategy meetings or activity to manage the child's retrieval and any subsequent health needs.

Designated education professionals should be informed and included in the review process.

Actions when the whereabouts of a Looked after Child is not known

Whenever the whereabouts of a looked after child is not known, the foster carer or the manager on duty in the children's home is responsible for carrying out preliminary checks to see if the child can be located. For example, if a child was supposed to have returned home from school but has not arrived within the normal journey time, checks could include finding out if there are transport delays, phone calls to the child, phone calls to the school to see if the child has been delayed etc. If these initial checks do not succeed in locating the child or there are still concerns that, despite contact being made with the child they are at risk, the individuals and agencies listed below should be informed.

It is clearly important that a deadline is set at the outset of these initial checks so that they don't continue beyond a reasonable timeframe. What timeframe is reasonable should be based on an assessment of the risks relating to the individual child. In some cases, there might be particular reasons to be worried for the child's safety immediately and the individuals agencies detailed below should be contacted straight away – this in conjunction with on-going attempts to contact the child and find out why they aren't where they are supposed to be.

The individuals and agencies who should be contacted when a child is missing or they are away from placement without authorisation:

- The local police;
- The authority responsible for the child's placement – if they have not already been notified prior to the police being informed;
- The parents and any other person with parental responsibility, unless it is not reasonably practicable to do so, or would be inconsistent with the child's welfare; and
- The **Independent Reviewing Officer (IRO)**.

The local Vulnerable Person's Pen Picture should be used when reporting the child missing to the police. As a minimum requirement, all reports should include the following information:

- The child's name/s; date of birth; status; responsible authority;
- Where and when they went missing;
- Who, if anyone, they went missing with;
- What was the child wearing plus any belongings such as bags, phone etc.;
- Description and recent photo;
- Medical history, if relevant;
- Time and location last seen;
- Circumstances or events around going missing;
- Details of family, friends and associates;
- Updated risk assessment.

The carer/s should take all reasonable steps, which a good parent would take, to secure the safe and speedy return of the child based on their own knowledge of the child and the information in the child's placement plan. If there is suspected risk of harm to the child the carer/s should liaise immediately with the police.

Following initial discussions between the allocated children's social care worker and the police, they should agree an **immediate strategy** for locating the child and an action plan. This to include a range of actions to locate and ensure the safe return of the child, including:

- Arrangements for attempts to be made to contact the child on a daily basis by, for example, calling their mobile phone or the phones of friends or relatives that they may be with;
- The **Independent Reviewing Officer (IRO)** should also try and contact the child;
- Visiting their parents' address/es and of any friends or relatives with whom they may be staying;
- Police should consider requesting a trace on the child's mobile phone and/or oyster card.

If the child remains missing from more than 72 hours the social worker will arrange a missing person's strategy meeting to share information and coordinate action to locate the child.

- Any publicity will be led by the Police, the use of harbouring notices etc. will be agreed at the missing person's strategy meeting. Recovery Orders may be used where the child is Looked After;
- During the investigation to find the missing/run away child, regular liaison and communication should take place between the police, Birmingham City Council children's social care services and the host authority (if an out of area placement) and any other agencies involved;
- Birmingham City Council should ensure that plans are in place to respond promptly once the child is found and for determining if the placement remains appropriate.

Actions when a Child has been found

When the child has been located, care staff/ foster carers should promptly inform the child's social worker and the independent reviewing officer

that the child has returned. Arrangements should have been made for Safe and Well checks and Independent Return Review interviews:

Safe and Well Checks

Safe and well checks are carried out by the police as soon as possible after the child has returned. Their purpose is to check for any indications that the child has suffered harm, where and with whom they have been, and to give them an opportunity to disclose any offending by or against them.

Where a child goes missing frequently, it may not be practicable for the police to see them every time they return. In these cases a reasonable decision should be taken in agreement between the police and the child's parent or carer with regard to the frequency of such checks bearing in mind the established link between frequent missing episodes and serious harm, which could include gang involvement, forced marriage, maltreatment or abuse at home, bullying or sexual exploitation. The assessment of whether a child might run away again should be based on information about:

- Their individual circumstances;
- Family circumstances and background history;
- Their motivation for running away;
- Their potential destinations and associates;
- Their recent pattern of absences;
- The circumstances in which the child was found or returned; and
- Their individual characteristics and risk factors such as whether a child has learning difficulties, mental health issues, depression and other vulnerabilities.

Independent Return Review

The independent return review is an in-depth interview and should be carried out by an independent professional (e.g. a social worker, teacher, health professional or police officer, not involved in caring for the child and who is trained to carry out these interviews). The child should be seen on their own unless they specifically request to have someone with them. The child should be offered the option of speaking to an independent representative or advocate. The IRO should be informed.

The responsible local authority should ensure the return review interview takes place, working closely with the host authority where appropriate. Contact should be made with the child within 72 hours of them being located or returning from absence, to arrange the independent return review interview in a neutral place where they feel safe.

The interview and actions that follow from it should:

- Identify and deal with any harm the child has suffered – including harm that might not have already been disclosed as part of the 'Safe and Well check' – either before they ran away or whilst missing;
- Understand and try to address the reasons why the child ran away;
- Help the child feel 'safe' / understand that they have options, to prevent repeat instances of them running away;
- Understand what the child would like to see happen next whether short term and/or long term;
- Gather the parents or carers views of the circumstances, if appropriate;
- Provide the child with information on how to stay safe if they choose to run away again, including helpline numbers.

It is especially important that the independent Return Review interview takes place when a child:

- Has been reported missing on two or more occasions;
- Is frequently absent without authorisation;
- Has been hurt or harmed while they have been missing;
- Is at known or suspected risk of sexual exploitation or trafficking;
- Is at known or suspected risk of involvement in criminal activity or drugs;
- Has contact with persons posing risk to children; and/or
- Has been engaged (or is believed to have engaged) in criminal activities during their absence.

Follow up

The local authority children's social care services, police and other agencies involved with the child should work together to assess the child and build up a comprehensive picture of:

- Why the child went missing;
- What happened while they were missing;
- Who they were with when they went missing and where they were found;
- What support they require upon returning home; and
- Whether a statutory review of the care plan is required.

Where children refuse to engage with the interviewer, parents and/or carers should be offered the opportunity to provide any relevant information and intelligence they may be aware of. This should help to prevent further instances of the child running away and identify early the support needed for them.

Repeat Running Away

If a child continually runs away actions following earlier incidents need reviewing and alternative strategies should be considered.

To reduce repeat running away and improve the longer-term safety of children and young people, the agencies involved may want to provide:

- Better access and timely independent return interviews, particularly for the most vulnerable;
- Safety planning with the child for their missing;
- Better access to support whilst a young person is away, which may come from the voluntary sector.

There may be local organisations in the area that can provide repeat runaways with an opportunity to talk about their reasons for running away, and can link runaways and their families with longer-term help if appropriate. Local authorities should work with organisations that provide these services in their area.

Children's homes staff and foster carers should be trained and supported to offer a consistent approach to the care of children, including being proactive about strategies to prevent children from running away; and to understand the procedures that must be followed if a child goes missing.

The competence and support needs of staff in children's homes and foster cares in responding to missing from care issues should be considered as part of their regular appraisal and supervision.

The Children's Homes Regulations 2015 require children's homes to have a missing child policy. They also require that before implementing, or making substantive changes to an existing policy, children's homes shall consult with relevant partners and have regard to any relevant local authority or police protocols on missing children. Finally, where a child is, or has been, persistently absent without permission from the children's home; or is at risk of harm, the children's home shall ask the local authority that looks after the child to review that child's care plan.

Please also refer to the Department of Education's, '[Statutory guidance on children who run away or go missing from home or care: Flowchart to accompany the statutory guidance](#)'.

Children Missing from Home

- [Children Missing from Home](#)
- [Notifying the Police](#)
- [Actions when a Child is Missing](#)
- [Actions when a Child has been Found](#)

Children Missing from Home

When Birmingham City Council and the West Midlands Police Force analyse trends and patterns in relation to children, who run away or go missing from home, particular attention should be paid to repeat 'missing' and 'absent' episodes.

Birmingham City Council and Birmingham Safeguarding Children Board should be alert to the risk of sexual exploitation or involvement in drugs, gangs or criminal activity such as trafficking and be aware of local "hot spots" as well as concerns about any individuals, who children run away to be with.

Birmingham City Council and Birmingham Safeguarding Children Board should also consider the 'hidden missing', who are children who have not been reported missing to the police, but have come to an agency's attention after accessing other services. There may also be trafficked children who have not previously come to the attention of children's services or the police. Research demonstrates that children from black and minority ethnic groups, and children that go missing from education are less likely to be reported as missing. Local authorities and the police should be proactive in places where they believe under reporting may be more likely because of the relationships some communities, or individuals, have with the statutory sector.

Children missing from home are subject to risks and vulnerabilities similar to those for children who are looked after. NHS designated and named professionals hold a statutory role with regards to safeguarding in the local health community, and must be included in the information sharing and management processes being put in place for children deemed to be at high risk.

Notifying the Police

The police will respond to all notifications of children categorised as 'missing' as medium or high risk in accordance with this guidance. Where a child is categorised as being absent, the details will be recorded by the police, who will also agree review times and any on-going actions with the person reporting.

The information required by the police to assist in locating and returning the child to a safe environment is as follows:

- The child's name/s; date of birth; status; responsible authority;
- Where and when they went missing;
- Who, if anyone, they went missing with;
- What the child was wearing plus any belongings they had with them such as bags, phone etc;
- Description and recent photo;
- Medical history, if relevant;
- Time and location last seen;
- Circumstances or events around going missing;
- Details of family, friends and associates.

Actions when a Child is Missing

Whenever there are concerns that a child who is missing may be suffering, or likely to suffer, significant harm child protection procedures must be initiated in collaboration with children's social care services. See [Referrals Procedure](#).

A risk assessment should be completed in line with this protocol and action by the police will include:

- An active and measured response by police and other agencies in order to trace the missing child and support the person reporting;
- A proactive investigation and search in accordance with the circumstances to locate the missing child as soon as possible;
- Putting family support in place;
- Notifying the UK Missing Persons Bureau of the case;
- Notifying CEOP and children's social care services.

Where a child is living at home, and is the subject of a child protection plan, or, the subject of a s47 enquiry, additional action is required. This includes:

- Ensuring that a strategy meeting is arranged as soon as practicable and in any event within 7 days. If the child has returned prior to the date of the strategy meeting, it is not a requirement for the meeting to go ahead. Representatives from both the Police Missing Persons Unit and Public Protection Unit should attend the strategy meeting, as well as other practitioners involved with the child;
- In addition, a member of the senior management team or similar command level must be involved in the examination of initial enquiry lines and approval of appropriate staffing levels.

Actions when a Child has been Found

Where the child is known to children's social care services or meets the criteria for referral to children's social care services, the Local Authority will ensure that an assessment takes place and there are a range of service options available to address the child's needs following the safe and well check and independent return review interview.

Young people who have run away and are at risk of homelessness may be placed in supported accommodation, with the provision of specialist support, for example, for those who may have been sexually exploited.

Safe and Well Checks

Safe and well checks should be carried out by the police as soon as possible after the child has returned. Their purpose is to check for any indications that the child has suffered harm, where and with whom they have been, and to give the child an opportunity to disclose any offending against them.

Where a child goes missing frequently, it may not be practicable for the police to see them every time they return. In these cases a reasonable decision should be taken in agreement between the police and the child's parent with regard to the frequency of such checks bearing in mind the established link between frequent missing episodes and serious harm. In addition consideration should be given to a referral to children's social care services for an assessment to understand the reasons why the child is going missing and to further assess the risk of harm.

The assessment of whether a child might run away again should be based on information about:

- Their individual circumstances;

- Family circumstances and background history;
- Their motivation for running away;
- Their potential destinations and associates;
- Their recent pattern of absences;
- The circumstances in which the child was found or returned; and
- Their individual characteristics and risk factors such as whether a child has learning difficulties, mental health issues, depression and other vulnerabilities.

Independent Return Review

The Independent Return Review is an in-depth interview and should be carried out by an independent professional (e.g. a social worker, teacher, health professional or police officer, who does not usually work with the child and is trained to carry out these interviews). Children sometimes need to build up trust with a person before they will discuss in depth the reasons why they ran away.

The police should make a referral to the children's social care services to ensure that a return review interview takes place. Contact should be made with the child within 72 hours of them being located or returning from absence, to arrange an independent return review interview in a neutral place where they feel safe.

The interview and actions that follow from it should:

- Identify and deal with any harm the child has suffered – including harm that might not have already been disclosed as part of the 'Safe and Well check' – either before they ran away or whilst missing;
- Understand and try to address the reasons why the child ran away;
- Help the child feel 'safe' and understand that they have options, to prevent repeat instances of them running away;
- Understand what the child would like to see happen next whether short term and/or long term;
- Gather the parents or carers views of the circumstances, if appropriate;
- Provide the child with information on how to stay safe if they choose to run away again, including helpline numbers.

It is **especially** important that the independent return review interview takes place when a child:

- Has been reported missing on two or more occasions;
- Is frequently absent without parental agreement;
- Has been hurt or harmed while they have been missing;
- Is at known or suspected risk of sexual exploitation or trafficking;
- Is at known or suspected risk of involvement in criminal activity or drugs;
- Has contact with persons posing risk to children; and/or
- Has been engaged (or is believed to have engaged) in criminal activities during their absence.

Following the safe and well check and independent return review, the local authority children's services, police and voluntary services should assess the child's needs and work together:

- To build up a comprehensive picture of why the child went missing;
- What happened while they were missing;
- Who they were missing with and where they were found; and
- What support they require upon returning home

Where children refuse to engage with the interview, parents should be offered the opportunity to provide any relevant information and intelligence they may be aware of. This should help to prevent further instances of the child running away and identify early the support needed for them.

Information about local help lines and agencies working with runaways should be provided to the child and family.

Children Missing from Education (CME)

- **Definition of Children Missing Education**

- **Recognition and Response**
- **Notifications and Actions**

Definition of Children Missing Education

For the purpose of the Statutory Guidance on Children Missing Education (2015), children missing education are defined as those who are not on a school roll or receiving suitable education otherwise than at school. Those who are regularly absent or have missed 10 school days or more without permission may be at risk of becoming 'children missing education'.

Recognition and Response

Enquiries into the circumstances surrounding a child who is missing from school can be effectively supported by schools adopting an admissions procedure which requires a parent/carer to provide documentary evidence of their own and the child's identity and status in the UK, and the address that they are residing at. These checks should not become delaying factors in the admissions process.

If a member of school/educational establishment/college staff becomes aware that a child may have run away or gone missing, they should try to establish with the parents/ carers, what has happened. If this is not possible, or the child is missing, the designated safeguarding teacher/advisor should, together with the class teacher, assess the child's vulnerability.

From the first day that a child does not attend school and there is no explanation or authorisation of the absence, the following steps should be taken:

- A trained staff member will make contact with the parents/carers (person with parental responsibility for the child) to seek reassurance that the child is safe at home;
- The outcome of the contact should be assessed and if there are any concerns a consultation with the school/establishment/colleges designated safeguarding adviser should take place to consider the child's vulnerability.

In the following circumstances a referral to children's social care and /or the police should always be made promptly:

- The child may be the victim of a crime;
- The child is subject of a Child Protection plan;
- The child is subject of s47 enquiries;
- The child is looked after;
- There is a known person posing a risk to children in the household or in contact with the household;
- There is a history of the family moving frequently;
- There are serious issues of attendance.

The answers to further questions could assist a judgement whether or not to inform LA children's social care and the police:

- In which age range is the child?
- Is this very sudden and unexpected behaviour?
- Have there been any past concerns about the child associating with significantly older young people or adults?
- Was there any significant incident prior to the child's unexplained absence?
- Has the child been a victim of bullying?
- Are there health reasons to believe that the child is at risk? e.g.
- Does the child need essential medication or health care?
- Was the child noted to be depressed prior to the absence?
- Are there religious or cultural reasons to believe that the child is at risk? e.g.
- Rites of passage or forced marriage planned for the child?
- Has the child got a disability and/or special educational needs?
- Have there been past concerns about this child and family which together with the sudden disappearance are worrying? e.g.
 - Is there any known history of drug or alcohol dependency within the family?
 - Is there any known history of domestic violence?
 - Is there concern about the parent/carer's ability to protect the child from harm?

The length of time that a child remains out of school could, of itself, be an alerting factor of risk of harm to the child. Accordingly if a situation is not resolved within 3 days the Education Welfare Service should be contacted, then referrals should be made to the police and LA children's social care, as appropriate over the next two weeks.

Extended leave of absence can be authorised by the head teacher, at which point a return date is set. In these cases the time line for enquiries starts from when the child does not attend school on the expected return date, not from the day the extended leave started.

Notifications and Actions

Day one

If the answers to any of the points set out in the previous section indicates that there are concerns about the child's safety then a referral should be made to the police and children's social care on day one. The education welfare service should be informed and requested to assist in locating the child.

Step one:

- Contact the local police station (24 hour response);
- Any suspicion/evidence of crime must be clearly stated;
- The circumstances and all available information regarding the child and family will be required.

Step two:

- The missing person report will be risk assessed and the local police response team will carry out immediate actions;
- The investigation will be progressed by the police response team, in conjunction with either the local Missing Persons Unit and/or the CID.

Step three:

- The missing person report will generate a notification to the police;
- The police will work with, and refer information to Birmingham City Council children's social care;
- LA children's social care, who must be contacted as soon as possible in these circumstances, will also liaise with the the Police Public Protection Unit in order to identify, and act upon, any suspicion of child abuse or child related crime.

Step four:

The school / educational establishment / college should work in collaboration with children's social care and the police and a safeguarding education representative should participate in any strategy discussions, s47 enquiries and Child Protection Conferences which may arise.

Reasonable enquiry:

If the judgement reached on day one is that there is no reason to believe that the child is suffering, or likely to suffer, significant harm, then the school may delay making a referral. The process of 'reasonable enquiry' has not been identified in regulations, however this includes school staff checking with all members of staff whom the child may have had contact with, and with the pupil's friends and their parents, siblings and known relatives at this school and others.

School staff should also make telephone calls to any numbers held on record or identified, sending a letter to the last known address, home visits by some school based staff and consultation with local authority staff.

Days two to twenty-eight

If the above response was unsuccessful, the school should contact the local authority Children Missing in Education (CME) Team, Tel: 0121 303 4983. The local authority should make enquiries by visiting the child's home and asking for information from the family's neighbours and their local community, as appropriate.

The CME Team should also check databases within the local authority, use agreed protocols to check local databases, e.g. LA housing, health and the police; check with agencies known to be involved with the family, with the local authority the child moved from originally, and with any local authority to which the child may have moved.

The child's circumstances and vulnerability should be reviewed and reassessed regularly jointly by the school's nominated safeguarding advisor and the CME Officer in consultation with children's social care and the police as appropriate.

Child missing from school for more than four weeks

A child may not be removed from the school roll before the end of four weeks. After 4 weeks the child's Common Transfer file should be uploaded to the Department for Education secure site for the transfer of pupil information when a pupil moves between schools. The Local Authority Children Missing in Education Team must also be informed.

Transfer of information when a pupil changes school

The Education (Pupil Information) (England) Regulations 2000 (SI 2000/297) (as amended by SI 2001/1212 and SI 2002/1680) governs the transfer of information between schools.

- Regulation 10(3) states that 'The head teacher of the pupil's old school shall send the information within fifteen school days of the pupil's ceasing to be registered at the school'.

However:

- Regulation 10 (4) states that 'This regulation does not apply where it is not reasonably practicable for the head teacher of the old school to ascertain the pupil's new school or where the pupil was registered at his old school for less than four weeks'.

If the CME team or any other agency becomes aware the child has moved to another school the service should ensure all relevant agencies are informed so that arrangements can be made to forward records from the previous school.

Children who are Foreign Nationals and go Missing

- **Definitions**
- **Action and Responsibilities when the whereabouts of a Child 'subject to restrictions' is not known**
- **Action when the Child 'subject to restriction' is found**

Definitions

This section applies to children who are 'subject to restriction'. I.e. who have:

- Proceeded through immigration control without obtaining leave to enter; or
- Left the border control area Border Force accommodation without permission; or
- Been granted temporary admission; or
- Been granted temporary release or bail; or
- Released on a restriction order; or
- Served with a 'notice of liability to deport' or is the dependant of a foreign national offender whose status in the UK is under consideration by criminal casework – these dependants could be British Citizens or have extant leave.

Action and Responsibilities when the whereabouts of a Child 'subject to restrictions' is not known

Home Office staff must make a missing person's referral to the police, the UK Missing Person Bureau and the local authority children's social care in a number of circumstances including:

- When a child 'subject to restriction' is identified as having run away from their parents;
- Where they are looked after and have gone missing from their placement;
- Where they are being hidden by their parents and where there is concern for the child's safety because they are being hidden by, or have gone missing with, their family.

A copy of the missing persons notification form must be faxed or emailed to the Multi-Agency Safeguarding Hub and the UK MPB.

If Home Office staff believe that a child is being coerced to abscond or go missing, they must treat this as a concern that the child has suffered or is likely to suffer significant harm and report it to the local police and children's social care services.

Notifications will also be made where a missing child is found by Home Office staff. See [Home Office Guidance: Missing Children and Vulnerable Adults Guidance](#).

The local authority and health are responsible for:

- Reporting any missing child who is in their care to the police;
- Notifying the Home Office when a child is reported missing to the police or is found.

The police are responsible for:

- Investigating all children reported missing by the Home Office - following receipt of a missing person's notification;

- Conducting joint investigations with the Home Office where necessary;
- Circulating a missing child on the Police National Computer (PNC).

The Police central point of contact is the PNC Team in Liverpool.

The local authority will also notify the Home Office Evidence and Enquiry Unit when a child in their care goes missing or when a missing child returns or is found. The Home Office must maintain regular weekly contact with the local authority and the police until the child is found and record all contact with the police and local authority.

Action when the Child 'subject to restriction' is found

Found by Home Office Staff

The local police and local authority must be informed immediately.

In consultation with the local police and local authority children's social care, a decision will be made as to where the child is to be taken, if they are not to be left at the address where they are encountered. The Home Office must follow up enquiries with the local police and children/adult services in order to identify if there are any safeguarding issues.

Found by the police or local authority

The Home Office Command and Control Unit [1] will be the single point of contact for the local police and the Evidence and Enquiry Unit [2] will be the single point of contact for local authorities to notify the Home Office that a child has been found.

[1] CommandandControlUnit@homeoffice.gsi.gov.uk

[2] [Home Office UK Border Agency](#), Evidence and Enquiry Unit, 12th Floor Lunar House, 40 Wellesley Road, London, CR9 2BY

Flowchart: Statutory Guidance on Children who Run Away or go Missing from Home or Care

[Click here to view flowchart showing roles and responsibilities when a child goes missing from care](#)

Relevant Legislation and Statutory Guidance

[The Education Act 1996](#)

[The Education Act 2002](#)

[The Children Act 1989](#)

[The Children Act 2004](#)

[Statutory Guidance for Local Authorities: Children Missing Education \(January 2015\)](#)

[The Education \(Pupil Registration\)\(England\) Regulations 2006](#), as amended (Education law regarding pupil registration where a child is on a school role):

[The Education \(Pupil Registration\) \(England\) \(Amendment\) Regulations 2013](#)

[Section 175 of the Education Act 2002](#)

[Section 11 of the Children Act 2004](#)

[The Children's Homes Regulations 2015](#)

Amendments to this Chapter

This chapter was updated throughout in August 2015 and should be re-read.

End.

SCOPE OF THIS CHAPTER

This procedure applies when a looked after child goes missing from a foster home or children's home.

This procedure does not apply to situations in which a looked after child seems to have been forcibly removed from their placement. This should be reported immediately to the police as a crime.

RELATED GUIDANCE

[Statutory Guidance on Children who Run Away or Go Missing from Home or Care \(January 2014\)](#)

[Children Act 1989 Guidance and Regulations Volume 4: Fostering Services \(2011\) Paragraphs 3.88 – 3.94](#)

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7. [Updating the Placement Plan and Care Plan](#)
8. [The Risk Assessment List](#)

1. Child/Young Person at Risk of Going Missing

All concerns that a looked after child may be at risk of going missing must be reported to the child's social worker who will review the [Placement Plan](#) with the carer (foster carer or key worker). This will take into account:

- The reasons why the young person may wish to go missing from the placement; and
- The risks to the young person's welfare if s/he goes missing from the placement.

The Risk Assessment List (See [Section 8, The Risk Assessment List](#)) may help in identifying any specific risks to the young person.

The social worker and the carer will:

- Consider whether any changes to the placement plan might reduce the risk of the young person going missing and the risks to the young person if s/he does go missing;
- Decide whether one or both of them should talk to the young person about the risks of going missing and the seriousness with which it is taken; and
- Draw up a vulnerable person's pen picture.

The vulnerable person's pen picture is a record of information about the young person that is likely to be necessary if s/he goes missing, including a physical description, information about particular risks relevant to his/her circumstances and information likely to be useful in tracing his/her whereabouts.

When a looked after child moves to a new placement, if there is a known risk that s/he will go missing, the social worker will:

- Complete a vulnerable person's pen picture with the new carer; and
- Ensure that the new placement plan sets out clearly how the carer will minimise the risk that the young person will go

missing and the actions to be taken if s/he does go missing.

2. If the Young Person Goes Missing from Placement

When a young person is **Absent Without Consent** from his/her placement, this will not necessarily raise immediate concerns for his/her welfare: the carer (foster carer or key worker) must exercise personal discretion in deciding how long to delay before taking action. The Risk Assessment List (See **Section 8, The Risk Assessment List**) may help in this decision.

The carer will normally try to locate the young person before contacting the police but may decide to alert them immediately if there seems to be an imminent risk of serious harm. After notifying the police s/he will continue to try to locate young person.

