



Promoting improvements
in policing to make
everyone safer

National Child Protection Inspections

The Metropolitan Police Service
1 February – 27 May 2016

November 2016

© HMIC 2016

ISBN: 978-1-78655-317-1

www.justiceinspectorates.gov.uk/hmic

Contents

Summary	5
1. Introduction	10
Background	10
Methodology	11
2. About the force	13
Size and structure of the force	13
Oversight: The Mayor’s Office for Policing and Crime	13
Structure for child protection	14
Resourcing for child protection	17
Planned changes to structure: the One Met Model 2020	18
3. Leadership, management and governance	19
Introduction: what is effective practice in this area?	19
Oversight of child protection issues at force level	20
How child protection work is split between the SOECA and TP commands	21
Performance management	21
Analysis and understanding of demand across the MPS.....	23
Representation on multi-agency boards	23
Conclusion	25
4. Analysis of case files	26
Introduction.....	26
Comparison of force self-assessment against HMIC’s assessment	27
HMIC’s assessment of 242 further cases	28
Breakdown of case file audit results by type of investigation	30
Conclusion	37
5. Initial contact	38

Introduction: what is effective practice in this area?	38
Calls from the public handled by the command and control centres.....	39
Referrals from professionals.....	42
Intelligence checks	43
Initial response	46
Conclusion.....	50
6. Assessment and help	51
Introduction: what is effective practice in this area?	51
Strategy discussions.....	52
MASH and CAIT	54
Sexual assault referral centres	55
Multi-agency risk assessment conference (MARAC).....	56
Multi-agency and sexual exploitation meetings, multi-agency professionals meetings and CSE.....	58
Missing and absent children (building the picture of the child's vulnerability)	62
Conclusion.....	64
7. Investigation.....	65
Introduction: what is effective practice in this area?	65
Training and resourcing of frontline officers.....	66
Investigations by specialists	68
Investigations by non-specialist borough officers	69
Child protection conferences	71
Investigation of indecent images of children.....	72
CSE	74
Recording investigation information and updates	77
Working with the Crown Prosecution Service.....	77
Conclusion.....	78

8. Decision-making	79
Introduction: what is effective practice in this area?	79
If the child needs immediate protection	79
Operation Makesafe	80
Decisions to take no further police action	80
Investigation outcomes	81
Listening to the child	82
9. Managing those posing a risk to children	83
Introduction: what is effective practice in this area?	83
MAPPA and registered sex offenders.....	83
Conclusion.....	86
10. Police detention.....	87
Introduction: what is effective practice in this area?	87
Results of the case file audit.....	87
Detention in custody after charging	89
Appropriate adults.....	90
Conclusion.....	92
Conclusion: The overall effectiveness of the force and its response to children who need help and protection	93
Next steps.....	94
Recommendations	95
Immediately	95
Within three months.....	97
Within six months.....	97
Glossary.....	99
Annex A – Child protection inspection methodology.....	112

Summary

This report sets out the findings from HMIC's 2016 inspection of child protection services in the Metropolitan Police Service (MPS).¹ This is part of our rolling programme of child protection inspections.²

Methodology

We used our standard child protection methodology (see Annex A and pp.11–12) to assess the service that the MPS provides to children in the Greater London area. This involved examining the effectiveness of the police response at each stage of their interactions with or for children, from initial contact through to investigation of offences against them. It also included scrutiny of the treatment of children in custody, and an assessment of how the force is structured, led and governed in relation to child protection services.

Our fieldwork comprised an audit of case files, a review of force self-assessments, and interviews to compare practice on the ground with the expectations for the police set out in the statutory guidance on child protection.³ This is our standard approach to inspecting child protection, but, in recognition of the scale and complexity of policing in London, we increased both the length of our fieldwork (from two weeks to ten weeks) and the number of case files we audited (from about 70 case files in a force to 374 in the MPS).

Throughout the course of the inspection, HMIC provided senior officers and staff at the MPS with details of our emerging findings. This ensured that the force was made aware of any identified failings and (where necessary) could take remedial action to address them. These briefings also provided an opportunity for the force to offer explanations or supplementary evidence.

¹ 'Child' in this report refers to a person under the age of 18. See the glossary for this and other definitions.

² For more information on this programme, see www.justiceinspectorates.gov.uk/hmic/our-work/child-abuse-and-child-protection-issues/national-child-protection-inspection/

³ *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015. Available from www.gov.uk

The specific assessment criteria used in inspecting each stage of the police's interactions with children are given in the introduction sections of the relevant chapters that follow.

Findings

We found examples of officers and staff throughout the MPS who are working with genuine commitment, dedication and empathy to protect and help children and young people. HMIC acknowledges the challenges of this work, which can be frequently distressing, often hard, and seldom straightforward.

However, these individuals and teams are not achieving consistently good results for children in London. In fact, when we reviewed our sample of child protection case files, we judged that almost three-quarters (278 of the 374 examined) demonstrated policing practice that either needed improvement or was inadequate. (See pp.26–37.)

We referred 38 of these cases back to the force because they contained evidence of a serious issue that could represent a continuing risk to a child or to children. Of these 38 cases, one had been judged as ‘requires improvement’ and three as ‘inadequate’ by the MPS itself (as part of the self-assessment of cases that formed part of our methodology, see p.26). However, until prompted by HMIC inspectors, the MPS had taken no action to address the issues it had itself identified. This is inexcusable and raises a significant concern about the ability of some staff to recognise the need to act and intervene to safeguard children in London. (See pp.29–30 for details of some of these cases.)

Effective child protection is not the sole responsibility of the police; other organisations (such as local authorities, children’s social care and clinical commissioning groups) are crucial to providing the best possible service. However, we found examples of poor practice at every stage of a child’s interaction with the police, and across all geographical areas of the MPS. No borough stands out as being either particularly good or particularly bad (although investigations carried out by the specialist central teams tended to show some evidence of better joint working with partner agencies, such as children’s social care, than those carried out by local officers working in the boroughs).⁴

Some of the other major themes to emerge from the case files, and from our wider fieldwork, were as follows:

- The police response to children who regularly go missing from home is poor: in the 38 cases of missing and absent children we inspected, we judged only 2 of them to be ‘good’ (and assessed 36 either as ‘requires improvement’ or ‘inadequate’). In some instances, we found evidence of a failure to take cases seriously, and a lack of understanding of the well-known link between children who regularly go missing and an increased risk of sexual exploitation. (See pp.40–42, and 62–64.)

⁴ See chapter 2 for more information on the structure of the MPS.

- The focus at a borough level on reducing MOPAC 7 crimes⁵ is set out in posters and at management meetings far more clearly and more frequently than the need to achieve good results on behalf of London's children. We were told in interviews that there was a greater focus on reducing these crimes than upon child protection. This requires urgent correction. (See pp.22–23.)
- While we found good examples of officers working quickly and effectively to protect children when the risk to them was evident and straightforward, they frequently failed to consider whether other children might be at risk from the same perpetrator, for example by checking which other young people he or she was in contact with on social media or in real life. (See pp.69–70.)
- Some officers and staff did not have the training they needed to do their jobs effectively. For instance, we found officers in roles focused on tackling child sexual exploitation (CSE) who had not been trained in the subject, and some staff within the force's command and control centres⁶ could not recall having had any safeguarding or CSE training as part of their initial training course. Given that these staff represent the first opportunity to recognise risk to a child and deploy the right resources to protect them, this is a very serious omission. (See pp.66–67.)
- Officers frequently failed to request strategy discussions⁷ with all relevant partner agencies (such as children's social care and health services). Police attendance at child protection review conferences⁸ was also patchy. These shortcomings mean that formal opportunities to share information and develop comprehensive and robust action plans to address identified risks with partner

⁵ The Mayor's Office for Policing and Crime (MOPAC) has established seven principal neighbourhood or 'MOPAC 7' crime types as particular priorities for the MPS: burglary, criminal damage, robbery, theft from a motor vehicle, theft from a person, theft of a motor vehicle and violence with injury. See pp.22–23 for more detail about the 'MOPAC 7' crime types.

⁶ These handle emergency calls and other incoming calls to the MPS, and despatching police officers to deal with incidents. See p.39 for more detail on the centres.

⁷ These multi-agency meetings or phone calls should involve children's social care services, the police, health and other bodies and be convened to plan rapid future action if there is reasonable cause to suspect a child is suffering (or is likely to suffer) significant harm. See *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015, pp.35ff. Available from www.gov.uk

⁸ These bring together family members (and the child where appropriate) with the supporters, advocates and professionals most involved with the child and family to make decisions about the child's future health, safety and development. These conferences are convened on completion of police work with children who are identified as 'in need' rather than 'at risk'. See *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015, pp.46ff. Available from www.gov.uk

agencies are not being fully exploited. As a result, decisions on how best to protect a child or decisions about the level of risk he or she faces are often taken more slowly than they should be, in isolation and without proper consideration of all the circumstances of the case. (See pp.52–54.)

- Officers and staff often do not assess cases properly or speak to children who are clearly at significant risk of CSE, and do not accelerate action to protect them and trace suspects – meaning they continue to be at risk of abuse. (See pp.74–77.)
- Children are frequently detained in custody after they have been charged rather than being moved to more appropriate accommodation (which should be provided by the local authority). In the 40 custody cases we audited, we found 39 that resulted in the child being charged, refused bail and kept in police custody to appear in court. The Police and Criminal Evidence Act 1984⁹ is clear that the police should avoid keeping children and young people in police custody any longer than necessary, both pre and post-charge. (See pp.87–92.)
- Borough officers are often unaware of the registered sex offenders in their areas and so miss opportunities to gather intelligence routinely about those who pose the greatest risk to children. (See pp.83–86.)
- We often found unacceptable delays, in all kinds of investigations, in gathering evidence, updating children on the progress of their cases, or acting on information (for instance, about individuals possessing indecent images of children). (See, for instance, pp.75–76.)

The MPS is the first force that HMIC has inspected as part of its child protection programme to have no single chief officer with responsibility and accountability for all child protection matters across the force.¹⁰ This has led us to conclude that there is an indefensible absence of strategic oversight of this very important issue. (See pp.19–25.)

We also found that the force does not adequately use MPS-wide police and partnership data analysis of child abuse and other related offence types to track incidents, interventions and outcomes for children. Instead, we found different teams and areas carrying out their own analyses of demand and trends, although frontline officers were frequently unaware of any analysis undertaken in their boroughs.

⁹ Section 38(6) and Code C.

¹⁰ The MPS has separate heads of profession at both commander and deputy assistant commissioner level for specific themed areas including domestic abuse, missing persons, sexual offences, harmful cultural practices and female genital mutilation.

The lack of connection among the IT systems, databases and spreadsheets that the MPS uses to record such analyses exacerbates this problem. As a result, information on victims, offenders and risks is too often kept in isolated pockets across the force. This contrasts sharply with the free movement of people (both victims and offenders) around the capital. (See, for instance, p.23.)

These serious problems are compounded by the limited searches conducted to link new reports of child protection cases with previous records, and by the generally poor use of information possessed by partner organisations (such as children's social care). The picture that emerges is one of significant gaps in information and therefore missed opportunities to act quickly and decisively to protect children and prevent offending. This requires urgent remedial action.

Recommendations and next steps

We fully recognise that monitoring and managing child protection across a force as large and complex as the MPS is far from easy, and that the responsibility for safeguarding children does not rest with the police alone. Nevertheless, the importance of the police getting this right – of managing offenders and protecting children – cannot be overstated.

This report makes a series of recommendations aimed at improving practice, building on the effective work we observed, strengthening strategic control of child protection, and bringing consistently good standards to the service provided to some of the most vulnerable children in London. The MPS's change programme Met 2020 could offer an opportunity to address some of these serious concerns.

We will return to the force to check on progress against our recommendations in 2017.

1. Introduction

Background

The police's responsibility to keep children safe

Under the Children Act 1989, a police constable is responsible for taking into police protection any child who he or she has reasonable cause to believe would otherwise be likely to suffer significant harm, and the police have a duty to inquire into that child's case.¹¹ The police also have a duty under the Children Act 2004 to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children.¹²

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

The duty to protect children extends to children detained in police custody.

In 2015, the National Crime Agency's strategic assessment of serious and organised crime established that CSE and abuse represents one of the highest serious and organised crime risks.¹³ CSE is also an important feature in the Strategic Policing Requirement.¹⁴

¹¹ Section 46, Children Act 1989.

¹² Section 11, Children Act 2004.

¹³ *National Strategic Assessment of Serious and Organised Crime*, National Crime Agency, June 2015. Available from www.nationalcrimeagency.gov.uk

¹⁴ The Strategic Policing Requirement was first issued in 2012 in execution of the Home Secretary's statutory duty (in accordance with section 37A of the Police Act 1996, as amended by section 77 of the Police Reform and Social Responsibility Act 2011) to set out the national threats at the time of writing, and the appropriate national policing capabilities needed to counter those threats. Five threats were identified: terrorism, civil emergencies, organised crime, threats to public order and a national cyber security incident. In 2015, the Strategic Policing Requirement was reissued to include child sexual abuse as an additional national threat. See *The Strategic Policing Requirement*, Home Office, March 2015. Available from www.gov.uk

Expectations set out in *Working together*

The statutory guidance *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*¹⁵ sets out the expectations of all partner agencies involved in child protection (such as the local authority, clinical commissioning groups, schools and the voluntary sector). 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 use of emergency powers to protect children.

These areas of practice are the focus of our child protection inspections.

Methodology

In order to assess child protection practices in the MPS, HMIC inspectors:

- examined the results of a self-assessment by the force of its practices, management and leadership;
- audited case files;
- interviewed staff both from the police and from the other agencies with which it works in protecting children;
- reviewed reports on significant case reviews and other serious cases; and
- reviewed statistics, reports, policies and other written sources.

Inspectors also spoke to directors of children's services and the chairs of independent local safeguarding children boards (where available) in each of the areas they visited. This provided an insight into local relationships and force involvement in child protection.

The full inspection methodology is at Annex A.

¹⁵ *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2015. Available from www.gov.uk

Changes to the methodology for the MPS inspection

In recognition of the size and complexity of the MPS, we increased the length of fieldwork, the number of interviews and the number of case files we audited. We also visited various central and local teams and departments across London, covering 16 of the 32 boroughs (chosen because they provide a cross-section of policing in Greater London):

- North – Brent, Islington, Haringey, Harrow;
- South – Lambeth, Southwark, Bromley, Bexley;
- East – Tower Hamlets, Havering, Waltham Forest, Newham;
- West – Richmond, Hounslow, Hammersmith and Fulham; and
- Central – Westminster.

This included inspecting specialist and London-wide child protection teams.

Matters that are out of scope

HMIC did not inspect allegations of non-recent child sex abuse within institutions or by high-profile perpetrators.

2. About the force

Size and structure of the force

The Metropolitan Police Service (MPS) is the largest police force in England and Wales. It serves a population of 8.53 million, and polices an area which is one of the world's most popular destinations for overseas visitors and covers 607 square miles.

To manage the complexity and scale of policing the capital, the MPS has a workforce of 43,900 people, of which:

- 32,125 are police officers;
- 9,521 are police staff; and
- 1,626 are police community support officers.¹⁶

The executive structure of the MPS is overseen by the Commissioner and the Deputy Commissioner and comprises MPS headquarters and four directorates, each led by an Assistant Commissioner (a London-specific rank equivalent to that of chief constable in other forces). The directorates are:

- territorial policing;
- specialist crime and operations;
- specialist operations; and
- professional standards.

Oversight: The Mayor's Office for Policing and Crime

The Mayor's Office for Policing and Crime (MOPAC) sets the direction and budget for the MPS and scrutinises its performance on behalf of the mayor. It has established seven principal neighbourhood or 'MOPAC 7' crime types as priorities for the MPS. These are:

- violence with injury (including domestic abuse);
- robbery;
- burglary;
- theft from person;

¹⁶ *Police workforce, England and Wales, 31 March 2016*, Home Office, July 2016. Available at: www.gov.uk/government/statistics/police-workforce-england-and-wales-31-march-2016

- theft/taking of motor vehicle;
- theft from motor vehicle; and
- vandalism (criminal damage).

These seven crime types have been selected by MOPAC because they are high volume, have a sizeable impact on Londoners and are clearly understood by the public. The MOPAC police and crime plan, published in March 2013, sets out the aim of achieving a reduction of 20 percent in these crime types across London by April 2016.

MOPAC has powers to commission services such as young people's advocates. These advocates at time of inspection provided support to young people affected by CSE across ten London boroughs.¹⁷ It also assigns budgets, including the allocation of funding across the 32 boroughs to cover adult and child safeguarding.

Structure for child protection

The MPS's organisational structure is set out in Figure 1.

As the text which follows shows, responsibility for the police response to child protection is split between central and borough commands.

¹⁷ Details about MOPAC may be found at www.police.uk/metropolitan/pcc

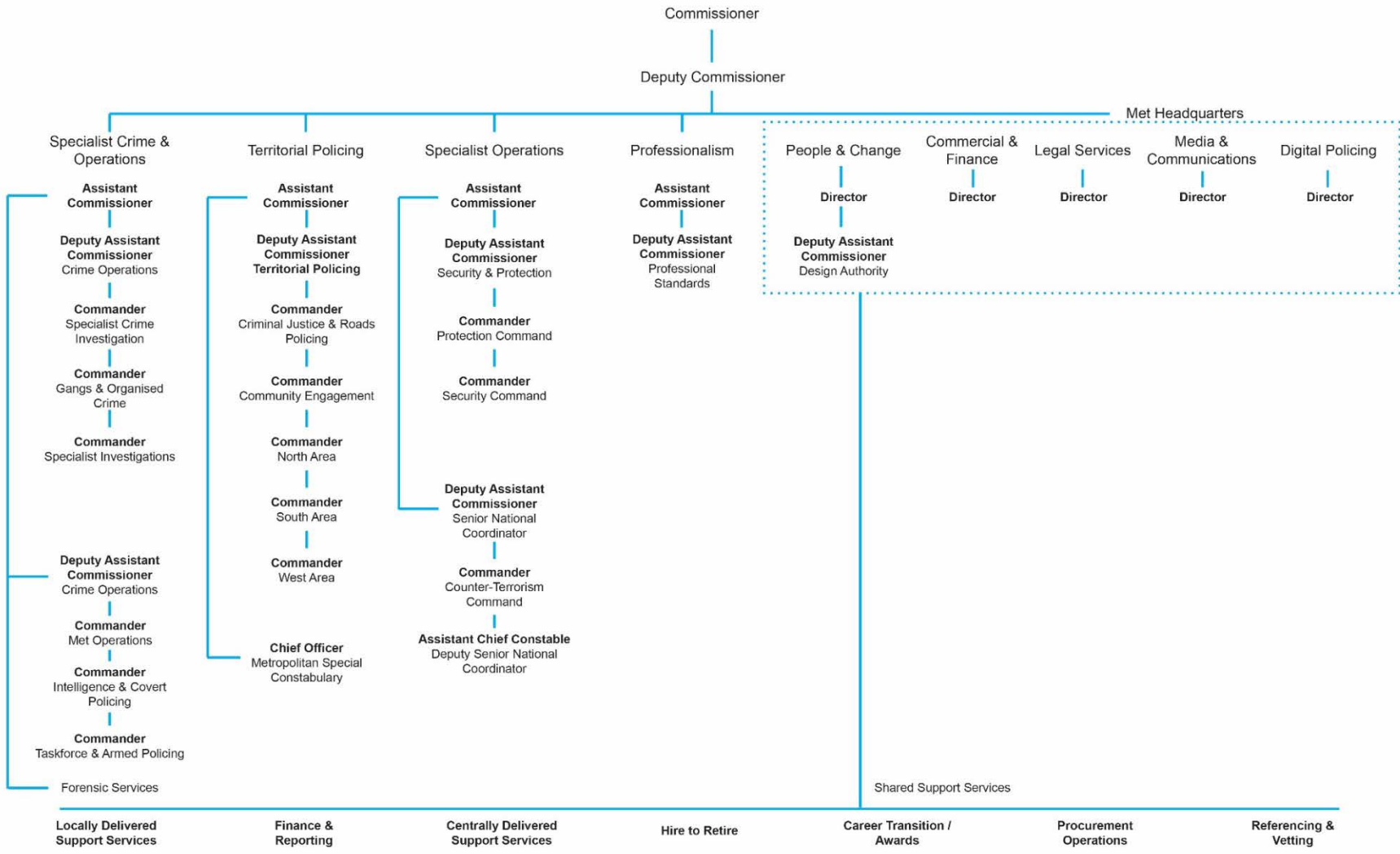


Figure 1: MPS organisational structure

Central: The sexual offences, exploitation and child abuse command

The Specialist Crime and Operations Directorate includes the sexual offences, exploitation and child abuse (SOECA) command. This is a large and complex investigation unit that is managed centrally but undertakes investigations locally in all London boroughs. SOECA also provides strategic support to the Territorial Policing (TP) Directorate (see further details below).