The carer will try to ascertain the young person's whereabouts by making phone calls to the young person's own phone, family members, friends etc. These initial calls may succeed in making contact with the young person, but the carer should be cautious about declaring that his/her whereabouts are known. It is not enough to accept the young person's assurance about where they are: the carer should seek confirmation - for example speaking to an adult whose voice they recognise or calling back on an identifiable landline.

The carer should check whether the young person has returned to the placement by searching the premises, and may wish to check other sites in the immediate area where the young person is likely to be.

If the young person's whereabouts cannot be ascertained the carer will notify.

- The police;
- The young person's social worker; and
- The young person's parents (unless this would not be reasonably practicable or would be inconsistent with the young person's welfare).

If out of hours the carer will also notify the Emergency Duty Team.

On receiving information that the young person has gone missing the social worker will immediately notify.

- The independent reviewing officer; and
- If the placement is outside the city, the host local authority.

The social worker will ensure that the young person's carer has clear instructions about the actions expected when the young person is located.

It is important to be aware that the police work to different definitions:

- Under the police definition a person is missing only if their whereabouts cannot be established **and** either the circumstances are out of character or the context suggests that the person may be the subject of crime or at risk of harm to themselves or another person. If the young person is classified as missing, the police will actively search for him/her;
- If the young person is not classified as missing the police will regard him/her as "absent". In this case they will not actively search for him/her. They will hold the information on record and review it from time to time, and may later decide that changed circumstances or new information require that the young person should now be regarded as "missing".

The social worker and carers should continue their efforts to locate the young person and return him/her to the placement.

3. Missing Person's Strategy Meeting

If the young person is missing for more than 72 hours the social worker will arrange a missing person's strategy meeting to share information and co-ordinate the action plan to locate the young person. The strategy meeting must be held within 5 working days of the 72 hour time limit being met.

The social worker may trigger this meeting earlier if s/he feels that the young person is at high risk – for example when there are concerns about possible sexual exploitation.

If two or more young people go missing together, then the social workers responsible for all the young people will consider

whether to arrange a single missing person's strategy meeting to address the needs of all of them. Recording this meeting may raise issues of confidentiality and a separate individual record of the meeting and a separate action plan must be drawn up for each young person.

The social worker and the child's carer (foster carer or key worker) will discuss who should be invited to the meeting. For example:

- Social Care - *The social worker, the child's foster carer or residential key worker and the independent reviewing officer. Is any other person undertaking direct work?*
- Police - *Missing persons coordinator; neighbourhood officer; Public Protection Unit if there is specific involvement or concern;*
- Education/LACES;
- The young person's family and other connected persons - *Who in the young person's network is likely to have relevant information about the young person's movements and/or have a role in the recovery plan?*
- Health;
- Other Agencies - *Any other professional who may have information concerning the disappearance, or have a role in the recovery plan (for example Youth Services, TESS, Youth Offending Service, Lifeline).*

The missing person's strategy meeting will be chaired by the team manager responsible for the young person. It will:

- Share and clarify information relating to the young person's disappearance and the action already taken to locate him/her;
- Consider what further information may be needed to locate the young person;
- Decide on action to be taken to locate and return the young person – by whom and within what timescale;
- Consider the need for legal action - police protection, emergency protection order or recovery order;
- Outline what action should be taken once the young person is located, including confirming that s/he will return to the same placement or making alternative arrangements;
- Consider any issues relating to involvement of the media; and
- Suggest actions that may reduce the risk of future incidents.

The strategy meeting will set out a plan of action to locate the young person and steps to be taken once s/he is located. This plan will identify tasks, allocate responsibility for them to specific individuals, and set time-scales.

The police are responsible for deciding whether media involvement will assist or hamper missing person enquiries. A decision to use the media will only be made after consultation with the parents and the team manager. Where media publicity is required, any statement made by agencies will normally be agreed between press (or media) officers.

In situations where a group of young people go missing together, the meeting will discuss the dynamics of this. However it is important to note that they will not necessarily remain together or be found at the same location. Each young person must be considered as an individual and an individual action plan devised.

The meeting should consider whether there are any concerns about possible organised abuse or sexual exploitation. If so, the social worker must consult the Multi-Agency Safeguarding Hub, who will advise about arranging a specific strategy meeting to address the identified concerns.

The chair will make a record of the agreed actions. These will clearly identify those responsible for tasks, time scales and a review date.

4. When the Young Person is Located

The young person may return to the placement willingly or may be located somewhere else in the city or outside it, and action may be needed to transport him/her back to the placement - or to alternative accommodation if the previous placement is no longer available or is no longer felt to be appropriate.

When the young person is located it is important not to assume that s/he is safe: urgent action may be needed to protect his/her welfare. The social worker must be notified as soon as possible and will coordinate action to return him/her to the

placement or to another place of safety. If the young person is located outside normal office hours the Emergency Duty Team must be notified and will ensure that his/her immediate welfare is safeguarded.

Responsibility for arranging the young person's return lies with the local authority, not with the police. Normally the social worker or the carer (foster carer or key worker) will go to bring him/her back. However it may be necessary to request police support if:

- Removing the young person from his/her current whereabouts would pose a significant risk to the safety of the young person or of another person; or
- An attempt has been made to remove the young person but s/he is refusing to cooperate and/or an adult is refusing to hand over the young person to City Council staff.

When the young person returns, or is returned, to the placement the carer will:

- Address any health and welfare needs that are immediately evident;
- Notify the social worker (if not already aware);
- Inform the young person of his/her right to an interview about the episode with a person independent of the placement and of the local authority (See [Section 6, Return Interview](#)); and
- If any child protection concerns come to light, report them immediately to the young person's social worker or the Emergency Duty Team.

On becoming aware that the young person has returned to the placement the social worker will inform:

- The parents and any other person who holds parental responsibility for the young person (unless this would not be reasonably practicable, or it would be inconsistent with the young person's welfare);
- The independent reviewing officer;
- If the placement is outside the city, the host local authority.
- The emergency duty team, if they were notified that the young person was missing; and
- The police, if they were notified that the young person was missing and are not already aware of the return.

The carer will discuss with the young person:

- His/her reasons for going missing;
- His/her whereabouts while s/he was missing;
- If s/he was away overnight, where s/he slept;
- Who the young person associated with while absent (both adults and other young people);
- How the young person funded him/herself (food, transport etc.); and
- Any harm s/he suffered or risk of harm during the episode.

The carer will notify the social worker of any significant information arising from this discussion. The social worker will discuss the implications with the police missing persons coordinator.

5. Safe and Well Check

If the police classified the young person as "missing" they will conduct a "safe and well check". If the young person was classified as "absent" they will not do this.

The purpose of the safe and well check is:

- To check for any indications that the young person has suffered harm;
- To check where the young person has been, and with whom; and
- To give the young person an opportunity to disclose any offending against or by them.

If the safe and well check identifies that the young person has suffered significant harm, the police officer will notify the social

worker, who will discuss with the team manager whether a strategy discussion is needed.

If the young person goes missing frequently it may not be practicable for the police to carry out a safe and well check every time s/he returns. However this pattern may point to issues with the potential for serious harm, such as gang involvement or sexual exploitation. The social worker will reach an agreement with the police about the frequency of checks and record the decision and the reasons for it on the young person's case file.

6. Return Interview

The social worker will ensure that the young person is offered an opportunity to talk about the episode with someone independent of the placement. The return interview should be carried out within 72 hours of the young person returning to their placement and should be held in a neutral place where the young person feels safe. The young person should be involved in the choice of an independent person – it should be someone with whom s/he feels comfortable.

The purpose of the return interview is to explore with the young person the reasons why s/he went missing and to identify the risks to the young person's welfare while s/he was missing. If the young person goes missing frequently it may not be appropriate to arrange a return interview after every episode. If so the social worker will decide when these should be arranged, in consultation with the young person

7. Updating the Placement Plan and Care Plan

The social worker and the carer (foster carer or key worker) will meet to discuss the implications of the incident and to update the young person's placement plan. This should include a strategy to minimise the likelihood of him/her going missing in the future.

The social worker should consider whether to request an early statutory review of the young person's care plan. This would include an opportunity to reconsider whether the current placement addresses the young person's needs.

If the young person goes missing frequently the social worker may feel that the young person cannot be kept safe in this placement. If so, s/he will discuss with the IRO whether an early statutory review should be arranged to revise the care plan.

8. The Risk Assessment List

When a looked after child goes missing from placement the risk assessment should consider the following issues:

- The young person's age and general vulnerability;
- Whether the young person has been prescribed essential medication or requires medical treatment;
- Any difficulties the young person may have in interacting safely with others or in an unknown environment, such as visual impairment or learning difficulty;
- Any diagnosed mental illness;
- Any history of threats of suicide, of suicide attempts or of self-harm;
- Any history of substance misuse;
- Any history of going missing and of suffering significant harm whilst missing;
- Whether the young person has been the subject of sexual exploitation, or is believed to be at risk of sexual exploitation;
- Whether the young person has made a threat of harm to another person before going missing;
- Whether the young person is considered likely to be in contact with a person posing a risk to children;
- Whether the young person is considered to pose a risk to children or young people;
- Whether the young person has recently been the victim of bullying or harassment;
- Any recent violent or confrontational incident involving the young person immediately prior to his/her going missing;
- Whether the young person exhibited unusual behaviour immediately before going missing;
- Any other pointers to the young person's state of mind at the time s/he went missing;

- Whether the timing, weather conditions and other circumstances at the time the young person went missing raise extra concerns for his/her welfare.

End



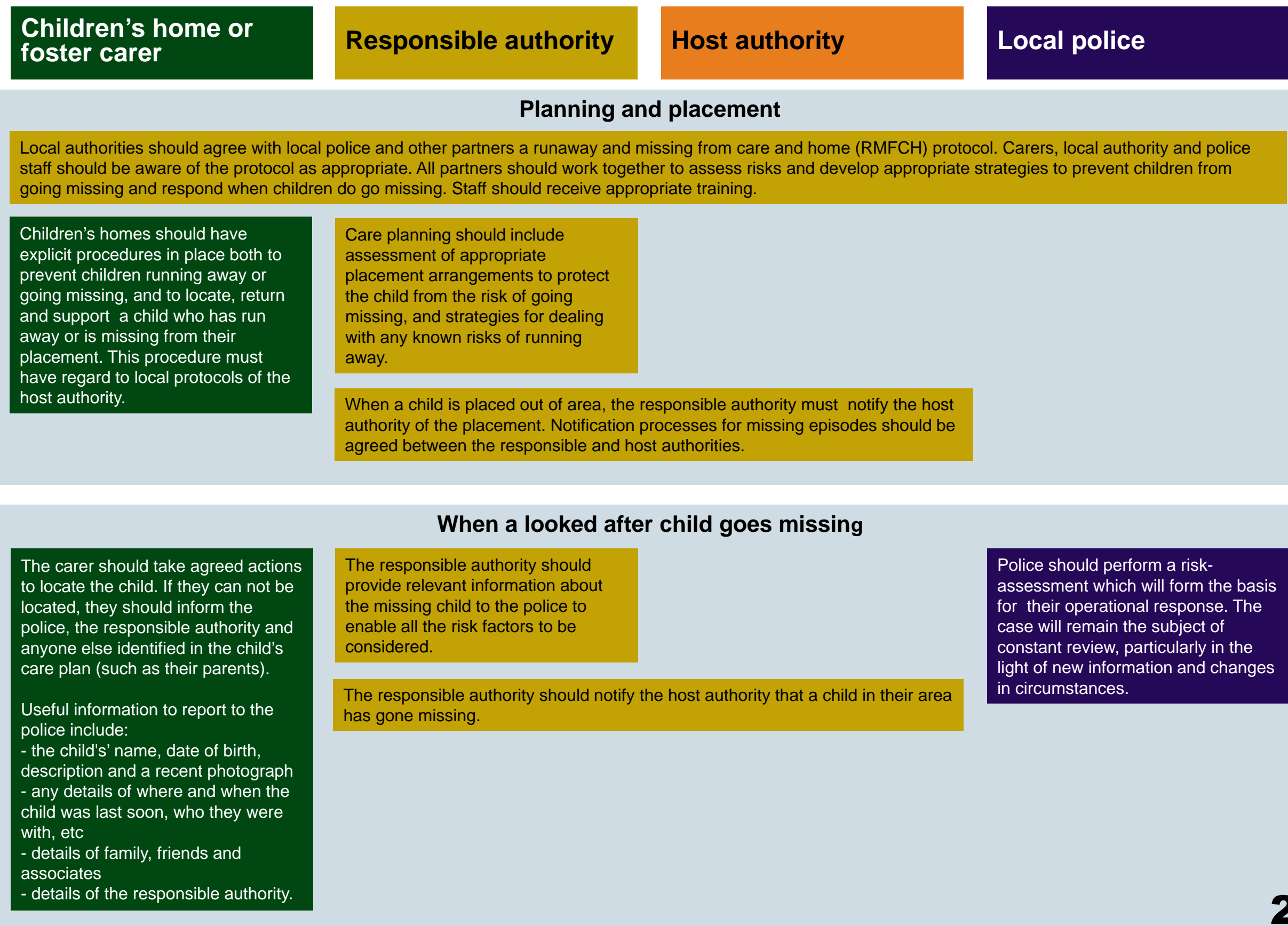
Department
for Education

Item 5

Statutory guidance on children who run away or go missing from home or care

Flowchart showing roles and responsibilities when a child goes missing from care

The following chart shows the main steps that need to be taken when a child goes missing from local authority care, and where responsibility lies for those steps. It should be read alongside the full statutory guidance on children who run away or go missing from home or care, and is not intended to be a comprehensive list of actions.



Children's home or foster carer

Responsible authority

Host authority

Local police

When a looked after child is found

If the child returns to their placement, the responsible authority and police should be informed.

Carers should continue to offer warm and consistent care when a child returns, and running away should not be viewed as behaviour that needs to be punished.

If the child is located but meaningful contact can not be established, the responsible authority and police should consider appropriate action.

An independent return interview should be offered and provided within 72 hours of the child's return. When a looked after child is placed in a host authority, the responsible authority should ensure the independent review interview takes place, working closely with the host authority.

A safe and well check should be carried out by the police as soon as possible after a child reported as missing has been found.

The responsible local authority should review whether the child's placement remains appropriate. The decision should be informed by discussions with the child and carers where appropriate.

Care plans should include a strategy to minimise future risk of repeated missing episodes.

IROs should be informed about missing episodes and address these in statutory reviews.

Data and analysis

Children's homes should be prepared to provide information on missing incidents to those conducting independent visits to monitor the effectiveness of the home.

Data on missing episodes, including intelligence from return interviews, should be analysed regularly by all relevant partners to map problems and patterns. Regular reports should be provided to council members and the LSCB.

Data for children missing or away from placement without authorisation should be reported to the Department for Education by the responsible authority through their annual data returns on looked after children.



Department for Education

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Department
for Education

Statutory guidance on children who run away or go missing from home or care

January 2014

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Introduction

1. Safeguarding and promoting the welfare of children is a key duty on local authorities and requires effective joint working between agencies and professionals. When a child goes missing or runs away they are at risk. Safeguarding children therefore includes protecting them from this risk. Local authorities are responsible for protecting children whether they go missing from their family home or from local authority care¹.

2. There are no exact figures for the number of children who go missing or run away, but estimates suggest that the figure is in the region of 100,000 per year². Children may run away *from* a problem, such as abuse or neglect at home, or *to* somewhere they want to be. They may have been coerced to run away by someone else. Whatever the reason, it is thought that approximately 25 per cent of children and young people that go missing are at risk of serious harm³. There are particular concerns about the links between children running away and the risks of sexual exploitation. Missing children may also be vulnerable to other forms of exploitation, to violent crime, gang exploitation, or to drug and alcohol misuse.

3. Looked after children missing from their placements are particularly vulnerable. In 2012, two reports highlighted that many of these children were not being effectively safeguarded: the Joint All Party Parliamentary Group (APPG) Inquiry on Children Who Go Missing from Care and the accelerated report of the Office of the Children's Commissioner's on-going inquiry into Child Sexual Exploitation in Gangs and Groups. Key issues identified suggested that:

- children in residential care are at particular risk of going missing and vulnerable to sexual and other exploitation; and
- Local Safeguarding Children Boards have an important role to play in monitoring and interrogating data on children who go missing.

4. The Ofsted report 'Missing Children' published in February 2013 on local authorities' work in relation to children missing from home and care highlighted a number of concerns. These were that:

- risk management plans for individual looked after children were often not developed or acted on;

¹ It is important that any looked after child should consider their placement as their home. This document uses the terms "missing from care" and "away from placement" to make clear the additional responsibilities of local authorities towards looked after children. When such a child goes missing, however, they should be considered as having gone missing from their home.

² The Children's Society: [Still Running 3: Early findings from our third national survey of young runaways \(2011\)](#)

³ *ibid*

- placement instability was a key feature of looked after children who ran away;
- reports about looked after children missing from their care placement were not routinely provided to senior managers in local authorities; and
- there was little evidence that safe and well checks or return interviews were taking place.

5. Although looked after children are particularly vulnerable when they go missing, the majority of children who go missing are not looked after, and go missing from their family home. They can face the same risks as a child missing from local authority care. The same measures are often required to protect both groups of children. The first part of this guidance therefore refers to protecting all children from the risks associated with going missing, whether from home or from care. A separate section sets out the additional steps to be taken in regard to children missing from care.

6. This guidance sets out the steps local authorities and their partners should take to prevent children from going missing and to protect them when they do go missing. It is not intended to provide a comprehensive review of best practice, research or evidence regarding missing children. This guidance replaces the statutory guidance issued in 2009, in line with changes in evidence, policy and the statutory framework covering looked after children.

Status of this guidance

7. This guidance is issued under Section 7 of the Local Authority Social Services Act 1970, which requires local authorities in exercising their social services functions to act under the general guidance of the Secretary of State. Local authorities must comply with this guidance when exercising these functions, unless local circumstances indicate exceptional reasons that justify a variation.

8. It also complements:

- Working Together to Safeguard Children and related statutory guidance (2013);
- the Missing Children and Adults Strategy (2011);
- Safeguarding Children and Young People from Sexual Exploitation (2009);
- the Tackling Child Sexual Exploitation Action Plan (2011); and
- the Children Act 1989 guidance and regulations volumes on care planning and review.

Who is this guidance for?

9. The guidance is addressed to Chief Executives, Directors of Children's Services and Lead Members for Children's Services. It will be of interest to Local Safeguarding Children Boards (LSCB) Chairs, senior managers within organisations providing services for children and families (including police, health, schools and the voluntary sector), as well as social care professionals, health and education practitioners and those who care for looked after children. Police forces should read this document in conjunction with Authorised Professional Practice guidance on Missing Persons.

Definitions used in this guidance

10. The terms below are used throughout this document with the following definitions:

- *Child*: anyone who has not yet reached their 18th birthday. 'Children' therefore means 'children and young people' throughout this guidance.
- *Young runaway*: a child who has run away from their home or care placement, or feels they have been forced or lured to leave.
- *Missing child*: a child reported as missing to the police by their family or carers.
- *Looked after child*: a child who is looked after by a local authority by reason of a care order, or being accommodated under section 20 of the Children Act 1989.
- *Responsible local authority*: the local authority that is responsible for a looked after child's care and care planning.
- *Host local authority*: the local authority in which a looked after child is placed when placed out of the responsible local authority's area.
- *Care leaver*: an eligible, relevant or former relevant child as defined by the Children Act 1989.
- *Missing from care*: a looked after child who is not at their placement or the place they are expected to be (eg, school) and their whereabouts is not known.
- *Away from placement without authorisation*: a looked after child whose whereabouts is known but who is not at their placement or place they are expected to be and the carer has concerns or the incident has been notified to the local authority or the police.

Police definitions

11. Since April 2013 police forces have been rolling out new definitions of 'missing' and 'absent' in relation to children and adults reported as missing to the police. These are:

- *missing*: anyone whose whereabouts cannot be established and where the circumstances are out of character, or the context suggests the person may be subject of crime or at risk of harm to themselves or another; and
- *absent*: a person not at a place where they are expected or required to be.

12. The police classification of a person as 'missing' or 'absent' will be based on on-going risk assessment. Note that 'absent' within this definition would not include those defined as "away from placement without authorisation" above: a child whose whereabouts are known would not be treated as either 'missing' or 'absent' under the police definitions. Guidance on how police forces will apply these definitions to children was issued by ACPO in April 2013. Paragraph 19 below explains how local protocols for safeguarding young runaways or children missing from home or care should reflect these definitions.

Roles and responsibilities

Local authority

13. Section 13 of the Children Act 2004 requires local authorities and other named statutory partners⁴ to make arrangements to ensure that their functions are discharged with a view to safeguarding and promoting the welfare of children. This includes planning to prevent children from going missing and to protect them when they do. Through their inspections of local authority children's services, Ofsted will include an assessment of measures with regard to missing children as part of their key judgement on the experiences and progress of children who need help and protection.

14. Local authorities should name a senior children's service manager as responsible for monitoring policies and performance relating to children who go missing from home or care. The responsible manager should look beyond this guidance to understand the risks and issues facing children missing from home or care and to review best practice in dealing with the issue. Some further resources are listed at Annex B of this guidance.

Local Safeguarding Children Board (LSCB)

15. In fulfilling their statutory roles, LSCBs should give due consideration to the safeguarding risks and issues associated with children missing from home or care. To do this, they will need to see that partners from children's social care, police, health, education and other services work effectively together to prevent children from going missing and to act when they do go missing. They should ensure that the local Runaway and Missing From Home and Care (RMFHC) protocol (see paragraph 19) is adequate and up to date. They should receive and scrutinise regular reports from the local authority analysing data on children missing from home and from care. As part of this, they should review analysis of return interviews. They should also review regular reports from children's homes used by the local authority or within the local authority area on the effectiveness of their measures to prevent children from going missing.

Multi agency working

16. The local authority and police should work together to risk assess cases of children missing from home or care and to analyse data for patterns that indicate particular concerns and risks. As part of their framework to safeguard children, individual local authorities and police forces should have an agreed RMFHC protocol.

⁴ [The Children Act 2004: Section 13](#)

17. Local authorities should also consider those children who have not been reported missing to the police, but have come to an agency's attention from accessing other services. There may also be trafficked children who may not have previously come to the attention of children's services or the police. For example, the Office of the Children's Commissioner's report (see Paragraph 3) highlights that children from black and minority ethnic groups, and children that go missing from education, are less likely to be reported as missing. Local authorities and the police should be pro-active in places where they believe under reporting may be more likely because of the relationships some communities, or individuals, have with the statutory services.

Voluntary sector

18. Those working in the voluntary sector, as well as youth workers working in both statutory and voluntary services, are experienced in building trusted relationships with children. Their projects can often provide a range of additional services, such as family mediation and specialist support to parents. They can also help play a part in engaging with children to develop a support package to meet their needs if they are at risk of running away.

Jobcentre Plus

19. In some circumstances, 16 and 17 year olds will be eligible to claim a Social Security benefit. Although the numbers of 16 and 17 year olds that are currently in receipt of benefit are low, most Jobcentre Plus (JCP) offices will come into contact with 16 and 17 year olds, some of who may be at risk of running away or who are already missing from their families or from care. JCP under 18 advisers are required to create and maintain close working links with local authority personal advisers, identifying and forwarding information required by local authorities.

Runaway and Missing From Home and Care (RMFHC) protocol

20. Local authorities should agree with local police and other partners a protocol for dealing with children who run away or go missing in their area. Where appropriate, they should also have agreed protocols with neighbouring authorities or administrations. The protocols should be agreed and reviewed regularly with all agencies and be scrutinised by the LSCB. Police force operational areas often cover more than a single local authority area. RMFHC protocols should therefore be agreed by agencies on a regional or sub-regional basis to ensure a consistent approach. The key elements that should be described in the protocol are detailed in the box below.

Responding to missing children

- details of the lead person in local authority, police and other agencies responsible for children missing from home or care
- an agreed inter-agency framework for assessing and classifying the degree of risk when a child goes missing from home or care or when a missing child comes to agency notice
- guidance on what responses different agencies will offer in relation to each degree of risk
- an agreed list of measures to ensure that police 'missing' and 'absent' definitions are applied to children with due consideration given to their age, vulnerability and developmental factors
- details of what assessments will be carried out following missing and absent episodes, particularly assessments under S17 and S47 of the Children Act 1989 and how this information should be shared
- responses for groups facing specific risks of going missing, such as children with learning difficulties who may have little understanding of their actions or the risks to them, or to previously trafficked children who may be at risk of returning to exploitation
- which agencies will support the family while the child is missing and after they return
- details of how safe and well checks are conducted
- arrangements for independent return interviews, agencies which can provide them and how they will be offered to young runaways

Additional arrangements relating to looked after children

- the actions residential or foster carers should take to locate the child before they are reported as missing (such as trying to contact the child by phone or contacting known friends)
- appropriate responses to children going missing or away from placement without authorisation, including an assessment of risk, the actions and arrangements for making reports to the police when looked after children go missing
- agreed local authority reporting and recording systems on children missing and away from placement without authorisation, including children placed in other local authority areas
- details of any agencies providing independent advocacy services to looked after children
- arrangements to monitor outcomes and analyse patterns including of children placed in the area by other local authorities

Intelligence and prevention

- arrangements for information sharing between the local authority, the police and other agencies
- arrangements for information sharing between different local authorities when a child runs away to another area
- details of data to be analysed on a regular basis, arrangements and frequency for data monitoring by LSCB and partners
- agreed safeguards for runaways and missing children to identify those at risk of significant harm, particularly looking at the length of the missing episode, frequency of running away, risk factors, family history of the child
- details of preventative approaches to avoid further instances of running away, including the provision of alternative accommodation when appropriate
- details of work with children, including both those in care and those not in care, so that they understand the risks associated with running away and the support that is available to them

When a child goes missing

21. The response set out in the RMFCH protocol should be put into action as soon as a child is reported as missing.

Access to support

22. When a child has run away or is missing from home they should be able to easily access support services, such as help lines or emergency accommodation. Support should also be made available to families to help them understand why the child has run away and how they can support them on their return.