The teams within SOECA include:

- the child abuse investigation teams (CAITs);
- the rape and serious sexual offences team (Sapphire);¹⁸
- the sexual exploitation team;¹⁹
- the predatory offenders unit;²⁰
- the partnership team;²¹
- the continuous improvement team;²² and
- the complex case team (managing investigations outside the capacity of investigative units).

All of these teams are involved in child protection work.

¹⁸ There are 15 CAITs and 20 Sapphire teams covering all 32 London boroughs. These teams are distributed across the capital, each led by a detective inspector. Sapphire teams investigate rape and serious sexual offences, and CAITs investigate abuse committed within families, as well as by professionals and other carers in paid or unpaid roles. More information on these teams, and on those which are briefly described in the footnotes that follow, is available from the MPS website (www.met.police.uk).

¹⁹ This team acts as a central point which reviews all CSE concerns after the initial assessment team has recorded, assessed and categorised them on the Crime Report Information System (CRIS).

²⁰ The predatory offenders unit specialises in combating the activities of those who manufacture and distribute indecent images of children. It also tackles child abuse on the internet by targeting the activities of paedophiles on line, including the grooming of potential victims.

²¹ The partnership team works with partner agencies and different organisations to improve the care of victims and the welfare of children who need safeguarding. It is also responsible for identifying opportunities to prevent child abuse and sexual offences.

²² The continuous improvement team is responsible for reviewing the quality of decision-making and practice, resourcing and processes across SOECA.

Borough: Borough operational command units

The Territorial Policing Directorate has responsibility for the day-to-day policing of the 32 borough operational command units (BOCUs), each of which is commanded by a chief superintendent (the borough commander). All the following BOCU teams and roles have some involvement in child protection matters:

- the community safety unit;²³
- the criminal investigation department;
- CSE officers;
- the missing persons unit;
- the Jigsaw team (which manages registered sex offenders); and
- response and safer neighbourhood officers.

Multi-agency safeguarding hubs

The force and partner agencies have established multi-agency safeguarding hubs (MASHs) in 32 boroughs, where agencies including the police children's social care and health services share premises to work together and exchange information to protect vulnerable people. Those working in a MASH assess risks to individuals in a range of cases, including those involving child abuse, domestic abuse and, in some MASHs, the abuse of vulnerable adults.

Local safeguarding children boards

Each BOCU is involved with its local safeguarding children board (LSCB). Established under the Children Act 2004, these boards exist to develop local safeguarding policy and procedures, to co-ordinate how agencies work together to safeguard and promote the welfare of children, and to ensure that safeguarding arrangements are effective.

Resourcing for child protection

The MPS reported that there are 1,000 officers working in SOECA, with a further 900 in territorial policing involved in working to protect vulnerable people.

The force recognises that it needs to be flexible with its workforce, adjusting resources to meet changing demand. In response, it has begun to increase child protection resources in both the CAIT and Sapphire teams, but vacancies remain.

²³ Community safety units have specialist staff investigating reported incidents of domestic violence, homophobia, transphobia, racism and criminal offences where a person has been targeted because of their perceived race, faith, sexual orientation or disability.

At the time of the inspection, there was no identified individual at chief officer level responsible specifically for safeguarding children (as there is, for example, for domestic abuse, missing persons and rape). The MPS advised in its self-assessment process that there was no single individual responsible for child protection, with chief officer leads responsible for different elements across child protection. We comment further on this lack of an identified lead for safeguarding children in the next chapter.

Planned changes to structure: the One Met Model 2020

The force is currently developing its change programme: the One Met Model 2020. This will set out how the MPS will operate by 2020 and how it will improve the service it provides to London. Although still in the early stages of planning, the current view is that the MPS's protecting vulnerable people functions²⁴ should come within borough commands, with a new lead (at superintendent rank) introduced in each of the proposed new borough command units, and a person with responsibility and accountability for protecting vulnerable people at chief officer level. This would mean that the oversight and management of the CAIT and Sapphire teams would be undertaken locally, rather than centrally as they are currently (although some specialisms will remain centrally managed).

The MPS states that these proposals will provide a more co-ordinated approach to child safeguarding, supported by a better understanding of demand (such as calls reporting crime, incidents the police respond to, or work connected to safeguarding the public). If successful, we consider that this approach offers opportunities for the MPS to have a better understanding of where there is a need for the police to take steps to protect children and so to design future safeguarding services with reference to the roles and responsibilities of other statutory agencies.

²⁴ Such as those teams focused on tackling domestic abuse, for instance, or investigating child abuse and rapes.

3. Leadership, management and governance

Introduction: what is effective practice in this area?²⁵

Effective practice at all levels depends on those at the top of the force ensuring that all officers and staff involved in child protection understand what they need to do, and what they can expect of other agencies, to safeguard children (as set out in the *Working together* framework).

We would therefore expect to see evidence of the following indicators (as set out in our published assessment criteria):

- There is leadership at a senior level demonstrated by an active interest in how well the service is meeting the needs of children and young people.
- The force (individually and in conjunction with partner agencies) understands the local population of children, young people and families and has developed approaches and services to meet their needs.
- The force understands the experience of children and families as they move through the child protection and criminal justice systems and this is reflected in policy, guidance and procedures.
- Research and intelligence and feedback about the quality of service delivery, outcomes and the experiences of children inform the design and delivery of services.
- There is a culture of listening to children.
- The police service is equipped to address the diverse needs of all children with whom they come in contact, irrespective of their race, gender, sexuality or abilities, and have access to additional support such as interpreters where this is necessary.
- Sound arrangements (jointly with the LCSBs or other services, e.g., mental health or drug and alcohol services) are in place to support agencies working together, including information sharing, and to resolve any conflicts that might arise.
- The LCSBs report regularly on how well children are helped and protected.

²⁵ The assessment criteria for and indicators of effective practice set out in each of the chapters of findings that follow are taken from *National Child Protection Inspection: Assessment Criteria*, HMIC, 2014. Available at: www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/ncpi-assessment-criteria.pdf

- The force reports regularly on its performance, its level of service and outcomes. The data gathered is actively considered and its analysis leads to changes in practice.
- All staff, from the bottom to the top of the organisation, know whom they are accountable to. They review and report regularly on their performance and how well they contribute to delivering good outcomes for children and young people.
- There is a professional lead (and staff have access to professional advice).
- Staff are supervised and supported, are competent to carry out the tasks expected of them and have had induction training in child protection.
- The force leadership takes responsibility for ensuring that all children and young people in police custody centres are fairly and properly treated.
- The force follows safe recruitment practices.
- There are policies and procedures in place to deal with allegations against staff.

Oversight of child protection issues at force level

The MPS is the first force that HMIC has inspected as part of its child protection programme to have no established chief officer lead with the responsibility and accountability for all child protection matters across the force (i.e. an individual who covers both the specialist and territorial teams and police practice).

We consider that this absence exacerbates inconsistency in officers' responses to child protection cases (see chapters 5–9), and is responsible for inconsistency in how the force works with partners across London (see pp.52–62). It also means that there is no effective force-wide oversight of how well the MPS understands or responds to the needs of the vulnerable children who are brought to their attention or how successful the MPS is in protecting them.

It is for these reasons that we have concluded that there is an unacceptable absence of strategic oversight in the MPS (see chapter 3).

We found that understanding of child protection matters is inconsistent among senior borough officers (see p.67). Staffing levels to deal with the increasing demand (in areas such as CSE, registered sex offenders and child protection conferences) are also inconsistent and do not adequately reflect the level of risk established by the child protection teams in question (see, for instance, pp.17; 83; and 71). Rather than making resourcing decisions regarding child protection matters corporately, the MPS is allowing senior borough officers (who have discretion at a local level to focus

resources on risks they identify within their borough) to make them in isolation, and so these decisions are not supported by force-wide analysis of demand (see p.72).

By contrast, the specialist CAIT and Sapphire teams (see p.16) have had increases in the number of personnel working in them because analysis has been conducted by the MPS into the types of offences they deal with and has established that there has been an increase in the need for their services.

The complex organisational structures of the MPS, and its current arrangements for child protection (with numerous teams responsible for different aspects of child protection or safeguarding issues), adversely affect its ability to provide a consistently good service to those who come into contact with the force.

Governance arrangements (which are integral to measuring and managing performance and demand) across all areas of child protection (specialist and territorial) provide unduly limited oversight due to the fragmented structures, reflecting the current leadership and oversight arrangements.

How child protection work is split between the SOECA and TP commands

The current child protection investigation arrangements across the MPS mean that some cases are dealt with by SOECA staff from the specialist crime command and others by local officers in the boroughs.

Although SOECA manages some child protection services centrally, the CAIT and Sapphire teams are spread across the territorial policing commands.

See chapter 7 for inspection findings on the effectiveness of investigations by the different teams.

Performance management

The MPS considers its child protection performance in a wide range of forums, including high-level strategic groups chaired at chief officer level, governance boards (such as the CSE governance board, which meets quarterly and is chaired by a commander), specialist crime and operations crime-fighters performance meetings, borough discussions, and – to a limited degree – at business group-level territorial policing crime-fighter meetings.²⁶ However, child protection is not an integral part of the overall MOPAC 7 performance regime.

For example, performance against the MOPAC 7 offences is reviewed at the business group-level territorial policing crime-fighter meetings, but the review does

²⁶ 'Crime-fighters' meetings are chaired each month by assistant commissioners and are attended by all borough commanders.

not specifically include offences against children. However, we were informed towards the end of our inspection that CSE was due to be included in the information on police performance which is scrutinised at these meetings (and comprises data on performance, with some commentary on what these indicate). This is a positive change, which will provide opportunity for the MPS's response to CSE to be discussed and scrutinised at executive level.

Performance information about the consequences of child protection work for children at risk of harm is therefore underdeveloped and disproportionately based on the MOPAC 7 quantitative indicators (see below, and pp.13–14). As a result, senior leaders (including at executive level) do not have a good enough understanding of the impact of child protection work on children or of the demand for these services across London. This cannot be justified.

Focus on MOPAC 7 crimes

Across the MPS, there is a strong focus on the MOPAC 7 crimes, and there have been welcome reductions in the number of victim-based crimes across the seven principal categories.

It is important to explain that the MOPAC 7 are crime types to which the mayor wanted the MPS to give particular priority, because they are prevalent and matter a great deal to Londoners. However, the MOPAC 7 does not include serious crimes such as terrorism, murder, sexual offences, kidnapping and firearms offences; nor does it include offences against children such as child abuse or sexual exploitation. This is not because the mayor regarded these other, more serious offences as of lower priority than the MOPAC 7; rather, it is fair to assume that the mayor established the MOPAC 7 in the expectation that the leadership of the MPS would always give due and very high priority to offences of the greatest severity.

We consistently found that child protection matters received less consideration at borough level compared to the attention given to measuring and monitoring the MOPAC 7 crime types. For example, many borough commanders had unacceptably limited knowledge of the work of the specialist teams, or even the child protection teams (such as the Jigsaw teams who manage registered sex offenders, see p.83) within their own boroughs.

In addition, the daily territorial 'grip and pace' meetings²⁷ we observed did not take into account the child protection work being conducted by other specialist teams. So, for instance, information on investigations conducted by a CAIT or Sapphire team in the area is not considered alongside the child protection or other policing work taking place in that borough. This means that opportunities to spot links between the

²⁷ 'Grip and pace' meetings are held three times a day, involving senior officers and other relevant staff, to review the latest intelligence and data to inform and co-ordinate police activities and resources for that day.

different strands of police child protection activity are missed, and the force cannot be sure it is allocating its resources based on the best possible picture of risk of harm to children in each area.

Given the above, we are therefore forced to conclude that the undue focus on the MOPAC 7 crime types has led to a lack of priority being given to child protection matters. This is unacceptable. Irrespective of the mayor's stated priorities, it is the responsibility of every police force to protect all citizens – particularly children, as they are the most vulnerable and have the most to lose.

Analysis and understanding of demand across the MPS

The force's current IT system impedes its ability to access routinely the information it holds that could help it to manage risk more effectively. Staff identified this as a recurrent issue, with some describing the information available as fragmented, making it difficult to see the whole picture across the MPS. In one borough, we found a whole team dedicating one day each week to researching IT systems to ensure that they were aware of any recent intelligence or information on sex offenders.

In some of the boroughs we inspected, we found staff creating their own stand-alone spreadsheets or management information tools (particularly in relation to missing children and CSE cases). As a result, it is impossible for the MPS at force level to see and understand the bigger picture – whether in terms of demand (numbers of cases), risk (which individuals or areas present the highest risk), or prevention activity (what actions are needed to protect children and stop offenders).

This lack of consistency across the boroughs is exacerbated through the use of standalone data systems and an absence of local analytical capability. Across the MPS, there was an absence of consistency in what type of data was recorded, with no London-wide information on vulnerability available. The lack of analysis (at both local and force level) and the separate data systems used across the boroughs mean that relevant information and intelligence is not easy to access or review as a whole. Instead, different data systems in each borough record different data. This impairs the MPS's ability to understand the levels of incidents and risks facing vulnerable children in London and to be proactive in its response.

Representation on multi-agency boards

Everyone who works with children, including teachers, GPs, nurses, midwives, health visitors, early years professionals, youth workers, accident and emergency staff, paediatricians, voluntary and community workers, social workers and the police, has a responsibility for keeping them safe.

No single professional or organisation can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right

time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.

For organisations and practitioners to collaborate effectively, it is vital that every individual working with children and families is aware of the role that they have to play and the role of other professionals. In addition, effective safeguarding requires clear local arrangements for collaboration between professionals and agencies.

Local agencies should work together to put processes in place for the effective assessment of the needs of individual children who may benefit from early help from services.

The police can hold important information about children who may be suffering, or likely to suffer, significant harm, as well as those who cause such harm. They should always share this information with other organisations when this is necessary to protect children.

Similarly, they can expect other organisations to share information to enable the police to carry out their duties. Offences committed against children can be particularly sensitive and usually require the police to work with other organisations, such as local authority children's social care. All police forces should have officers trained in child abuse investigation.

As part of multi-agency meetings, the principal role of the police is to assist other agencies to carry out their responsibilities where there are concerns about a child's welfare, whether or not a crime has been committed.

The MPS is represented on all LSCBs. The chairs of the LSCBs and directors of children's services value the force's involvement, but reported that the high turnover of senior staff representing the MPS has an adverse effect on efficiency and effectiveness.

Police attendance at, and contributions to, multi-agency public protection arrangements (MAPPA, see p.86)²⁸ and multi-agency risk assessment conferences (MARACs)²⁹ was considered to be good (see pp.56–58).

²⁸ These multi-agency public protection arrangements provide the mechanism through which local criminal justice agencies (police, prison and probation trusts) and other bodies dealing with offenders work together in partnership to protect the public from serious harm by managing sexual and violent offenders. They were established in each of the 42 criminal justice areas in England and Wales by sections 325 to 327B of the Criminal Justice Act 2003.

²⁹ A MARAC is a locally-held meeting of statutory and voluntary agency representatives to share information about high-risk victims of domestic abuse, at which 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.

Conclusion

We were extremely concerned to find that the MPS has no overall strategic lead for child protection at executive (chief officer) level. This means there is no individual who is responsible for and who has oversight of the child protection work carried out by both the specialist and the borough teams. This has been recognised by the MPS both within the self-assessment provided to HMIC and the current One Met Model 2020 design principles for protecting vulnerable people.

Neither does the force use any sophisticated MPS-wide police and partnership data analysis of child abuse and other related offences. Instead, we found different teams and areas carrying out their own analyses of demand and trends. Borough commanders also cited that there was insufficient analytical capability available in boroughs, following a decision to centralise the analytical capability with a focus on MOPAC 7 offences. They gave examples of the adverse effect this had had on creating intelligence reports about gangs and CSE. We also found that frontline officers were frequently unaware of any analysis undertaken in their boroughs.

The lack of connection between the MPS IT systems, databases and spreadsheets used to record such analyses exacerbates this problem. As a result, much of the information on victims, offenders and risk is kept in isolated pockets across the force. This contrasts sharply with the free movement of people (both victims and offenders) around the capital.

The focus at a borough level on reducing MOPAC 7 crimes is set out in posters and performance management meetings far more clearly and more frequently than the need to achieve good results on behalf of London's children, and we were told in interviews that the focus was on these crimes as opposed to child protection. This requires urgent correction.

4. Analysis of case files

Introduction

As is clear from the previous chapter, we had strong concerns about the inconsistencies in child protection practice between boroughs, the lack of effective working arrangements between the territorial (i.e. 32-borough) command and the specialist teams, and the lack of a senior officer with responsibility for ensuring that the force is dealing with all child protection matters in the MPS effectively and efficiently.

However, this would be of far less concern to us if the force's practice were nonetheless resulting in good outcomes for children.

To determine how well the MPS was dealing with specific cases, we asked the MPS to self-assess the effectiveness of its practice in 132 child protection cases.³⁰ The force used criteria we provided to grade the practice on display in each case as 'good', 'adequate', 'requires improvement', or 'inadequate'. HMIC inspectors then assessed these cases and compared their results with the MPS results. In addition, we also assessed a further 242 child protection cases from across the MPS during our inspection.

A summary of the findings from both tranches of work is given below. Pertinent findings on particular aspects of child protection practice, together with examples of good and poor practice (shown as text in the boxes below), feature in the chapters that follow.

³⁰ The case types and inspection methodology are set out in Annex A

Comparison of force self-assessment against HMIC’s assessment

Table 1: Cases assessed by both the MPS and HMIC inspectors

	Good	Adequate	Requires improvement	Inadequate
Force assessment	76	32	16	8
HMIC assessment	22	9	54	47

As Table 1 shows, we identified considerably more weaknesses in practice than the force self-assessors:

- the MPS assessed roughly 80 percent (108/132) of cases as ‘good’ or ‘adequate’; while
- we judged about the same percentage (76 percent, or 101/132) as ‘requires improvement’ or ‘inadequate’.

Examples of contrasting assessments by the MPS and HMIC include the following:

Online CSE case. Force assessed it as ‘good’ – HMIC assessed as ‘inadequate’

This case involved a female child engaging online with a 30-year-old man. The girl had begun to go missing (which was described as out of character by her parents), and was receiving gifts from the man, with indications that she was being paid for sex.

The child disclosed that she had been in contact with the man since she was 14 years old, and had been supplied with alcohol and cigarettes and subjected to sexual assaults. Despite the family contacting the suspect to tell him they had informed the police, he continued to message the child, asking what time she finished school.

It took 17 days for the case to be allocated to an officer to investigate the offences that had been disclosed.

Explanation for HMIC’s assessment – The family’s initial report to the police was not acted on for two days, leaving the child at risk of CSE. This delay was then compounded when it took nearly a month to interview the child and then arrest the suspect. During this time the suspect was still sending messages to the child and indicating that he wanted to meet after school, so she was clearly still at risk. Referrals were made to children’s social care, but there was no evidence of any strategy discussions or meetings taking place as a result.

Missing person case. Force assessed it as ‘good’ – HMIC assessed as ‘requires improvement’

This case involved a vulnerable 17-year-old female living in a residential placement working towards independent living, who was reported missing by her support worker. Intelligence held by the MPS identified that her boyfriend had connections to gangs, and that she had previously prostituted herself. She returned home 36 hours after she was reported missing.

Explanation for HMIC’s assessment – There was no safe and well check by the police with this child following her return home. The girl had been missing 46 times before this occasion, but there was no record of a strategy meeting involving other agencies to address underlying concerns and keep her safe.

HMIC’s assessment of 242 further cases

Table 2: Additional cases assessed by HMIC inspectors

	Good	Adequate	Requires improvement	Inadequate
HMIC assessment	51	14	95	82

As Table 2 shows, in this second tranche of case audits, we once again judged around three-quarters of the cases (177/242) as either ‘requires improvement’ or ‘inadequate’.

HMIC referred 38 cases back to the force, because we considered they contained evidence of a serious issue of concern – for example, failure to follow child protection procedures and/or a child at immediate risk of significant harm. The force responded to the concerns raised by inspectors in these cases, either by taking action or providing an updated assessment. However, there was still a failure by some staff to recognise wider investigative or safeguarding opportunities.

Some of these 38 cases were among the 132 self-assessed by the MPS. As part of that exercise, four had been judged as 'inadequate' or 'requires improvement' by the MPS itself. However, until prompted by HMIC inspectors, the MPS had taken no action to address the issues they themselves had identified. In three of those four cases, the MPS allocated officers to make contact with the victims to address the concerns raised by HMIC, and in one case amended their processes in managing backlogs in the MASH cases. This lack of action until prompted is both extremely disappointing and raises significant concern about the ability of some staff in the MPS to recognise the need to act and intervene to safeguard children.

Examples of the cases referred back to the MPS included:

Domestic abuse referral case. Force assessed it as 'inadequate' – HMIC assessed it as 'inadequate'

This case was reported by an independent domestic violence advisor, raising concerns that a ten-year-old girl may have been abused by her father, and have witnessed significant domestic abuse (involving her mother being raped and stabbed with a screwdriver). The father was charged with the assault and given police bail regarding the allegation of rape.

Despite the force determining itself that this case was inadequate, during the subsequent audit of the case by HMIC, we found that there had been no contact with the child or investigation into concerns raised that the child had been abused by her father and had witnessed a violent domestic assault on her mother. This falls well below what we would have expected to see.

CSE internet case. Force assessed it as 'inadequate' – HMIC assessed it as 'inadequate'

This case involved a 13-year-old girl who was believed to be sexually active with both boys her own age and older men, based on graphic messages viewed on her Facebook account by her family. The report of online abuse and exploitation was not investigated by the MPS and the child was not spoken to, or safeguards put in place.

In this case there were allegations that the child was being sexually exploited – but evidently these had not been investigated, and the case was closed wrongly before enquiries were made or the child was spoken to. The MPS identified the same issues as HMIC and assessed this as 'inadequate', but took no action until HMIC referred it back to the force. Again, we would have expected the MPS to have acted on this matter as soon as it identified that the matter had not been dealt with properly.

Missing person case. Force assessed it as ‘inadequate’ – HMIC assessed it as ‘inadequate’

This case involved a 15-year-old girl reported as missing by her family, which was described as out of character. Upon her return she did not disclose where she had been, and her parents believed her to be under the influence of alcohol. It was established that she had been with a man she met on Instagram.

An inspector spoke to this man (who was 18 years old), and advised him not to have any further contact with the child. Research identified that this man had been a suspect in an incident where he threatened to burn down the house of a girl he had met and to throw acid in her face. He was also believed to have links to gangs.

The child in this instance had not been missing before; but there was no attempt to obtain any detail about the circumstances of the child going missing, indicating a failure to recognise a risk of CSE. The decision by the inspector to speak to the man was inappropriate, both from the view of the CSE risk and more importantly given the intelligence held about him. There is no evidence that this risk or that the wider risk this may pose to other children was identified or any plans put in place to mitigate it. This remained the case at the time of the HMIC audit.

Breakdown of case file audit results by type of investigation

Table 3: Cases assessed involving enquiries under section 47 of the Children Act 1989

Case type	Good	Adequate	Requires improvement	Inadequate
Enquiries under section 47 of the Children Act 1989	15	6	19	14

These are cases where a child has been identified as in need of protection, and so is suffering or likely to suffer significant harm. Further detail of section 47 enquiries, and of some of these individual cases is given in the chapters that follow (see, for instance, p.53). Common themes across cases include:

- evidence of the police working together effectively with children’s social care, with strategy discussions held as they should be;
- some cases clearly showing that children were listened to, and that the police considered their interests – but in others, children were not even spoken to;
- some investigations inappropriately carried out by children’s social care working alone, with no police involvement;
- medical examinations sometimes not carried out, with no reason to justify this; and
- Merlin pre-assessment checklist (PAC)³¹ forms not being completed.

Table 4: Cases assessed involving referrals relating to domestic abuse incidents or crimes

Case type	Good	Adequate	Requires improvement	Inadequate
Referrals relating to domestic abuse incidents or crimes	9	6	14	8

Further detail of some of these individual cases is given in the chapters that follow (and an example is given on p.29 above). Common themes across cases include:

- good initial police response to reports of domestic abuse offences;
- an inconsistent approach to ensuring the police speak directly to the child involved; and
- good completion of DASH³² forms.

³¹ The Merlin PAC form is used to record incidents where a child or young person comes to the notice of police and there are concerns about their well-being or safety.

³² The Domestic Abuse, Stalking and Honour Based Violence assessment is used to identify, assess and manage the risks to victims from these offences. It was adopted by UK police forces in 2009.

Table 5: Cases assessed involving referrals arising from incidents other than domestic abuse

Case type	Good	Adequate	Requires improvement	Inadequate
Referrals arising from incidents other than domestic abuse	15	3	18	6

Further detail of some of these individual cases is given in the chapters that follow (see, for instance, p.68). Common themes across cases include:

- again, a good initial police response to reported offences;
- good work with other agencies (such as children’s social care) to protect children;
- failures in investigation of cases; and
- evidence that the children involved were neither seen nor spoken to.

Table 6: Cases assessed involving children at risk from CSE arising from the use of the internet

Case type	Good	Adequate	Requires improvement	Inadequate
Children at risk from CSE arising from the use of the internet	2	2	10	29

Further detail of some of these individual cases is given in the chapters that follow (see, for instance, p.29). Common themes across cases include:

- huge inconsistencies in the length of time it took for officers to conduct investigations, with a range from days to years;
- unacceptable delays between the police receiving information about a possible offence or offender and the execution of a search warrant (which took 96 days in one case);

- delays of between 5 and 15 months between electronic devices (which might contain evidence of offending) being seized, and them being examined;
- a failure to conduct appropriate and proportionate investigations into reported incidents/crimes;
- crimes not always being recorded (including one rape offence); and
- poor recording of information such as strategy discussions.

Table 7: Cases assessed involving children at risk from CSE arising out of local contact and not from the internet

Case type	Good	Adequate	Requires improvement	Inadequate
Children at risk from CSE arising out of local contact and not from the internet	8	0	15	24

Further detail of some of these individual cases is given in the chapters that follow (see, for instance, p.77). Common themes across cases include:

- failure to safeguard children at the earliest opportunity;
- delays in investigations;
- missed investigative opportunities;
- children not spoken to;
- lack of detailed records; and
- an absence of strategy discussions being held.

Table 8: Cases assessed involving missing and absent children

Case type	Good	Adequate	Requires improvement	Inadequate
Children missing and absent	2	0	18	18

Further detail of some of these individual cases is given in the chapters that follow (see, for instance, p.41). Common themes across cases include:

- no evidence of strategy discussions to address the identified issues;
- no evidence of problem solving or joint planning with children’s social care to help protect children;
- use of the absent category resulting in missed opportunities to speak to children upon their return home; and
- an absence of recognition of the potential link between a child going missing from home and the risk of child exploitation.

Table 9: Cases assessed involving children taken to a place of safety under section 46 of the Children Act 1989

Case type	Good	Adequate	Requires improvement	Inadequate
Children taken to a place of safety by police officers using section 46 of the Children Act 1989 powers	12	1	11	3

These are cases where the police have used emergency powers to take a child into police protection. Further information on these powers is given at pp.79–80), with detail of some of these individual cases is given in the chapters that follow (see, for instance, p.46). Common themes across cases include:

- early recognition of safeguarding concerns;
- appropriate use of powers; and
- failure to record crimes such as neglect appropriately following the power being exercised.

Table 10: Cases assessed involving sex offender management where children have been assessed as at risk from the person being managed

Case type	Good	Adequate	Requires improvement	Inadequate
Sex offender management where children have been assessed as at risk from the person being managed	2	2	12	10

Further detail of some of these individual cases is given in the chapters that follow (see, for instance, p.84). Common themes across cases include:

- outstanding lines of enquiry not followed up;
- sometimes significant delays in visiting offenders;
- referrals to children’s social care not taking place when they should have; and
- failure to act on breaches (for instance, if an offender does not comply with requirements to notify the police if he or she moves house).³³

Table 11: Cases assessed involving children detained in police detention

Case type	Good	Adequate	Requires improvement	Inadequate
Children detained in police detention	4	2	20	14

³³ Notification requirements for registered sex offenders is a set of instructions that they must comply with when placed on the Sex Offenders Register. For instance, under the Sexual Offences Act 2003 (Notification Requirements) (England and Wales) Regulations 2012, they must, within three days of conviction, notify the police (in person, and at a prescribed police station) of their name, address, date of birth, passport details, credit card and bank details, and national insurance number, and then of any changes to these details.

Further detail of some of these individual cases is given in the chapters that follow (see, for instance, p.89). Common themes across cases include:

- arrests were necessary and proportionate;
- delays in appropriate adult attendance in some cases;
- a failure to request alternative accommodation to transfer children out of police custody; and
- a poor standard of record keeping, sometimes with contradictory grounds for refusing bail recorded.

Table 12: Cases assessed involving Sapphire teams³⁴

Case type	Good	Adequate	Requires improvement	Inadequate
Sapphire rape cases	3	1	5	2

Further detail of some of these individual cases is given in the chapters that follow (see, for instance, p.43). Common themes across cases include:

- good joint working with partners such as children’s social care;
- good investigations;
- lack of recording of what happened at the conclusion of the case; and
- limited evidence of strategy discussions taking place.

Table 13: Cases assessed involving the Gangs Unit

Case type	Good	Adequate	Requires improvement	Inadequate
Gangs unit cases	2	0	4	0

A common theme in these cases was that we found limited recording of work with partner agencies such as local authorities to tackle child protection offences related to gangs.

³⁴ See p.16 for an explanation of ‘Sapphire’.

Table 14: Cases assessed involving a MASH³⁵

Case type	Good	Adequate	Requires improvement	Inadequate
MASH	0	0	2	1

Conclusion

Our audit did find good practice in some cases such as:

- evidence of the police working together effectively with children's social care when undertaking enquiries under section 47 of the Children Act 1989;
- good initial police responses and good work with other agencies to protect children in cases involving referrals arising from incidents other than domestic abuse;
- appropriate use of police powers in recognition of safeguarding concerns for children taken to a place of safety;
- arrests involving children being necessary and proportionate; and
- good joint working with partners such as children's social care in rape cases.

However, this good practice was not consistent and the MPS did not achieve good results for children in London in almost three-quarters of the cases we reviewed. In fact, we referred 38 cases back to the force because we believed a child (or children) might still be at risk.

We found examples of poor practice at every stage of the child's interaction with the police, and across both the central specialist teams and all geographical areas of the capital, with no borough standing out as being either particularly good or particularly bad.

³⁵ See p.42 for an explanation of 'MASH'.

5. Initial contact

Introduction: what is effective practice in this area?

Our inspection considered the extent to which, from the first point of contact, officers and staff are alert to, and can identify, children and young people at risk of harm – and act to protect them from harm.

Evidence of this (as set out in our published assessment criteria) includes the following indicators:

- Officers and staff observe, listen to and are alert to the needs of the child. The response to risks and needs is proportionate to the circumstances and any residual concerns are addressed later but promptly.
- Where a child is evidently in danger or the act of intervening, of itself, poses a risk to the child, immediate steps are taken to protect the child followed by a more informed assessment.
- Immediate needs such as that for medical care, reuniting with a parent or reassurance are attended to.
- When dilemmas and conflicts are balanced and managed on the spot and under stress, decisions are reviewed as soon as time allows and every effort is made to minimise any negative effects. For example, this may be done by alerting more senior staff to unaddressed needs, taking an early opportunity to speak and re-engage with the child, or seeking additional support from another service.
- All staff know what to do when they are concerned about a child.
- All staff likely to come into contact with children, whatever their role, are appropriately trained to identify risk and make initial enquiries.
- There are simple and reliable systems for raising concerns and protecting children, including children at risk of sexual exploitation and trafficking, and children missing from home or education.
- Management support and structuring of work enable concerns to be adequately addressed in a timely manner.
- Access to more specialist advice (for the officer or the manager) is readily accessible when needed.

Calls from the public handled by the command and control centres³⁶

Call-handlers based within the command and control centres are generally the first point of MPS contact for members of the public requiring assistance from the police. Despatch officers in the three command and control centres are then responsible for deploying the appropriate police response to all types of reported incidents.

Training and tools to help call-handlers identify child protection issues

The command and control centre staff we spoke to as part of this inspection did not remember receiving any safeguarding or CSE training on the initial six-week call-handler training course, and there are no designated days for training (on any issue) in the control room staff shift pattern. The force therefore relies heavily on the 15-minute briefing periods at the start and end of the working day, emails, or e-learning from the National Centre for Applied Learning Technologies³⁷ to provide staff with important messages or training. This limits the opportunity the force has to refresh or revise the knowledge of call-handlers on important matters, such as identifying the signs of CSE and how it can link to occasions when children go missing. Inspectors were also told that there is no record of who has received what training.

We found that call-handlers can access a number of standard operating procedures³⁸ on the command and control centre IT systems. These generate a template containing a set of questions (called a 'proforma') that they must ask the caller. The questions are comprehensive, acting as prompts to ensure that they gather all the necessary information.

For example, when someone reports a missing person, the standard operating procedures proforma acts a guide to assist the call-handler to ask questions, such as the age of the person, whether he or she has gone missing previously, and whether he or she is particularly vulnerable for any reason.

However, the caller may not have all (or indeed any) of this information, and staff in the communications centres do not conduct further specific work to fill in any gaps.

³⁶ These three communications centres are situated across London (in Bow, Lambeth and Hendon), with 1,706 members of staff working across them, handling emergency calls and other incoming calls into the MPS and despatching police officers to deal with incidents across the capital. They also provide specialist police communications support for many large-scale public occasions and events.

³⁷ The National Centre for Applied Learning Technologies produces and provides e-learning on a range of policing topics to the 43 police forces in England and Wales (as well as national forces, such as the British Transport Police). Established in 2002 through a collaboration between the MPS and the Central Police Training and Development Authority (Centrex, which was established under Part 4 of the Criminal Justice and Police Act 2001, and was the primary means of police training in England and Wales), it is now part of the College of Policing. See www.ncalt.com

³⁸ These set out the activities necessary to complete a task in accordance with force standards.

Any intelligence checks that are conducted are in relation to the safe deployment of officers to an incident. This means the proforma answers do not on their own provide a sound basis for making an assessment of risk.

In some cases, the communications centres receive new information, and so must reconsider the level of risk to a child, as the following case study shows (to note, the difference between 'absent' to 'missing' is explained in the next section).

Example of changing the level of assessed risk

A worker from a children's home answered 'no' to the question whether there was a risk of CSE. As a result, the child was initially classified as absent, as opposed to missing, by the police.

The despatch supervisor rang the informant back later (as per the protocol) and spoke to a different staff member, who stated that the child was at risk of CSE.

The classification was then changed to missing.

Classification of children as 'missing' or 'absent'

A 'missing person' is defined by the police as anyone whose whereabouts cannot be established and where the circumstances are out of character, suggesting the person may be the subject of crime or at risk of harm to him or herself or to another.

An 'absent person' is a person who is not at a place where they are expected or required to be and at no apparent risk.

The police treat cases of people who are missing from home more seriously and with greater urgency than those of people who are considered to be absent. This is because, if there is no apparent risk, the expectation is that the individual will return of his or her own accord, without the need for a police investigation.

In 2014, the MPS introduced a policy on how to respond to people reported either missing or absent. This was updated in March 2016 (and effective from May 2016) to include an aide-memoire to assist staff in making decisions around risk, and an aide-memoire on how to respond to a missing person.

The policy states that:

- children under 13 years of age, or who are known to be at risk of CSE (i.e. there is a flag on a force system), will be classed as missing in all cases;
- all children reported missing (i.e. anyone under 18) will always be categorised as no lower than medium risk when designated missing; and

- if a child is categorised as absent and still remains unaccounted for after 24 hours, he or she will then be recorded as missing.

Being classified as 'missing' means that the police will actively seek to establish the person's location. However, if a person is classified as 'absent' (which is a lower priority than a low-risk 'missing'), it is still the responsibility of the despatch supervisor to maintain regular contact with the informant. This should be within an hour of the initial call, and then at periods of between four and eight hours (as agreed with the informant).

We learned that staff within the command and control centres had received no training on the new 2016 policy, and we have significant concerns about how it is being applied. The force stated that, while it had provided an e-briefing and a 15-minute update to its operators, it accepted that this was not the most effective method for providing training. When reviewing the case files, we found that staff in the communications centres do not appear to be consistent in their approach with regard to the classification of incidents. In some cases, absent episodes appeared in the midst of missing episodes and risks were not adequately recognised despite clear indications that the children in question were vulnerable. This means that wider safeguarding risks were missed, and as a result opportunities to intervene early to develop protective plans and reduce the number of episodes were lost.

In addition, staff stated that children who were frequently reported missing were regarded as behaving in a way that was not out of character and therefore, in the absence of any other apparent risk factor, were generally regarded as absent – despite the fact that their age, circumstances and previous recorded history of vulnerability should have ensured that they were classified as missing.