Risk assessment

23. The police will prioritise all incidents of children categorised as 'missing' from home or care as medium or high risk. Where a child is categorised as 'absent', the details will be recorded by the police, who will also agree review times and any on-going actions with child's family, carer or responsible local authority.

24. A missing child incident would be prioritised as '*high risk*' where:

- the risk posed is immediate and there are substantial grounds for believing that the child is in danger through their own vulnerability; or
- the child may have been the victim of a serious crime; or
- the risk posed is immediate and there are substantial grounds for believing that the public is in danger.

25. The high risk category requires the immediate deployment of police resources. Police guidance makes clear that a member of the senior management team or similar command level must be involved in the examination of initial enquiry lines and approval of appropriate staffing levels. Such cases should lead to the appointment of an Investigating Officer and possibly a Senior Investigating Officer and a Police Search Advisor (PoISA). There should be a media strategy and / or close contact with outside agencies. Family support should be put in place. The UK Missing Persons Bureau should be notified of the case immediately. CEOP and local authority children's services should also be notified.

26. A missing child incident would be prioritised as '*medium risk*' where the risk posed is likely to place the subject in danger or they are a threat to themselves or others. This category requires an active and measured response by police and other agencies in order to trace the missing person and support the person reporting. This will involve a proactive investigation and search in accordance with the circumstances to locate the missing child as soon as possible.

27. Where a child is categorised as 'absent' within the police definition, the details will be recorded by the police. Review timings and any on-going actions will be agreed as set out in the RMFCH protocol. The case will remain the subject of constant review, particularly in the light of new information and changes in circumstances.

When a child is found

28. The attitude of professionals, such as police officers and social workers, towards a child who has been missing can have a big impact on how they will engage with subsequent investigations and protection planning. However “streetwise” they may appear, they are children and may be extremely vulnerable to multiple risks. A supportive approach, actively listening and responding to a child’s needs, will have a greater chance of preventing the child from going missing again and safeguarding them against other risks.

Safe and well checks

29. Safe and well checks are carried out by the police as soon as possible after a child reported as missing has been found. Their purpose is to check for any indications that the child has suffered harm, where and with whom they have been, and to give them an opportunity to disclose any offending by or against them. Further guidance is available in the ACPO guidance on Missing People.⁵

30. Where a child goes missing frequently, it may not be practicable for the police to see them every time they return. In these cases a reasonable decision should be taken in agreement between the police and the child’s parent or carer, or their social worker, with regard to the frequency of such checks bearing in mind the established link between frequent missing episodes and serious harm, which could include gang involvement, forced marriage, bullying or sexual exploitation. The reason for a decision not to conduct a safe and well check should be reported on the case file.

Independent return interviews

31. When a child is found, they must be offered an independent return interview. Independent return interviews provide an opportunity to uncover information that can help protect children from the risk of going missing again, from risks they may have been exposed to while missing or from risk factors in their home.

32. The interview should be carried out within 72 hours of the child returning to their home or care setting. This should be an in-depth interview and is normally best carried out by an independent person (ie, someone not involved in caring for the child) who is trained to carry out these interviews and is able to follow-up any actions that emerge. Children sometimes need to build up trust with a person before they will discuss in depth the reasons why they ran away.

⁵ Association of Chief Police Officers and National Policing Improvement Agency: [Guidance on The Management, Recording and Investigation of Missing Persons, Second Edition \(2010\)](#)

33. The interview and actions that follow from it should:

- identify and deal with any harm the child has suffered – including harm that might not have already been disclosed as part of the ‘safe and well check’ – either before they ran away or whilst missing;
- understand and try to address the reasons why the child ran away;
- help the child feel safe and understand that they have options to prevent repeat instances of them running away;
- provide them with information on how to stay safe if they choose to run away again, including helpline numbers.

34. The interview should be held in a neutral place where the child feels safe. The interview provides an opportunity hear from the child about why they went missing and to understand the risks and issues faced by the child while missing. This could include exploring issues where a child:

- has been reported missing on two or more occasions;
- is frequently away from placement (or their home) without authorisation;
- has been hurt or harmed while they have been missing;
- is at known or suspected risk of sexual exploitation or trafficking;
- is at known or suspected risk of involvement in criminal activity or drugs;
- has contact with people posing risk to children; and/or
- has been engaged (or is believed to have engaged) in criminal activities while missing.

35. The assessment of whether a child might run away again should be based on information about:

- their individual circumstances, including family circumstances;
- their motivation for running away;
- their potential destinations and associates;
- their recent pattern of absences;
- the circumstances in which the child was found or returned; and
- their individual characteristics and risk factors such as whether a child has learning difficulties, mental health issues, depression and other vulnerabilities.

36. Following the safe and well check and independent return interview, local authority children’s services, police and voluntary services should work together:

- to build up a comprehensive picture of why the child went missing;

- to understand what happened while they were missing;
- to understand who they were with when they were missing and where they were found; and
- what support they require upon returning to home or their care placement in accordance with the 'Working Together' guidance.

37. Safe and well checks and independent return interviews provide an opportunity to inform case planning, for wider strategic planning and for professionals to take into account children's views. The outcomes of the checks and interviews should therefore be recorded on case files so that they can be shared with professionals.

38. Where children refuse to engage with the independent interviewer, parents and carers should be offered the opportunity to provide any relevant information and intelligence of which they may be aware. This should help to prevent further instances of the child running away and identify early the support needed for them.

39. When children missing from home are located but have not been reported missing to the police by their families, parents and carers should be encouraged to report any future episodes of running away. This may require particular work in some communities, for example those with high levels of gang crime. Local authorities should pro-actively consider investigating further to identify early any safeguarding concerns, or whether the child and their family need further support.

Emergency accommodation

40. It is important that emergency accommodation can be accessed directly at any time of the day or night. Bed and breakfast (B&B) accommodation is not considered suitable for any child under the age of 18 even on an emergency accommodation basis.

41. The police have powers to take immediate action to protect a child⁶. Should it be necessary to take the child into police protection, the child must be moved as soon as possible into local authority accommodation. The local authority should consider what type of accommodation is appropriate in each individual case. It is important that children are not placed in accommodation that leaves them vulnerable to exploitation or trafficking.

16 and 17 year olds

42. When a 16 or 17 year old runs away or goes missing they are no less vulnerable than younger children and are equally at risk, particularly of sexual exploitation or involvement with gangs. A 16 or 17 year old who has run away may present as

⁶ [The Children Act 1989, Part V - Protection of Children, Section 46](#)

homeless. In this case, local authority children's services must assess their needs as for any other child. Where this assessment indicates that the child is a child in need and requires accommodation under section 20 of the Children Act 1989, they will become looked after.

43. The accommodation provided must be suitable, risk assessed and meet the full range of a child's needs. Sustainability of the placement must be considered. Children who have run away and are at risk of homelessness may be placed in supported accommodation. For example, the accommodation may include provision of specialist support for those who have been sexually exploited.

44. Local authorities should have regard to statutory guidance issued in April 2010⁷ to children's services authorities and local housing authorities about their duties under Part 3 of the Children Act 1989 and Part 7 of the Housing Act 1996 to secure or provide accommodation for homeless 16 and 17 year olds.

Children who repeatedly run away and go missing

45. Repeatedly going missing should not be viewed as a normal pattern of behaviour. For example, repeat episodes of a child going missing can indicate sexual exploitation. In addition to strategies and issues already highlighted, the following should also be considered when dealing with this specific group.

46. If a child has run away two or more times, local authorities should ensure a discussion is held, either with the child, their family or both, to offer further support and guidance. Actions following earlier incidents should be reviewed and alternative strategies considered. Access to and timeliness of independent return interviews should also be reviewed.

47. There may be local organisations in the area that can provide repeat runaways with an opportunity to talk about their reasons for running away, and can link runaways and their families with longer-term help if appropriate. They may also be able to provide support to children while they are away from home or care. Local authorities should work with organisations that provide these services in their area.

Collecting, sharing and analysing data on children who go missing

48. Early and effective sharing of information between professionals and local agencies is essential for the identification of patterns of behaviour. Relevant data may include

⁷ Department for Education: [Provision of Accommodation for 16 and 17 year old young people who may be homeless and/or require accommodation \(2010\)](#)

times and duration of missing episodes, information from return interviews, absence data from schools, etc. This may be analysed to identify areas of concern for an individual child, or to identify 'hotspots' of activity in a local area. This will help authorities to identify risks in their area, such as exploitation, gangs or crime related activity that might not be apparent. It will also help identify trends, for example, whether children are going missing from a particular children's home or other patterns across the local authority.

49. Data and analysis of children who go missing both from home and from care should be included in regular reports to council members, especially to the lead member for children's services and in reports by the local authority to the LSCB.

Additional actions to protect looked after children

50. Looked after children are particularly vulnerable. Though the number of looked after children going missing is a small percentage of the overall number of children that go missing, it is disproportionately high compared with the children's population as a whole. Further responsibilities on local authorities for looked after children who go missing are detailed below.

Looked after children who are away from placement without authorisation

51. Sometimes a looked after child may be away from their placement without authorisation. While they are not missing, they may still be placing themselves at risk because of where they are. For example, they may choose to stay at the house of friends where the carer has concerns about risks of sexual exploitation. The police will not consider this child as missing or absent, but the RMFHC protocol should describe the appropriate course of action to protect the child and seek their return.

Reducing the risk of looked after children running away

52. Local authorities have a duty to place a looked after child in the most appropriate placement available, subject to their duty to safeguard and promote the welfare of the child. Placing the child in an appropriate placement should help to minimise the risk of the child running away. The care plan should include details of the arrangements that will need to be in place to keep the child safe and minimise the risk of the child going missing from their placement.

53. Any decision to place a child at distance should be based on an assessment of the child's needs including their need to be effectively safeguarded. Evidence suggests that distance from home, family and friends is a key factor for looked after children running away.

54. Listening to a child is an important factor in protecting and minimising the chances of a child running away. The Children's Rights Director (2012) reported that "*one of the major influences of them running away is having a sense that they are not being listened to and taken seriously*", particularly about placement decisions and moves. All looked after children should be informed about their right to be supported by an independent advocate.

Care planning and review

55. Care plans should include a detailed assessment of the child's needs, including the need for the provision of an appropriate placement that offers protection from harm. Where a child goes missing from a placement, a statutory review of their care plan can provide an opportunity to check that it addresses the reasons for an absence. The review should result in the development of a strategy to minimise a repeat of the missing episode. In particular, any issues relating to the vulnerability of the child to sexual exploitation, trafficking or criminal or gang involvement should be identified. Actions to address these needs and ensure the child is kept safe should be clearly set out in the care plan. The police and other relevant agencies should be given the opportunity to contribute to the review.

56. Where a child already has an established pattern of running away, the care plan should include a strategy to keep them safe and minimise the likelihood of the child running away in the future. This should be discussed and agreed as far as possible with the child and with the child's carers and should include detailed information about the responsibilities of all services, the child's parents and other adults involved in the family network. Independent Reviewing Officers (IROs) should be informed about missing and away from placement without authorisation episodes and they should address these in statutory reviews.

Out of area placements

57. When a child is placed out of their local authority area, the responsible authority must make sure that the child has access to the services they need. Notification of the placement must be made to the host authority and other specified services.

58. If children placed out of their local authority run away, the local RMFHC protocol should be followed, in addition to complying with other processes that are specified in the policy of the responsible local authority. It is possible that the child will return to the area of the responsible authority so it is essential that liaison between the police and professionals in both authorities is well managed and co-ordinated. A notification process for missing and away from placement without authorisation episodes should be agreed between responsible and host local authorities.

Children's home staff and foster carers

59. Children's home staff and foster carers should be trained and supported to offer a consistent approach to the care of children. This should include being proactive about strategies to prevent children from running away and understanding the procedures that must be followed if a child goes missing.

60. The competence and support needs of children's home staff and foster carers in responding to missing from care issues should be considered as part of their appraisal and supervision.

National Minimum Standards – looked after children

61. The National Minimum Standards (NMS) for Children's Homes and those for Fostering Services⁸ set out expectations about how providers should take account of the needs of the children who rely on their services. Standards concerned with protecting children from abuse and neglect, countering bullying, promoting leisure opportunities, privacy and confidentiality, access to advocacy, and maintenance of familial contact are likely to be relevant to creating a constructive caring environment designed to minimise the likelihood that children will run away from their placements.

62. Registered children's home providers are required to have quality assurance arrangements in place. As a minimum, this will involve an independent person visiting the home at least once a month to monitor the effectiveness of the home's arrangements for safeguarding children and for promoting their wellbeing. This visit may be unannounced. The independent person undertaking the visits will wish to be satisfied that the home has an effective approach to behaviour management. They should routinely examine missing person's reports to check the home provides stable, secure and safe care. The visit must, wherever possible, include private interviews with children and young people living at the home (and if appropriate their parents, relatives or carers). Staff employed at the home must also be interviewed privately. A written report on the conduct of the home must be prepared after the visit and sent to Ofsted, to the local authorities responsible for the care of each child in the home, to the homes provider and manager, and, on request to the authority where the home is located.

63. The Children's Home Regulations require providers to have explicit procedures in place both to prevent children going missing and to take action if they do go missing. This policy must specify the procedures to be followed and the roles and responsibilities of staff when the child is absent. For example, this may include whether there is an expectation that staff attempt to locate missing children and how staff should support children on return to the home. This procedure must take into account the views of appropriate local services and have regard to police and local authority protocols for responding to missing person's incidents in the area where the home is located. The NMS specifies that staff should actively search for children and, where appropriate, work with the police.

64. On 1 April 2013, regulations came into force requiring Ofsted to provide details of the locations of children's homes to local police forces to support the police in their

⁸ Department for Education: [Children's Homes: National Minimum Standards \(2011\)](#)

strategic and operational approach to safeguarding children. This duty is in addition to the existing obligation for Ofsted to provide this information to local authorities. A protocol published alongside the regulations sets out the responsibilities of the public authorities to use information about the location of children's homes only for the purposes for which it was disclosed, and to share it onward only where this is compatible with safeguarding children and promoting their welfare⁹.

Care Leavers

65. Care leavers, particularly 16 and 17 year olds may go missing from their home or accommodation and face the same risks as other missing children. Local authorities must ensure that care leavers live in "suitable accommodation" as defined in regulation 9(2) of the Care Leavers (England) Regulations 2010, (made under section 23B(10) of the Children Act 1989). In particular, young people should feel safe in their accommodation and the areas where it is located. Local authorities should ensure that pathway plans set out where a young person may be vulnerable to exploitation, trafficking or going missing, and put in place support services to minimise this risk.

When a looked after child goes missing

66. Whenever a child runs away from a placement, the foster carer or the manager on duty in their children's home is responsible for ensuring that the following individuals and agencies are informed within the timescales set out in the local RMFHC protocol:

- the local police;
- the authority responsible for the child's placement – if they have not already been notified prior to the police being informed; and
- parents and any other person with parental responsibility, unless it is not reasonably practicable or to do so would be inconsistent with the child's welfare.

Please see the accompanying document, *Statutory guidance on children who run away or go missing from care: Flowchart to accompany the statutory guidance*.

When a looked after child is found

67. The responsible authority should ensure that plans are in place to respond promptly once the child is located. Care staff should inform the child's social worker and the independent reviewing officer that the child has returned. If the child is located but

⁹ Department for Education: [Joint protocol: children's homes - procedure for disclosing names and addresses \(2013\)](#)

professionals are unable to establish meaningful contact, then the responsible authority should contact the police and consider the appropriate action to take.

68. When the child has been located, the responsible local authority should review whether the child's placement remains appropriate. The decision should be informed by discussions with the child and carers where appropriate. The outcomes and reasons for the decision should be recorded.

69. An independent return interview should be offered when a missing looked after child is found. Where possible, the child should be given the opportunity to talk before they return to their placement. The person conducting the interview should usually be independent of the child's placement and of the responsible local authority. An exception maybe where a child has a strong relationship with a carer or social worker and has expressed a preference to talk to them, rather than an independent person, about the reasons they went missing. The child should be offered the option of speaking to an independent representative or advocate. When a looked after child is placed in a host authority, the responsible authority should ensure the independent review interview takes place, working closely with the host authority.

70. Children's home staff or foster carers should continue to offer warm and consistent care when a child returns, and running away should not be viewed as behaviour that needs to be punished. The need for safe and reliable care may be particularly significant for a child who faces pressure to run away from their placement as a result of circumstances beyond the control of their carers. In these circumstances, it will be even more important that the child's care and placement plans are kept up-to-date and include a strategy to reduce the pressure on the child to run away.

Data on looked after children who go missing or are away from placement without authorisation

71. Looked after children who go missing, or who are away from placement without authorisation, can be at increased risk of sexual or other forms of exploitation or of involvement in drugs, gangs, criminal activity or trafficking. Particular attention should be paid to repeat episodes. Data on these episodes should be analysed regularly in order to map problems and patterns. Regular reports on this data should be provided to council members and the LSCB.

72. Data for children missing or away from placement without authorisation should be reported to the Department for Education by the responsible authority through their annual data returns on looked after children.

Looked after children who may have been trafficked from abroad

73. Some looked after children are unaccompanied asylum seeking children or other migrant children. Some of this group may have been trafficked into the UK and may remain under the influence of their traffickers even while they are looked after. Trafficked children are at high risk of going missing, with most going missing within one week of becoming looked after and many within 48 hours. Unaccompanied migrant or asylum seeking children who go missing immediately after becoming looked after should be treated as potential victims of trafficking.

74. The assessment of need to inform the care plan will be particularly critical in these circumstances and should be done immediately as the window for intervention is very narrow. The assessment must seek to establish:

- relevant details about the child's background before they came to the UK;
- an understanding of the reasons why the child came to the UK; and
- an analysis of the child's vulnerability to remaining under the influence of traffickers.

75. In conducting this assessment, it will be necessary for the local authority to work in close co-operation with the UK Human Trafficking Centre (UKHTC) and immigration staff familiar with patterns of trafficking into the UK. Immigration staff who specialise in trafficking issues should be able to advise on whether information about the individual child suggests that they fit the profile of a potentially trafficked child.

76. Provision may need to be made for the child to be in a safe place before any assessment takes place and for the possibility that they may not be able to disclose full information about their circumstances immediately. The location of the child should not be divulged to any enquirers until their identity and relationship with the child has been established, if necessary with the help of police and immigration services. In these situations the roles and responsibilities of care providers must be fully understood and recorded in the placement plan. Proportionate safety measures that keep the child safe and take into account their best interests should also be put in place to safeguard the child from going missing from care or from being re-trafficked.

77. It is essential that the local authority continues to share information with the police and immigration staff, concerning potential crimes against the child, the risk to other children, or other relevant immigration matters.

78. 'Safeguarding Children Who May Have Been Trafficked'¹⁰ contains practical guidance for agencies which are likely to encounter, or have referred to them, children

¹⁰ HM Government: [Safeguarding children who may have been trafficked: practice guidance \(2011\)](#)

and young people who may have been trafficked. Where it is suspected that a child has been trafficked, they should be referred by the local authority into the UK's victim identification framework, the National Referral Mechanism (NRM). The Trafficked Children Toolkit¹¹, developed by the London Safeguarding Children Board, has been made available to all local authorities to help professionals assess the needs of these children and to refer them to the NRM.

79. NSPCC Child Trafficking Advice Centre provides specialist advice and information to professionals who have concerns that a child may have been trafficked. Phone 0808 800 5000 Monday to Friday 9.30am to 4.30pm; email help@nspcc.org.uk; or web http://www.nspcc.org.uk/Inform/research/ctail/ctail_wda84866.html

¹¹ London Safeguarding Children's Board: [The Trafficked Children Toolkit](#)

Annex A

Checklist for local authorities

This is a short checklist that local authorities may find helpful to refer to the relevant paragraph in the guidance.

Checklist	Paragraph
Do you have a lead manager in place with strategic responsibility for children who run away or go missing?	13-14
Do you have a Runaway and Missing From Home and Care Protocol (RMFHC Protocol)?	15, 16, 20
Do you have a clear definition of a child who has run away?	10, 11-12, 20
Does your LSCB have in place systems to monitor prevalence of and the responses to children who go missing, including gathering data from LSCB members and other local stakeholders in order to understand trends and patterns?	15, 20, 49, 71
Do you have effective working relationships with your local police force?	16, 20, 23-27, 66
Do you have effective partnerships with the voluntary sector, relevant specialist services and information about national level resources, eg, helplines for missing children?	18, 22, 79
Do you have clear procedures in place to offer return interviews when a missing child is found?	31-39, 69
Do you have support services in place for children and their families?	22, 40-41
Do you have a strategy to prevent children from running away and to deal with repeat runaways?	20, 45-47, 52-54

Annex B

Associated resources

General guidance

- Working Together to Safeguard Children (2013) clarifies the core legal requirements on individuals and organisations to keep children safe, including the legal requirements that health services, social workers, police, schools and other organisations who work with children must follow.
<https://www.gov.uk/government/publications/working-together-to-safeguard-children>
- Joint statutory guidance, DCLG and DfE 'Provision of Accommodation for 16 and 17 year old young people who may be homeless and/or require accommodation' (April 2010)
<https://www.gov.uk/government/publications/provision-of-accommodation-for-16-and-17-year-olds-who-may-be-homeless-and-or-require-accommodation>

Missing children guidance, strategy and police resources

- Association of Chief Police Officers (ACPO) guidance on the Management, Recording and Investigation of Missing Persons <http://www.acpo.police.uk/documents/crime/2011/201103CRIIMP02.pdf>
- Missing Children and Adults strategy (2011) <https://www.gov.uk/government/publications/missing-children-and-adults-strategy>
- Child Exploitation and Online Protection Centre (CEOP) website <http://www.ceop.police.uk/>

Prevention and supporting missing children and their families

- Railway Children Reach model, which looks at before, during and after incidents (RMFHC)
<http://www.railwaychildren.org.uk/our-solution/where-we-work/uk/reach-model/>
- ChildLine (telephone: 0800 1111)
<http://www.childline.org.uk/pages/home.aspx>
- Safe@Last, working with and on behalf of children and young people at risk through running away
<http://www.safeatlast.org.uk/>

- What to do if a child goes missing: a guide for those working in education and youth work (2013) from the Children's Society http://www.childrenssociety.org.uk/sites/default/files/tcs/pro_guide_to_runaways_-_online_versionfinal_0.pdf
- What to do if your child goes missing: practical advice for parents and carers (2013) from the Children's Society http://www.childrenssociety.org.uk/sites/default/files/tcs/runaways_parents_guide_2013_final_six-page.pdf
- Developing local safeguarding responses to young runaways. Planning guide for professionals (2013) from the Children's Society <http://www.childrenssociety.org.uk/what-we-do/resources>
- Missing People research: reports on various related issues <https://www.missingpeople.org.uk/missing-people/about-the-issue/missing-people-research>

Child sexual exploitation

- Safeguarding Children and Young People from Sexual Exploitation (2009) <https://www.gov.uk/government/publications/safeguarding-children-and-young-people-from-sexual-exploitation-supplementary-guidance>
- Tackling child sexual exploitation action plan (2011) <https://www.gov.uk/government/publications/tackling-child-sexual-exploitation-action-plan>
- What to do if you suspect a child is being sexually exploited. A step-by-step guide for frontline practitioners (June 2012) <https://www.gov.uk/government/publications/what-to-do-if-you-suspect-a-child-is-being-sexually-exploited>
- National Working Group website, a UK network of over 1000 practitioners working on the issue of child sexual exploitation (CSE) and trafficking within the UK. includes relevant resources for practitioners www.nationalworkinggroup.org
- Parents Against Child Sexual Exploitation (PACE) <http://www.paceuk.info/>

Child trafficking

- Safeguarding Children Who May Have Been Trafficked Guidance (2011) <https://www.gov.uk/government/publications/safeguarding-children-who-may-have-been-trafficked-practice-guidance>

- NSPCC Child Trafficking Advice Centre (CTAC)
http://www.nspcc.org.uk/Inform/research/ctail/ctail_wda84866.html
- London Borough of Hillingdon resources for trafficked children
at <http://www.hillingdon.gov.uk/article/16450/Child-trafficking-sub-group>
- On the Safe Side: Principle of Safe Accommodation of Child Victims of Trafficking (ECPAT UK, 2011) link available
here: http://www.ecpat.org.uk/sites/default/files/on_the_safe_side.pdf
- Conducting good return interviews for young people who run away (2014) from the Children's Society
http://www.childrenssociety.org.uk/sites/default/files/tcs/8pp_a5_runaway_return_interviews_final.pdf



Department
for Education

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Reference: DFE-00009-2014

Birmingham City Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the local safeguarding children board¹

Inspection date: 18 March 2014 – 09 April 2014

Report published: 23 May 2014

The overall judgement is **Inadequate**

There are widespread and serious failures that leave children and young people at risk of harm

It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.

1. Children who need help and protection	Inadequate
2. Children looked after and achieving permanence	Inadequate
2.1 Adoption performance	Inadequate
2.2 Experiences and progress of care leavers	Inadequate
3. Leadership, management and governance	Inadequate

The effectiveness of the Local Safeguarding Children Board (LSCB) is inadequate

The LSCB is not demonstrating that it has effective arrangements in place or the required skills to discharge its statutory duties.

¹ Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspection Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

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Section 1: The local authority

Summary of key findings

This local authority has serious weaknesses and is not yet good because:

1. The most vulnerable children in Birmingham continue to be failed by the local authority. There is an insufficient focus on children who need help and protection and who need to be cared for.
2. Too many children are not seen quickly enough or properly assessed when first referred. For example, at the point of the inspection over 400 children in need cases, some of which were referred more than two months previously, had still not been robustly risk assessed or the children seen. In addition, between October 2013 and January 2014, the local authority made a decision, based on a lack of social worker capacity, to close a significant number of children in need cases without them having been risk assessed. This means that some children have not received an appropriate response or intervention to ensure their safety.
3. Long standing and historical corporate and political failures continue to impact upon the current political and professional leadership of children's services in Birmingham. In addition, inadequate strategic partnership arrangements have undermined a range of initiatives to improve services.
4. Structures, systems and processes for supporting social workers are inadequate. The legacy of poor management and practice in Birmingham children's services remain. These failures have become so entrenched that, despite recent efforts to improve management practice and outcomes, the progress being made to date is too slow and has had little or no impact. There have been too many 'false dawns' that have raised expectations but have ultimately failed to deliver adequate care and protection for vulnerable children in Birmingham.
5. Although there is a range of plans and strategies in place to improve safeguarding and care for children and young people, there has been a significant and unaccountable delay in implementation. As a consequence, help and support to the most vulnerable children and young people in Birmingham continues to be inadequate.
6. Governance arrangements are poor between the Safeguarding and Adoption Improvement Board, the Birmingham Safeguarding Children Board (BSCB) and the Health and Wellbeing Board. This inhibits the arrangements and accountability for the work of these boards.
7. The corporate parenting board is weak and, until very recently, there has been no corporate parenting strategy. This has contributed to the needs of looked after children not being met in a significant number of cases. In

addition, the absence of a Children's Strategic Partnership hampers progress in implementing, for example, an overarching multi-agency early help strategy.

8. There is a widespread lack of understanding about thresholds in and between children's social care services and their partners. This, combined with a lack of confidence in decision making, undermines any attempt to improve the quality of services. Children and young people have been left at risk of harm for too long before being protected by the care system. Timely decisions are not taken when children and young people need to be cared for by the local authority.
9. Inconsistent management oversight of social workers practice leads to a lack of focus on outcomes for children and young people. Children are sometimes left at risk of significant harm for too long without timely intervention. Some agencies fail to share information on children about whom they are concerned. Core groups do not effectively monitor the progress of children's plans to ensure that outcomes are improving and children are protected from harm.
10. The performance management system, including performance information, is ineffective. This results in a lack of focus on improving outcomes for children and young people. While a significant number of audits of practice are undertaken by managers, there is limited evidence to suggest that the impact of learning from these audits drives improvements.
11. There is a lack of strategic planning and coordination for children and young people who go missing from education, home and care or who are at risk of sexual exploitation. A significant number of children (144) are currently missing from education and are believed by the local authority to have moved abroad. As a consequence, there can be no assurances about their safety and wellbeing.
12. Independent reviewing officers (IROs) and child protection chairs do not fulfil their statutory duties adequately in improving the quality of planning and practice. The quality of assessment and planning of looked after children's cases is poor. Assessments are often out of date, are not updated following reviews and do not inform current care planning.
13. The achievement of looked after children in their education is inadequate. The attainment gap between them and all other children in Birmingham is widening in terms of the qualifications they achieve.
14. Adoption is not considered for all children who cannot return home. There is a lack of ambition and delay in pursuing adoption in some cases, for example where brothers and sisters need to live together or where children have complex needs or are disabled. There are insufficient approved local adopters to meet the needs of children waiting for adoption and there is a lack of a

range of in-house foster placements to meet the current needs of children and young people.

15. Children are often placed with 'connected persons carers' before assessments and relevant checks are completed and before cases are presented for approval at panel. This means that statutory requirements are not met, risks are not fully assessed and this can lead to children experiencing unplanned placement moves.
16. Pathway planning for care leavers is poor: it does not start early enough and too many young people leave care without a plan in place.
17. The proportion of 19-year-old care leavers who are not in education, employment or training (NEET) is significantly worse than for care leavers of this age nationally.

The local authority has the following strengths

18. Some children and young people who receive help and support from the family support teams build effective relationships with workers and in many cases this is helping them to improve their lives. Some older children and families receive good support from Think Family (Troubled Families) that leads to improved outcomes.
19. Looked after children's health reviews are comprehensive and a very large majority (90%) are undertaken in a timely way. Quality assurance processes for health assessments are robust and service provision is informed by feedback from children and young people.
20. The Therapeutic Emotional Support Service (TESS) provides an effective service to looked after children and young people who do not meet the threshold for specialist Child and Adolescent Mental Health Services (CAMHS); it is accessible to all of Birmingham's looked after children, wherever they are living.
21. The number of children who are adopted is increasing. The Birmingham Improvement Team (BIT), led by the Principal Social Worker, is having a positive impact on improving practice. For example, the average timescale for court proceedings has reduced from 79 weeks to 41 weeks and, since October 2013, the average has been 21 weeks.
22. The Workforce Strategy is comprehensive and detailed. There is evidence that there has been considerable effort to respond to a ministerial letter which advised the local authority to stabilise the workforce and reduce caseloads. Some notable progress has been seen in the appointment of newly qualified social workers and experienced team managers.
23. Overall, inspectors found evidence that social workers are now committed to the children of Birmingham and they report that they enjoy working for the

authority. Staff report increased morale, reduced caseloads and smaller teams.

What does the local authority need to improve?

Priority and immediate action

24. Strengthen operational and senior management arrangements so that there is sufficient capacity and experience to tackle the deficiencies in the service.
25. Ensure that strategic and operational management oversight is effective, including supervision and that case file audit arrangements are robust so that workers have a full understanding of their roles and responsibilities and deliver work of a consistently high standard.
26. Improve performance management and information systems to ensure that managers at all levels have timely, relevant and accurate performance information to enable them to do their job effectively and deliver improvements.
27. Strengthen governance arrangements between the local authority and its partners, to enable effective and coherent strategic relationships to be developed with defined accountabilities and responsibilities.
28. The local authority and its partners should ensure that the range of draft plans that have been designed to support strategic and operational practice are accompanied by appropriate delivery arrangements that include training and development opportunities for staff.
29. Ensure that the delayed Early Help Strategy is implemented urgently and that partners are fully engaged in the work to achieve this.
30. The local authority and partners should re-launch the 'threshold document' *Right Service, Right Time* and ensure that partners have a full understanding of and confidence in their roles and responsibilities about what actions they must take when they have concerns about children and young people.
31. Ensure that the system to manage contacts and referrals, including domestic abuse notifications, is secure and provides the professional basis to support social workers in keeping children and young people safe and protected.
32. Senior leaders and managers need to take urgent action to ensure that all unallocated cases are appropriately risk assessed. In addition, they need to ensure that the large number of children in need cases that have been closed as part of the recent system cleansing process are reviewed and that outstanding concerns and risks to children and young people are identified and responded to appropriately.
33. Revise the function and purpose of the corporate parenting board and strategy to ensure that the needs of looked after children are paramount and that the right actions are taken to improve the quality of their lives.

Areas for improvement:

34. Review and strengthen assessment and care planning processes to ensure that interventions and ongoing work with children and young people are properly targeted to meet their identified needs.
35. Senior leaders and partners should develop effective, strategic multi-agency systems and practices to respond to children missing from care, home and education so that their exposure to risk can be minimised.
36. Strengthen the role, function and practice of child protection conference chairs and independent reviewing officers so that they meet their statutory responsibilities and take the necessary steps to identify and promote the quality of services that children and young people need.
37. Ensure that there is a sufficient range of placement choice, including permanency options, to meet the needs of looked after children in timely ways.
38. Strengthen the quality of education, employment and training support and provision for looked after children and care leavers to ensure that they achieve to their full potential.
39. Ensure that care leavers have good, targeted and timely pathway plans in place so that they can make a successful transition to adulthood.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the local safeguarding children board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of 10 of Her Majesty's Inspectors (HMI) from Ofsted.

The inspection team

Lead inspector: Marie McGuinness Senior HMI

Team inspectors: Mary Candlin, Lynn Radley, Wendy Ghaffar, Paul D'Inverno, Fiona Millns, Tracey Metcalfe, Nancy Meehan, Christine Davies, Janet Frazer

Information about this local authority area²

Children living in this area

- Approximately 274,135 children and young people under the age of 18 years live in Birmingham. This is 25.5% of the total population in the area.
- Approximately 32% of the local authority's children aged under 16 years are living in poverty, compared with 20.6% across England.
- The proportion of children entitled to free school meals:
 - in primary schools is 34% (the national average is 19%)
 - in secondary schools is 33% (the national average is 17%).
- Children and young people from minority ethnic groups account for 60.6% of all children living in the area, compared with 29.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian/Asian British (35%) and Pakistani (20%).
- The proportion of children and young people with English as an additional language:
 - in primary schools is 43% (the national average is 18%)
 - in secondary schools is 38% (the national average is 14%).

Child protection in this area

- As at 27 March 2014, 8,188 children had been identified through assessment as being formally in need of a specialist children's service compared to 11,390 at 31 March 2013.
- As at 31 March 2014, 844 children and young people were the subject of a child protection plan compared with 1,149 at 31 March 2013.
- As at 3 April 2014, 28 children lived in a privately arranged fostering placement compared with 32 as at 31 March 2013.

Children looked after in this area

- As at 31 March 2014, 1,826 children were being looked after by the local authority (a rate of 67 per 10,000 children) compared with 1,931 (70 per 10,000 children) at 31 March 2013.
- Of this number:
 - 740 (41%) live outside the local authority area

² The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

- 188 live in residential children’s homes, of whom 32% live out of the authority area
 - none live in residential special schools
 - 1,268 live with foster families, of whom 41% live out of the authority area
 - 102 live with parents, of whom 17% live out of the authority area
 - 13 children are unaccompanied asylum-seeking children.
- In the last 12 months:
- there have been 119 adoptions
 - 60 children became subjects of special guardianship orders
 - 748 children have ceased to be looked after, of whom 7% subsequently returned to be looked after
 - 90 children and young people have ceased to be looked after and moved on to independent living.

Other Ofsted inspections

- The local authority operates 10 children’s homes: eight were judged to be good and two to be adequate in their most recent Ofsted inspections.
- The previous inspection of Birmingham’s arrangements for the protection of children was in September 2012. The local authority was judged to be inadequate.
- The inspection of safeguarding and looked after children in 2010 judged Birmingham’s safeguarding services as inadequate for overall effectiveness and capacity for improvement. For looked after children, it judged overall effectiveness and capacity for improvement to be adequate.

Other information about this area

- The Director of Children’s Services has been in post since July 2013, initially in an interim capacity and, since December 2013, as the Director for People, which includes children’s services.
- The chair of the LSCB has been in post since October 2011.

Inspection judgements about the local authority

The experiences and progress of children who need help and protection are inadequate.

40. Children and young people in Birmingham who need help and protection still do not receive the help and support they need to be effectively safeguarded and protected. Systems and processes are neither child-centred nor fit for purpose and do not support social workers in keeping a clear focus on children in most parts of the service. Significant deficits, including poor management oversight, poor assessment of risk and lack of understanding and implementation of thresholds, lead to some children being left at continuing risk of significant harm.
41. Children and families do not always receive the help they need early enough to prevent problems from escalating. Early help services are not well targeted or consistently available across the city. The prevention and early intervention strategy is in draft, and there has been delay in its implementation.
42. The establishment of the locality based hubs – with family support teams, 'team around the family panels' (TAFs) and safeguarding teams, many of which are co-located within children's centres - is leading to more timely access to coordinated services for some families. A range of tools are used, including the graded care profile, to enable more effective identification and assessment of children suffering from neglect. In addition, champions within family support teams specifically focus on working with adults who suffer from substance misuse, domestic abuse and mental health issues. This is driving improvements in practice and leading to effective interventions with some families, which means they do not require statutory support from children's services. However, as the early help offer is not fully available across the city, some children do not benefit in the same way from the TAF processes and they are not helped by the local authority's lack of knowledge about the extent and type of need that exists across the city.
43. In those areas where early help services are not fully established, numbers of early help assessments remain relatively low and the low numbers completed by partner agencies remain an area of concern. For example, due to a historical lack of confidence in the quality and consistency of response from children's services, schools do not routinely engage in the TAF process. Instead, a large majority of schools have chosen to commission their own support services and a consequence of this is that some schools are not engaged in partnership with the local authority and other key strategic agencies. These challenges emphasise the importance and significance of the work that must be undertaken with partners before there can be any prospect of a successful launch of the recently drafted early help strategy.
44. Older children who need help and support are provided with some effective interventions. Think Family (Troubled Families) works well to provide

pathways for referral, and for a small number of young people, particularly those on the edge of care, means they remain with their families. There are currently 3,700 families within Birmingham who have been identified as meeting the criteria for Troubled Families and Think Family is providing interventions for 2,600 of them.

45. When children and young people need statutory social work intervention, they do not experience good help and support from the Information and Advice Support Service (IASS). There is a lack of clarity and understanding about the threshold for referral to children's social care. The absence of qualified social workers in the IASS team means that children do not benefit from a timely response from children's services. Social work advice is not readily available to partners to help them make decisions as to whether to refer children to social care, nor to determine the right level and support for children. The quality of referrals by partner agencies to children's social care is not good enough and the significant number of inappropriate referrals to the service results in referral and advice officers having to undertake extensive work to establish the level and nature of concerns about children. This means that the IASS is unable to respond in a timely way to the persistently high level of demand.
46. On the first day of the inspection there were 137 contacts and referrals awaiting allocation to a referral and advice officer, including some that dated back to the end of February. Lack of robust management oversight means that managers do not always know which contacts have been screened and, as a consequence, there is no effective system to monitor and track this work. In addition, 1,287 police notifications of domestic abuse were awaiting joint screening by police, social care and health. However, where domestic abuse cases were judged to be so serious that a child was at risk of immediate harm, there was evidence that intervention followed without delay.
47. When children's cases need to be progressed from the IASS to safeguarding teams, arrangements to do this are not always timely or effective. Some contacts were closed when further action was required, and others were not acted on by the safeguarding teams, because safeguarding team managers overturned original IASS decisions. There is a lack of trust and confidence between managers about thresholds and the decision making process and this means that some children do not receive a service.
48. Children who are identified as being at risk of immediate harm are subject to a strategy discussion, normally involving the police and social care, to determine the course of action to be followed. These discussions are recorded, but neither the discussion nor the record benefits from information that other partners could contribute to the risk assessment process. Children experience initial child protection visits to be appropriate and timely, and visits are carried out by suitably qualified social workers.
49. The local authority recognises that the threshold for initiating child protection enquiries has been too high. They acknowledge that this has been due to a

lack of staffing capacity. Between February and November 2013, the number of child protection conferences undertaken had reduced by half compared with the previous nine months. This has meant that a significant number of children and young people have not been subject to an investigation to assess the level of risk to them nor been the subject of a child protection case conference. New measures have now been introduced to tackle this issue, and there is some early evidence that this is beginning to have an impact, with an increase in the number of child protection enquiries. Enquiries that do progress to an initial child protection conference are managed appropriately.

50. The quality of information sharing between partners and parents at child protection conferences has recently improved due to the introduction of the 'strengthening families' model. This is a national initiative to enhance the ability of families to resolve their own issues. However, this improvement is limited and problems still persist due to lack of attendance of some partners and their failure to submit written reports to conferences or to the children's parents. Consequently, parents are not always properly equipped to play a full role in the process and the decision making of child protection conferences and partners does not contribute important intelligence and information to ensure that risks are fully identified and discussed.
51. Social workers' child protection reports are not always supported by a comprehensive assessment; do not have chronologies; and lack sufficient analysis. This results in the full extent of risks to children not being understood. Only a small proportion of children attend and participate in their child protection conferences and there is a lack of access to an advocacy service. Overall, children's and young people's views are not sufficiently taken into account in child protection conferences.
52. Child protection plans are not always focused on the outcomes that need to be achieved to keep children safe. They are frequently too long, tasks are not allocated and responsibilities are not clearly defined. The format of the plan does not support social workers to do their work effectively. As a consequence, visits to children, although frequent, often lack a clear purpose or a focus on the actions identified in the child protection plan.
53. The quality of management oversight of social workers' practice is generally poor and, with some exceptions, there is a lack of focus on outcomes for children and young people. Frontline managers do not always ensure that agreed actions have been followed through in a timely way. Supervision arrangements are also poor, which means that workers are not sufficiently challenged to improve their practice. In addition, a lack of effective challenge and monitoring by child protection chairs means that a further opportunity of quality assurance is lost in promoting good practice and improvements. In cases where child protection chairs have identified and formally reported concerns about social work practice, team managers have not routinely responded with appropriate action to address the issues raised, and chairs too often fail to follow up their concerns with managers.

54. When children no longer require a child protection plan, they become subject to a child in need plan. Although there are exceptions, most of these plans are not well developed and do not set measurable progress targets nor specify contingencies should progress not be achieved. Decisions to remove children from child protection plans have not always been well considered, and professionals are too optimistic in some cases about parents' ability to maintain positive changes and therefore to be able to protect their children.
55. Most child protection core groups are held regularly, but, overall, there is a general lack of purpose and focus to meetings and core group members do not always recognise that plans are drifting or that risk is increasing for children. Consequently, children have been left for too long in situations where they have been at risk of significant harm without purposeful and timely intervention.
56. Children in need who are identified as requiring a single assessment, rather than a child protection enquiry, do not experience services being delivered promptly or effectively. In excess of 400 children in need cases, some of which were referred more than two months previously, are still awaiting a single assessment without having been risk-assessed or the children seen. Some of these cases, sampled by inspectors, identified children who were at risk of harm, and who had not received an appropriate response or intervention to ensure their safety.
57. Between October 2013 and January 2014, the local authority undertook a cleansing activity in respect of all children in need cases which resulted in a significant number of cases being closed. This activity was undertaken without the benefit of a robust risk assessment on each individual case. Inspectors found examples of decisions to close children in need cases that were based on social work capacity within teams and not children's needs. Therefore, the local authority cannot be assured that the closure of all children in need cases as part of the cleansing activity was appropriate. The local authority has provided an assurance that these cases will be reviewed.
58. Overall, the quality of single assessments is poor. Assessments are not child-focused and chronologies are not routinely used, which means that assessments do not identify historical concerns about parents and the impact of these on children's lives. As a result, they can too often contain an over-optimistic view of parents' ability to change and not enough focus on the impact of parents' behaviour on the lives of children. Children's individual needs, including culture, identity and their wishes and feelings, are not given sufficient consideration nor recorded consistently. This all contributes to a failure to identify correctly what type of support children need to improve their lives.
59. Children who are placed in private fostering arrangements do not always experience timely assessments to ensure that their safety and wellbeing are assured. The local authority acknowledges that the number of private

fostering arrangements is too low compared with the national picture and states that it is trying to tackle this under-reporting through a variety of awareness-raising activities. However, to date, progress has been limited.

60. When allegations are made against adults working with children, the response through the local authority designated officer (LADO) service is inadequate. Procedures for tracking and monitoring outcomes in approximately 70% of these cases are not robust. This means that the local authority cannot be assured that children are adequately safeguarded when an allegation against an adult in a position of responsibility has been made.
61. A lack of a strategic, coordinated response to collate and analyse information about children missing from education, home and care means that the local authority and partners are not aware of the risks to or whereabouts of all of these children. This means that responses to identify and reduce risk and harm are not well coordinated or focused. Data on children missing from home has recently begun to be collated, and return interviews are now undertaken by the Children's Society (a voluntary agency) contracted to act on the local authority's behalf.
62. A significant number of children (144) are currently missing from education and are believed by the local authority to have moved abroad, although this has not been confirmed by the UK Border Agency. There is a system to undertake checks with other agencies to identify the whereabouts of children who are missing from education, but this consists of a simple 'checking' process that is not sufficiently rigorous. At the present time, there is no robust system in place to ensure that the potential safeguarding concerns that exist in each of these children's cases are being properly addressed.
63. Systems to support agencies in identifying children and young people at risk of sexual exploitation are in place. However, there is no evidence to demonstrate that the multi-agency response is appropriately robust and that children and young people are suitably protected as a result. In some cases seen where young people have been at risk of sexual exploitation, effective action has not taken place to ensure that these children are adequately protected. In November 2013, a West Midlands Strategic Leader – Preventing Violence against Vulnerable People - was appointed on a two year secondment and is based in Birmingham City Council. The position involves developing joint work to tackle child sexual exploitation by seven local authorities, West Midlands Police, the criminal justice system and the voluntary sector.

The experiences and progress of children looked after and achieving permanence is inadequate

64. Children and young people have been left at risk of harm for too long before being protected by the care system and when it is recognised that they need to be looked after, they do not benefit from timely decision making. Poor case

management has resulted in drift and delay for some children and young people and until recently there has been limited use of the Public Law Outline (PLO) process. The absence of a strategic plan for looked after children has resulted in a lack of corporate awareness of the particular needs of this vulnerable group.

65. Children and young people who enter the care system do not generally experience good quality needs assessment and case planning. In the large majority of cases, assessments are out of date, are not updated following reviews and do not inform current care plans. Care plans lack detail and do not focus sufficiently on the needs and long-term welfare of children and young people. In a small number of cases, better standards of practice were seen, with good case work, and improved assessment and care planning that resulted in positive outcomes for children and young people. This was due to timely work and the diligence of individual staff demonstrating an appropriate focus on the needs of children.
66. Children and young people are beginning to benefit from an improvement in the timeliness of court proceedings that lead to decisions being made about their future. In all cases initiated since October 2013, government targets of 26 weeks for the conclusion of proceedings are being met and the quality of assessments is improving. This has been in part due to the influence of the principal social worker and the head of legal services working effectively together to specify expectations of performance, and to monitor more closely case progress of the dedicated court teams. However, the local authority is still dealing with a substantial backlog of cases, so the average length of time for proceedings in 2013–14 is still 46 weeks.
67. Not all children and young people in Birmingham who need to be looked after benefit from early, fully informed and detailed consideration of the right permanence option for them. As a result, some children experience delay in achieving permanence. In some cases, good use has been made of Special Guardianship Orders (SGOs) to avoid children needing to be looked after in public care. However, where a child is placed with a foster carer who wishes to secure permanence for them through an SGO, the current policy leads to them being financially disadvantaged. In some cases, carers have attempted to circumvent this by making private law applications for residence orders and seeking judicial directions, for example to provide funding or provision of equipment. This is unacceptable practice and impacts adversely on children and young people and their carers. The local authority has acknowledged this and has plans to urgently review policies to address the matter.
68. The local authority does not meet statutory requirements when it is considering whether to place children and young people with family members, friends and others who are 'connected' to them. Children are often placed with connected persons carers before assessments and relevant checks are completed and before cases are presented for approval at panel. This means

that risks are not fully assessed and results in some children having to make unplanned and avoidable moves to alternative placements.

69. Most children and young people who become looked after in Birmingham live in foster care placements. Of the 1,822 children and young people looked after at the end of February 2014, 1,265 were placed in foster families. However, there is an insufficient range of suitable in-house foster placements to meet the current needs of children and young people. Children and young people have regular, planned and appropriate contact with their families, although arrangements are not always recorded fully in care plans; this means that there is no clear record of observed risks to inform ongoing assessment. Families are supported well by social workers to stay in touch with their children. However, a high proportion of children and young people in Birmingham have experienced too many changes in social workers, which has resulted in a lack of continuity of practice and delay in progressing their future plans. Statutory visiting is timely, and children and young people are seen alone by their social workers and consulted about their wishes and feelings. However, visits are not consistently purposeful and do not link to the progression of the care plan.
70. Foster carers engage well with their supporting social workers. Recent improvements to the annual review process, with a good focus on the work that carers have carried out with children and young people, have been well received. Good support is also available from the well-established Birmingham Foster Care Association (BFCA), which offers buddies, a telephone helpline and a resource centre. However, a lack of investment in training has meant that foster carers are often unable to access places on courses they need to attend. The local authority has recognised this shortfall and new funding for training for carers has been identified for next year.
71. When there is a plan for children to return to live in their families, this is not well supported by careful, considered planning to ensure that they are protected and risks are minimised. However, in some areas of the city, inspectors did see a small number of good assessments of risks, including the use of written agreements.
72. The quality of management oversight of social workers' practice is inconsistent and fails to focus on outcomes for children and young people. Supervision of staff does not sufficiently explore or challenge assessments, planning decisions, the quality of practice, the timeliness of work or the impact on children and young people. This is exacerbated by the poor work of independent reviewing officers (IROs), who do not fulfil their statutory duties adequately, including visiting and consulting children and young people outside the statutory review process. Despite efforts to improve the IRO service over the last 12 months, which includes reducing caseloads from 140 to 85, poor practice within social work teams is still not consistently brought to the attention of managers and concerns are not routinely followed up. This often results in further unacceptable delay for children and young people.

73. The local authority now has 10 residential homes, having recently voluntarily closed two establishments that had been judged to be providing an inadequate level of service to children and young people. The young people who were displaced as a result of these closures experienced a poor service, typified by a lack of sensitive planning and the identification and the availability of appropriate placements. Significantly, in eight cases, emergency placement decisions were based on resource considerations rather than on the needs of the young person. This resulted in young people being placed prematurely in semi-independent hostels and residential provision without being appropriately prepared. Outcomes for these young people are poor, which results in an escalation in missing episodes, placing some at risk of both child sexual exploitation and increasing offending behaviour.
74. The quality of the remaining children's homes is currently judged to be at least adequate or better following their most recent Ofsted inspections. The care experienced by children with disabilities in five of the homes is good. However, Ofsted has issued compliance notices on a small number of homes that provide care for young people with emotional and behavioural problems, and this has resulted in those homes improving their standards and providing a satisfactory level of care.
75. For children and young people who are placed out of area, their experiences of the support they receive are generally poor. However, those children with complex needs whose cases were tracked received a good service within commissioned specialist provision. This was characterised by timely and responsive education and health services based on effective placement planning between the local authority and the provider.
76. Looked after children and young people experience good support for their health needs. Health reviews are timely and comprehensive and health needs are well considered in statutory reviews, with appropriate action plans developed. Children and young people have had the opportunity to provide feedback on the quality of their reviews, which has informed positive changes to the way in which services are provided. An audit of 100 case files by the designated looked after children nurse in 2013 showed significant positive improvement in wellbeing for a large minority of looked after children in care.
77. Looked after children and young people, including those living out of area, are encouraged to complete a strengths and difficulties questionnaire about their wellbeing; this also informs their health plans. However, the experience of children and young people with emotional and behavioural difficulties was more variable, with some being unaware of the content of their plans and not having appropriate education and health services to support them. Where emotional support needs are identified for children living out of area, the local authority's Therapeutic Emotional Support Service (TESS) ensures that appropriate referrals for Child and Adolescent Mental Health Services (CAMHS) are made. However, despite a clear procedure established for services delivered by local providers to be re-charged to the Birmingham Clinical

Commissioning Groups (CCGs), some children living out of area experience unacceptable delays in accessing specialist CAMHS.