The MPS is not following its own policy with respect to responding to children reported either missing or absent and this is placing children at risk of harm.

Incorrect classification as 'absent'

A 17-year-old looked-after child told her carer that she was going out for the night and would not be back. The carer contacted the police, who established that the child had bipolar disorder, took medication for seizures, and was identified as being at risk of CSE. She had also previously attempted suicide.

The control room operator correctly recorded her as a 'missing' person; however, an inspector stated that she should be categorised as 'absent'. As a result of this, the police did not look for her and the child was placed at greater risk.

Inconsistent classification

A 13-year-old child, in the care of the local authority, had been reported missing on 30 occasions and absent on 16 occasions.

We found no consistent approach to classifying the incidents involving this child, with missing episodes interspersed with absent episodes in the records.

We found limited evidence of joint working or problem-solving activity to reduce the number of repeat missing episodes and ensure there was a joint plan to safeguard the child from significant harm.

We were also concerned by the following quote taken from one of the missing persons co-ordinators' (see p.63) monthly reports (published in March 2016), which provides updates to boroughs relating to the 'absent' process. The report described that it worked well in some areas but not in others. The report then stated that approximately 96 percent of 'absent' reports related to those aged under 18 and that:

"It follows that those boroughs with a high proportion of mispers [missing persons] within this age range will benefit more from the 'absent' process."

This reinforced the view reported to inspectors by communications centre staff that repeated reports of a young person going missing should generally lead to an 'absent' categorisation because it had happened before, rather than seeing the fact that the young person was going missing so frequently as a cause for concern and further investigation.

Referrals from professionals

Multi-agency safeguarding hubs and CAIT referral desks

Multi-agency safeguarding hubs (MASHs) bring together staff from police, local authorities and other agencies (such as children's social care, health and education services) to work from the same location, sharing information and ensuring a timely, consistent and coherent approach to protecting children and vulnerable adults.

The 30 MASHs and the Child Abuse Investigation Team (CAIT) referral desks³⁹ are the twin routes for information exchange and inter-agency planning on all child protection issues across London. Inspectors visited 14 of the MASHs and found a lack of consistency in the operating practices across the force area. For instance, some deal with both adult and child referrals; some manage CSE cases; and some

³⁹ The MASH receives safeguarding concerns from professionals such as teachers and doctors as well as members of the public and family members.

have access to child social care systems while others do not. While HMIC understands that these arrangements are made in conjunction with partner organisations and the relevant local authority, we are disappointed that the force has not assessed the effectiveness of the different models that are in operation across the capital. The CAIT referral desks are expected to provide a timely response by researching and assessing risks to children and creating joint plans during multi-agency strategy discussions. However, we found delays in some cases and that partner agencies such as children's social care were referring cases such as rape to these desks which should have been reported via 999 for a swift response. These then require onward transmission to the Sapphire teams. This results in delays in developing protective plans and in conducting effective investigations of those cases.

Delays in cases being allocated and progressed

A 14-year-old girl who reported that she had been raped by another child was referred by children's social care to the CAIT referral desk. Following a strategy discussion, it was decided that the case should be investigated by officers from the Sapphire rape team.

There was then a delay of four days before the case was allocated to an officer; a further delay of three days before contact was made with the family; and another six days passed before the dedicated Sexual Offences Investigative Techniques (SOIT) officer spoke to the child.

The family again contacted the police to report that threats had been made by the suspect to the victim via a friend.

The girl subsequently withdrew her complaint, but requested that the boy should be spoken to by the police. A month after the complaint was withdrawn, a detective inspector identified that the suspect has still not been contacted. At the time of the inspection, the other child in this case had still not been spoken to – four months after the matter was reported to the police.

Intelligence checks

Research

An 'intelligence pod' situated in the Lambeth communications centre supports all three centres, carrying out checks of MPS systems for any relevant additional information about most of the incidents (not just for child protection) that pass through the central communications centre. These checks are known as 'deployment intelligence checks'.

However, staff told us that the main purpose of these checks is not to provide information on any previously recorded vulnerability or child protection issues (so

that officers responding to calls are well prepared). Instead, the checks seek to establish any potential risks to the safety of either the officer or the public from offenders, as the MPS seeks to get officers to the scene rapidly so they can make a full risk assessment. Victim-focused checks are conducted for specific incidents, such as domestic abuse, but staff described these as a requirement to be vigilant for vulnerabilities, rather than as additional research.

As a result, officers responding to a call in some cases may not be aware of any history the force may hold about child protection matters and may deal with the incident in isolation.

The force told us that conducting more detailed checks of records within the central communications centre before despatching officers to incidents would lead to slower police response times. They stated that it might also mean that some children in urgent need of police protection might not be identified as quickly as they could be, because the process of carrying out more extensive checks would take longer than immediate deployment. Instead, the MPS's current policy is that the officer who attends an incident will carry out further and more detailed checks; however, staff told us that such checks are not always done. Therefore any subsequent action or assessment of risk taken without a complete understanding of what other information is held by the MPS may have an impact on the effectiveness of any safeguarding planning.

Flagging

Children who are the subject of a protection plan⁴⁰ and those at risk of CSE (including those suspected of being perpetrators) can be flagged on the crime recording information system (CRIS), with some details also recorded on the computer-aided despatch system for officers attending incidents to see. This means that they respond to calls armed with important information about the child's circumstances and vulnerability, and can draw connections between incidents.

However, staff stated that this information is not easy to locate on the CRIS system. It is also a complicated system: for instance, the CSE guidance for officers gives them a choice of 12 different flags to use. Furthermore, staff told us that the responsibility for adding flags rests with individual officers, and is neither universally adhered to nor universally understood.

⁴⁰ The MPS informed HMIC at the time of the inspection that there were approximately 8,200 children in London subject to child protection plans (which may be drawn up by local authorities after child protection conferences, if a decision is made that a child is at risk. Child protection plans set out how the child can be kept safe, how things can be made better for the family and what support they will need).

Our findings in relation to the flagging and retrieval from the police computer systems of relevant information about child protection issues are a particular concern. Without accurate data, it is impossible properly to assess the effectiveness of the police response, and the difficulty of locating information on the current force IT systems risks cases being dealt with in isolation, leading to potential intelligence gaps.

Incorrect classification as 'absent', despite risks being flagged

A 15-year-old looked-after child was reported missing. The recorded history on police systems said that the child was extremely vulnerable, and had previously gone missing on many occasions.

The child was flagged as being at risk of CSE and was the subject of a child protection plan due to neglect. Records also showed that the child was abusing drugs and alcohol.

Despite these vulnerabilities and known risks, the child was categorised as absent rather than missing, and therefore the police made no attempt to locate them or to establish the circumstances of the absence.

The police therefore could not evidence that they had done everything possible to protect the child from harm. Since this incident, the child has been reported missing on a further 21 occasions.

In December 2015, CSE flagging was reviewed across the MPS. The purpose of the review was to ensure that those flags attached to individual records were relevant. The force had established that a number of cases had been closed with an assessment made that the child in question was at no risk of CSE. However, the flag had remained on the record in some cases. The reason for the flag remaining on the record was described as 'just in case'. The MPS also established that at December 2015, it had 973 active CSE reports within its crime system, and 1,711 CSE flags recorded on the police national computer. As a result, the MPS removed 600 flags from the records of individual children. The force considers that this step will help officers to use the flagging system properly to assess risk and prioritise vulnerability.

While we did not inspect the consequences of the force's decision to remove the flags, we have significant concerns about this process. It does not appear to have involved checking with partner organisations (such as social or health services) whether they possess any information about a child's risk of being subjected to CSE. This means that children may remain at risk of CSE but not now be flagged correctly. Furthermore, those children who are no longer flagged as being at risk of CSE who go missing in the future may be wrongly categorised as absent rather than missing, without consideration of CSE concerns previously identified and flagged by the force.

Initial response

Inspectors found examples of a good initial response by frontline and specialist staff to clearly defined child protection concerns which required immediate attention. In some of the cases which raised obvious concerns that we examined, officers responded quickly, carried out prompt enquiries, and used their powers to arrest or safeguard where necessary. These include powers under section 46 of the Children Act 1989 which enable a police constable who has reasonable cause to believe that a child is at risk of suffering significant harm to remove him or her to suitable accommodation.

Example of a good response to children at risk of harm

Officers were despatched to an address identified from an abandoned 999 call. They forced entry to the premises, where they found children living in squalid conditions.

They spoke to the children and subsequently removed them under police protection powers. Officers recorded relevant evidence on their body-worn cameras and arrested the parents. Following a strategy discussion, the police and children's social care agreed to undertake a joint investigation and to establish and to implement a safeguarding plan for the children.

We also found evidence in some cases of officers showing sensitivity when undertaking initial contact and interviews, ensuring that they considered welfare implications and listened to the child. This approach at the initial stage of an investigation helps to build a rapport with the child and to obtain good evidence to support the investigation.

Putting the needs of the child first

A 16-year-old girl made an initial report to another police force that she had been raped on numerous occasions over a three-year period by a group of men in London. If she refused to meet the men, threats would be made that they would hurt her and her family. The force categorised this as a case of CSE quickly and, importantly, assessed the wider risk posed by the perpetrators. A properly-trained officer spoke to the child at length, exploring all investigative opportunities, despite the child declining to undergo a medical examination or to provide clothing for forensic examination. The victim was fearful that the perpetrators would locate her at her home address, therefore arrangements were made for her to stay at a different location and appropriate markers were added to police systems.

The case was also flagged to the local multi-agency sexual exploitation (MASE) meeting (at which borough police officers and partners such as the local authority and children's social care agree activity to tackle CSE threats).

It is clear from the case file that the welfare of the child, who was described as being extremely fragile and vulnerable, was at the centre of all activity. Officers listened attentively throughout, considering the child's wishes at all stages of the investigation. They continued to build a rapport with the girl and sent her text messages of support.

Prompt liaison with children's social care resulted in a strategy meeting and an initial child protection conference, where the child was put on the child protection plan under the category of sexual abuse. A number of other meetings of professionals also took place, to ensure that specialist services were provided (such as support from the Child and Adolescent Mental Health Service). The investigation was still underway at the time of the inspection.

Response to missing or absent children

In 2014/15, the MPS recorded 25,379 children reported as missing and 4,846 children as absent in London. HMIC has significant concerns about the protection of these children. This is because, while we found some evidence of the force undertaking appropriate immediate enquiries to locate and safeguard children reported missing, the overall response was poor. Of the 38 cases of missing or absent children that we examined, only 2 were assessed as 'good'. The others were judged as either 'requires improvement' or 'inadequate'.

We found that:

- each borough has its own missing persons unit, but the structure and staffing of these units varies significantly across London, with no evidence that there has been any evaluation force wide of what would be the most effective approach;
- most staff in these units have not received the training to equip them to do this work, and therefore do not possess all the required skills to assess or act appropriately in these cases;
- repeat incidents are not always considered as part of a pattern (which might indicate escalating risk to the child), but rather as isolated incidents;
- the assessment of risk often does not reflect the intelligence the force holds, or is otherwise inaccurate (for instance, we saw cases graded as being at medium risk of harm on the basis that the children in question were 'streetwise and able to take care of themselves');

- there were delays in the process of interviewing children who had (or had been) returned home to gather information on why they had gone missing, and in making referrals to other organisations (for instance, in one case it took 17 days to have a debrief with the child and a further 17 days before the matter was referred to children's social care, and in another, it took 3 days for the debrief to occur and a further 2 weeks before the case was referred to children's social care);
- in some cases there was no record to indicate that the child had physically been seen and spoken to;
- there was limited evidence of joint working with partner agencies to develop comprehensive action plans to address the identified risks and reduce the incidence of the child going missing;
- the MPS's missing persons database, Merlin, is not accessible to communications centre staff, who therefore cannot update an active missing file when a child is reported to have returned or been found. This can result in delays to finding children or an incorrect assessment of risks posed to the child, as the available information to control room staff and response officers is incomplete.

The importance of correctly identifying risk

A 17-year-old girl, assessed as medium risk, was missing at the time of the case audit (and had been for four days). There were many significant risk factors in this case, all widely known to agencies.

These included the fact that the girl was at risk of CSE, had recently formed a relationship with a 17-year-old boy who was also at risk of CSE, and that she posed a risk to other children by involving them in sexually exploitative situations.

This was confirmed when she brought a 15-year-old girl from her care placement to London, who then engaged in a sexual act with a 21-year-old man.

We referred this case back to the force, stating that we considered the girl to be at high as opposed to medium risk. On the basis of our intervention, the force accepted the initial categorisation was incorrect and amended the risk to high, and took swift investigative action, as a result of which the girl was found.

No plan to reduce long-term risk

A 14-year-old boy was in care because of serious neglect by his mother. At the time of the inspection, he had been missing on 22 occasions, and he was shown as absent on four occasions.

He was involved in a wide variety of offences (including robbery), and also had connections with gangs, and associations with girls known to be at risk of CSE.

We found no evidence of the police actively working to reduce the number of missing episodes, and we noted significant delays in conducting debriefs and updating systems (on one occasion, it took 8 days to conduct a debrief and a further 11 days to update the police records). The child therefore continued to be at risk.

Incorrect classification and decision making

A 13-year-old girl at risk of CSE who went missing overnight was assessed as being at medium risk because she was described as being 'streetwise'.

Separately from the missing incident, the communications centre had received another report that the child was alone and unsafe in a house with three men; this information had been in an email inbox in the MPS for 14 hours before the force acted on it.

This additional information, when the force did act on it, resulted in the risk level being raised to 'high'. The child was found, but, in an effort to safeguard her, rather than taking her into police protection, officers arrested her for a minor assault on her mother.

At the time of the case audit, the MPS had not formally interviewed the three men she was with while she was missing, which meant that potentially they still posed a risk.

Conclusion

Some officers and staff did not have the training they needed to do their jobs effectively. For instance, staff within the command and control centres could not recall having any safeguarding or CSE training on their initial training course, and had not received up-to-date training on child protection matters. Given that these individuals are often the first who have the opportunity to recognise risk to a child and deploy resources to protect them, this is a serious omission.

We also found that officers and staff often do not properly assess children who are clearly at significant risk of CSE and do not accelerate action to find and protect them.

In particular, the response to children who regularly go missing from home is simply not good enough. Of the 38 cases of missing and absent children we inspected, we assessed only 2 as 'good' (and assessed 36 as either 'requires improvement' or 'inadequate'). We found evidence of a failure to take cases seriously in some instances, and of a lack of understanding of the link between children who regularly go missing and an increased risk of sexual exploitation.

6. Assessment and help

Introduction: what is effective practice in this area?

Our inspection considered the extent to which the MPS works with others to help and protect children. We also considered how effective that help is, and how far it makes a positive difference to the lives of children and families.

Evidence of this (as set out in our published assessment criteria) includes the following indicators:

- Assessments include a clear analysis of risk and protective factors, use all the available information and involve all relevant agencies.
- Assessments and plans take account of the case history, including other significant events and changing levels of patterns of behaviour/risk.
- Assessments and plans are informed by research and expertise.
- Plans include what help is to be provided and by whom, how risk will be managed and contingency arrangements (such as for a domestic abuse defendant breaching bail).
- Help is proportionate, appropriate and timely and focuses on outcomes for the child.
- Children's views and experience inform the plans, which are responsive to the child/family's age, disability, ethnicity, faith or belief, gender, gender identity, language, race and sexual orientation.
- Agencies work together and ensure responsibility for protecting a child and meeting need; information-sharing is timely, specific and effective.
- The work is co-ordinated to prevent the child becoming subject to a number of agency processes and assessments, or falling through gaps.
- Plans specify who will do what and within what timescales, and how progress will be monitored and reviewed.
- Plans are prepared and shared with children and families. They know what help they can expect from agencies and what measures agencies will take to protect the child.
- Plans are regularly reviewed and amended.
- Officers and staff remain alert to needs and risks. They review and take action when new circumstances come to light.

- Changes in circumstances are responded to quickly and risk is reassessed. Officers and staff complete enforcement activity and meet contingency plan obligations promptly.
- Work structures and shift patterns are designed to ensure that the right people (decision-makers) attend meetings and delays are minimised.
- The service has alert systems in place to ensure any breach or a change in the level of risk will be noted and acted upon.
- Assessment tools are evidence based and appropriate training on their use is provided.
- Time and opportunity for thinking and review are built into guidance and procedures. Staff are supported in their reviewing role, i.e. prior to inter-agency reviews, internal agency reviews are undertaken, and reports (where appropriate) are written and submitted sufficiently in advance to be useful to those attending the reviews. Relevant staff attend, who are empowered to make decisions on behalf of the police service.

Strategy discussions

Working together states that, as a minimum, a social worker, his or her manager, health professionals, and a police representative should be involved in a strategy discussion, in the following circumstances:

“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 (including the fostering service, if the child is looked after), the police, health 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.”

The role of the police in such strategy meetings is to discuss the basis for any criminal investigation and any relevant processes that other agencies might need to know about, including the timing and methods of evidence gathering. They should also lead the criminal investigation where joint enquiries take place.

In the cases we reviewed, we found that strategy discussions or meetings did not always take place before MARAC meetings, and that there was sometimes no record of what information had been shared. Where these discussions did take place, they were often only between two agencies (the police and children’s social care).

The Tri-Borough LSCB reported similar problems in 2015, following publication of a serious case review about a girl named Sofia,⁴¹ that identified that telephone discussions were taking place only between children's social care and police, excluding any other agency, even if that other agency had most of the relevant information on the case or child.

As a result, decisions regarding a child and a case are being taken in isolation and without the full circumstances being considered. This means that elements of vulnerability that would inform any actions or interventions could be missed, resulting in the exposure of a child to continuing risk.

Importance of other agencies being involved in decision making

A general practitioner reported to children's social care that a parent had come to the surgery with a three-year-old child who had injuries that were not consistent with the explanations given, and that medical advice had not been sought for older injuries (falling down stairs and a burn).

Children's social care made a referral direct to CAIT, resulting in a strategy discussion between the police and children's social care, who concluded that there was reasonable cause to suspect that the child was suffering or was likely to suffer significant harm and that therefore the case met the threshold for section 47 enquiries to be made and agreed on a joint visit and a medical examination.

CAIT was unable to provide an officer to attend, so children's social care co-ordinated and undertook all the enquiries and the medical examination by themselves. The CAIT supervisor relied on updates from children's social care to make an assessment of whether there was any role for the police (such as the requirement to investigate a criminal offence). Children's social care advised that the explanations provided by the family were acceptable and that there were no older injuries, so the case was closed and recorded as 'no crime'.

This response was wrong: the strategy discussion should have included the GP as the referring agency, to ensure that all relevant information was shared and the concerns explored in detail. Despite the agreed joint investigation, children's social care led both the section 47 enquiries and the assessment of the child's welfare (which it has responsibility for), and acted as investigator to ascertain whether there was a basis for a criminal investigation (which is not its role, and could jeopardise any subsequent investigation and prosecution) because of a lack of resource within the CAIT.

⁴¹ *London Borough of Hammersmith & Fulham, Royal Borough of Kensington and Chelsea, City of Westminster – Serious Case Review: Sofia*, Hammersmith & Fulham, Royal Borough of Kensington & Chelsea, City of Westminster LSCB, 22 December 2015.

MASH and CAIT

While HMIC recognises the challenges of working across a large number of local authorities and with numerous partners (such as children's social care and health services), we found limited evidence of the MPS collaborating effectively with others in the MASHs to ensure appropriate and effective safeguarding of children. Often we found the MASH to be a one-way process for passing police information to partners, rather than a vehicle for sharing information to inform the right joint response.

We also identified (sometimes significant) backlogs in the MASH in some boroughs and we found a number of cases that were awaiting in-depth analysis to inform the final assessment. Staff told us that some of these delays were due to the level of demand and lack of capacity. In one borough, there were 132 cases waiting to be dealt with, and the oldest delay was over a month. In another borough, there were 92 cases, the oldest being 15 days' old, and in a third area they described having between 120 and 140 cases in the backlog.

Delays in assessing and addressing risk

In a domestic abuse case where the initial responding officers identified child protection concerns, it took 23 days for the initial risk assessment to be completed, and a further 3 days for intelligence checks to be conducted, before children's social care were notified.

It is vital that police officers and staff involved at the assessment stage – including in the MASH – have the right experience and skills to ensure decisions and risk assessments lead to the correct response; but we were told that many had not received specific training for their roles. The majority of those working in the MASH did not have a background in child protection and had not undertaken the specialist child abuse investigator's development programme training.⁴²

We were told that the MPS intended to commission an independent review of the London safeguarding hubs in 2016.

⁴² A specialist child abuse investigator course that defines child abuse and enables officers and staff to identify it.

Sexual assault referral centres

There are three specialist sexual assault referral centres in London, known as Havens. These provide forensic medical examinations and immediate aftercare for both adults and children who have been raped or sexually assaulted. The centres are managed by King's College Hospital NHS Foundation Trust and jointly funded by NHS England and the MPS, and are based in Camberwell, Paddington and Whitechapel.

A young person's advocate is based at each of the Havens, while two psychologists and one child independent sexual violence advisor⁴³ cover the three sites. These professionals also conduct weekly safeguarding meetings at which all child cases are discussed.

All three Havens offer a 24/7 service for children aged between 13 and 17. However, services for those younger than 13 are less comprehensive, with the timeliness of examinations dependent on the availability and location of a paediatrician. During weekdays, between the hours of 9am and 5pm, there are two forensic medical examiners and paediatric doctors who are able to conduct examinations of those under 13 at any of the sites. This level of service started in March 2016 and is increasing, but it is still limited.

The most recent Havens' performance report set out a target for 95 percent of children aged 12 and under to be offered a forensic medical examination within 90 minutes of an appointment being requested with the Haven. The actual performance was 63 percent in 2013/14 and 68 percent in 2014/15. This compares to 95 percent compliance for adult and adolescent cases.

Initiative: Barnahus model

The MPS is currently collaborating with the NHS, the Crown Prosecution Service and MOPAC following the securing of funding from the Home Office Innovation Fund to provide an inter-disciplinary and multi-agency response to child abuse, following the principle of child-friendly justice.

The objective is to establish child houses (also known as the Barnahus model, from Scandinavia). These have been identified internationally as the best approach, in that they provide all the relevant services needed by any child or young person under the age of 18 years (or under the age of 25 years with additional needs/vulnerabilities who would benefit from a paediatric approach) where there is a suspicion or disclosure of child sexual abuse including sexual exploitation, including medical examinations, joint interviews and victim therapy, under one roof.

⁴³ An independent worker, commissioned by the police, who can provide practical and emotional support to 11 to 17-year-old victims of rape, sexual abuse or sexual exploitation. The worker liaises between the police, courts and other agencies, acting as an advocate for the victim.

The first stage in this process is to set up houses for children who have suffered sexual abuse and exploitation. These houses, once established, have the potential to provide a significant improvement in services for children.

Multi-agency risk assessment conference (MARAC)

A MARAC is a meeting at which representatives of the local police, health and children's social services, housing practitioners, independent domestic violence advisors (IDVAs),⁴⁴ probation, and other specialists from the statutory and voluntary sectors share information on the highest-risk domestic abuse cases.

The force refers high-risk⁴⁵ domestic abuse cases to a MARAC so that it can develop longer-term safeguarding plans. However, we found the criteria for such referrals vary greatly from borough to borough, leading to inconsistency of service provision to victims from the MARACs.

The minutes from 14 separate MARACs also showed a lack of consistency. Some were detailed and very clear, presenting a good overview of the referral, reflecting exploration of child safeguarding matters, and recording decisions on action where necessary. Others did not provide the reason for referral, gave a limited narrative, lacked clarity on what actions had been agreed and demonstrated limited joint planning to manage risk to the domestic abuse victim or their children, or failed to recognise risk. They also highlighted that strategy discussions were not being convened where appropriate or were not being recorded. While the MPS does not have specific responsibility for minutes taken at a MARAC, it is incumbent upon them and other represented partners to ensure minutes provide an accurate record of each case and, where this is not happening, to raise this concern.

Also, we examined further some of the cases detailed in the MARAC minutes. In some instances, we observed gaps in information-sharing, inadequate strategy meetings and a lack of appropriate action.

⁴⁴ IDVAs provide a service to victims at high risk of harm from intimate partners, ex-partners or family members, with the aim of securing their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from their point of crisis, to assess the level of risk, discuss the range of suitable options and develop safety plans.

⁴⁵ 'High risk' is the term used when, following a DASH risk assessment (see p.31) there are identifiable indicators of risk of serious harm. The potential event could happen at any time, and the impact would be serious.

MARAC not used effectively

One case concerned a family where a 3-year-old girl was present, where there was long-running domestic abuse, including an assault by the father on the mother resulting in injuries, and threats to kill. The MARAC was held in March 2016.

Following the assault, the mother (who had been injured) refused to engage with the police, and was taken to an address outside London. The father followed and attempted to get into the house, threatening to kill her. A Merlin form was completed by the police, but contained limited details for external agencies, including no detail of why the mother failed to engage with police. There was also no record of whether a strategy meeting had taken place.

This is of particular concern as the mother withdrew her complaint due specifically to concerns that it would lead to her losing contact with her daughter. She also had real concerns for her daughter's safety; but there were no further enquiries to follow up the nature of those concerns, or actions to let other agencies know about them, meaning both the child and vulnerable mother were left at risk of harm.

A subsequent Merlin form in February 2016 recorded that the mother had shown a complete disregard for the child's well-being and safety and that her daughter's well-being did not seem to be a priority for her. A strategy discussion or meeting should have been triggered by this information. The officer has clearly recognised the risks to the child and the mother's failure to be able to protect her.

In this case, the completion of Merlin referrals was inconsistent, strategy meetings were not convened where appropriate, and there was no consideration of the cumulative effect of the number of domestic incidents occurring within this family, leaving the child exposed to continuing risk.

Lack of joint or single-agency working

A 16-year-old girl had suffered multiple miscarriages, with a history of suffering physical and sexual violence, and was regularly reported as missing. We found limited evidence of any action taken by the police or partner agencies to mitigate the risk of CSE.

This case demonstrates the disconnect between the various services working to support this girl, including the MARAC, local CSE team, and central CAIT.

In addition, none of the agencies in this case appears to have done any work with the young male suspect, who was 15 years old, and was considered to present a high risk of violence to the girl. There was an expectation that the police would use police powers in appropriate circumstances, rather than an immediate application by children's social care for an emergency protection order (which gives the applicant the power to remove the child or to keep the child in a safe place for a specified duration, and which might have been more appropriate, as the girl was assessed as being unable to keep herself safe and her mother was not in a position to provide adequate safeguarding).

Multi-agency and sexual exploitation meetings, multi-agency professionals meetings and CSE

The procedures for the management of CSE cases, and the range of different meetings to support this, are outlined in *The London Child Sexual Exploitation Operating Protocol*.⁴⁶ These meetings include:

MAP meetings – these are designed to manage identified CSE cases, share relevant information and agree a plan to safeguard the individual child. The findings of these meetings are then disseminated to the MASE meetings.

Monthly MASE meetings are chaired by the local borough police. They are not designed to replace other referral and assessment processes, but are rather forums for agreeing activity to tackle CSE threats, focused on safeguarding victims, disrupting perpetrators, targeting locations where offences are known or thought to be likely, and exchanging information. Some boroughs have merged this meeting with the MAP meetings.

⁴⁶ This sets out how public and third sector agencies and organisations (including the MPS, Barnardo's and London councils) across London identify and address child sexual exploitation, with the aim of providing a standard and consistent response across the capital. *The London Child Sexual Exploitation Operating Protocol*, Metropolitan Police Service, London Children's Safeguarding Board et al., 2nd edition, March 2015. Available from www.met.police.uk

However, we found that the 2015 London CSE Operating Protocol is applied inconsistently. This has led to duplication and delays in the development of plans which will help protect a child and in the approach to meetings. It has also blurred the lines between the planning role of the MASE, and the case management and case reviews held at the MAP meeting. This means that work is duplicated and the MASE meetings do not adequately perform their planning role. In some boroughs, the MASE meetings are managing specific cases. This should be the role of the MAP meetings.

We observed a MASE meeting in one borough and found that, while the meeting was well attended by agencies, none had conducted sufficient research in advance, and they were therefore unable to share information effectively. In addition, tasks given to agencies at previous meetings had not been completed.

The statutory guidance *Working together* states that sharing information is crucial to providing effective early help where there are emerging problems identified through reported incidents, intelligence or individual cases. Serious Case Reviews have shown how poor information-sharing has contributed to the deaths or serious injuries of children.

In order to assess the impact of this meeting, we selected and examined a CSE case which had been discussed at the meeting. We found that the response had been poor, despite multiple agencies being involved. Actions which could have reduced the risk to the child, such as the use of child abduction warning notices,⁴⁷ were not discussed or considered. The case was assessed by HMIC as 'inadequate'.

A second meeting was observed at which the chair raised a number of concerns arising from previous tasks agencies had been given to complete at earlier meetings. None of these tasks had been completed, and therefore the opportunities to prevent offending and protect children had been missed.

Attendance was poor on the part of some agencies (such as education, housing and a missing children's charity), who were neither at this meeting nor the previous meeting. While the MPS does not have responsibility for the attendance of other partner agencies, it and other agencies should raise such concerns through the LSCB.

It was unclear how the MASE related to other meetings which are held to keep children safe, and there seemed to be overlaps between them. This was also raised by an attendee at the meeting, highlighting that social workers were confused about the role of the meetings. The agenda did not follow the CSE action plan, and it was unclear how progress was monitored. The London CSE operating protocol states

⁴⁷ Child abduction warnings can be issued by the police against individuals who are suspected of grooming children, stating that they have no permission to associate with the named child and that, if they do so, they can be arrested under the Child Abduction Act 1984 and Children Act 1989.

that MAP meetings will be convened by the lead agency, often children's social care, and the MASE meeting should be chaired by the local borough police at a rank not below inspector; however, this was not the case, with the local authority chairing in one borough.

Strategy discussions

The *London Child Protection Procedures* set out what should happen when a child or young person is believed to be in need of support.⁴⁸ It states that strategy meetings or discussions should be convened within three working days of child protection concerns being identified, except in the following circumstances:

- for allegations or concerns indicating a serious risk of harm to the child (e.g., serious physical injury or serious neglect), the strategy meeting or discussion should be held on the same day as the referral was received;
- for allegations of penetrative sexual abuse, the strategy meeting or discussion should be held on the same day as the referral was received if it is needed to secure forensic evidence;
- where an agency (such as the police or children's social care) needs to take immediate action, the strategy meeting or discussion must be held within one working day; and
- where the concerns are particularly complex (e.g., organised abuse or allegations against staff) the strategy meeting/discussion must be held within a maximum of five working days, but sooner if there is a need to provide immediate protection to a child.

However, we found that CSE strategy meetings were not routinely held before MAP or MASE meetings took place. While strategy discussions will often be convened by children's social care, when they are not, the police should raise this directly with them where it is appropriate for a strategy meeting to take place. This is an area of concern, as those at risk of CSE are likely to be suffering, or at risk of, significant harm and should therefore be considered as child protection cases immediately and dealt with accordingly, including through formal referral within the set timescales.

⁴⁸ *London Child Protection Procedures*, London Safeguarding Children Board, 5th edition, 2015. Available from www.londoncp.co.uk

The problem of not recording decisions made at MASE meetings

A female child who was on a protection plan under the category of emotional harm was reported at risk of CSE.

A MASE meeting considered this case, but there was no record of a strategy meeting to develop joint plans to protect this child.

The effect of this was that there was no detail of what analysis had been done, what information had been gathered on the case, or what the nature and level of the child's needs were. Nor was there any detail of the level of risk, if any, she may have been facing and any mitigating action required.

Undue delay in involving other agencies in a CSE case

There was a delay of two months before a MASE meeting discussed a CSE case the police were investigating. We found no evidence of any other multi-agency meetings about the victim taking place in the intervening period, despite the fact that the girl in question continued to be reported as missing on a frequent basis and information suggested she was with an older man.

This meant that there were no agreed plans in place with partner agencies. The child was left exposed to risk and harm through continued contact with the older man.

The importance of strategy discussions for cases involving children cannot be over-emphasised. Whilst the MASH process gathers and assesses information in a multi-agency setting, we found that in most boroughs strategy discussions, when convened, took place outside the MASH structure.

The force has a target for all such discussions to be held within 24 hours of initial report. In 2015/16, however, 13,714 discussions involving the CAIT were recorded, of which only 60.8 percent took place within 24 hours of the initial report; the remainder were delayed and did not take place within the established timescales. In the majority of cases, the initial CAIT strategy discussions take place with children's social care via telephone. Officers in missing persons and CSE teams reported that they did not have the capacity they needed to attend all strategy meetings. Partners stated that CAIT attendance at strategy meetings was often poor and considered that this related to problems of capacity and workload.

Officers did not have a sense of strategy meetings being used to plan future investigation and safeguarding responses, but saw them rather as a response at a point of crisis for the child and for managing risk. They rarely sought a strategy

discussion or meeting and saw this as the responsibility of children's social care. The police therefore often do not raise any issue when a strategy meeting has not been called. The lack of police attendance at strategy meetings means that the meetings do not generate joint plans and they take decisions without full information or guidance from the police.

Missing and absent children (building the picture of the child's vulnerability)

As explained earlier in this report (see pp.40–42), we have serious concerns about the force's response to missing and absent children. The same inconsistencies and poor practice were also evident when we inspected the effectiveness of MPS's information-sharing about missing or absent episodes.

Police generally completed a 'safe and well' check when missing children were located. The purpose of this check is to allow the police to ensure that the missing person is safe and not in need of medical attention or other support, but also to understand the circumstances of their absence and where they were, and if they have been victims of crime. However, we found variable local authority provision of independent 'return to home' interviews for children,⁴⁹ with some local authority areas carrying out interviews with all children who return, and other local authorities being selective as to who receives the service. These interviews, which may be provided by the voluntary sector, can provide a wealth of information about why a child is running away, particularly when this is becoming more frequent and he or she is reluctant to speak to police or other agencies. While the MPS does not have responsibility for return to home interviews, it is acknowledged that the failure to conduct them presents a potential missed opportunity to gather intelligence, and the force reported that it had raised this concern with the LSCB, Ofsted, and the London Safeguarding Children's Board in March and May 2016.

There is also inconsistent feedback and sharing of information from these interviews with partner organisations (in particular with the police) to help inform plans to reduce risk to a child and the development of trigger plans (plans to locate a child quickly when he or she goes missing) to help prevent repeat episodes. The effect of this information gap is that officers lack crucial information to help them locate missing children, and children receive differing levels of service depending on where they live.

⁴⁹ A child who is found must be offered an independent 'return to home' interview by the local authority. Independent 'return to home' 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 homes. 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. Available from www.gov.uk

Missing persons' co-ordinators

In 2014, the MPS introduced missing persons' co-ordinators to support each borough's response to missing persons. They are not involved in the investigation of missing people, but instead co-ordinate sharing of information about missing people across the MPS, and find opportunities to develop longer-term solutions for particular problems or areas that are associated with, or contribute to, people being reported missing (for example, by working with a local transport hub, where young people will often go to take buses when they go missing). The 20 co-ordinators work in teams, serving 4 MPS clusters located in the north, south, east and west of the capital.

However, we found that the co-ordinators do not operate consistently across the MPS. This is exacerbated by a lack of clarity and understanding about the MPS co-ordinators' role among officers and staff working in the boroughs, with limited interaction between borough management and the missing persons' teams. The effect of this is an inconsistent service and approach to the co-ordination and sharing of information of missing people across the MPS.

Lack of training

We were also concerned to find that members of the specialist team of missing persons' co-ordinators were not specifically trained to carry out the role. We were told that the majority of the team have little background in dealing with missing person cases, and staff had received no training for the role. The unit was created in 2014 and staff stated there was inconsistency in the way in which missing person cases are dealt with across the MPS. Staff told us that a missing persons' course is being designed currently to provide bespoke training to all missing person unit staff and missing persons' co-ordinators, but it was not operating at the time of the inspection.

Lack of analysis

As set out above, the MPS's missing persons' policy states that, although co-ordinators cannot be directly involved in the investigation into a missing person, they must deal with problem-solving and intelligence-sharing in investigations. We found that co-ordinators do not instigate strategy discussions for missing or absent children. As outlined earlier in this report, strategy discussions are vital in sharing information to inform decision making and agreeing a plan of action to support a child and reduce instances of missing and absent episodes. A co-ordinator is an important individual who should have oversight of all reports to identify those that need to be referred and discussed in a multi-agency forum.

We also found limited analysis of data or evidence identifying geographical areas of specific concern. Where locations from which children frequently go missing were shared with the boroughs via a monthly update report, missing persons' co-ordinators we spoke to had limited understanding of how this would be used to address local concerns.

Lack of connections with CSE identification and investigation

We also found that, while the co-ordinators attend some MASE meetings, they do not have an active role in CSE identification or investigation. This is of concern, as the links between missing children and risks of exploitation are well documented.

Furthermore, the current absence of systematic identification and analysis of child protection risks or problems severely inhibits the understanding of those in the 'missing' or 'absent' categories and the possible links to the risk of CSE.

Conclusion

We found that officers frequently failed to request strategy discussions with all relevant partner agencies. This means that formal opportunities to share information and develop comprehensive and robust action plans to address identified risks with partner agencies are not being fully exploited. As a result, decisions on how best to protect a child or about the level of risk he or she faces are often taken more slowly than they should be, in isolation and without proper consideration of all the circumstances of the case.

7. Investigation

Introduction: what is effective practice in this area?

Our inspection considered the extent to which MPS child protection investigations are thorough, timely and demonstrated that the needs of children are central.

Evidence of this (as set out in our published assessment criteria) includes the following indicators:

- Investigations and inquiries are undertaken promptly and are thorough and timely and the needs of children are central to the investigation. The right information is collected.
- Enquiries are well planned and avoid repeat examinations or interviews with the child.
- From the outset, the right support for the child from the most appropriate source (police, family or other agencies) is put in place.
- Officers and staff work at the child's pace and in a way that takes account of his or her age and development or any special needs.
- Where children or others are limited by reason of age, health or ability in what evidence they can provide, every effort is made to find and use the appropriate specialist resources that can support the investigation (e.g., interpreters, intermediaries, trusted mental health professionals).
- Police interview schedules, recordings, forensic findings and other evidence are proportionate, comprehensive and accurate and are collated in such a way as to enable sound and prompt judgments or recommendations to be made about next steps (bail or remand, prosecution, child protection plans, closure of the case, etc.).
- Potential negative effects of any investigation are assessed and plans made to mitigate these.
- Where another agency has to be involved, this transition is handled in a way that supports and reassures the child.
- Staff are highly skilled in interviewing children and understanding evidential limitations, and creative in developing investigatory approaches that can support the investigation.
- Management support staff and revise plans and directions in light of how the case is progressing.