78. Young people receive good support from a wide range of health and voluntary sector services when they experience problems in their lives relating to drug misuse. Good examples included drug workers providing targeted programmes to engage with young people in residential settings. In cases seen during the inspection, young people about to leave care benefited from appropriate counselling from Barnardo's 'SPACE' project for complex issues around drug and alcohol misuse.
79. Looked after children do not achieve well in education and the attainment gap between them and other children in Birmingham is widening in terms of the qualifications they achieve. On entry to primary school they are not well prepared for education, with their achievement and progress being lower than that of children in care nationally at the end of Key Stage 1. Support from the virtual school team, such as the Letterbox Club literacy scheme, has helped to improve some children's writing, and those children now do better than others nationally at the end of Key Stage 2 in English and mathematics. Progress from Key Stage 2 to Key Stage 4 has deteriorated over the last three years and is now slower than in both statistical neighbour authorities and for looked after children nationally.
80. The proportion of looked after children achieving one qualification or five GCSEs graded A to G in 2013 was higher than for looked after children nationally. A very small minority (13% – 17 young people out of 135) achieved five or more good GCSEs (A* to C including English and mathematics) in the last year, which is a significantly smaller proportion than for looked after children nationally and for others in their age group in Birmingham. The attainment gap is growing (47.3 percentage points) and is significantly greater than statistical neighbour authorities (28.4) and four points greater than the England average (43.3). When they are ready to leave school, young people's achievement is low compared with looked after young people nationally.
81. The Virtual School team, Looked After Children Educational Support (LACES), works in partnership with schools to make sure that every child in care has a school place. However, there is a lack of concerted corporate ambition and a quarter of looked after children (478) are not in good or better schools. The quality of personal education plans (PEPs) is poor, typified by a lack of challenging targets or details of any additional support that should be identified to improve children's progress through the use of pupil premium funds.
82. When looked after young people require alternative educational provision, this is of good quality. The City of Birmingham School (the pupil referral unit for Birmingham) supports looked after children by providing a unified service of strategic advice, behaviour support to pupils and settings and a pupil referral

service in 11 units dispersed around the city. Home tuition and bespoke programmes also ensure that looked after children have their full entitlement of 25 hours of education when they are not in school. The rate of fixed term exclusions for looked after children generally is higher, at 13%, than the national average of 11.8%. However, this is partly explained by the local authority's determination to avoid permanently excluding looked after children and numbers of permanent exclusions are very low.

83. Looked after children and young people are provided with appropriate advocacy services through the rights and participation service, who attend reviews and meetings. Independent visitors are commissioned through the National Youth Advocacy Service (NYAS). The advocacy service also supports children and young people through the complaints process. Timeliness in responses to complaints made by looked after children and young people has historically been poor and inconsistent. Recent improvements are being seen through the introduction of monthly performance meetings, with clear management oversight, but this practice is not embedded. The website for looked after children is under-developed, which means that there is no easily accessible way to share information and ensure that all looked after children understand their rights.
84. The Children in Care Council (CiCC) has recently recruited some enthusiastic new members, who are in the process of receiving induction into their role. Until recently, there has been limited impact due to the ineffectiveness of the corporate parenting board, but notwithstanding this, the care leaver's grant has recently been increased to the government guideline of £2,000 and young people are now involved in the recruitment and training of newly qualified social workers. CiCC members are keen to see further developments, especially in how social workers and IROs work and support them. For example, young people said that some social workers do not always listen to what children and young people say. Furthermore, in their statutory reviews, children feel that they are being talked about and not consulted or involved, and that their opinions are not considered as important. Members of the CiCC told inspectors that some professionals in schools and social care do not pay due attention to the feelings of children about being looked after. This means that in school they can feel discriminated against and embarrassed when their care status is revealed publicly to their peers. Where young people have disclosed bullying to carers, in most cases school staff have acted appropriately.

The graded judgement for adoption performance is inadequate

85. When a decision has been made that children and young people cannot return home, adoption is not always considered as a viable permanent alternative. This reflects a lack of ambition on behalf of children who need a new family.
86. Children and young people experience delay at all stages of the adoption process. In too many cases where adoption plans are made, the plans are

changed as a result of unsuccessful family finding. This, in turn, results in further delay for some children and young people. Although these delays are recognised by IROs, they are not followed up by the implementation of decisive recommendations for action.

87. The adoption service is not always aware of children who need adoptive parents early enough to support prompt and robust family finding activity. There is confusion among practitioners as to when a referral should be made to the family finding team. As a result, the system has been reviewed and teams have undergone a recent restructure to improve the focus on active and creative family finding. A recent recruitment campaign using TV advertising has been undertaken and there are plans to develop the use of DVDs and to improve tracking systems to support early, targeted family finding. These changes are still very recent and it is too early to evidence any impact. Although there is no 'fostering to adopt' scheme in place, some children benefit from being adopted by their foster carers. Plans to formalise the scheme are currently being developed.
88. Until very recently, the quality of child permanence reports (CPRs) has been mostly poor, typified by incomplete and sometimes incorrect information. Full and accurate records of the reasons why children need to be adopted are frequently missing, and these deficiencies are not identified through normal line management processes. In some cases, this leads to delays in decision making. Training on completion of these reports has now been provided, but so far there is only limited impact on improvements.
89. The Department for Education adoption scorecard for 2010-13 shows that it took 877 days more time for children in Birmingham to be placed with their adoptive parents than the national performance of 650 days. This figure has now reduced to 708 days. This progress has been achieved due to the knowledge and commitment of the adoption team managers and the early implementation of plans to address identified barriers to progress.
90. The number of children who are adopted is also increasing. Figures provided by the local authority show that 17% of children who left care during 2013-14 were adopted. The most recent figure (56% for March 2014) demonstrates significantly improved performance for children being placed for adoption within 21 months of coming into the local authority's care. Although this figure exceeds statistical neighbour authorities, it remains slightly below the national average. Until recently, 21 children remained subject to freeing orders. Plans made in conjunction with the courts and Cafcass are in place to address this, and have resulted in the orders being rescinded for three children, while work remains ongoing to ensure that progress is made in the remaining cases. While acknowledging that this action should have been taken earlier, the local authority and partners (courts and Cafcass) have plans to complete this task shortly.

91. There are insufficient approved local adopters to meet the needs of children waiting for adoption; currently, 145 children with plans for adoption are waiting to be matched with adoptive families. In 2013-14, 62 adoptive families have been approved, which is fewer than the 67 approved in the previous year. A further 30 prospective adopters have completed the assessment process but have not yet been to panel for approval, which continues to create delay for children and young people who need to be adopted. Some adopters have experienced delay in their assessment due to a lack of social worker capacity to provide sufficient training courses last year. However, prospective adopters who have received training speak highly of the courses that are provided, commenting that they were thought-provoking, gave them increased understanding of the range of reasons children need adoptive parents and were helpful in preparing them to adopt.
92. Adoption panel minutes are of a good quality, with detailed recording of discussions that take place. They accurately reflect where challenges have been made by panel members, for example in relation to the quality of CPRs or a failure to properly assess whether a father could care for his child. However, the panel has not produced an annual report this year, which is a statutory requirement, and panel members do not meet with the adoption decision maker to share their concerns. This is a missed opportunity to provide the local authority with valuable feedback on the quality of the work seen by the panel.
93. Consideration is given to meeting children's needs arising from their ethnicity, culture, religion or disability. Inspectors saw a good example of a young child with a life-limiting condition being matched with an adoptive parent and other examples of children being matched with adoptive parents who can meet their complex needs. When children are preparing to move from foster placements to their adoptive families, foster carers are thoughtful in preparing children and supporting introductions. Examples were seen by inspectors of foster carers using stories and photographs to prepare children for their move. However, in too many cases, formal life story work is not completed in a timely way in line with requirements.
94. A range of good adoption support services are available to adopters, both before and after the adoption order is made. Adoptive parents have access to a helpline that provides advice and signposts them to services. Inspectors saw good examples of bespoke packages of post-adoption support for individual children, including those placed outside Birmingham. Birth parents are supported by a service commissioned by the authority.

The graded judgement for the experiences and progress of care leavers is inadequate

95. Young people report their experience of preparation to leave care as being 'too rushed' and the inspection evidence supports this view. Pathway planning is generally poor and does not start early enough, and too many young people

leave care without a viable plan in place. This view was also expressed in a recent authority-led survey of the views of children in care and care leavers. Although some steps are said to have been taken in response, the impact on the quality of pathway planning is yet to be seen.

96. The 'staying put' policy, under which care leavers can remain with their foster families beyond the age of 18 years, is not fully developed. This can affect the stability of their placement and can mean that some young people move into independence before they are ready to do so.
97. Leaving care advisors build positive personal relationships with young people, but the absence of purposeful assessment and pathway plans means that their work too often lacks focus. Plans fail to underpin the actions that need to be taken to support young people in making the transition towards independence.
98. Young care leavers who do well at school and are ambitious are supported very well to access and pursue further and higher education and training for employment. The Looked After Children's Education Service (LACES) tracks young people with the potential to achieve GCSE, A level or level 3 vocational qualifications, and supports aspirations with college taster days. However, those less ambitious young people are not supported well enough to stay in school or college or to take up employment. The proportion of 19-year-old care leavers who are not in education, employment or training (NEET) is significantly worse – at 46% at the end of 2013 – than for care leavers of this age nationally (34%). Vulnerable groups, such as care leavers who become parents, are not offered the support that they need to remain engaged with education, employment or training and often drop out without robust follow up.
99. There are some small, successful work placement schemes in place such as the partnership with Marriott Hotels, which gave eight care leavers the chance to work in Germany for two weeks. Additionally, nine care leavers have been well matched to apprenticeships in the area. However, too few young people engage and benefit to make any difference to the proportion who are not in education, employment or training. Apprenticeships and work placements in the local authority and with partners are all under-developed at present, and plans to improve the universal and specific offers are at a draft stage only. The current situation reflects the long-standing failure of corporate parenting.
100. A wide range of housing options are available to care leavers, so that most needs are met after initial assessment and support programmes have been completed. Most young people experience one or more interim moves before settling in safe and sustainable housing. The range of support in housing schemes for care leavers with low and medium need for support is good, and it is adequate for those with greater needs: 96% are in suitable accommodation.

101. The knowledge that care leavers have about their entitlement to services depends on the amount of contact they have with an advisor, and the knowledge of that practitioner. The care leaving team, which is newly formed, is building its expertise, but at this stage knowledge gaps remain that have not yet been filled by training. For example, they still have a lack of knowledge about the legal rights of unaccompanied asylum seekers. Care leavers are under-represented in the CiCC and a care leavers' forum is not yet in place.
102. Care leavers have access to a range of health-related support and advice services. The leaving care team is active in directing and encouraging care leavers to access services, such as the drug and alcohol misuse service, smoking cessation, sexual health advice and counselling. There is an effective and timely Care Leaver Mental Health Service. This comprises two members of staff who provide screening of all care leavers and the offer of outreach services. They are able to respond immediately to young people in need, and either refer them to an appropriate service or provide a brief intervention themselves. The dedicated looked after children health service has recently appointed a care leavers' nurse, who ensures that young people have access to their full health history in preparation for their transition to independence.

Leadership, management and governance are inadequate

103. The local authority has failed to adequately drive improvements to safeguard and care for children and young people in Birmingham; practice remains poor and children are not protected or cared for effectively. Serious and widespread failures have not been tackled quickly enough to make the service safe. The child protection inspection in September 2012 found the service to be inadequate, and the significant concerns identified then remain across the whole of the service, including services for children who are looked after. Too much drift and delay in dealing with child protection concerns means that children are not promptly identified when they need to be cared for by the local authority.
104. In 2010, the looked after children service was judged to be adequate, but services have deteriorated and the service is now inadequate. The local authority does not discharge its corporate parenting responsibilities effectively. The corporate parenting board is weak and, until very recently, there has been no strategy in place. This has meant that the needs of looked after children have not been sufficiently focused on. Following the last inspection in 2012, the local authority experienced significant organisational turmoil, and services further deteriorated in quality. Senior management arrangements changed, with new appointments of an Interim Director of Children's Services in July 2013, and a Chief Executive in December 2013, who took up post in March 2014.
105. In July 2013, the Department for Education reported the service to be in a 'fragile and unsafe state'. The Parliamentary Under Secretary of State for Children and Families, Edward Timpson, wrote to the Leader of the Council with four key instructions:
- to stabilise the workforce
 - to improve frontline practice
 - to establish an operational structure that staff understand
 - to put in place a vision and plan for sustained improvements.
106. Since this time, the Director of Children's Services has been focused on the key issues highlighted. In December 2013, the Interim Director for Children's Services was appointed as the Director for People, which includes responsibility for adults' and children's services. A 'test of assurance' to evaluate the possible impact of combining these functions has not yet taken place.
107. There is evidence of some increased corporate and political ownership of the risks in children's services. The provision of an additional £9.6 million into the service, when there has been significant cutbacks in all other services in the local authority, has supported the intention to improve the workforce and provide some much needed stability. Middle management arrangements have

been strengthened, with the re-introduction of Heads of Service. During the inspection, staff reported increased morale, reduced caseloads and smaller teams. There are also some improvements to the adoption service, with waiting times for adoption reducing significantly and, in some parts of the city, improved early help arrangements.

108. Notwithstanding the improvements noted above, much remains to be done before services for children and young people are made safe. Senior managers can clearly articulate what is required to tackle the failings across the service, but there is limited evidence that this has yet translated into coherent action or plans with a demonstrable impact on improving services. The draft Children's Social Care Improvement Plan is very new and not yet fully informed by clear actions, milestones and responsibilities.
109. A range of plans and strategies are in draft, and there has been significant delay in the implementation of a number of these. For example, the early help strategy was identified as a priority for change in the previous child protection inspection undertaken in 2012. The inspection report highlighted the need to implement an overarching strategy that secures partnerships between agencies to allow vulnerable children to receive help earlier. To date, this strategy remains in draft and partners have not yet reached a shared definition of early help. Progress has also been affected by partnerships failing to establish the extent of unidentified need in the city.
110. The local authority's efforts to improve the Information and Advice Support Service (IASS) have been ineffective, and the service remains not fit for purpose. The proposal to replace the IASS with a multi-agency safeguarding hub (MASH), without addressing some of the fundamental challenges that affect almost all aspects of the contact and referral system, means that it is unlikely that any replacement would have significant prospects for success. Partners fail to take responsibility for their actions in respect of child protection and this is reflected in the poor quality of referrals and the lack of consistent and sustained contributions to joint working. These difficulties undermine any attempt to improve the quality of services to children and young people.
111. A range of commissioned services is available to support families and vulnerable children, and some individual services are effective, such as the St Basil's project, which works successfully with children and young people who are considered to be on the edge of care. This service helps to keep some children and families together, avoiding the need for children and young people to be accommodated by the local authority. However, the overall impact of commissioned services is diminished by the absence of an integrated strategic approach to commissioning, which would allow children and young people's needs to be more easily met and resources to be used more efficiently. Commissioning capacity has been increased since the current Director has taken up post, and the new draft joint strategic commissioning strategy has been developed to improve performance in this area. However,

the local authority is fully aware that the absence of reliable child level data is a major risk to the effectiveness of this strategy.

112. In summer 2013, the Children's Strategic Partnership was disbanded and the lack of a replacement hinders the work of partners to work together to ensure that safeguarding of children is effective. The Birmingham University INLOGOV report completed in 2013, which was focused on partnership work, highlighted failings in the quality of work, particularly between Children's Services, the Police and Education.³ Partners contributed to this review and continue to engage in 'think tank' sessions to take work forward. However, partnership issues continue to pose significant risks to multi-agency working. For example, the absence of a Birmingham Safeguarding Children Board (BSCB) education sub-committee to coordinate the work of the school sector on safeguarding issues affects the BSCB's ability to improve the quality of joint work between schools and children's services. The Birmingham Education Partnership has been set up by the Local Authority and schools to establish collective leadership of schools and learning in Birmingham. In addition, it will deal with historical and long-standing problems of confidence in the quality of the social care response to reported concerns about children, and there is some early evidence of a new desire to strengthen fractured relationships.
113. Since July 2013, governance arrangements between the Leader of the Council, the Lead Member, the Chief Executive and the Director of People have been re-confirmed and are understood by each party. Their focus during this time has been dominated by a local government review, a partnership review and the government-commissioned Le Grand review.⁴ A draft improvement plan has now been produced in response to the Le Grand review, but it is too early to see evidence of impact. The Director of People continues to meet weekly with the Lead Member, who now has a clear grasp of the issues and risks in children's services. Cross-party scrutiny arrangements are also in place, although the chair of scrutiny acknowledges that they are not as effective as they should be. They have, however, raised concerns about the poor quality of performance information they receive that has prevented them from carrying out their responsibilities. Governance arrangements between the Safeguarding and Adoption Improvement Board, the BSCB and the Health and Wellbeing Board are not yet fully established, which inhibits arrangements and accountability for the work of these boards.
114. Operational performance management, quality assurance and supervision arrangements are weak. The lack of an effective performance management

³ The Institute of Local Government Studies at the University of Birmingham (INLOGOV) was asked by Birmingham City Council (BCC) to undertake an independent peer review of the ways in which the Council and its partners work together to protect and to improve the lives of children in Birmingham.

⁴ Report to the Secretary of State for Education and the Minister for Children and Families on ways forward for Children's Social Care Services in Birmingham by Professor Julian Le Grand.

system, including poor performance information, is evident throughout most of the service and does not support the drive for improvements to be made. Management oversight of social care practice is poor, with too many children and young people continuing to be left at risk of harm. This is further hampered by the poor quality of data, including, for example, a lack of robust information on assessments and supervision arrangements. While a significant number of audits of practice are undertaken by managers, there is limited evidence to suggest that the impact of learning from these audits drives improvements. These difficulties have also been identified by two of the external reviews, and the need to address them has been seen as fundamental to securing quality practice. This has not yet been achieved.

115. There is a lack of understanding and effective communication between frontline management and senior managers. While senior managers can clearly articulate what they are seeking to achieve, it is evident that they are not fully conversant with the detail of the pressures facing operational staff. For example, senior managers were unaware that the unallocated cases, currently in excess of 400, had not been risk-assessed appropriately, as they had been assured by frontline managers that they had been. In addition, during the inspection, it was agreed that children in need cases had been 'removed' from the system and closed without a robust risk assessment, resulting in some children not receiving services that they need.
116. The Workforce Strategy is comprehensive and detailed. There is a clear plan to reduce reliance on agency social workers and a recruitment and retention group has been established to oversee this process. There is evidence that there has been considerable effort to respond to the Minister's letter of September 2013 - to stabilise the workforce and reduce caseloads - with some notable progress seen, particularly in the appointment of newly qualified social workers and experienced team managers. However, a number of frontline positions remain vacant and long-term sickness absence and vacancy rates, while improving, remain high and continue to pose a significant risk to securing and retaining permanent experienced staff. This is an ongoing challenge in spite of the efforts made, and poses a threat to achieving and sustaining progress.
117. The Birmingham Improvement Team (BIT), led by the Principal Social Worker, is having an impact on improving practice in some areas. There has been demonstrable improvement in the average timescale for court proceedings, from 79 weeks to 41 weeks; since October 2013, court proceedings now take an average of 21 weeks, which has been noted by Cafcass. In the past 10 months, the team has made a good contribution to driving some improvements through training and, in particular, through challenging poor practice within safeguarding teams and supporting workers at all levels to improve frontline practice. However, evidence of this remains limited and children in need services have not yet benefited from the influence and support of the Principal Social Worker and the progression team, which is a missed opportunity.

118. The local authority has committed £2 million to improvement work and has a clear social worker pathway to support continuous professional development. A notable achievement is the contribution to the training and development of team managers and social workers within the newly established court teams across the city through targeted practice improvement reflection groups. All newly appointed team managers have benefited from induction training and 1,000 staff have received training on the Public Law Outline (PLO) to drive up standards. A range of new initiatives is being developed to drive improvement in practice, such as the recent investment in the training for the introduction of the *Safeguarding assessment and analysis framework* and the 'In My Shoes' model of direct work with children.
119. Overall, inspectors found evidence that social workers are committed to the children of Birmingham and they report that they enjoy working for the local authority. Some team managers and social workers report that recent improvements in the management of the service have resulted in them deciding to continue to work for Birmingham City Council. In some cases, feedback from parents and children showed that social workers had made a real and positive difference to their lives. However, in some teams, caseloads remain high and staff report a backlog of work that causes delays in children being seen. The magnitude of the problems that continue to face the local authority can only mean that progress is fragile and that children will continue to remain highly vulnerable until services can be consistently improved to an acceptable standard.

What the inspection judgements mean: the local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people, and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place. However, the authority is not yet delivering good protection, help and care for children, young people and families.

An **inadequate** local authority provides services where there are widespread or serious failures that result in or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

Section 2: The effectiveness of the Local Safeguarding Children Board

The effectiveness of the LSCB is inadequate

Priority actions

120. The BSCB to ensure that each partner agency urgently develops and can demonstrate stronger and more effective accountability within its organisation for their roles and responsibilities in safeguarding children and young people in Birmingham particularly at middle and frontline manager levels.
121. Strengthen governance arrangements between the BSCB and the Health and Wellbeing Board and ensure that these arrangements routinely include a record of impact and effectiveness.
122. Ensure that partners urgently agree a definition of early help and drive the implementation of the Early Help Strategy, so that partners are fully engaged in the work to achieve and deliver this.
123. BSCB to ensure that single and multi-agency audits are undertaken, analysed and evaluated and that findings are used to help to improve standards of practice in all agencies.
124. The BSCB to work with partners urgently to develop and implement systems and processes to ensure that they fully comply with safeguarding audit requirements. Progress towards compliance, with a requirement to complete these audits, must be routinely tested and reported regularly to BSCB.
125. Develop and implement a comprehensive programme of multi-agency child protection training (levels 1, 2 and 3), with clear arrangements for evaluation of impact to inform future training needs.

Areas for improvement

126. The BSCB to improve the degree to which partners at the Board use their role to properly influence their own strategic and corporate governance, and to ensure the Board's work is integrated into their own strategic, operational and business as well as workforce development.
127. The BSCB to ensure that a range of mechanisms, platforms and processes are in place to support schools to own and fully engage with their statutory responsibilities for safeguarding children and young people.
128. The BSCB to provide robust challenge and scrutiny to ensure that the arrangements between schools and their partners, especially the local authority, are secure and progress on these arrangements should be reported routinely to the safeguarding board.

129. Work with partners to develop good quality collection and collation of data on missing children so that partners have a full understanding of the risks to these children and can identify what actions they need to take to minimise these risks. Scrutiny of challenge to this data and related performance must be included in the routine work of the BSCB.
130. Improve the attendance of partners at sub-groups and assure that sub-groups are resourced appropriately to undertake the tasks and actions that are required, and that they maximise learning from their work.
131. Ensure that learning from serious case reviews is used effectively to inform practice and that audits begin to demonstrate that learning is having an impact on improving practice across partner agencies.

Key strengths and weaknesses of the LSCB

132. Effective partnership working is not yet developed and remains a significant challenge for the Board. Frontline practice has not demonstrated significant improvements in response to the Board's influence. Attendance by partners at child protection conferences remains unacceptably low, which results in some agencies failing to contribute to identifying risks and protecting children.
133. As yet, an overarching early help strategy has not been agreed or implemented, which was a recommendation of the Ofsted child protection inspection in 2012. BSCB cannot be assured that early help is targeting the right children early enough or that services are effective. Partners have not yet reached a shared definition of early help in Birmingham or accurately assessed the extend of unidentified need in the city. This results in a partnership that does not take full or collective responsibility for strategically designing and driving effective early help for children and their families.
134. Despite strategic engagement to develop the new threshold model of *Right Service Right Time*, shared understanding and ownership of the model amongst practitioners is poor. Some partners report being insufficiently prepared to use the model and that a multi-agency change management programme has not been put in place to support the implementation of this important initiative. Compliance by agency operational staff with new policies and procedures is poor. Much work remains to be done by BSCB to fully utilise training that will raise the standard of frontline practice and management to an acceptable level. There is limited evidence of partners holding each other to account at operational level, although general practitioner practices now have named safeguarding champions in place as a result of the BSCB's encouragement for them to become more involved in child protection work.
135. BSCB does not receive data on children missing from home, care or education and receives insufficient data on child sexual exploitation. This is a deficit of significant magnitude, not least because it shows that the local authority and partners do not collect, collate and analyse this information in a systematic

way. As result, partners cannot be assured of the whereabouts or safety of these young people. The child sexual exploitation strategy agreed by the Board in January 2014, has not yet been implemented and this delay means that agencies are not yet working together effectively to provide the appropriate level of safeguarding support to children and young people who are risk of/or are suffering sexual exploitation.

136. Formal arrangements are in place for the Chair of the LSCB to have regular, recorded meetings with the Chief Executive, Director of People, Lead Member and Chair of the Health and Wellbeing Board. The BSCB annual report is shared with the Health and Wellbeing Board and is also reported to the Children’s Safeguarding and Adoption Monitoring Board. However, in practice, there is little evidence to demonstrate how these strategic bodies hold each other to account or if these arrangements are effective.
137. The BSCB annual report is detailed and comprehensive and highlights both strengths and weaknesses. Progress to secure strategic agreement around joint priorities, sharing risks and coordinating services is set out clearly. The BSCB strategic plan 2014-17 has three appropriate priorities:
 - voice of the child
 - early help
 - safe systems.
138. These and the associated actions, although devised independently, align with the city’s most significant challenges in protecting children. However, the PREVENT agenda and the needs of looked after children are not sufficiently reflected in either the annual report or the business plan and this is an omission.
139. Much work has been done to engage schools, which are now represented on the Board. There is also now a Birmingham Education Partnership, which has a significant number of schools engaged. Despite this, many schools neither fully understand nor accept their own safeguarding responsibilities or understand the difference in statutory roles and responsibilities between the Board and the local authority. This results in some school staff lacking the knowledge and experience needed to provide effective safeguards to children and young people. The strategic plan for 2014-17, details the reinstatement of a schools safeguarding sub-group which is much needed as only 63% of approximately 437 settings responded to a Section 175 Education Act audit, which was commissioned to assess safeguarding standards in educational establishments. Low compliance was reported in five key areas, including training about diversity and training for governors in child protection and safeguarding.
140. An established BSCB sub structure exists, but some key groups are not sufficiently effective. The serious case review sub-group is poorly attended

and their practice is process-driven rather than focusing on maximising learning from each case. Some agencies have not adequately supported members to participate and it remains challenging to resource sub-groups with effective business support. A current review of sub-group governance aims to improve these arrangements.