- Force policy and guidance enable staff to take accountable decisions, even ones that may go beyond force policy, when this is in the best interests of the child.
- Management ensure all staff working with young victims of offending have the appropriate knowledge and skills (child development and its many variations, expertise in communicating with children and working with families who may be both distressed and under suspicion, good investigative practice in this area of work, and knowledge of the role of other agencies and potential support systems). There is access to specialist or supplementary advice when this is needed.
- The force understands the level of need it has for support services (interpreters, intermediaries, access to mental health professionals, etc.) and has arrangements in place so that these can be called upon quickly.
- The force helps other professionals, such as paediatricians, understand the need both to gather good forensic evidence and to take into account the health needs of the child.
- The staffing and structure of all aspects of investigation (including DNA or computer analysis) can be arranged promptly.
- The culture of the force enables officers to recognise and acknowledge their limitations (especially in unusual or infrequent types of case). These concerns are addressed and significant cases are reviewed to aid learning.
- The quality of police investigative work is audited.

Training and resourcing of frontline officers

In October 2015, the MPS introduced a 13-week training programme for new officers. This includes sections on child protection, covering:

- the principles of Every Child Matters;⁵⁰
- dealing with missing and absent children; and
- CSE.

⁵⁰ Every Child Matters was a set of reforms to services for children, supported by the Children Act 2011. It was launched in 2003 in response to the death of Victoria Climbié, with the aim that every child, whatever his or her background or circumstances, should have the support needed to be healthy; stay safe; enjoy and achieve; make a positive contribution; and achieve economic well-being. Available at: www.education.gov.uk/consultations/downloadableDocs/EveryChildMatters.pdf

However, this course is only for new officers. Therefore it is not available to the officers who had been trained before it was devised.

All frontline staff receive professional development days four times a year. These have previously covered de-mystifying rape, neglect, domestic abuse and gang culture. Specialist officers from Specialist Crime and Operations have also provided training on CSE. However, the force does not know how many staff have received this training, as there is no record of attendance. This means that the force cannot be certain that frontline staff have received the right training in protecting children.

We were extremely concerned to find that some staff in important roles, such as borough CSE officers and custody and communications centre staff, often had a limited awareness of CSE. They told us that they had not received training, with many describing themselves as self-taught and as having 'learnt on the job'. For example, the role of CSE officers working in boroughs involves supporting and working with individual children being groomed or targeted for CSE, as well as taking a proactive approach to exploring the nature and patterns of sexual exploitation locally, and sharing information with partner agencies about those at risk and potential offenders. We spoke to an individual in this role who did not have a background in child protection, was not a trained detective, had not been given any training for the role, and was not aware of the guidance and protocols to be followed when dealing with child protection matters. This individual reported feeling worried about making mistakes. We were extremely concerned by the absence of training in such key roles and the obvious impact this will have on any police action taken to protect those children at risk of CSE.

Welfare and support

All forces have a duty of care for their staff's health and welfare. It is important for staff working in child protection to be able to access welfare support, and they should be encouraged to seek counselling and support when they need it. We found that those in specialist teams (such as CAITs and Jigsaws) completed an annual psychometric questionnaire and received a health screening. In one CAIT, this was supplemented by 'well-being' ambassadors, who provide advice and support to colleagues, or advise them where to get that support. This provision was not replicated for those staff in boroughs, where access to such support was either via self-referral to occupational health services or via supervisors, despite their involvement in investigating cases of indecent images of children, which required them to view those images themselves.

Investigations by specialists

Throughout the inspection, inspectors found some good examples of child protection work by child abuse investigators, who displayed a mix of investigative and protective approaches. This ensured that safeguarding children remained central to their efforts, while they nevertheless pursued all criminal investigative opportunities.

Example of where specialist investigation has been effective

A school called the police about 2 pupils aged 13 and 14, who they believed were in sexual relationships with men much older than themselves.

The initial response to the incident was good: the police contacted both girls and spoke to them with their parents present, resulting in both investigative and safeguarding activity.

The case was discussed at a MASE meeting and a child protection conference. The investigation was conducted by specialist officers from the Sapphire team and included serving child abduction warning notices on the suspects.

Example of where joint working has been effective

A 16-year-old girl went missing, and her parents raised their concerns about uncharacteristic behaviour and activities (such as drugs and unaccounted for possession of items) that indicated she was either a victim of, or at risk of, CSE.

Police action resulted in the child being found, placed in police protection and put into a secure placement. We found detailed, structured updates on CRIS that reflected a caring, tenacious and professional investigation.

The case involved management across both force and agency boundaries to ensure the best result for the child and robust interventions with the perpetrator, including the serving of a child abduction warning notice on the suspect. The child and family received a significant amount of contact, advice and support from all interested parties, with the police playing a leading role.

Investigations by non-specialist borough officers

We considered that investigations carried out by non-specialist borough officers were generally of a lower standard than those conducted by specialist officers, with some delays in investigation and a failure to recognise and manage obvious risks.

Officers also failed to recognise wider risks, such as other children at risk and suspects who posed a risk to other children, and they missed clear warning signs of CSE.

As part of our case file analysis, we found that, of the 38 cases of CSE arising from the internet that borough staff dealt with, 24 were found to be 'inadequate' and 10 'requires improvement'. In many cases, we found no investigation to identify the suspect, and delays of several months in other investigations (often in the execution of search warrants following referrals from Child Exploitation Online Protection,⁵¹ and in the examination of seized digital material such as computers).

Ineffective consideration of wider risk

A member of the public reported to the police that they had found a USB stick containing images and videos of an indecent nature. There was a good, timely initial response from territorial policing staff to the incident, and the suspect was arrested.

However, the focus of the investigation was on the images contained on the USB stick, and officers did not explore the wider safeguarding issues and risks associated with the suspect until inspectors referred the case back to the MPS. These included the suspect potentially being involved in babysitting and having access to children.

⁵¹ The Child Exploitation and Online Protection (CEOP) Command is a command of the UK's National Crime Agency with responsibility for working both nationally and internationally to establish what the main threats to children are and to co-ordinate activity against these threats to bring offenders to account, including online child sex offenders, and those involved in the production, distribution and viewing of child abuse material.

Ineffective consideration of wider risk

A vulnerable 15-year-old girl was in an online relationship with two adults, one of whom turned out to be a 60-year-old man. This man had given the girl money and made arrangements to meet her. The girl stated that she had made a number of arrangements to meet, but he had never turned up to meet her.

The case was assessed by the CSE initial assessment team within SOECA and was categorised as level 1 (i.e. there are concerns a child is being targeted and groomed, but there is no evidence as yet of an offence being committed), for borough staff to investigate. There had been no attempt to ascertain the identity of the man or assess any wider safeguarding concerns.

We were also concerned to see the police log updated with the statement that “there is no evidence of any grooming or sexual intent by the suspect nor has he made any attempts to meet the victim”. This was in direct conflict with what had been recorded earlier in the log.

The other adult had also made efforts to meet up with the girl, which included sending her two broadband routers via an online delivery service. We found some evidence of a supervisor in force checking the case was progressing as it should, with the right decisions being made; this was, however, superficial and did not identify the wider concerns in this case, stating that, following appropriate advice and intervention, the case could be closed.

This lack of investigation has not enabled other agencies to consider the wider safeguarding implications and the risks that these people may pose to others. There was clear information in this case to suggest an offence of grooming.

Unacceptable delays

In November 2012, the MPS received intelligence from two separate police forces that a user of a file-sharing programme was making images and movies of child sexual abuse available for distribution.

In May 2013, following further enquiries, the force identified a suspect. In February 2015, it executed a warrant and arrested the suspect. This investigation took far too long, over two-and-a-half years, and we saw no evidence of any supervision of the case (to check it was progressing as it should, with the police making the right decisions along the way), despite the fact that during this period the force received further intelligence indicating that the suspect, whose identity the police knew, was still actively sharing images.

Child protection conferences

The London Child Protection Procedures state that an initial child protection conference must be convened when the outcome of a section 47 enquiry confirms that the child is suffering, or is likely to suffer, significant harm. A review conference is intended to consider explicitly whether the child is suffering, or is likely to suffer, significant harm and therefore continues to require safeguarding from harm through a formal child protection plan.

Each CAIT co-ordinates the police involvement with the child and provides a dedicated police conference liaison officer who is based within the CAIT and is responsible for attending child protection case conferences.

However, we found that attendance at initial and review conferences varied, despite the MPS having targets for attending 100 percent of initial child protection conferences (ICPCs), and 50 percent of review conferences. In 2015/16, police actually attended an average of 95 percent of ICPCs (the lowest was 86 percent in the Eastern area) and 19 percent of review conferences (the lowest was 9 percent, also in the Eastern area).

Force attendance at conferences is dictated by set targets (i.e. did the MPS meet its attendance target), with no risk assessment process to define what officers should expect to contribute to or draw from initial or review conferences. This means the MPS evaluates success in terms of mere attendance at such conferences rather than in terms of their effective contribution to them. Such an approach is simply not good enough.

We found that performance data is not being used to track and direct resources, based on levels of risk of harm associated with a child, offender or place. We would expect the MPS to make resources available in line with demand; this was not always the case. A better informed and considered approach, and improved working with partner agencies, may assist the MPS to reconsider its current targets.

The force reported a desire to use video and telephone conferencing for child protection conferences to improve this position and reduce travelling time as well as cost. However, these methods were not in use at the time of the inspection, and the MPS had no timetable for implementing this approach. Also, they advised that, in cases where the police do not attend, it sends a report to the conference. While this may be appropriate in some cases, significant value is lost when the police is not present to respond to or challenge discussions regarding how to manage a child's welfare.

The area of child protection conferences demonstrates clearly the effect of the significant and increasing number of child protection cases and the absence of a force response to respond to this: a team of 5 staff was dealing with 252 current plans involving 514 individuals, with 26 of the children having been on child protection plans for over 15 months. The supervisor explained that they were unable to update the identified risk factors on police systems (which should be done after checks every six weeks) because there were not enough staff to do all of the necessary work. As a result, the information needed by frontline staff when dealing with these vulnerable children is not always visible or taken into account when they are responding to risk. This is of serious concern, as it means children may be left in danger, when the police have the information that showed they need immediate protection.

Investigation of indecent images of children

Technology has created a range of new opportunities for criminals, resulting in an increase in the sharing of indecent images of children. This criminal activity is now almost entirely conducted over the internet.

In response, the MPS has invested in forensic software that enables it to screen digital media before a full forensic examination takes place. This process is referred to as 'previewing', and aims to establish:

- if the digital media contains indecent images;
- which digital media will provide the best evidence to support a prosecution;
- whether any risk factors are evident; and
- the identity of any potential victims as soon as possible.

The responsibility for the initial recording and investigation of reported cases of indecent images of children (whether making, possessing or distributing them) normally rests with territorial policing, unless there are 'aggravating factors', in which case they would be dealt with by specialists within the serious crime and operations directorate.

The force lists these aggravating factors within its standard operating procedures for investigations of indecent images of children as:

- the suspect being in a position of trust (e.g. teacher, scout leader, priest);
- the case having the potential to present a reputational risk to the MPS;
- the suspect having ready access to vulnerable children (other than family members); and

- registered sex offenders who were suspected of still committing contact offences (i.e. physically abusing children, as opposed to grooming).

It also states that all allegations identifying possible 'intra-familial' child abuse photographs and images must be brought to the attention of the local CAIT or the SOECA local intelligence team. The SOECA Command has the remit to investigate all allegations of 'intra-familial' child abuse.

The original standing operating procedures were created in June 2015 and, while the force advised that the current procedures that this relates to have yet to be approved as formal policy, inspectors were concerned to note that the aggravating factors did not include circumstances where the suspect had access to children within his or her own family. This means that children in a suspect's family will have less protection than other children.

Not recognising clear risk factors

The MPS received a referral from CEOP about an individual who had uploaded an indecent image of a child. Research identified the user as a 41-year-old man living at an address where there were 2 children aged 17 and 15 years.

This information clearly indicated that the suspect had ready access to children within his own home; however, as they were believed to be family members, they were not assessed as aggravating factors (i.e. as being at particular risk), and the case was referred to territorial policing for non-specialist officers to investigate. This is deeply concerning.

We were also very concerned to see that, in some instances, officers investigating indecent images of children were viewing them in open-plan offices. Such images are distressing and can have a significant effect on those working on such cases. Therefore, it is critically important that viewings take place in a secure and contained environment, to prevent wider staff being unnecessarily affected by such imagery.

Operation Bellona

Operation Bellona is being conducted by staff from SOECA. It is a proactive investigation (i.e. seeking out offences and offenders, as opposed to reacting to reported crimes) into the sharing and distribution of indecent images of children online. It started in January 2016.

The dedicated unit aims to deal with the 50 most serious cases a month during the pilot scheme. However, it is currently only managing to deal with 31.

Meanwhile, the operation is resulting in new identification of those involved in the sharing and distribution of indecent child images, of around 400 a month. This area of online child abuse image offending carries significant risk, specifically for those cases not in the high-risk category, which are therefore not subject to investigation to identify suspects or victims, or to undertake safeguarding.

Despite force investment in staff specifically for Operation Bellona, maintaining the capacity and capability to deal with the significant scale of online offending remains a serious problem. The capacity and staffing problem has been recognised and recorded as a risk, together with an acknowledgement of the risk that those online accounts not subject to investigation represent to children.

CSE

Officers and staff working in the boroughs reported they did not have access to, or were not aware of, analytical information about CSE or missing children to provide them with a comprehensive understanding of the local picture. This is despite evidence that some boroughs do have local profiles (i.e. analytical products setting out where there are trends or concentrations of offences, victims or places where crimes take place), and the fact that the force has recently developed a CSE 'dashboard' (i.e. summary of information held), produced from police data. This is more focused, however, on high-level management data, rather than giving any analysis of what this might be indicating. So it provides top-line numbers on matters such as victim gender, alcohol or drug involvement, the number of flagged CSE categories and investigation status.

In December 2015, the National Police Chiefs' Council collected information on the nature and prevalence of CSE from all the relevant agencies across England and Wales (such as local authorities, and health and education services). The purpose of this exercise was to produce regional problem profiles or assessments. A London CSE problem profile is in preparation, with completion expected in June 2016.

However, the MPS still needs to do more to understand the extent and nature of CSE locally within each borough, and particularly across London. At present there is insufficient information and intelligence about CSE in London, especially in terms of knowing where perpetrators live and offend, and links to missing children.

Furthermore, the information and intelligence about CSE that does exist is not used effectively to safeguard children. While some individuals in other agencies know about children who are at risk and the work the police may be doing to manage that risk, better analysis of all the information held by all relevant agencies could lead to more targeted and effective work to protect children and prevent offending. Such analysis would also help refine the requirement of what information should be gathered by which agency.

Responses to CSE were variable, depending on where the investigation was managed (i.e. by specialist teams or in a borough). We audited a total of 90 cases of children at risk from CSE, arising both from the use of the internet and from instances where the perpetrator had contact with the child in real life, of which 53 were assessed as 'inadequate' and 25 as 'requires improvement'.

In the cases we audited that the sexual exploitation team had investigated, we saw child-focused investigations carried out promptly and appropriately, with good evidence of victims being safeguarded. However, the majority of CSE cases we audited had been categorised as category 1 (no evidence of criminal offences, but concerns that a child is being groomed or targeted) and therefore were dealt with by non-specialised, territorial policing staff, many of whom had not undergone the required level of training. By contrast, all staff joining the SOECA command complete an induction course which contains a CSE element.

In the cases we audited, officers often did not recognise indications that some children might be at risk of CSE. We found delays between the initial report and contact being made, and in some cases no contact was recorded. There were also significant investigative delays (ranging from days to years), limited evidence of supervision (to ensure they are progressing as should be, and that the right decisions were being made), and a failure to recognise or consider wider safeguarding risks. Nor did they make appropriate contact with other children who were clearly at significant risk, or accelerate action to find and safeguard them. These are serious failings.

Unacceptable delay and lack of follow-up

Children's social care sent the force a referral about a pregnant 15-year-old it believed might have been at risk of CSE and female genital mutilation (FGM). She had gone missing a number of times and she was not attending school. A strategy meeting took place three days later, but there is no record of any agreed plan to take action to protect her.

Police only spoke to the girl four weeks after the referral, when they made a home visit. The girl told the officers that she was in fact 18 years old, confirmed she was six months pregnant and denied having been subject of FGM, but that the matter was discussed when she was younger, with her father refusing to allow the procedure to take place. We could find no evidence of any further liaison with children's social care or consideration of her unborn child being at a similar risk of female genital mutilation, should it be a girl.

Not effectively recognising risk

Police officers attended an address where they spoke to a 16-year-old Romanian girl, who was dressed inappropriately and was in a room with five much older males. One of the officers was able to speak in Romanian with the girl, who confirmed that she had arrived in the UK two weeks earlier, and was staying at the address with her father (the police then spoke to him). While at the address the girl propositioned the officer. Officers also noted that the girl's mobile phone was constantly ringing with English-speaking males calling her.

Police protection powers were considered but the officers deemed that she was not likely to suffer significant harm. This was a missed opportunity to safeguard the child at the earliest opportunity, despite the officers having concerns about her behaviour and living conditions.

The officers made a referral, and the initial assessment team in the sexual exploitation team conducted a risk assessment in relation to CSE and categorised the risk as being category 1 (which means there are concerns a child is being targeted and groomed, but currently there is no evidence of any offences). The case was therefore handed to the borough. A strategy discussion took place with children's social care, at which it was agreed that a joint visit should be made to the address.

This visit took place six days after the first police interaction with the girl. She was found in identical circumstances, with older men present. The living conditions were found to be squalid, and a decision was made for the girl to be taken into police protection.

An interview was conducted with the child. She made no disclosures in relation to CSE, but accepted that she had offered the officer sex for money as she was desperate for money.

The child was subsequently placed into foster care with the intention of returning to Romania. A review of the case concluded that there was no evidence to suggest that exploitation has taken place. The file was closed but it is not confirmed if the child did return to Romania or if the risk of CSE remains.

Poor investigation and unacceptable delay

A 15-year-old disclosed to staff at school that she had met and performed sex acts on a person with whom she had first had contact online. This case was reviewed by the initial assessment team (IAT), who advised that there was no clear evidence of CSE and that therefore they would not grade it.

The IAT went on to advise that the case should be considered as one of underage sexual intercourse rather than CSE, as the girl did not receive any money or gifts. There were significant delays in efforts to contact the family and the police cancelled an agreed appointment to see the girl.

The family did not respond to further messages, which was understandable given the time that had elapsed since the incident. The case was closed some nine months later, without the investigating officer having made contact with the family, despite a supervisor stating that the police should at least speak to the mother and the child, and if possible seize any evidence from the phone used.

Unacceptable delays

The MPS received information from CEOP indicating that a man had uploaded videos of indecent images of children to the internet. The local intelligence team conducted further research and confirmed the address and identity of the male suspected of having committed this offence.

The MPS executed a warrant on the address four months after receiving the intelligence, and three months after HMIC had referred the case back to it because of concerns over the lack of investigative activity.

Recording investigation information and updates

Accurate and timely recording of information is essential for good decision making in child protection matters. However, we found that information on child protection matters (such as minutes from MASE strategy discussions) generally was not recorded on police systems. In addition, case records did not always reflect or record all the assessments or decisions that had been made, particularly those by other agencies (such as children's social care).

Working with the Crown Prosecution Service

Staff told us that they experience significant delays waiting for advice or charging decisions from the Crown Prosecution Service (CPS) because it is dealing with such a large caseload. They also reported that bail extensions were commonplace, with some suspects remaining on bail for over a year while waiting for a charging appointment. In one rape case they referred to, the suspect had to be re-bailed on four occasions.

We found that the delay for CPS advice was at least 90 days, which means that the target of fewer than 65 percent of suspects being on bail for over 90 days for serious sexual offences (as required by the CAIT performance regime) is not achievable. Delays are not in the best interests of children, or indeed of the suspect.

Staff reported that there has been reluctance within the CPS across London to accept streamlined forensic reporting⁵² for the examination of digital exhibits. This has added to the workload of the high-tech crime unit, causing some frustration.

We found two initiatives aimed at improving case management between the police and the CPS:

- the force, together with the CPS, has recently introduced an electronic two-way interface system known as COPA (case overview preparation application), enabling officers to submit their case files direct to the CPS, and the lawyers to liaise directly with the officer through the COPA, asking them for extra details when required to build a better case. This is regarded by the force as a positive step in joint electronic file and case management; and
- a rape and serious sexual offences (RASSO) lawyer⁵³ works in Holborn Police Station to provide early investigative advice to both the CAIT and the Sapphire team. Although there are plans to increase the number of RASSO lawyers, no further progress had been made at the time of the inspection, and there was no timetable for implementing this change.

Conclusion

Some officers and staff lacked the training they needed to do their jobs effectively. For instance, we found officers in roles focused on tackling CSE who had not been trained in the subject. This lack of adequate training for officers dealing with some of the most complex and difficult cases, involving some of the most vulnerable individuals, needs urgent redress.

Often, we found unacceptable delays, in all kinds of investigations, in gathering evidence or acting on information (for instance, about individuals owning indecent images of children) to keep children safe.

⁵² Streamlined forensic reporting is intended to provide forensic evidence for the court which is proportionate to the seriousness of the offences charged and which adequately conveys the scope of the offending behaviour for sentencing purposes. The rationale is to reduce the need for full forensic evidence that addresses issues that are not in dispute.

⁵³ Rape and serious sexual offences (RASSO) units, staffed by specially-trained lawyers, provide specialist legal advice, decision making and support to victims, and deal with cases of rape and serious sexual offences, including child sexual abuse.

8. Decision-making

Introduction: what is effective practice in this area?

Our inspection considered the extent to which decisions taken by the MPS in child protection cases are child-centred, prioritise their needs and are based on good-quality evidence. These decisions may include those to remove a child from his or her home, to work jointly with other agencies or organisations to protect a child, to find and increase the number of sources of evidence that an offence may be taking place, and to conclude a case (for instance, through a charge, or through no further action being taken).

Evidence of this (as set out in our published assessment criteria) includes the following indicators:

- Decisions are based on good-quality evidence, supported by thorough investigations and the use of specialist services when needed.
- Children are listened to and understood, and their views are taken into account in all decision making.
- Decisions reflect the likely effect of the chosen course of action on the child and, where there is a risk of harm, plans are put in place to mitigate it.
- Where there are no criminal proceedings but a child is deemed to be at risk and referred to children's social care, relevant information will be passed on and investigating officers will work jointly with other agencies on a child protection plan, where this is appropriate.
- In cases where serious criminal offences are alleged, decisions to take no further action or not to charge are appropriately reviewed by senior officers, with further investigations or support for the child strengthened where appropriate.
- All decisions are undertaken by suitably qualified staff and/or managers as appropriate, and the decisions and their reasoning are recorded.

If the child needs immediate protection

The police have emergency powers under section 46 of the Children Act 1989 to enter premises and remove a child to ensure their immediate protection. These powers can be used if the police have reasonable cause to believe a child is suffering, or is likely to suffer, significant harm. When these powers are exercised, the child is considered to be in police protection. No child may be kept in police protection for more than 72 hours.

It is a very serious step to exercise these powers and remove a child from their family. In the 27 cases we examined, we assessed 12 as 'good'; 1 as 'adequate'; 12 as 'requires improvement' and 3 as 'inadequate'. In the 'good' cases, we found decisions to take a child to a place of safety were well considered and in his or her best interests. In those assessed as 'requires improvement' or 'inadequate', there were poor records of the action taken, and in some cases identified offences were not recorded or appropriately investigated.

Where a case was clearly identified as a child protection matter from the start and there were significant concerns about the safety of children, we found that officers handled incidents well.

Operation Makesafe

The force and its partner organisations have been working to raise awareness of CSE with members of the business community through Operation Makesafe. This is a good example of increasing and improving the response to, and protection of, children at risk of CSE, in that it raises awareness of CSE in businesses, including hotels, taxi companies and licensed premises. It was piloted initially in the borough of Waltham Forest in October 2014 and was launched across London in March 2015.

Participants receive training to help them to recognise the signs of CSE. They are directed to call 101, quoting Operation Makesafe, if they suspect suspicious behaviour or activity on their premises or in their vehicles.

While the force has made a decision to continue to refresh and extend Operation Makesafe across London, it does, however, need to do more work on this scheme, as it emerged that the calls received by the force in the context of the operation are not consistently tagged within the communications centre. This prevents the force from analysing the effectiveness of the operation and from arranging further training in areas where the operation is not eliciting calls or contacts. Also, it is a missed opportunity to inform resourcing and operational decisions in light of the information provided.

Decisions to take no further police action

Decision making in respect of no further action (NFA) by the police on criminal investigations and closure of crime reports is recorded on the crime recording system. The force has a rape 'no crime' panel chaired by a commander, where all cancelled crimes of potential rape are assessed, prior to further assessment by the force crime registrar.

In cases of NFA, the force has a rape scrutiny panel chaired by the Sapphire superintendent and attended by the CPS and Rape Crisis.⁵⁴ This examines police decisions to take no further action in cases of rape to ensure compliance with policy and to identify what has been learned. The panel undertakes a dip-sample of recently closed cases. The force reported one issue that it had recognised through this process which was the absence in some cases of a documented rationale explaining why a case was NFA. It was addressing this.

Investigation outcomes

The police can use a range of disposals to deal with offenders and secure an effective end result it must decide which is most appropriate to the circumstances of a case. Such disposals include both formal criminal charges and out of court disposals as a way of dealing with a crime or offence that does not require a prosecution in court (for instance, through use of restorative justice, cautions or community resolutions).

SOECA has carried out pilot trials of the use of community resolutions⁵⁵ in CAIT cases where it is appropriate and in the best interests of the child and the family, and has now extended this approach across the force area. However, we assessed three out of the four cases we looked at in which community resolutions were used as 'requires improvement' or 'inadequate'. This was because of incorrect use of the resolution (for instance, in a case where the suspect did not admit the offence), and a delay of six months from report to resolution.

Incorrect sanction applied

After a domestic abuse incident in a family with two young children aged six and three, each parent separately reported that the other had physically abused the children on separate occasions, and had filmed this abuse on their phones.

There was a joint strategy discussion with children's social care and, following an ICPC, both children were made the subject of child protection plans. The case records outlined that the mother stated she had recorded the father hitting

⁵⁴ Rape Crisis is a charity that aims "to promote the needs and rights of women and girls who have experienced sexual violence, to improve services to them and to work towards the elimination of sexual violence". See 'About us' on www.rapecrisis.org.uk

⁵⁵ 'Community resolution' is the term used for dealing with a less serious offence or anti-social behaviour incident through informal agreement between the parties involved, as an alternative to progression through the traditional criminal justice process.

the child with a slipper; while the footage was unclear, it showed the father together with the sound of a slap, and the child also disclosed that he had been hit in the face with a boot.

The father admitted the assault and provided footage of the mother slapping the children, a number of years earlier. These parents had not actively confronted each other with their behaviour at the time of the offences; but, despite this, the father received a community resolution.

This case highlighted evidence of physical and domestic abuse within a family with very young children, where both parents had failed to act to protect the child involved. Therefore it was not suitable to deal with the matter by way of a community resolution.

Listening to the child

We found some cases where the needs of the child were taken into account. However, there was very little information in the majority of case files on the views of the child, the impact of the issues in the case on him or her, or the results of any police intervention. The force needs to do more work to ensure the voice of the child is heard and his or her views are documented in case files.

Use of intermediaries

Intermediaries work with vulnerable victims and witnesses, assisting with communication between children and the police to allow officers to gather complete, coherent and accurate evidence. However, staff across the capital reported different experiences in accessing intermediary services; some said this could be difficult, leading to delays. As a result, we were told of officers and partners conducting interviews without intermediaries in the first instance. Such an approach may impede the ability of, and opportunity for, a child to provide a clear account of an incident, and therefore compromise an investigation.

Senior managers in the MPS have recognised the limited availability of registered intermediaries⁵⁶ and the negative effect this has on the quality of the service provided to children and young people, and have raised this with relevant partner organisations, such as the Ministry of Justice.

⁵⁶ Intermediaries communicate with and on behalf of vulnerable victims and witnesses as they move through the criminal justice system. Their functions were established by section 29(2) of the Youth Justice and Criminal Evidence Act 1999.

9. Managing those posing a risk to children

Introduction: what is effective practice in this area?

Our inspection considered the extent to which officers and staff identify those who pose a risk to children and young people, and work with staff from partner agencies to protect children from them.

Evidence of this (as set out in our published assessment criteria) includes the following indicators:

- Police identify those who present a risk to children and young people, both convicted and un-convicted.
- Police assess the risk of harm posed to children and, together with other agencies, plan to reduce it.
- The views of children, young people and their families are taken into account.
- Police take action to protect children from those who present a risk of harm to them.

MAPPA and registered sex offenders

Each borough has a team dedicated to multi-agency public protection arrangements, aimed at managing known registered sex offenders (RSOs) and other dangerous individuals. These are known as Jigsaw teams. They are supported by a central Jigsaw team.

We found that the number of offenders that officers were responsible for managing varied across the force. Most managed between 50 and 60 offenders each; in one borough, however, officers were managing 100 offenders each.

Officers are trained in the use of the Active Risk Management System. This is a structured assessment process to assess risk factors known to be associated with sexual re-offending, and factors known to be associated with reduced offending. It is intended to provide police and probation services with information to enable them to plan the management of convicted sex offenders in the community.

As more offenders are registered, managing them, collecting intelligence about them and disseminating it appropriately becomes increasingly demanding. Local officers can help with managing the risks if they are briefed and deployed effectively.

We found some good examples of early responses to cases by the specialists from SOECA, but borough responses were often poor. In the 26 borough cases we examined, we assessed 10 as 'inadequate' and 12 as 'requires improvement'. There

were delays in visits, and in a number of cases we could not tell whether the borough had shared information with children's social care, or if there had been a strategy discussion.

Poor supervision or investigation

A British citizen committed an offence abroad and was deported back to the UK. His deportation triggered a good response from the MPS. The central team applied for and obtained a summons and subsequent notification order.

There was then an unacceptable delay in borough Jigsaw staff visiting the offender at his home (during this period he was resident at two addresses, one for a period of 12 days and the second for 15 days), which did not happen until nearly a month after he returned to the UK. The risk assessment was carried out at this point and the offender was classed as very high risk.

The offender contacted Jigsaw officers to state that he had received some emails that were subsequently found to contain indecent images of children. The response to this offence was not effective. There was a delay in despatching an officer once the Jigsaw team received the information, and then they decided against arresting him at the first opportunity.

We found very little evidence of supervision of this case, and at the time of the audit there was no evidence of what enquiries were being made to identify the sender of the email.

Unacceptable delay

A British citizen was voluntarily deported from abroad. He had an extensive criminal record, including a number of child sex offences and indecent images of children offences.

The initial response by the central Jigsaw team was good: they met the offender off the flight at the airport, with a notification order obtained on that same day. Staff from the borough Jigsaw team then took responsibility for his management; but they then did not see the offender for 27 days after he had registered his details with the police.

As a result, a very high-risk registered sex offender was resident in the UK for a number of weeks without being seen at his home address for a full assessment of the risk he posed.

Not effectively using powers available

Police received seven separate reports about a registered sex offender exhibiting worrying behaviour, such as talking to children or being seen in parks where children were present.

They missed opportunities to make an application for a sexual harm prevention order (which can be used to impose wide-ranging prohibitions on individuals previously convicted of certain sexual offences, and thought to pose current risk of sexual harm to the public), or to work actively on the case (for instance, by arresting the offender for failing to comply with notification requirements).

We found that many local officers are not aware of the registered sex offenders living in their areas, and they therefore miss opportunities to gather routinely intelligence about those who pose the most risk to children. Some staff in the Jigsaw teams saw the sharing of such information as problematic and risky, in terms of not having control over how local officers would use the information, underestimating the opportunities that such a collaborative approach would bring to the management of an individual.

Performance management processes for Jigsaw teams are inconsistent and underdeveloped. The absence of consistent quantitative and qualitative data (such as figures on overdue or unsuccessful visits to sex offenders, on breaches of orders and action taken, or on the ratio of offender managers to offenders managed) prevents senior officers, specifically borough commanders, from developing a full understanding of the risks being managed locally, and of any associated issues.

We found backlogs in visits in some of these teams. One borough had a backlog of 70 overdue visits, and in another there were 40 outstanding visits to registered sex offenders, the oldest being from October 2015. There were no clear governance arrangements in place to manage these significant areas of risk.

Staff cited one case where an RSO had not been seen during a home visit, but only when attending the police station since October 2013, which prevented officers from gathering the sort of intelligence obtainable from a home visit to assess risk. In another borough, an officer stated that they had an RSO who had not been seen in three years, because he had never been in when the police called.

MAPPA

MAPPA include regular meetings aimed at:

- sharing information to support multi-agency risk assessments; and
- formulating effective risk management plans to manage the risk of serious harm posed by dangerous offenders, including registered sex offenders.

Our review of MAPPA minutes showed that sometimes important agencies (such as children's social care) were not in attendance. The absence of major partners could compromise the effectiveness both of these meetings and of any risk management plans discussed and agreed. We recognise that it is not the role of the police to secure attendance of partners at such meetings, but they do have a role in escalating this as a concern to the MAPPA co-ordinator.

MAPPA guidance currently states that the police should attend all level 2 and 3 meetings, with the rank of officer required for level 2 meetings being inspector, and, for level 3 meetings, superintendent. We found that on some occasions the representative for level 2 was a sergeant and for level 3 a chief inspector. It is vital that such attendees are appropriately briefed and knowledgeable and have the ability to make decisions and where necessary commit resources on behalf of the force.

Overall, we found good evidence of agencies working together to formulate effective plans to mitigate the risks posed by individuals.

Conclusion

Borough officers are often unaware of the registered sex offenders in their areas and so miss opportunities to gather intelligence routinely about those who pose the most risk to children. Also, we were concerned to find backlogs in visits to registered sex offenders, and reluctance on the part of some Jigsaw officers to share information with their borough colleagues.

10. Police detention

Introduction: what is effective practice in this area?

Our inspection considered the extent to which children and young people are detained in police custody only when absolutely necessary. We sought evidence that children in custody are protected from harm and every effort is made to release them or to transfer them to more appropriate accommodation.

Evidence of this (as set out in our published assessment criteria) includes:

- Initial arrests are lawful (in accordance with the Police and Criminal Evidence Act 1984), proportionate and necessary.
- Arrests are authorised by custody officers who understand and recognise the needs of children and make decisions taking their needs into account.
- Arrested children and young people are provided with prompt access to appropriate adults⁵⁷ and other people able to support them while in detention.
- Children and young people are protected from harm while in police detention, e.g., there are risk assessments, they have appropriate rooms and regular visits, and they are kept away from adult detainees.
- Post charge (or decision to release without charge), arrested children and young people who are recognised as needing continued detention or to be accommodated are transferred to the care of the local authority, unless it is unsafe to do so.
- Children and young people detained under the provisions of section 136 of the Mental Health Act 1983 are taken to a 'place of safety' other than a police custody centre (for instance, a hospital).
- Where arrested children or young people are identified as being at risk of harm, police work with partners to remove or reduce it.

Results of the case file audit

The detention of people in police custody within the MPS comes under the responsibility of the MPS Detention Command.

We examined 40 cases of children in detention (34 boys and 6 girls). The youngest was 11 years old and the oldest 17. They had been detained on suspicion of offences which included common assault, robbery, possession of an offensive

⁵⁷ Information on the role of an appropriate adult is set out on p,x,

weapon and murder. No child had been detained under section 136 of the Mental Health Act 1983. We found children routinely were handed over to custody in handcuffs (in almost all the cases examined); in one case a 15-year-old female was handcuffed to a co-detainee.

Two senior officers we spoke to stated that there was a focus on keeping prolific offenders in custody to prevent further offending, that if a child had been detained after charge, then custody was the best place for them because they could be protected, and the public would not expect the police to release such offenders into the care of the local authority. Some supervisors stated that, if a child had been charged and bail was refused, then secure accommodation was the only option. While some of the cases audited were in relation to allegations of serious offences, the current approach by the MPS identifies a clear failing to appreciate the child protection implications of such an approach.

The MPS acknowledges that there is a need to improve the post-charge response for children in custody and ensure appropriate accommodation outside custody is found.

Some 34 out of the 40 cases we examined were assessed as either 'requires improvement' (20 cases) or 'inadequate' (14 cases). MPS had self-assessed 12 of the 40 cases we assessed. MPS assessed 11 as 'good' and 1 as 'adequate'. This contrasts with our assessment of those 12 cases, where we judged 6 as 'inadequate', 4 as 'requires improvement', 1 as 'adequate' and 1 as 'good'.

We examined the ways that officers recognised, assessed and recorded the risk relating to children's detention in custody, and were concerned to find them inconsistent and frequently unsatisfactory. We found that officers did not always submit Merlin reports to refer safeguarding concerns for further assessment, and, where information was recorded, it was not used to inform the assessment of risk or the actions of staff.

The failure to record or consider such assessments restricts the ability of custody staff to take previous risks into account, and results in poorer decisions, which are not in the best interest of children.

We were informed, however, that suspects that are dealt with by the Predatory Offenders Unit are provided with supportive literature from the Lucy Faithfull foundation (which is a child protection charity specialising in working with individuals perpetrating and affected by child sexual abuse) and given information about supportive services prior to their release from custody.

Identifying risk of self-harm

A 17-year-old was arrested for harassment and breach of a non-molestation order. During the period of detention, it was alleged that he had taken a significant amount of crack cocaine before he was arrested, so officers called an ambulance. After the disclosure regarding the drugs, and while he was waiting for the ambulance, the detainee tied his top round his neck, which was regarded by staff as disruptive behaviour.

Although the detainee did then remove the jumper from round his neck, it was not seized by custody staff. Officers visited the detainee 26 minutes later and found that he had tied the jumper round his neck again, which was still considered to be attention-seeking rather than an attempt at self-harm.