141. Serious case reviews are initiated where necessary and in line with statutory guidance, the progress of reviews and the completion of subsequent recommendations are appropriately monitored and reported to the Board. Reviews are published and accessible events to disseminate learning are arranged. A formalised learning and improvement framework is not currently in place, so opportunities to identify improvements for practice are not comprehensive or sufficiently effective. The impact of learning from serious case reviews is not evident in frontline practice. Eight cases have been notified to Ofsted and the Department for Education this year. One review was published, three serious case reviews are ongoing and another is subject to early scoping. A recent court case has led to a review being re-commissioned in light of new evidence.
142. Multi-agency and single agency audits undertaken by BSCB are not effective and do not demonstrate impact in improving standards of practice. Furthermore, auditors were not sufficiently independent or robust and audit findings simply reinforced what was already known. The audit programme for the next year, which will use revised and more qualitative audit tools, is appropriately focused on 'the voice of the child'.
143. The present BSCB multi-agency data set is not of sufficient quality to enable robust scrutiny of multi-agency performance and to drive improvement. Performance information is vast in quantity but poor in quality and data reliability remains questionable. A functional and interactive performance scorecard system has been commissioned and will be implemented this year. A recent West Midlands wide Protocol setting out the principles and practice standards governing child protection processes has been developed, led by BSCB, and subject to any final changes after consultation will be agreed and implemented in the early Summer. This protocol is designed to improve attendance at child protection case conferences.
144. Training is available to all partners and take up is generally good from most agencies (94%). However, attendance rates for social workers and police officers are low and, in light of the authority's significant challenges with practice, this is inappropriate. In 2013, two major programmes accompanied the launch of the implementation of the 'Strengthening Families' model of child protection conferencing and Right Services Right Time threshold document. Multi-agency child protection training at levels 1 and 2 is delivered by individual agencies with their own agency content and curriculum and a consequence of this is that there are no common standards or multi-agency curriculum. This approach also means that the advantages of training staff on a multi-agency basis is lost.

What the inspection judgements mean: the LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Its evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An **inadequate** LSCB does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and it fails to identify where improvements can be made.

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Getting to Great

Strategic Plan **2015-17** and
Business and
Improvement Plan **2015-16**



Introduction

In April 2014 we published this three year Strategic Plan following the publication of the Keanu Williams Serious Case Review, the Local Government Association (LGA) Peer Review of safeguarding arrangements Government Review led by Julian Le Grand in January 2014 and the Ofsted Inspection in March 2014. It meant the previous plan had to be revised significantly and led to a three year Strategic Plan and an annual Business and Improvement Plan. The Improvement Plan for 2014/15 included the action being taken in response to the Ofsted recommendations.

This revised plan was agreed by the Birmingham Safeguarding Children Board on 23rd June 2015 after a review of the previous year's performance and progress. The Board reaffirmed their commitment to driving forward a strong plan for achieving the radical changes needed to deliver real improvement over the next two years of the plan up to 31st March 2017. Year one has established some firm foundations and ensured that the basic requirements of an effective Board are put into place. It is now time to build on this foundation over years two and three.

We have agreed to retain our three priorities as a Board (although we have added two more elements to the "safer systems" priority. We will obsess constantly about them – in everything we do. That does not mean we stop doing everything else – far from it. It does mean we will focus much more on what life is like for a single vulnerable child living in Birmingham, and on changing that and every child's life for the better.

We must continue to unequivocally ensure that all professional staff in the city working with children, and with families know when to act to safeguard the vulnerable children and young people in our city and what to do when they are worried about a possible risk. We must, unequivocally, ensure they walk in the shoes of a child, and see the world through the eyes of a child, whenever they do something that might affect the life of a child for the better. We want their decisions to be shaped by the children and young people they serve, and for the support they provide to be tailored to the child's needs. We must support, supervise and train those people to do difficult work not just well but excellently, based on what works and what the evidence tells us is effective, and we must hold everyone to account for how they do it. As a Board, we must continue to provide high support, but also high challenge and aim high for our children. We want to ensure the Board provides great support, great training and great challenge.

In two years' time I want us all to hear children tell us that the adults they have supporting them have made their lives better. It is our responsibility as a Board to achieve this. This is our plan for how we will get to that point



Jane Held
Independent Chair
Birmingham Safeguarding Children Board
23rd June 2015

Our vision

“Making it safer for the children of Birmingham through high support and high challenge.”

Our priorities

Whilst we have a responsibility to ensure all children in the city are safeguarded, we particularly want to get it right for our most vulnerable children and young people, who have, we know, historically been the least safe and whose outcomes have been the worst. This means our strategic priorities will focus on safeguarding the most vulnerable children in the city, but we will not lose sight of the need to safeguard and promote the welfare of all children and young people.

Our Strategic Priorities

<p>1. The voice of the child – central to everything we do.</p>	<p>By 2017 we will know that:</p> <ol style="list-style-type: none"> 1. All the children getting support say they feel heard. 2. Most children getting support say they feel safer as a result. 3. All our statutory agencies have systems in place to engage with, involve, see, listen to, and respond to the children and young people using their services.
<p>2. We provide early help – when problems first arise.</p>	<p>By 2017 we will know that:</p> <ol style="list-style-type: none"> 1. The majority of children and young people living in families which need early help get it quickly. 2. The number of early help assessments and has increased, year on year, and the number of referrals has decreased, year on year. 3. All our statutory agencies can demonstrate how well they identify, assess and engage in providing early help services to children and families. 4. Families are involved in solving their problems and developing their own solutions in every situation (NEW for 2015/16)
<p>3. We run safe systems – to ensure children are properly safeguarded.</p>	<p>By 2017, we will know that:</p> <ol style="list-style-type: none"> 1. The number or re-referrals and children made subject to a protection plan for the second time are both reducing year on year. 2. Children and families are assessed and receive the right service at the right time, within statutory timescales. 3. Where children are the subject of a family support or child protection plan the family can tell us they know what has to happen why and by when, and what will happen if this isn't achieved. (amended for 2015) 4. All our statutory agencies are able to demonstrate how well their safeguarding systems are functioning, what needs to be improved and what action they are taking to achieve this.

These priorities are the areas in which we will focus our attention and devote most of our time. In addition we have a range of activities related to the day-to-day operation of a safeguarding children board which we refer to as “business excellence” activity. This includes specific areas of work with vulnerable groups, such as our Child Sexual Exploitation work, work with children living in households where there is domestic violence, mental ill-health, drugs and alcohol, where neglect compromises their welfare and wellbeing, or where they may be harmed as a result of female genital mutilation or forced marriage.

The governance activity of the Board, as well as statutory functions such as Child Death Overview, Serious Case Reviews, Performance and Quality Assurance, policies, procedures, protocols and standards, and Learning and Improvement activity continue to operate “business as usual” work streams as well as work streams focussing on improvement and the three priorities.

Improved governance, business processes to support and monitor safe systems of practice developing front line practice and creating a workforce development programme all feature as important aspects of delivering our three priorities and creating Business Excellence.

What’s it like growing up in Birmingham?

Birmingham City Council is the largest local authority in England. It has a population of over 1million. There are an estimated 287,000 children and young people under the age of 19, representing 28% of the overall population. This number is anticipated to rise to 314,000 by 2020, a 9% increase. Approximately half of these children and young people are from minority ethnic groups with more than 50 community languages spoken. The largest minority ethnic communities are Pakistani (20%), African Caribbean (10%), Indian (7%), Bangladeshi (4%) and children of mixed heritage (6%).

Birmingham has significant areas of deprivation. Only six of the 40 wards in the council area have fewer children living in poverty than the national average (20.1%). In the seven wards with the highest levels of deprivation, the percentage of children living in poverty ranges from 40.2% to 46.5%. This represents a significant challenge for the city as poverty is frequently associated with poorer than expected outcomes for children and young people. It can also lead to an acceptance of lower than acceptable standards of care as being ‘normal’ because of the degree and prevalence of problems related to homelessness, poverty and unemployment, as well as mental ill-health, alcohol and substance abuse, and domestic violence.

At the end of February 2014, there were 852 children with a child protection plan. This has dropped from 1149 children in March 2013 to a low point of 806 in December 2013 and is gradually rising again. These numbers indicate too many children were below the national average during 2013 but that action to ensure the right children are being protected was having an impact by the end of the year. Between March 2013 and March 2014, 2,223 child protection investigations were carried out. In addition, too many children were still not safe enough on a sustained basis, as the percentage of children becoming subject of a child protection plan for a second or subsequent time in 2013/14 was significantly higher than national and statistical neighbour averages at 20% (as opposed to a national figure of 14.9%).

The city is vibrant and energetic. There are many significant business and arts based activities located here. The thriving nightlife brings its own range of challenges in relation to safeguarding children and young people. The city has nine MPs and 120 city councillors, and is currently labour controlled. The Leader and Council have made safeguarding children the first of the council’s business priorities, and improving those services is the highest priority for the Children’s Services.

Birmingham is served by a wide range of statutory service providers and agencies, as is reflected in the large number of partners involved with the Safeguarding Board. This includes 427 schools and a large number of early-years settings. Many third sector children’s organisations (both national and

local) also work in Birmingham as do a range of private providers including two private social work providers working mainly with schools.

Several of the statutory providers operate over non co-terminus areas, and there are significant challenges in delivering cross boundary services, especially for the police and NHS. There is considerable movement in populations in the West Midlands, from outside the area as well as between local authority areas, which can complicate the degree and consistency and support offered to protect children and support families.

In health care, several partner trusts provide regional and national services and expertise, and are extremely large and complex multi-site organisations. For example, the Heart of England NHS Foundation Trust is the largest provider of maternity care in Europe. Over 140,000 children use the services of the Birmingham Children's Hospital each year and it is a major regional resource offering tertiary and quaternary specialist services.

Between them, the National Probation Service and the Community Rehabilitation Company for the area provide probation services to 14,500 offenders in the community and employing over 1,800 staff. These two services were established in September 2014 being formed out of the previous Staffordshire and West Midlands Probation Trust. This has increased the degree of complexity other professionals need to relate to in relation to managing risk of harm to others.

In June 2014 the Children's Society, working with Birmingham City Council established the Birmingham Commission for Children to consider what systematic improvements should be put in place across the city to improve children's lives and wellbeing in 10 years' time. The key messages published in [*'It takes a city to raise a child'*](#) in September 2014 resulting from the Commission's work included those from children and young people themselves. They told us that:

- Relationships are the most important thing in their lives, especially relationships with their families
- Every group of children across the whole city want to feel safer in the city. They feel they lack safe affordable spaces and activities that allow them to be with friends and family
- They want to have a say on the issues that matter to them, they want their voices to be heard and acted upon
- They were positive about school and valued the opportunities that education gave them
- They wanted skills and knowledge that were useful for getting a job and being a good citizen. They valued their community and their sense of place
- They wanted a positive story to be told about Birmingham, that valued and about their achievements as the children and young people of the city.

The Commission also provided some very important and key messages from families and communities in the city who together told us that:

- Families with young children were often in 'survival mode' and lacked the time, energy and resources for reflective parenting. Parenting skills and support need to be considered alongside improving the resources available to families
- Families, in particular single parent families, were often socially isolated, and this tended to be driven by fear – of crime, of difference and of judgement. Trust and confidence building relationships were the way out of this social isolation.
- All the families had aspirations, for some that meant work, while for others it meant focussing on bring up their children
- Effective services work to both understand where parents are, and where they want to be
- As children got older, parents found it harder to help with schoolwork and many parents found it challenging to support teenage children with their education
- Young people wanted more space in which to socialise outside school. Religious spaces and institutions were safe places and could be used more

As a consequence of the City's size and make-up there are large numbers of front-line staff whose work directly contributes to effective safeguarding. This means that the work of the Board is complex, multi-faceted and includes significant challenges. However these key messages in particular underpin the second two years of this plan, and of Birmingham City Council's Improvement Plan for Early Help and Children's Social Care (2015-2017). Together with the plans

of all partner agencies in relation to their statutory responsibilities to safeguard children and promote their welfare we now share a clear and collective set of priorities that will make a difference by 2017 to children and young people's lives.

Our purpose

Our role is straightforward – to support agencies to co-ordinate their service development and service provision to safeguard children, and to promote their welfare (High Support) and to monitor, scrutinise and challenge agencies as to how well they do this (High Challenge).

We do this in a number of ways, through evidence, relationships and influence. We are directly responsible for developing multi-agency policies, frameworks, protocols, standards and procedures, for providing extensive multi-agency training, for robust, rigorous performance management and quality assurance of safeguarding practice across all agencies and by learning from what we know in order to improve.

If confidence in the quality of services to children in the city is to grow from its current level, we have to do this in such a way as to ensure there is extremely robust, objective, and evidence based scrutiny and challenge as well as a relentless focus on the quality of practice.

The Board, overall, is greater than the sum of its parts. We use our collective power, resources, capacity and energy together to understand and influence what happens, by sharing learning, by holding each other to account and by rigorous efforts to understand and improve practice in order to get the best for our children. Children and young people are best safeguarded by what people do, and how they talk to each other as well as through the relationships they build with the children, young people and families they work and with each other. It is our job to support people to do this effectively.

Section 14 of the Children Act 2004 sets out the statutory Local Safeguarding Children Board objectives which are:

- To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- To ensure the effectiveness of what is done by each such person or body for those purposes.¹

What do we mean by the system?

We know that it is impossible to understand services, and what we provide and do in isolation, one service from another. We know children, young people, their families and communities exist in relationship with each other, and with the world in which they live. What one person does, affects others, and what one service does also affects others. Safeguarding children and young people requires everyone working with children, young people, their parents and their families to work together, and to recognise their relationships to each other. The safeguarding 'system' is made up of the whole of the city's activity to safeguard children and promote their welfare, and the interactions of all those who are involved with that activity.

¹ Working Together to Safeguard Children 2013 – Statutory guidance

Working together – our governance

We are a statutory body and partnership set up under the Children Act 2004 to co-operate with each other in order to safeguard children and promote their welfare. All that we do is governed by Working Together to Safeguard Children 2015, the statutory regulations that underpin the legislation.

We are an independent board, holding to account each other and our respective governance bodies for how they are working together. The Independent Chair is appointed by and accountable to the Chief Executive of Birmingham City Council together with the Board's partners.

We are responsible, collectively as a Board, for leading, co-ordinating, challenging and monitoring the delivery across the city of effective safeguarding practice by all of our agencies. We are not responsible or accountable, as a Board, for actually delivering safeguarding services. That is the responsibility of each of our agencies separately and collectively. We do not deliver safeguarding services on anyone's behalf, or duplicate work that is a priority for any or all agencies, but we necessarily need to work collaboratively with them. We influence what they do, and we hold them to account for how well they do it.

Each individual partner retains their own lines of accountability for safeguarding practice. On the Board we share responsibility collectively for the whole system, and not for our own agency.

We work closely with the governance bodies of all our organisations, especially the Council's Executive, the Police and Crime Commissioner, and all the NHS organisations in Birmingham. We share responsibility for driving improvement in practice in the city.

We work with the Health and Wellbeing Board, (HWB) and in particular, the HWB Children's Joint Commissioning Board. We also work closely with the Adult Safeguarding Board and the Community Safety Partnership on areas of shared concern such as domestic violence, drugs, alcohol and mental health which can affect children's safety and wellbeing. We link into the Regional Preventing Violence against Vulnerable People Board and its Regional CSE Group. A strong relationship and proper protocols between the Local Safeguarding Children Board and these other partnership bodies are essential in order to ensure there is a common shared understanding of who is responsible for what, and to avoid unnecessary duplication and inefficiency.

In addition we work closely with, and provide regular reports to the City Council's Overview and Scrutiny Arrangements. We share the responsibility with the Education and Vulnerable Children Overview and Scrutiny Committee to properly scrutinise and challenge the local authority in particular, as well as other partners. This includes joint scrutiny exercises as necessary.

We are required to report formally on an annual basis to the Council's Executive, the HWB Board, and the Police and Crime Commissioner, and will also report to the relevant NHS governance bodies. The annual report is published and available on our website. In return we expect each statutory partner's governance body to provide us with an annual safeguarding report and formal assurance statement in relation to their practice.

We share funding for the work of the BSCB and re-negotiate each partner's contributions to the budget each year.

Our functions

- “Working Together to Safeguard Children 2015” sets out the statutory guidance for LSCBs.

Our statutory functions² are to:

Develop policies, procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

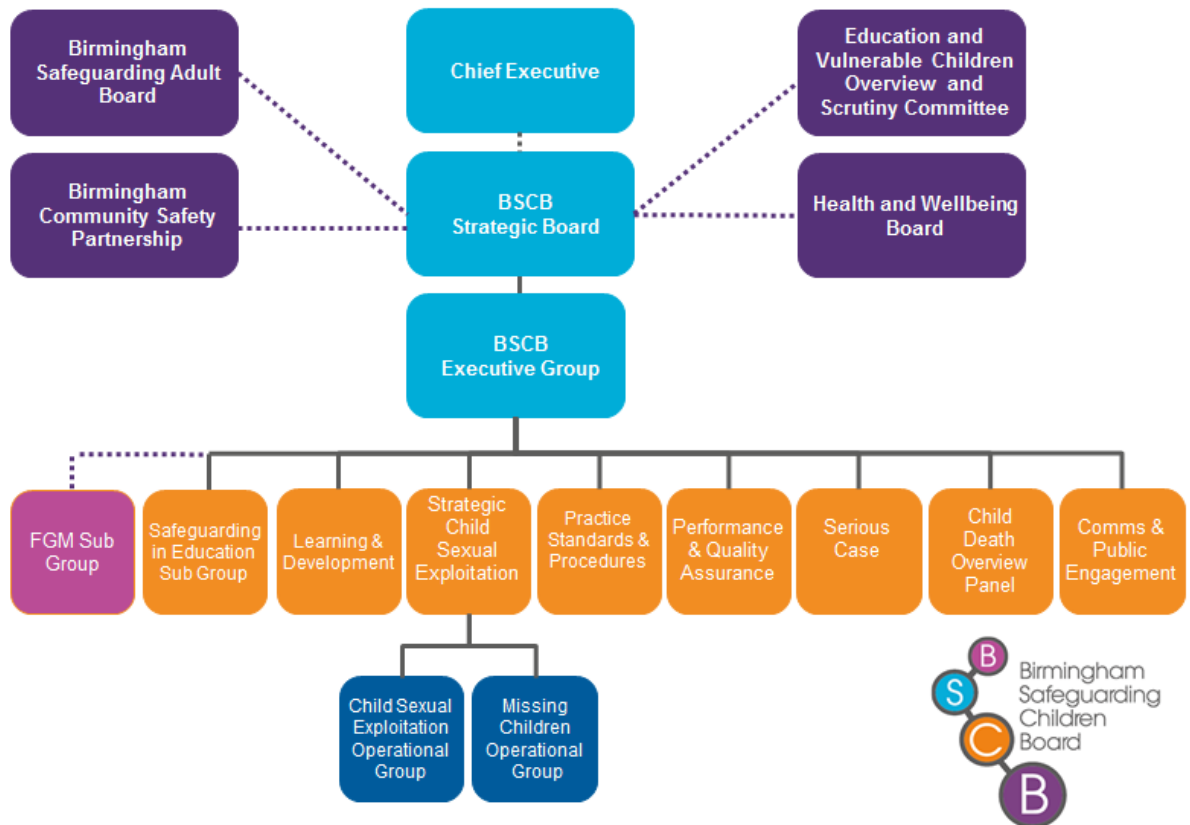
- The action to be taken when there are concerns about a child’s safety or welfare, including thresholds for interventions (ie who does what when they are concerned a child may need extra help, whether it’s early help to stop problems growing or immediate help);
- the training of people who work with children in relation to matters which affect their safety and welfare;
- the recruitment and supervision of people who work with children;
- the investigation of allegations concerning persons who work with children;
- the safety and welfare of privately fostered children;
- cooperation with neighbouring authorities and LSCBs;
- communicating across the area the need to safeguard and promote the welfare of children, raising awareness of how and encouraging improvements;
- monitor and evaluate the effectiveness of what is done by the local authority and board partners individually and collectively to safeguard and promote the welfare of children;
- participate in the local planning and commissioning of children’s services and;
- under take serious case reviews and advising the authority and their Board partners on lessons to be learnt.

Much of the business associated with these functions takes place on a day-to-day basis, through the work of the BSCB Sub-Groups, and through the BSCB Business Support Unit.

² Regulation 5 of the Local Safeguarding Children Boards Regulations 2006

Our structure in 2015

Birmingham Safeguarding Children Board Structure



May 2015

Putting children and young people at the heart of what we do

Placing children and young people at the centre of the work of the BSCB requires us to receive, understand and act upon their views of safeguarding arrangements and in particular of journeys they have made when using early help services, multi-agency targeted services, child protection processes and 'looked after' services. The Board will work with established participation programmes in the city to receive views and suggestions for improvements to services and to request exploration of specific safeguarding themes.

In addition, the Board will continuously challenge partners to demonstrate the centrality of the child's voice in what they do, both in planning and delivering services, and in the everyday relationships frontline staff and managers have with children and families. Every audit we run will look at how individual staff see, hear and listen to the children they are working with, and every assessment we make of the quality of practice, as well as the effectiveness of that practice will be based first and foremost on how child focussed and responsive it is to the child's needs.

We will also over the next three years, be developing the ways in which we can engage directly with children and young people in our work (i.e. the governance of safeguarding practice) as well as with those who provide services designed to safeguard the children and young people of the city.

How we do things in Birmingham

In Birmingham, when working together to safeguard children, we expect all our managers and staff to remember the Birmingham Basics:

- The child comes first
- Do the simple things better
- Never do nothing
- Do with, not to, others
- Have conversations, build relationships

PART TWO

Our Business and Improvement Plan 2014-15

Introduction to Part Two

The second part of our strategic plan consists of our annual Business and Improvement Plan. This is monitored monthly and progress towards our outcomes and goals will be reported to the Board quarterly. Responsibility for delivering the plan rests with the relevant sub group chairs (and their sub group colleagues) working with the partners on the Board. Each statutory partner is responsible for ensuring that the Board's work is properly implemented and delivered within their own agency

Improvement work is by its nature changeable. As things change over the year the actual plan will change too, as new work streams and objectives are identified or key national policy priorities change. What is crucial is that we stick to our priorities and do what we say we are going to. It is also important that we do this at a pace, and that at all times we remember this is about making the children of the City safer.

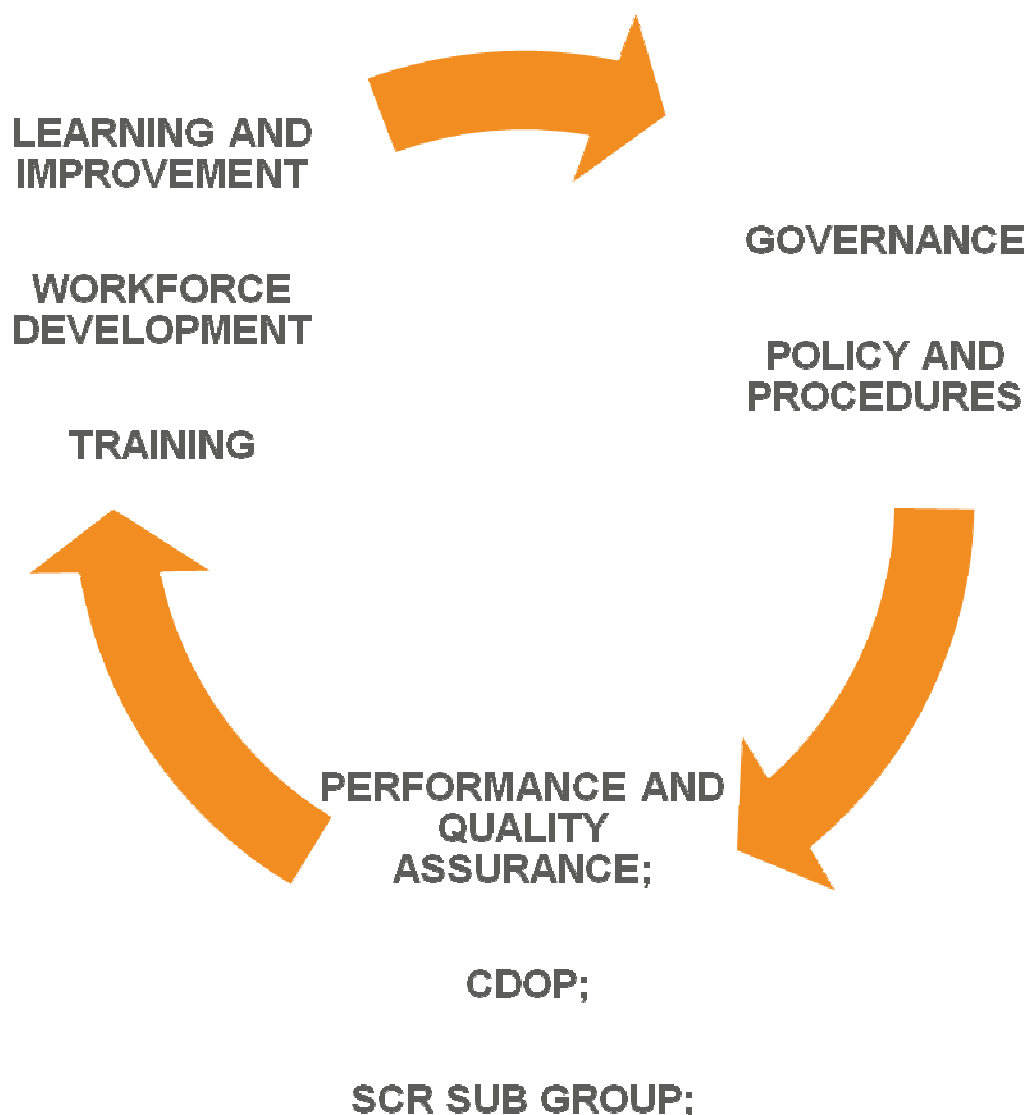
How we plan to deliver this business plan

The Strategic Plan provides the priorities for the work of the BSCB from 2014-17. Within this the BSCB Business and Improvement Plan is developed and refreshed on an annual basis. The Business and Improvement Plan identifies the key priorities and sets out the objectives that we will focus on each year. It includes the measures we will use to inform us whether we are achieving the outcomes we want to and making the improvements needed.

The BSCB Sub-Groups and Forums act as 'programme boards' to drive the work forward. For each sub objective allocated to them they develop detailed work programme plans which identify specific project tasks and officers responsible for carrying them out, as well as the milestones they need to achieve and the date by when the projects will be completed. The whole system builds on the activity of each sub group. (See diagram 1) and each Sub Group must ensure it works collaboratively with the others.

The year two plan includes a number of key actions under our priorities rolled forward from year one as they remain relevant and have not been completed. It also includes additional actions agreed over the 2014/15 business year as a result of the Education Improvement Plan arising following the Trojan Horse inquiries and reviews, and from the CSE Inquiry undertaken during the year by the Education and Vulnerable Children Overview and Scrutiny Committee. These actions are identified at the end of the priority actions set out below

Diagram 1 – our delivery model



Our Priorities for 2014-2017

We will over the next three years focus on the following strategic priorities:

1. **The Voice of the Child:** to ensure that everything we do is informed by children and young people's experiences, views, wishes and feelings.
2. **Early Help:** to support, scrutinise and evaluate the development and co-ordination of comprehensive early help services when families using our universal services need additional support and to put appropriate systems, processes and training in place to support the early help strategy and framework
3. **Safe Systems:** to ensure that there are safe, properly applied systems, protocols and processes in place to support frontline staff in responding to need at all points of a child's journey with a focus in year 2 on:
 - a. the functioning of the front door (contacts and referrals) and child protection processes.
 - b. Court processes and care planning for looked after children
 - c. Our identification, assessment of and response to children at risk of CSE

Our Business and Improvement Plan 2014-15.

This plan sets out all our improvement objectives. They are allocated to each Sub Group. The Work and Improvement Programme for each sub group contains the detailed actions required in order to deliver the improvement objective, with the milestones set, and the named responsible officers. These programmes will be monitored monthly by the Chair and each two months by the Executive of the Board. Quarterly reports will go to the full Board. Improvement Objectives in response to the Ofsted recommendations are in red (for priority actions) and blue for areas for improvement. The rest of the improvement priorities, selected through the analysis of our understanding of what needs improved in the 2012/13 Annual Report, are in black. Both sets of objectives are equally important. Some of our improvement objectives have been developed jointly with the Council so that the interdependencies between the Council's Improvement Plan and the Board's Plan are properly recognised and delivered.

Priority I: Voice of the Child.

<p>PRIORITY THEME 1</p> <p>The Voice of the Child: to ensure that everything we do is informed by children and young people's experiences, views, wishes and feelings.</p>
<p>DESIRED OUTCOME:</p> <p>Children tell us they feel listened to and heard, and can influence what happens to them</p>
<p>EVIDENCE OF IMPACT AND EFFECTIVENESS</p> <ul style="list-style-type: none"> • Feedback from children and young people enhances the Board's evaluation of the effectiveness of safeguarding arrangements in Birmingham. • Findings from performance and quality assurance activity demonstrate that the views of children and young people have been taken into account.

Priority 1: The Voice of the Child Improvement Objectives

No.	Priority Action	Lead sub group
1.1	We know how children and young people are engaged and involved in the development and planning of services across the city and what they are telling us about their lives and use that information to inform what we do (map and gap analysis)	Comms and Engagement
1.2	We have developed an involvement model that will enable children and young people to directly challenge the Board about its role and work. (tap and wrap activity)	Comms and Engagement
1.3	We have established core standards for practitioners in all partner agencies in terms of engaging with and involving children and young people in the services they receive	Practice Standards and Procedures
1.4	All audits identify the degree to which the practice includes, listens to and takes account of the child's views, wishes and feelings	Performance and Quality

		Assurance
1.5	The curriculum of every multi-agency training programme run by the Board includes the core practice standards (1.3) and guidance on ensuring the voice of the child is central to practice	Learning and Development
1.6	To ensure that the voice of the child is threaded across all sub group work programmes throughout the year	Comms and Engagement

PRIORITY 2 Early Help

PRIORITY THEME 2

Early Help: to support, scrutinise and evaluate the development and co-ordination of comprehensive early help services when families using our universal services need additional support and to put appropriate systems, processes and training in place to support the early help strategy and framework

DESIRED OUTCOME:

Families get help with caring for their children safely and appropriately early in the life of a problem and risk to those children is minimised

EVIDENCE OF IMPACT AND EFFECTIVENESS

- There is tangible evidence that early help training is impacting on the children’s workforce.
- Robust dataset that provides evidence of early help outcomes.

Priority 2: Early Help Improvement Objectives

No.	Priority Action	Lead sub group
2.1	We have a framework for agreeing, undertaking, reviewing and evaluating early help support plans, and integrated family support plans at universal plus and additional needs level	Early Help working group
2.2	We have agreed and commissioned a common set of intervention tools building on the neglect strategy, and other interventions, and a common set of tools to evaluate outcomes	Early Help working group
2.3	We have agreed the framework for evaluating the effectiveness of early help in the City.	Performance and Quality Assurance
2.4	We have developed, commissioned and are providing rolling multi-agency training and support on the use of the framework, tools and processes, on identifying and assessing the need for early help, on engaging with challenging families, and on information sharing and consent, in order to underpin the cultural and behavioural changes needed within the children’s workforce	Learning and Development

Priority 3: Safe Systems: Front Door and Child Protection

PRIORITY THEME 3

Safe Systems: Safe Systems: to ensure that there are safe, properly applied systems, protocols and processes in place to support frontline staff in responding to need at all points of a child's journey with a focus in year 2 on:

- The functioning of the front door (contacts and referrals) and child protection processes.
- Court processes and care planning for looked after children
- Our identification, assessment of and response to children at risk of CSE

DESIRED OUTCOMES:

- Staff working with children, young people and their families demonstrate they know what to do when, are supported to do it through clear protocols and standards and are able to exercise good professional judgements on a single and multi-agency basis
- Children get the right service at the right time which meets their expressed and assessed needs quickly and which makes a difference to their lives

EVIDENCE OF IMPACT AND EFFECTIVENESS

- Evidence that practitioners understand and are able to apply Right Service, Right Time threshold guidance.
- Families recognise the benefit of participation in the strengthening families' conference process.
- The Board has robust data that informs and stimulates action to improve performance.

Priority 3: Safe Systems:

a. Front Door and Child Protection Improvement

3.1	To evaluate the implementation of Right Service Right Time after 6 months and adjust the roll out requirements and training programmes we provide accordingly over the second 6 months	Performance and Quality Assurance
3.2	To provide multi-agency Right Service Right Time training on a rolling programme basis all year	Learning and Development
3.3	To maintain and extend the audit programme provided through the Performance and Quality Assurance Sub Group	Performance and Quality Assurance
3.4	To review the effectiveness of the Strengthening Families Model, and the application of the West Midlands Child Protection Protocol and develop any relevant changes to the model and the protocol	Performance and Quality Assurance
3.5	Review and refresh the multi-agency training programmes provided to support the child protection system (Strengthening Families, attending child protection case conferences, and working in core groups)	Learning and Development
3.6	Develop a set of multi-agency practice standards relating to making contacts and referrals, and to contributing to the child protection process	Practice Standards and Procedures

Priority 3: Safe Systems:		
b. Children looked after (to ensure children who are looked after have the same life chances as their peers)		
3.7	Receive and monitor the implementation of the new Corporate Parenting Strategy and reports from the Corporate Parenting Board	Executive
3.8	To develop a framework for monitoring and working with children and young people missing from care and the responses made to them	Missing Sub Group
Priority 3: Safe Systems:		
c. Child Sexual Exploitation		
3.9	Complete and implement the CSE Strategy	CSE Sub Group
3.10	To review, adjust and implement CSE procedures and protocols based on the West Midlands model, but integrated into the Birmingham frameworks for early help (universal plus and additional needs) and child protection processes (complex and significant needs)	Practice Standards and Procedures
3.11	Develop a set of performance indicators and outcome measures informed by the West Midlands regional model	Performance and Quality Assurance
3.12	Develop a range of rolling multi-agency training programmes to support professionals to identify, assess and respond to concerns about the risk or CSE for individual children	Learning and Development Sub
3.14	Develop an intelligence capacity and data base system	Child Sexual Exploitation Sub Group
3.15	Establish the missing sub group, and adjust the COG/MASE model to reflect the Birmingham approach and service delivery framework with three local areas (and three MASE groups)	Child Sexual Exploitation Sub Group

4. The Business Workstream

PRIORITY THEME 4		
Business Excellence		
DESIRED OUTCOME:		
The Board works collectively and collaboratively and delivers on its statutory requirements		
EVIDENCE OF IMPACT AND EFFECTIVENESS		
<ul style="list-style-type: none"> Learning from Serious Case Reviews is embedded in front-line practice. In Birmingham a national model of good practice in the commissioning and publication of learning from Serious Case Reviews has been established. 		
4.1	Complete the governance review and evaluate its effectiveness by the end of the year (March 2016)	Executive
4.2	Establish the annual assurance cycle for all statutory partners and	Performance

	implement it fully	and Quality Assurance
4.3	Respond to the decisions following Lord Warner's final report and develop the Board as required	Executive
4.4	Review and agree a revised Risk Register and develop a challenge log process	Executive
4.5	Support and challenge partners with the development of a strategic children's leaders forum and revised arrangements for commissioning services	Executive
4.6	Establish a Practice Standards and Procedures Sub Group and Safeguarding in Education Sub Group and expend capacity within the Business Support Unit to support two new Sub Groups and the affiliated Birmingham Against Female Genital Mutilation group	Executive
4.7	Ensure single agency organisational changes are appropriately "stress tested" in relation to their safeguarding arrangements	Executive
Practice Standards and Procedures:		
4.8	Develop a new series of simple practice guides and new standards and protocols covering our key priorities and disseminate/embed working with communications and engagement sub group and performance and QA sub group	Practice Standards and Procedures
4.9	Review all current multi agency procedures and protocols for compliance with Working Together to Safeguard Children 2015	Practice Standards and Procedures
4.10	Work with the West Midlands Chairs to establish regional policies, procedures and protocols	Practice Standards and Procedures
Child Deaths:		
4.11	Use annual data analysis to inform the JSNA and relevant public health activity and service commissioning	Child Death Overview Panel
Safeguarding in Education:		
4.12	Ensure that a range of mechanisms, platforms and processes are in place to support schools to own and fully engage with their statutory responsibilities for safeguarding children and young people.	Safeguarding in Education
4.13	Explore the potential for accrediting providers that schools use to improve the governance and quality of the early help and safeguarding services they offer and use	Safeguarding in Education
Serious Case Review Sub Group:		
4.14	Complete the NSPCC and Sequeli commission to undertake development work with the Board and Sub Group on undertaking management reviews, and Serious Case Reviews and develop a new system, framework, training and a manual for undertaking reviews.	Serious Case Review Sub Group
4.15	Review the Learning and Improvement Strategy to ensure that learning from serious case reviews is used effectively to inform practice and that audits begin to demonstrate that learning is having an impact on improving practice across partner agencies.	Serious Case Review Sub Group



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Right Service, Right Time

Delivering effective support for children and families in Birmingham

Guidance for Practitioners

March 2015 (Version 2)



Delivering effective support for children and families in Birmingham

Foreword

Children and families are supported most effectively and efficiently when services and information sharing are planned and delivered in a co-ordinated way. The vision across Birmingham is to deliver the right service to the right child at the right time, supported by flexible and responsive services.

This framework provides everyone with clear advice about what to do and how to respond if a child and their family need extra help. Underpinning it is our determination to put the child at the centre of what we do. Our aspiration is for Birmingham to be a city where all professionals across the system put the voice of the child at the centre of their planning, decision-making and service delivery.

We need to have a collective understanding of the needs of the child and the family so we can work more effectively together to make a real difference.



Independent Chair
Birmingham Safeguarding Children Board

Introduction

This guidance is for everyone who works with children, young people and their families in Birmingham. It sets out four levels of children's needs: **Universal, Universal Plus, Additional Needs and Complex/Significant.**

The aim is to achieve consistency in understanding and practice, when responding to children, young people and their families who need extra support.

All children access universal services, such as maternity and health visiting, school and youth services. These services are also well placed to recognise and respond when extra support may be necessary. Children will always receive universal services whatever their needs.

There are times, however, when extra support is necessary. This may be because the child's needs become increasingly complex or because of parental or family circumstances.

Children who have additional or complex needs may require targeted

support from a range of services provided by statutory, voluntary and private sector organisations.

We all recognise that, in the vast majority of situations, parents want to help serve the best interests of their children and are best placed to meet their needs. When thinking about how best to support families, an assessment needs to take into account any previous history of support, any vulnerability, risk or protective factors and the context they are living in. This should be considered against the guidance set out in this document.

Some children may do well, even in the most adverse circumstances, while others appear to have little capacity to cope with small amounts of stress. What is important is that



individual families are offered services that will respond to their particular needs.

This guide describes potential indicators of concern for children, young people and their families and should be used to enhance collective understanding of risk. The information needs to inform 'professional conversations' between services to improve the quality and consistency of assessments. There will always be circumstances that are not covered in this guide or particular issues that will rely on the professional judgement of frontline workers and of their managers but overall those can still be understood within this framework.

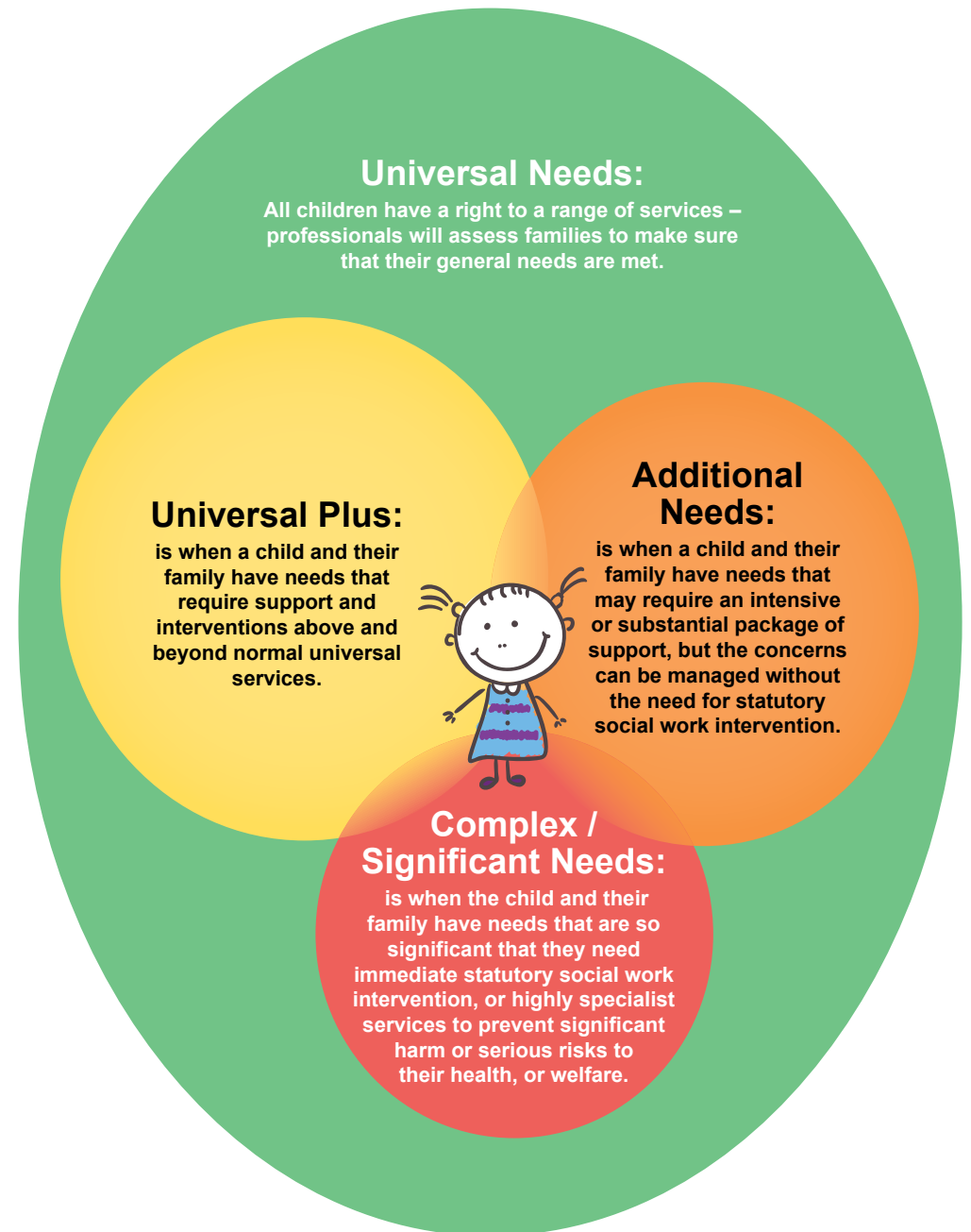
The diagram reinforces that the child is at the centre of all we do. It also shows the relationship between four levels of need;

- **Universal Needs,**
- **Universal Plus,**
- **Additional Needs**
- **Complex/Significant Needs.**

Universal Plus is when a child and their family have needs that require support and interventions above and beyond normal universal services.

Additional Needs is when a child and their family have needs that may require an intensive or substantial package of support, but the concerns can be managed without the need for statutory social work intervention.

Complex/Significant Needs is when the child and their family have needs that are so significant that they need immediate statutory social work intervention, or highly specialist services to prevent significant harm or serious risks to their health, or welfare.



Guiding principles

- Wherever possible, the needs of children and families will be met by universal services.
- As soon as any professional is aware that a child has any additional needs which may require the involvement of more than one professional, they should talk to that child and their family and offer advice and support.
- Do with - not to - and empower families to identify their own problems, needs and solutions. In most cases, outcomes for children will only be improved by supporting and assisting parents/carers to make changes.
- When support is needed, your job is to talk to the child on their own and to the family, work out with them and your colleagues what they need, agree a plan and then share responsibility for making the plan work. (See, Plan, Do, Review)
- We will work with the child and family to help them to help themselves. Once improvement is made, services will reduce or end so as not to create dependence.
- Our aim is always to build resilience in children and families and the capacity to overcome their own difficulties for the remainder of their lives.
- We will be open, honest and transparent in our approach to supporting children and their families.
- We will identify problems as early as possible so that the child and their family receive appropriate support in a timely way to prevent the problem from escalating.
- Never do nothing. If you think a family needs support, get involved and help make a difference.
- Professionals should have conversations with each other to agree how to respond to need as well as develop a plan.



Determining need – questions to ask yourself

- Is this family coping?
- Are this child's needs being met?
- Have I ensured that the child has had an opportunity to speak, be heard and listened to?
- What are the relevant factors at the core of the child's needs? Do I have a picture of the family as a whole, their parental capability and environmental factors?
- Have I used this guide to prompt me to think more clearly and understand the situation?
- Have I considered any previous history of support, service involvement and the current risk and protective factors within the family? Think about what the child's experience really is.
- Am I sure about my understanding of the information? If not, take advice in the first instance from your line manager or your agency's safeguarding advisor.
- Have I discussed my analysis of the identified needs with other professionals involved with the child to achieve a more holistic approach?
- Have I discussed my concerns with the child and their family and offered advice and support?
- Have I asked the parents for written consent to my involvement, my assessment and /or referral and to information sharing to help engage services quickly?
- Have I been professionally curious?
- Have I thought about the needs of any siblings?

Put yourself in the child's place!



Universal Plus is when a child and their family have needs that require support and interventions above and beyond normal universal services.

Development needs of child/young person:

Health	<ul style="list-style-type: none"> • Defaulting on immunisations/development checks/health appointments • Minor concerns regarding diet/hygiene/clothing • Slow in reaching developmental milestones
Education and Learning	<ul style="list-style-type: none"> • Has some identified learning needs • Patterns of regular absences – school attendance 94-86% • Not reaching educational development potential • Low motivation/not engaged in learning
Emotional/ Behavioural development	<ul style="list-style-type: none"> • Some difficulties with peer group relationships and with some adults • Evidence of some inappropriate behaviour • Finds managing change difficult
Identity	<ul style="list-style-type: none"> • Some insecurities around identity expressed • May experience bullying around 'difference'
Family and relationships	<ul style="list-style-type: none"> • Limited support from family and friends • Some difficulty in sustaining relationships
Social Presentation	<ul style="list-style-type: none"> • Can be over friendly or withdrawn or not aware of risk • Age inappropriate clothing and appearance • Change in communication leading to a more guarded/secretive self • Presenting vulnerabilities but not currently at risk of being groomed for sexual exploitation
Self-care skills	<ul style="list-style-type: none"> • Not always adequate self-care/hygiene • Slow to develop appropriate self-care skills

Parent and Carer Factors:

Basic Care	<ul style="list-style-type: none"> • Poor parental engagement with services • Parent requires advice on parenting issues • Physical needs not always met
Ensuring safety	<ul style="list-style-type: none"> • Some exposure to dangerous situations in home/ community • Parental stress starting to affect ability to ensure child's safety • Lack of emotional warmth • Inconsistent responses to child by parents • Unable to develop other positive relationships
Stimulation	<ul style="list-style-type: none"> • Spends much time alone • Rarely exposed to new experiences
Guidance and boundaries	<ul style="list-style-type: none"> • Can behave in an antisocial way e.g. alcohol, smoking, minor offending behaviour • Inconsistent boundaries offered • Lack of positive role models or existence of significant others who are poor role models
Stability	<ul style="list-style-type: none"> • Key relationships with family members not always kept up • Difficulties with attachments

Family and Environment Factors:

Family history and functioning	<ul style="list-style-type: none"> • Experienced loss of significant adult • May look after younger siblings • Parent has health difficulties • Domestic Abuse with the potential for emotional impact on child/ren
Wider family	<ul style="list-style-type: none"> • Limited support from family/friends
Housing	<ul style="list-style-type: none"> • Poor housing • Family seeking asylum or are refugees i.e. no access to public funds
Employment	<ul style="list-style-type: none"> • Wage earner has periods of unemployment • Parents have limited formal education
Income	<ul style="list-style-type: none"> • Low income and lack of financial resources
Family's Social Integration	<ul style="list-style-type: none"> • Family new to area • Some social exclusion problems
Community resource	<ul style="list-style-type: none"> • Limited access to universal resource

Additional Needs is when a child and their family have needs that may require an intensive or substantial package of support, but the concerns can be managed without the need for statutory social work intervention.

Development needs of child/young person:

Health	<ul style="list-style-type: none"> Health concerns not accepted or addressed – treatment not being sought/adhered to Multiple health problems/disability Consistently missing required health appointments Over weight/under weight Continence issues Substance misuse inc drugs/alcohol Developmental milestones not met
Education and Learning	<ul style="list-style-type: none"> Learning needs continuing to impact negatively Not achieving Key Stage benchmarks School attendance below 85% ≥3 fixed term exclusions or >15 days excluded in any year Permanently excluded from school
Emotional/ Behavioural development	<ul style="list-style-type: none"> Difficulty in coping with anger/frustration and upset Disruptive/challenging behaviour Emerging, concerning mental health issues e.g. low mood, self harm, emerging eating disorders etc Cannot manage change Unable to demonstrate empathy
Identity	<ul style="list-style-type: none"> Subject to persistent discrimination Very poor self-esteem Exhibiting extremist language/behaviour/aligned to a gang
Family and relationships	<ul style="list-style-type: none"> Lacks positive role models Involved in conflict with and between peers/siblings Regularly cares for family member, parent, partner
Social Presentation	<ul style="list-style-type: none"> Provocative behaviour/appearance Hygiene problems Missing from home or change in behaviour/routine suggesting development of inappropriate relationship May be at risk of being groomed for sexual exploitation
Self-care skills	<ul style="list-style-type: none"> Poor self-care for age Precociously able/required to care for self

Parent and Carer Factors:

Basic Care	<ul style="list-style-type: none"> Difficult to engage parents/carer – reject advice/support Parent continually struggling to provide care Parent previously looked after by the Local Authority Professionals concerned basic care will not be provided
Ensuring safety	<ul style="list-style-type: none"> Parents perceive safety to be a real problem Neglect identified Unsafe situations e.g. DV, criminal activity, drugs, alcohol
Emotional warmth	<ul style="list-style-type: none"> Receives erratic/inconsistent poor quality care Parental capacity affects ability to nurture Absence of positive relationships
Stimulation	<ul style="list-style-type: none"> Not receiving positive stimulation – lack of new activities
Guidance and boundaries	<ul style="list-style-type: none"> Erratic/inadequate guidance Parent is a poor role model
Stability	<ul style="list-style-type: none"> Has multiple carers Parent in prison Frequent/unplanned moves causing disruption/instability

Family and Environment Factors:

Family history and functioning	<ul style="list-style-type: none"> Incidents of Domestic Abuse with impact on victim and children Acrimonious divorce/separation Family has serious physical/mental health difficulties Drug use or alcohol dependency by parent/carer Bereavement or loss of family member
Wider family	<ul style="list-style-type: none"> Poor relationship/little communication with family Family is socially isolated Housing / poor state of repairs Statutory overcrowding Vulnerable accommodation e.g. friend's house, not secure High mobility e.g. refugee asylum seeking status
Employment	<ul style="list-style-type: none"> Lack of basic skills hinder parents employability Stressed due to unemployment or 'over working'
Income	<ul style="list-style-type: none"> Debt/poverty impacts on ability to meet basic needs
Family's Social Integration	<ul style="list-style-type: none"> Parents socially excluded Lack of a support network
Community resource	<ul style="list-style-type: none"> Access problems to poor quality universal/targeted resources

Complex/Significant Needs is when the child and their family have needs that are so significant that they need immediate statutory social work intervention, or highly specialist services to prevent significant harm or serious risks to their health, or welfare.

Development needs of child/young person:

Health	<ul style="list-style-type: none"> Severe/chronic health problems, developmental delay or disability where treatment not being sought or adhered to Persistent substance misuse Pregnancy of a child under 13 Repeat dental extraction under general anaesthetic (or multiple dental extractions)
Education and Learning	<ul style="list-style-type: none"> Persistent School refusal if in conjunction with other Complex/Significant Needs
Emotional/ Behavioural development	<ul style="list-style-type: none"> Moderate to severe mental health problems Significant impact of traumatic event Deterioration of mental health leading to risk to self and/ or others
Identity	<ul style="list-style-type: none"> Experiences of persistent discrimination e.g. re ethnicity, sexual orientation or disability Chronically socially isolated Participates in gang activity Participates in extremist actions in language and behaviour
Family and relationships	<ul style="list-style-type: none"> Periods accommodated by Local Authority Family breakdown leaves child at risk Child is main carer for family member Subject to physical, emotional or sexual abuse or neglect
Social Presentation	<ul style="list-style-type: none"> Persistent poor and inappropriate self presentation Inappropriate relationship with an adult (not family member), frequently missing from home environment At significant risk or already being sexually exploited
Self-care skills	<ul style="list-style-type: none"> Neglects to use self-care skills due to development delay, learning difficulties or alternative priorities e.g. substance misuse

Parent and Carer Factors:

Basic Care	<ul style="list-style-type: none"> Parents consistently unable to provide 'positive enough' parenting that is adequate and safe Parent's mental health problems or substance misuse significantly affects care of child Parents unable to care for previous children Domestic violence in pregnancy
Ensuring safety	<ul style="list-style-type: none"> Persistent instability and violence in the home Parent and/or child have significant involvement in crime Parents unable to keep child safe and secure Child's behaviour poses unmanageable risk
Emotional warmth	<ul style="list-style-type: none"> Parents inconsistent, critical or apathetic attitude to child may result in significant harm
Stimulation	<ul style="list-style-type: none"> Grossly under stimulated
Guidance and boundaries	<ul style="list-style-type: none"> No effective boundaries set or adhered to Perpetrator or victim of significant anti-social behaviour
Stability	<ul style="list-style-type: none"> Beyond parental control Nobody providing appropriate care

Family and Environment Factors:

Family history and functioning	<ul style="list-style-type: none"> Incidents of Domestic Abuse with a significant impact on victim and child Poor/harmful sibling relationships Young person persistently running away or absconding Threat of forced marriage
Wider family	<ul style="list-style-type: none"> No effective support Destructive/unhelpful involvement Negative influence from family involved in drugs/crime
Housing	<ul style="list-style-type: none"> Physical accommodation places child at risk of harm Emergency housing needs as a consequence of fleeing domestic violence/gang reprisal
Employment	<ul style="list-style-type: none"> Unable to gain employment due to long-term issues e.g. chronic health, substance misuse which impairs capacity
Income	<ul style="list-style-type: none"> Extreme poverty/debt impacting on ability to care for child
Family's Social Integration	<ul style="list-style-type: none"> Family chronically socially excluded No supportive network Community Resources Poor quality services with long-term difficulties accessing target populations

How to access support based on need

All partners working with children, young people and their families should offer support as soon as they identify a need. We will always seek to work together to provide support to children, young people and their families at the lowest level possible according to their needs, but also be ready to respond if there is an escalation in the child's needs.

Universal Needs covers children who will require no additional support beyond that which are universally available.

Children with **Universal Plus** needs are best supported by those who already work with them, such as children's centres or schools, organising additional support with local partners as necessary.

For children whose needs are **Additional**, a co-ordinated multidisciplinary approach is usually best, involving a family common

assessment framework (fCAF) and a Lead Professional to work closely with the child and family to ensure they receive all the support they require.

Complex/Significant Needs are where the child's needs are so great that statutory and/or specialist intervention is required to keep them safe or to ensure their continued development. Examples of specialist services are children's social care, child and adolescent mental health service (CAMHS) Tier 3 and 4 or the Youth Offending Service.

By identifying and responding to children with **Universal Plus** needs and by providing co-ordinated multi-disciplinary support and services for those with **Additional Needs**, we seek to prevent more children and young people requiring statutory interventions and reactive specialist services.

The following guidance sets out action to be taken and support available based on specific levels of need;

Universal Needs – universal services should be accessible to all children and families in Birmingham. The children's information and advice service (CIAS) can assist in signposting professionals to appropriate services available for families in each locality. **0121 303 1888** or email on familyinformation@birmingham.gov.uk

Universal Plus – seek advice from the designated manager in your agency. Speak to the family about your concerns. Consider using the family common assessment framework (fCAF) or a specific type of assessment for your service to help record your concerns and what is working well within the family and use it to help create an action plan.

Clarify the range of services your organisation can provide to support the child and their family.

You can also contact the children's information and advice service (CIAS) on **0121 303 1888** or email on familyinformation@birmingham.gov.uk for information, advice and guidance on other services that can support families.

Additional Needs – seek advice from the designated manager in your organisation. Speak to the family about your concerns and gain their consent to the intervention and to information sharing. Where more than one agency is involved in providing support to the family, use the family common assessment framework (fCAF) to carry out a multi-agency assessment and draw up an integrated support plan (ISP). This may need you or a colleague to take the role of lead professional later on.

Help and advice is available from:

- children's information and advice service (CIAS), who can signpost and provide guidance on available services to support families with additional needs in your area.



- the early help brokerage and support team (EHB) for ongoing assistance and guidance on the family common assessment framework (fCAF) visit www.birmingham.gov.uk/caf
- local family support and safeguarding hubs which provide support for lead professionals and convene and chair 'team around the family' (TAF) panels to co-ordinate the provision of services in that locality for children with additional needs. You can find the contact details for local family support and safeguarding hubs at www.lscbbirmingham.org.uk





Complex/Significant Needs – if your assessment indicates that a child is at risk of physical, emotional or sexual abuse, seek advice from the designated manager in your organisation, then contact the multi-agency safeguarding hub (MASH) on **0121 303 1888/ MASH@birmingham.gov.uk**. This will enable you to discuss your concerns with a qualified social worker.

A multi-agency referral form (MARF) should be completed. You should inform the family of the action you intend to take, unless you have grounds to believe this will increase the risk of harm.

The MASH operates between **8.45am and 5.15pm Monday to Thursday and 8.45am to 4.15pm on Fridays**. Outside these hours, please call the emergency duty team (EDT) on **0121 303 1888**.

Where an immediate response is required because the child's physical health is at risk of immediate harm, contact health professionals by dialling **999** for an ambulance.

In an emergency where a child's safety is at immediate risk of significant harm, contact the police by dialling **999**.



UNIVERSAL NEEDS & UNIVERSAL PLUS

Children's Information and Advice Service can provide information on:

- Advice & School Admissions
- Childcare Provision
- Support groups for Families
- What's on for Families in Birmingham – leisure / holiday activities



ADDITIONAL NEEDS

Help and advice available from:

- Children's Information and Advice Service (CIAS) who can signpost and provide guidance on available services to support families with additional needs in your area.
- The Early Help Brokerage and Support Team for ongoing assistance and guidance on Family Common Assessment Framework (fCAF).
- Area based Local Family Support and Safeguarding Hubs provide support for lead professionals and convene and chair Team Around the Family Panels to coordinate the provision of services in that locality for children with additional needs.



COMPLEX / SIGNIFICANT NEEDS

- If your assessment indicates that a child is at risk of physical, emotional or sexual abuse seek advice from the designated manager in your organisation, then contact the Multi-Agency Safeguarding Hub (MASH). This will enable you to discuss your concerns with a qualified Social Worker.
- A multi-agency referral form (MARF) should be completed. You should inform the family of the action you intend to take, unless you have grounds to believe this will increase the risk of harm.



Contact the Children's Information & Advice Service on **0121 303 1888** to access **Early Help Brokerage Support Team, Local Family Support and Safeguarding Hubs** and **Multi-agency Safeguarding Hub**.

In an emergency where a child's safety is at immediate risk of significant harm, contact West Midlands Police on **999**

Where to go for further information

For a copy of Hub directories and further information on how to use this guidance and illustrative case studies please visit www.lscbbirmingham.org.uk





National Child Protection Inspection Re-inspection

West Midlands Police
13-24 July 2015

December 2015

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www.justiceinspectors.gov.uk/hmic

Foreword

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

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

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

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

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

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

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1. Introduction

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

2. Background

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

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

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

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

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

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

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

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

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

3. Context for the force

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. The police role in child protection

Under the Children Act 1989, the police service, working with partner agencies such as local authority children's social care services, health services and education services, is responsible for making enquiries to safeguard and secure the welfare of any child within their area who is suffering (or is likely to suffer) significant harm.⁵ The police are duty-bound to refer to the local authority those children in need they find in the course of their work.⁶ Government guidance⁷ outlines how these duties and responsibilities should be exercised.

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

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

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

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

⁵ Section 47 of the Children Act 1989.

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

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

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

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

During the course of the inspection, West Midlands Police assessed 33 cases in accordance with criteria provided by HMIC. The force was asked to rate each of the 33 self-assessed cases. Practice was viewed as good by the force assessors in 14 of the cases, adequate in 4 cases, requiring improvement in 6 cases and inadequate in 9 cases.⁸ HMIC also assessed these cases, rating 5 as good, 6 as adequate, 10 as requiring improvement and 11 as inadequate. One was not assessed because the information required by inspectors to review the case was inaccessible⁹. Inspectors selected and examined a further 54 cases where children were identified as being at risk. Nine were assessed as good, 7 as adequate, 19 as requiring improvement and a further 19 as inadequate.

Initial contact

Recommendations from the October 2014 inspection report

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

Re-inspection findings

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

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

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

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

- the steps taken when a mother contacted police stating that her seven-year-old son had been assaulted by his father whilst staying with him. A strategy meeting¹⁰ and a joint investigation with children's social care services were undertaken promptly. Officers attended with social workers and the father was interviewed. Officers gave careful consideration to the boy's needs, and a medical examination was handled sensitively. The early contact and engagement with children's social care services ensured that longer-term safeguarding measures were initiated promptly; and
- the action taken when a woman was seen assaulting her son by a member of the public. When officers attended they found the mother to be intoxicated and immediately checked on the welfare of all four of her children. Protecting the children was at the forefront of the decision-making process. Officers identified that they were already the subject of a child protection plan and ensured that appropriate referrals were completed to ensure longer-term safeguarding planning was undertaken. Officers used their powers to protect the children whilst offences of neglect were investigated.

As a result of concerns from the previous inspection, control room procedures had been reviewed and revised guidance had been issued to all staff on how to respond to child protection concerns through the force wide Operation Sentinel¹¹ training programme. This training included a focus on children involved in domestic abuse situations to ensure that officers recorded observations about a child's behaviour and demeanour and control room staff escalated concerns about a child to an inspector if police were delayed in attending the incident.

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

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

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

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

- a mother called 999 stating that she was being verbally assaulted by her partner who was drunk and had mental health issues. The caller stated that her partner had hurt her daughter in the past and she was concerned about her other two children who were also present. The control room operator incorrectly graded the call as requiring a non-immediate response and the officers who attended failed to gather all available information (for example, officers did not identify that the partner had previously threatened to 'slit the children's throats') to assist decision making. No domestic abuse, stalking and harassment and honour based violence (DASH) risk assessment was completed and once the partner was removed from the premises the incident was closed with no crime being recorded. Despite there being evidence of risk to the children, officers did not record that they had checked on their welfare; and.
- a 15-year-old boy in the care of the local authority had been charged with possessing a bladed implement and went missing following his release from police custody. He had been reported missing six times previously. The matter was not reported to police by his social worker for over nine hours and as a result the control room operator was not prepared to treat the boy as missing and closed the incident. Consequently there was little effort on the part of the force to locate the boy and when he returned no welfare checks were completed.

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

For example:

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

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

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

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

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

Assessment and help

Recommendation from the October 2014 inspection report

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

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

- We recommend that, within three months, West Midlands Police:
 - ensures that MARACs record what safeguarding action has been taken, and what actions are planned for the future;
 - provides information (e.g. history of abuse, number of children in the family) to other agencies before the MARAC takes place;
 - identifies the range of responses and actions that the police can contribute to multi-agency plans for protecting victims and children in high-risk domestic abuse cases; and
 - improves the timeliness for screening domestic abuse cases in Birmingham.

Re-inspection findings

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

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

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

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

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

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

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

The force had taken some important steps to identify and protect children at risk of sexual exploitation. Bespoke trigger¹² and safeguarding plans were in place to protect the 720 children identified as being at risk across the force area. Inspectors were pleased to find that the implementation of plans was well supervised and trigger plans were regularly updated with details of the safeguarding plans in place. The number of children identified by the force as being at risk through a quarterly child sexual exploitation (CSE) assessment had increased consistently as the process evolved.

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

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

- a 12-year-old girl had been sent explicit images of an older man over the internet and had made an arrangement to meet him for sex. Whilst a referral to children's social care services was made, and a strategy discussion took place, this was not until five days after the information had been received by police and after the meeting between the girl and the man was supposed to have occurred. The girl was spoken to by police in the presence of her parents, however the investigation was closed without enquiries to identify the suspect being completed. The victim's phone was not seized despite images having been viewed on the device and no consideration was given to the likelihood of the suspect attending the meeting and whether this presented an opportunity to effect his arrest; and
- children's social care services contacted police after concerns were raised about two girls aged 11 and 13 who had engaged in sexualised communications with older men and exchanged indecent images with them. There was an eight day delay in holding a strategy discussion and inspectors found no evidence of a longer-term joint safeguarding plan to protect the girls from further exploitation. There was some evidence of supervision of the case by police, however there was a failure to identify and investigate criminal offences properly.

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

In some cases, children, most notably those in the care of the local authority, were reported missing over ten times without any action being taken to protect them. In the majority of cases examined, officers conducted 'safe and well' checks promptly (to check their immediate safety) after a missing child was located, although some records contained scant information. Inspectors found that independent return interviews¹³ for children missing from home were available across all local authority

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

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

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

- a 15-year-old girl had been reported missing on numerous occasions from her home. She had previously been known to associate with older men and smoke drugs. While some multi-agency work took place and the girl was 'flagged' as being at risk of sexual exploitation, there was little evidence of this being given proper consideration by police when assessing her vulnerability when she was reported missing again. A 'missing person report'¹⁴ was not created until the morning after her disappearance and police received, but did not properly consider, information that she intended to travel to France; and
- a 14-year-old girl in local authority care had been reported missing on over 20 previous occasions. Police records indicated a risk of sexual exploitation and a history of self-harm but this did not feature as part of the risk assessment or the response in the most recent episode. When the child was located there was no evidence of a referral being submitted to children's social care services. An investigation did not take place when she alleged that she had been held by her boyfriend against her will and had to escape by climbing out of a window. No further assessment was undertaken of the wider risks to the girl and there was no evidence of longer-term safeguarding measures being considered.

www.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care_3.pdf

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

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

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

Investigation

Recommendation from the October 2014 inspection report

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

Re-inspection findings

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

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

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

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

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

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

- a mother contacted police and stated that the father of her three-year-old daughter had picked her up by the neck, and that this had been witnessed by the girl's seven-year-old sister. The initial police response was good, an investigative plan was put in place by a supervisor and the father was quickly arrested and interviewed. The suspect was bailed and the investigation was then allowed to drift, with limited evidence of action or protective measures having been put in place. The child was not medically examined, her sister was not interviewed by a specialist child protection officer and there was no evidence that a strategy discussion had taken place. At the time of the inspection, this investigation was still ongoing some two months after the initial allegation; and
- police were called to reports of a three-year-old boy seen wandering alone in the street with no shoes. The initial response was good, with police attending promptly, locating the child and arresting his grandfather who was caring for him (he had known the boy was lost but had not contacted police). Police also ensured that the boy's two siblings were seen and safeguarded. However, following the initial interview of the suspect there was no supervisory input to the case until 16 days after the initial incident. Although a strategy discussion did take place and a joint investigation was agreed, there was no evidence that either the other children or their mother had been spoken to since the original incident. At the time of the inspection, two months after the incident, there were no further updates on this case.

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

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

- a case concerning a 16-year-old boy who was offering himself for sex on the internet and frequently going missing. He was suspected of using alcohol and drugs and of being in an inappropriate relationship with a 72 year-old man (he was also on bail for stealing from this man). The boy had been identified as being at risk of CSE at an early stage and was engaging with a specialist CSE officer. A comprehensive multi-agency safeguarding plan was in place with regular oversight provided by supervisors. Criminal matters were properly investigated, but the wider vulnerability of the boy was always recognised. The police file was closed once there was evidence that the risk had been reduced; and
- a 14-year-old girl disclosed to her school that she and two other girls of the same age had been sexually exploited by a 19-year-old man who had taken them to a hotel where they were made to engage in and watch sexual activity. Police attended promptly and completed a thorough initial investigation. An investigation plan was developed and the suspect was identified and arrested. There was clear evidence of effective supervision and good multi-agency working to develop appropriate safeguarding plans to support the victims and reduce the risks they faced.

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

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

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

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

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

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

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

Recommendations

- We recommend that West Midlands Police takes immediate steps to ensure that officers and staff within specialist child protection teams have received the necessary training to enable them to investigate the full range of child abuse offences.
- We recommend that, within three months, West Midlands Police takes steps to eradicate the backlog in the HTCU and continues to work with the CPS to reduce timescales for charging decisions.

Decision making

Recommendation from October 2014 inspection report

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

Re-inspection findings

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

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

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

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

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

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

Trusted adult

Recommendation from October 2014 inspection report

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

Re-inspection findings

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

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

- in the case of a referral from a school that an eight-year-old boy had disclosed that he and his sister were hit with a stick by their father if they misbehaved. A joint visit was made to the children by police and children's social care services. The boy and his sister were spoken to and safeguarding actions were agreed. The parents were interviewed, and the father was issued with a caution and agreed to accept support from social services. Throughout the case there was support from children's social care services and the school; and
- in the response to an emergency call to an incident involving a two-year-old boy alone in the street. Officers attended promptly and located the boy and, following some initial enquiries, identified his home address. The officers spoke with the child and his mother and made a detailed record of his demeanour and living conditions. Officers were not concerned for the child's immediate safety as this appeared to be an isolated, and accidental, incident. However, they made a referral to children's social care and a strategy discussion took place. The views and demeanour of the child were the main consideration when this decision was taken.

Managing those posing a risk to children

Recommendation from October 2014 inspection report

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

Re-inspection findings

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

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

Across the force, the violent and sex offender units were dealing with caseloads in excess of the ratio recommended for sex offender managers by national guidance¹⁶, with approximately 80-90 offenders being managed by each manager. Consequently, there was limited capacity for proactive work within these units because of the large number of sex offenders requiring supervision.

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

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

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

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

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

We found that links between the sex offender management teams and neighbourhood policing teams¹⁷ varied across the force area. Officers were not routinely made aware of registered sex offenders living in their area who posed a risk to children. As a result, information from local units about these individuals was not regularly submitted limiting the supply of potentially valuable information. .

Police detention

Recommendation from the October 2014 inspection report

- We recommend that, within three months, West Midlands Police undertakes a review (jointly with children's social care services and other relevant agencies) of how it manages the detention of children. This review should include, as a minimum, how best to:
 - improve custody staff awareness of child protection and of the standard of risk assessment required to reflect the needs of children and the support they require at the time of detention and on release;
 - assess at an early stage the likely need for secure or other accommodation and work with children's social care services to achieve the best option for the child;
 - ensure that custody staff comply with statutory duties and complete child detention certificates if children are detained in police custody for any reason;
 - ensure that custody staff make a record of all actions and decisions on the relevant documentation; and

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

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

Re-inspection findings

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

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

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

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

In the cases examined by inspectors, twelve of the children, all under 17-years-old, were charged and refused bail by the custody sergeant. In these circumstances the local authority is responsible for providing appropriate accommodation if a child is to be detained¹⁸. It should only be in exceptional circumstances (such as during extreme weather) that the transfer of the child to alternative accommodation would not be in their best interests. In rare cases – for example, if a child presented a high risk of serious harm to others – secure accommodation might be needed.

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

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

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

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

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

6. Findings: leadership, management and governance

Protecting vulnerable people is a priority for the force and the PCC and is reflected as such in the police and crime plan²⁰. The chief constable, his chief officer team and the PCC all have a strong commitment to child protection and there was clear evidence of work progressing at a strategic level to improve the force's ability to manage identified risks concerning the safeguarding of children.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Initial contact

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

Assessment and help

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

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

Investigation

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

Decision making

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

Trusted adult

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

Managing those who pose a risk to children

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

Police detention

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

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

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

8. Progress towards October 2014 Recommendations

Immediately

<p>We recommend that West Midlands Police immediately ensures that there are procedures in place to:</p> <ul style="list-style-type: none"> escalate any concerns about an incident involving children at risk if, for whatever reason, police have been delayed in attending the incident or alleged crime; and ensure that the incident is not downgraded without proper justification, and the appropriate checks have been made on the welfare of the child. 	
Partially Achieved	Revised guidance had resulted in improved awareness and processes however the quality and supervision of some assessments required improvement.

<p>We recommend that West Midlands Police immediately:</p> <ul style="list-style-type: none"> takes steps to ensure that children receive the right level of service irrespective of the team to which the case is allocated; develops a force-wide good practice regime aimed at improving the standards of investigation; takes steps to improve staff awareness, knowledge and skills in these types of investigations; takes steps to reduce the delays in analysis of material sent to the high-tech crime unit; and initiates discussions at a senior level with the CPS to address the delays in charging decisions. 	
Partially Achieved	Almost all child abuse allegations are now investigated by specialist officers and some improvements were apparent. However, supervision was inconsistent and staff expressed concern about a lack of further specialist training. The service improvement framework was a positive development but an explicit focus on quality and outcomes is required. Work to reduce backlogs and improve timeliness had begun but little evidence of improvement could be found.

We recommend that West Midlands Police takes immediate steps to:

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

Partially Achieved

Reviewed guidance had been issued to all staff about their responsibilities to safeguard children. However, while there was evidence of effective decision making this was undermined by inconsistencies in the quality and timeliness of recording.

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

Partially Achieved

The force had created a dedicated team to identify perpetrators and a number of CSE suspects had been arrested. However, safeguarding plans for those children linked to or at risk from RSOs were often poor.

Within three months

We recommend that West Midlands Police ensures that officers always record their observations of a child's behaviour and demeanour in domestic abuse incident records, so that a better assessment of a child's needs can be made.

Achieved

Inspectors found that in most cases assessed the behaviour and demeanour of children had been recorded allowing for better assessments.

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

- the unit is fulfilling its purpose to receive, assess and coordinate multi-agency activity to safeguard children effectively;
- background checks, initial assessments and strategy discussions between agencies take place in good time and do not leave children at risk; and
- there is supervisory oversight at a senior level to ensure that the unit is working properly and that any problems are speedily resolved.

Partially Achieved

There was some evidence of improved processes and assessments however the quality of recording and supervision was of a poorer standard.

We recommend that West Midlands Police:

- ensures that MARACs record what safeguarding action has been taken, and what actions are planned for the future;
- provides information (e.g. history of abuse, number of children in the family) to other agencies before the MARAC takes place;
- identifies the range of responses and actions that the police can contribute to multi-agency plans for protecting victims and children in high-risk domestic abuse cases; and
- improves the timeliness for screening domestic abuse cases in Birmingham.

Partially Achieved

There was some evidence of improved information sharing however recording was inconsistent and the development of safeguarding plans was not always timely.

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

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

Partially Achieved

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

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

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

<ul style="list-style-type: none"> • ensure that custody staff make a record of all actions and decisions on the relevant documentation; and • work with local authorities to ensure that no child who is looked after by the local authority is refused accommodation by them. 	
Not Achieved	The force had undertaken an internal review however there was no evidence of the involvement of other agencies and children were still being unnecessarily detained in police custody overnight.

Within six months

<p>We recommend that West Midlands Police:</p> <ul style="list-style-type: none"> • records the views and concerns of children; • records any available outcomes at the end of police involvement in a case; • informs children, as appropriate, of decisions made about them; and • ensures that information about children's needs and views are made available on a regular basis for consideration by the police and crime commissioner. 	
Not Achieved	While inspectors found examples of sensitive decision making that took account of the needs of the child no evidence could be found of the views of children being routinely recorded.

9. Further Recommendations and Next steps

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

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

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

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

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

Annex A

Child protection inspection methodology

Objectives

The objectives of the inspection are:

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

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

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

These areas of practice are the focus of the inspection.

Inspection approach

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

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

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

Methods

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

The purpose of the self-assessment is to:

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

Self-assessment and case inspection

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

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

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

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

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

Annex B Glossary

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

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Children's Services and Skills
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a non-ministerial department,
independent of government, that
regulates and inspects schools,
colleges, work-based learning and skills
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education and training in prisons and
other secure establishments, and the
Children and Family Court Advisory
Support Service; assesses children's
services in local areas, and inspects
services for looked-after children,
safeguarding and child protection;
reports directly to Parliament

police and crime commissioner
(PCC)

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

registered sex offender

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