Previous concerns about the risk of self-harm for this individual had been recorded in the MPS system on a Merlin report, when a support worker had contacted the police about the individual's threats to harm himself with a knife.

This should have established the risk of self-harm this young person posed while in custody, so that the incidents of him placing his clothing round his neck could have been interpreted as indicative of self-harm rather than as disruptive behaviour. We could not find a Merlin record for this case that listed the drug and self-harm events that happened during this detention.

Detention in custody after charging

In cases of post-charge detention, the local authority is responsible for providing appropriate accommodation if a child is to be detained overnight.⁵⁸ It is only in exceptional circumstances 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.

Given this, we were concerned to see high numbers of children detained in custody after being charged. In the 40 cases we audited, we found 39 resulted in the child being charged, refused bail, and kept in police custody to appear at court.

In the one case where a child was bailed from the police station for an offence of common assault, we found that it was 17 hours before an appropriate adult attended. The child remained in custody for over 19 hours, yet the case was subsequently finalised as requiring no further action.

⁵⁸ 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 or she certifies that 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.

We found examples of custody officers requesting secure accommodation when alternative accommodation should have been requested. Secure accommodation should be requested only if other accommodation would not protect the public from serious harm from that child. Furthermore, we found contradictory entries in a review of detention, in custody records and in detention certificates specifying why a child was being detained and why a type of accommodation was required.

Poor record keeping is a significant concern, particularly in the context of important information, such as legal grounds for the serious step of detaining children, the rationale for refusing bail, and explanations for not transferring children to local authority accommodation.

Staff told us about a lack of appropriate bed provision in some cases, but we have not been able to find evidence of escalation by senior officers with relevant partners to resolve the issue. LSCB chairs and directors of children's services reported that this issue had not been escalated to them, although they acknowledged that the availability of secure beds was problematic.⁵⁹

Appropriate adults

An appropriate adult⁶⁰ is responsible for protecting (or 'safeguarding') the rights and welfare of a child or 'mentally vulnerable' adult who is detained by police. Their responsibilities are:

- to support, advise and assist the child or young person while in detention, including during any interview;
- to ensure that the child or young person understands their rights and that the appropriate adult has a role in protecting their rights;
- to observe whether the police are acting properly, fairly and with respect for the rights of the child or young person and to tell them if they are not; and
- to assist with communication between the child or young person and the police.

⁵⁹ In January 2015, the then Home Secretary and the Secretary of State for Education wrote to lead members for children's services highlighting problems in some areas in complying with the need to transfer children from police custody to local authority accommodation.

⁶⁰ An appropriate adult is a parent, guardian or social worker, or if no person matching this description is available, any responsible person over 18. In England and Wales, an appropriate adult must be called by police whenever they detain or interview a child or vulnerable adult. They must be present for a range of police processes, including intimate searches and identification procedures, to safeguard the interests of children detained or questioned by police officers.

We found that responsibility for making the request for appropriate adults to attend often rested with the investigating officer rather than with custody staff (contrary to Code C of the Police and Criminal Evidence (PACE) Act 1984), so the request was often linked to the times of interviews rather than to the need to support a child in detention. This is leading to unacceptable delays. The cases we examined revealed significant delays for children presented to custody in the evening, who often did not have an appropriate adult until the investigating officer was ready to interview the following day.

We also found cases where the child's rights were not repeated in the presence of an appropriate adult (or, if they had been, there was no endorsing signature to that effect). Similarly, charge sheets were not routinely signed by the appropriate adult, suggesting that they had not been present when the child was charged.

We had significant concerns about officers' failures to keep children informed about the progress of an investigation while they were detained in police custody. A number of custody PACE reviews⁶¹ (which examine the need for continued detention without charge) had been conducted over the telephone as the reviewing inspector was at another location, or when the child was asleep or in interview. In one case, the child's detention was subject to three reviews by an inspector during the period of detention, but none of them involved a conversation with the young person to tell him that his continued detention had been authorised; it was documented that the child had been asleep during all the reviews.

While staff working in custody have received some training, the staff we spoke to for the purpose of this inspection told us that they had not undertaken training in child protection or sexual exploitation. This is of concern, as it undermines the police's ability to recognise signs of exploitation, vulnerability and risks to detainees in order to refer them or offer support while they are in custody.

We learnt of a positive initiative at Kingston custody area, where a forensic mental health practitioner from the mental wellbeing charity Together works within the custody area. The aim is to ensure that vulnerable individuals have access to qualified mental health practitioners at the earliest opportunity, so they can be referred on to appropriate support. Staff will speak to all young people who come into custody to identify any social need that makes them vulnerable. They will also try to screen for CSE risks and, where appropriate, make referrals to the local MASH and children's social care. The post is currently funded by the clinical commissioning group until March 2017.

⁶¹ *Police and Criminal Evidence Act 1984 Code C*, Revised code of practice for the detention, treatment and questioning of persons by police officers.

Conclusion

Children are frequently detained in custody after they have been charged rather than being moved to more appropriate accommodation. In the 40 custody cases we audited, we found 39 that resulted in the child being charged, refused bail and kept in police custody to appear in court.

While staff working in custody have received some training, we are particularly concerned that the staff we spoke to for the purpose of this inspection told us that they had not undertaken training in child protection or sexual exploitation. This weakens the police's ability to offer the right kind of targeted support while young people are in custody.

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

It is clear to inspectors that the majority of specialist staff responsible for managing child abuse investigations are knowledgeable, skilled, committed and motivated. Despite this, there are inconsistencies and significant weaknesses in the service the MPS provides to vulnerable children in a wide range of areas.

The MPS is the first force that HMIC has inspected as part of its child protection programme to have no chief officer appointed to be responsible and accountable for all child protection matters across the force (i.e. an individual who covers both the specialist and territorial teams and police practice).

This absence of oversight cannot be justified; it exacerbates the inconsistency of officers' responses to child protection cases and the inconsistency in how the force works with partner organisations across London.

Also, it means that there is limited force-wide oversight of how well the MPS understands or responds to demands and outcomes in relation to child protection.

The force has already recognised many of the challenges detailed in this report, particularly the inconsistency in practice across London. Although it is not possible at this stage to assess the framework that is being developed for a new structure to protect vulnerable people within the 'One Met Model', this work could offer a real opportunity to improve the current response.

Too many cases fell well short of the expected standards required for a good investigation. Many took too long to progress and had no effective supervisory oversight, resulting in a lack of protection for victims, loss of evidence, and continuing risk from offenders.

Staff whose job it is to respond to and investigate such challenging and often distressing cases need to be competent, trained and supported. This is not consistently the case in the MPS.

The response to children who regularly go missing from home needs improvement, with a focus on early intervention and on ensuring that officers and staff understand the link between children who regularly go missing and sexual exploitation.

The force and its partner organisations have undertaken work locally to develop a greater understanding of CSE within their areas. However, there is still much more to do to understand the nature and full extent of CSE across all the communities they serve, and how these cases often transcend borough boundaries, to ensure appropriate and timely sharing of information on which to base an active response to

these problems. The management of registered sexual offenders also needs to improve urgently.

Too many children are being detained unnecessarily in police custody after being charged, when they should be transferred to the care of the local authority.

There is a lack of child protection performance data in boroughs, and of oversight and therefore leadership in the context of children detained in custody, or subject to CAIT or Sapphire investigations.

The strongest evidence in this report comes from the findings of the case audit reviews conducted by HMIC. They clearly demonstrate a gap between child protection policy and procedures, and what happens on the front line.

Next steps

Within six weeks of the publication of this report, HMIC will require an update on the action that the MPS is taking to respond to those recommendations (see pp.95–98) which are to be acted on immediately.

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

HMIC will return to the force in 2017 to assess how it is managing the implementation of its response to all of the recommendations.

Recommendations

Immediately

1. The Metropolitan Police Service should put in place arrangements which ensure that it has clear governance structures in place to monitor child protection practices, across both borough teams and specialist units. The force should then provide officers and staff with a clear understanding of what good service looks like and the standards it expects, and begin to develop a performance management framework that will operate to achieve consistent standards of service across London.
2. The Metropolitan Police Service should put in place an action plan to ensure it improves practice in cases of children who go missing from home. As a minimum, this should include:
 - improving staff awareness at all levels within the central communications command of the need to create better risk assessments and to enable appropriate use of the 'absent' category. Staff should be aware of the importance of drawing together all available information from police systems, including information about those who pose a risk to children;
 - providing training in relation to the use of both the absent and the missing persons' categories;
 - improving staff awareness of the links between children going missing from home and the risk of sexual exploitation, particularly where there are repeat episodes; and
 - putting arrangements in place to ensure that, where there are repeat missing or absent episodes, they work with partner organisations to share information and implement 'trigger plans' to forestall further episodes.

3. The Metropolitan Police Service should put in place an action plan to ensure that it:

- reinforces messages to all staff about their individual and collective safeguarding responsibilities, ensuring they assess actively both any immediate risks or concerns and any wider risks that may affect other children when they respond to incidents or conduct investigations;
- records and communicates any such concerns or incidents appropriately, flags them and submits them promptly on Merlin forms;
- reviews together with children's social care its responsibilities for attendance at and contribution to strategy discussions and child protection conferences; and
- provides guidance on what information (and in what form) this should be recorded on systems to ensure that it is readily accessible in all cases where there are concerns about children.

4. The Metropolitan Police Service should take action to:

- review the current standing operating procedures and identified aggravating factors regarding officers dealing with suspects for possessing indecent images of children, and those suspects' access to children within their own family;
- reduce the delays in visiting registered sex offenders and improve the management and response to them;
- review attendance at MAPPA, ensuring it is at an appropriate level to be able to take decisions on behalf of the MPS to protect vulnerable children from those who pose the most risk of harm; and
- ensure that appropriate information on registered sex offenders is made available routinely to local officers.

Within three months

5. The Metropolitan Police Service should ensure that it:
 - develops and improves planning of its responses to and investigation of child abuse, child sexual exploitation and missing children, so that it can protect children at an earlier stage; and
 - develops a performance framework to report on the results of the service it provides to children.
6. The Metropolitan Police Service should take action to improve child protection investigations by ensuring that:
 - it provides guidance to staff that identifies the range of responses and actions that the police can contribute to multi-agency plans for protecting children;
 - every referral the police receives is allocated to those with the skills, capacity and competence to undertake the investigation;
 - investigations are supervised and monitored, with supervisor reviews recording clearly any further work that may need to be done;
 - it conducts regular audits of practice that include assessing the quality, timeliness and supervision of investigations; and
 - it works with the Crown Prosecution Service to monitor and improve the timeliness of case management.

Within six months

7. The Metropolitan Police Service should demonstrate the use of a performance framework (that it has developed within three months) to inform resourcing and planning decisions in order to bring about improvement.

8. The Metropolitan Police Service, in conjunction with children's social care services and other relevant agencies, should review how it manages the detention of children. As a minimum, the review should enhance child protection by:

- improving the awareness of custody staff of child protection and CSE, and of the support children require at the time of detention and on release;
- ensuring the prompt submission of a Merlin form to record the child's detention to help inform future risk assessments;
- assessing at an early stage the need for secure or other accommodation and working with children's social care services to achieve the best option for the child;
- ensuring that custody staff comply with their statutory duties by completing detention certificates and custody record entries to the required standard, if children are detained in police custody for any reason; and
- securing adequate appropriate adult support in a timely fashion.

9. The Metropolitan Police Service should undertake a skills audit to:

- assess the training required for those undertaking specialist child protection work with no previous detective or child protection experience;
- establish that staff in both boroughs and the Specialist Crime and Operations directorate dealing with child protection matters such as child abuse, indecent images of children, child sexual exploitation and missing persons are appropriately trained to carry out their duties; and
- determine how well staff understand CSE, including its potential links with missing and absent children.

Glossary

absent	defined by the NPCC as "A person not at a place where they are expected or required to be and there is no apparent risk."; absent cases are treated with less urgency by the police than when individuals are classified as 'missing', because the expectation is that the individual will return of his or her own accord, without the need for a police investigation
appropriate adult	a parent, guardian or social worker or, if no person matching this description is available, and responsible person over the age of 18 who is responsible for protecting the rights and welfare of a child or 'mentally vulnerable' adult who is detained by the police; in England and Wales, must be called by police whenever they detain or interview a child or vulnerable adult; must also be present for a range of police processes, including intimate searches and identification procedures, to safeguard the interests of children detained or questioned by the police; role was established alongside the Police and Criminal Evidence Act 1984
BOCU	borough operational command unit
borough operational command unit	MPS unit providing policing services which are aligned to local communities; one in each of the 32 London boroughs; commanded by a chief superintendent
CAIT	child abuse investigation team

central communications command	centres responsible for receiving emergency and non-emergency calls to the MPS
CEOP	child exploitation and online protection
child	person under the age of 18
child abduction warning	notice the police may issue to an adult who is spending time with a child under 16 (or under 18 if looked after by the local authority) if the police think the adult may be harmful to the child; can prohibit contact between the adult and the child; can be a powerful tool in discouraging contact between an adult and vulnerable child established by the Child Abduction Act 1984
child abuse investigation team	MPS team; responsible for investigating allegations of abuse relating to children under 18 years of age
child exploitation and online protection command	National Crime Agency unit responsible for working both nationally and internationally to establish what the main threats to children are, and to co-ordinate activity against these threats to bring offenders to account (including online child sex offenders, and those involved in the production, distribution and viewing of child abuse material); formerly the independent Child Exploitation and Online Protection Centre; absorbed as a command in the National Crime Agency in 2013

child in need	defined under the Children Act 1989 as a child who is unlikely to reach, or maintain, a satisfactory level of health or development, or whose health and development will be significantly impaired without the provision of services, or a child who is disabled
child independent sexual violence advisor	independent worker, commissioned by the police, who can provide practical and emotional support to 11 to 17-year old victims of rape, sexual abuse or sexual exploitation; liaises between the police, courts and other agencies, acting as an advocate for the victim
child protection review conference	multi-agency meeting or phone call involving children's social care services, the police, health and other bodies to plan rapid future action if there is reasonable cause to suspect a child is suffering (or is likely to suffer) significant harm
child sexual exploitation	as set out in the nationally-agreed NPCC definition, the sexual exploitation of children and young people under 18 which involves exploitative situations, contexts and relationships where the young person (or third person/s) receives 'something' (e.g., food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing sexual activities, and/or having others performing sexual activities on them; CSE can occur through the use of technology without the child's immediate recognition; for example, being persuaded to post images on the internet/mobile phones without immediate payment or gain
ChISV	child independent sexual violence advisor

College of Policing	professional body for policing; established to set standards in professional development, including codes of practice and regulations, to ensure consistency across the 43 forces in England and Wales; also has a remit to set standards for the police service on training, development, skills and qualifications
(Met) Command and Control centres	three MPS communications centres, based in Bow, Lambeth and Hounslow; responsible for handling emergency calls and other incoming calls into the MPS, and despatching officers to deal with incidents across the capital; also provides specialist police communications support; 1,706 staff work across the three centres
community safety unit	MPS unit within the BOCUs; comprise specialist staff who investigate reported incidents of domestic violence, homophobia, transphobia, racism, and criminal offences where a person has been targeted because of their perceived race, faith, sexual orientation or disability
continuous improvement team	MPS team within the SOECA command; responsible for reviewing the quality of decision-making and practice, resourcing and processes across SOECA
CSE	child sexual exploitation
DASH assessment	model for identifying, assessing and managing the risks to victims from domestic abuse, stalking and harassment offences; aims to help frontline practitioners identify high-risk cases involving these offences; adopted by UK police forces in 2009

emergency powers	police powers to enter premises and remove a child to ensure that child's immediate protection; provided for by section 46 of the Children Act 1989
emergency protection order	order which provides the applicant with the power to remove a child, or to keep him or her in a safe place for a specified duration; applications for the order must be made to the court; under section 44 of the Children Act 1989, the court must be satisfied that the child is suffering, or if likely to suffer, significant harm
executive level	chief police officer team
flags	markers on police IT systems which highlight particular characteristics or needs, and which enable police officers to assess risks effectively
Havens	three specialist sexual assault referral centres in London, which provide forensic medical examinations and immediate aftercare for both adults and children who have been raped or sexually assaulted; managed by King's College Hospital NHS Foundation Trust, and jointly funded by NHS England and the MPS; based in Camberwell, Paddington and Whitechapel
IDVA	independent domestic violence advisor
independent domestic violence advisor	independent worker, responsible for being the primary point of contact for victims at high risk of harm from intimate partners, ex-partners of family members, with the aim of securing their safety, and those of their children

(independent) return interviews	carried out by non-statutory agencies with children who go missing when those children have returned to try to establish why the child went missing and what might need to be done to prevent it happening again or to keep the child safe in the future
intermediary	individual who works with vulnerable victims and witnesses, communicating with and on behalf of them as they move through the criminal justice system; functions established by section 29(2) of the Youth and Criminal Evidence Act 1999
Jigsaw team	MPS team responsible for the management of sexual and violent offenders
local safeguarding children board	statutory body, established in every local authority, which is independently chaired and consists of senior representatives of agencies and organisations working together to safeguard and promote the welfare of children and young people in the City; established by section 13 of the Children Act 2004
LSCB	local safeguarding children board
MAPPA	multi-agency public protection arrangements
MARAC	multi-agency risk assessment
MASE	multi-agency sexual exploitation meeting
MASH	multi-agency safeguarding hub
Merlin	MPS's missing persons database

missing	defined by the NPCC as "Anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be the subject of a crime or at risk of harm to themselves or another"; missing cases are treated more seriously and with greater urgency by the police than when individuals are classified as 'absent'; in the MPS, a missing classification means the police will actively seek to establish the person's location
missing persons' coordinator	a person who collates information on all instances of absence and missing people in order to inform interventions to prevent repeat episodes
missing persons unit	MPS team responsible for investigations when people are missing
MOPAC	Mayor's Office for Policing and Crime
MOPAC 7	MOPAC's seven principal neighbourhood crime types which are to be particular priorities for the MPS; these are burglary, criminal damage, robbery, theft from a motor vehicle, theft from a person, theft of a motor vehicle and violence with injury
MPS	Metropolitan Police Service; the police service for the people of London

multi-agency public protection arrangements

mechanism through which local criminal justice agencies (police, prison and probation trusts) and other bodies dealing with offenders work together in partnership to protect the public from serious harm by managing sexual and violent offenders; established in each of the 42 criminal justice areas in England and Wales by sections 325 to 327B of the Criminal Justice Act 2003

multi-agency risk assessment conference

locally-held meeting of statutory and voluntary agency representatives to 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; agencies that attend vary, but are likely to include the police, probation, children's, health and housing services; over 250 currently in operation across England and Wales

multi-agency safeguarding hub

hub in which public sector organisations with responsibilities for the safety of vulnerable people work; it has staff from organisations such as the police and local authority social services, who work alongside one another, sharing information and coordinating activities to help protect the most vulnerable children and adults from harm, neglect and abuse

multi-agency sexual exploitation meeting

forum for the police and partner organisations to agree local operational activity to tackle CSE threats, focused on safeguarding victims, disrupting perpetrators, targeting locations and exchanging information; chaired by the local borough police, and attended by the strategic leads for partners such as the local authority and children's social care

National Centre for Applied Learning Technologies

collaboration between the MPS and the College of Policing which produces and provides e-learning on a range of policing topics to the 43 police forces in England and Wales (as well as national forces, such as the British Transport Police); established in 2002 through a collaboration between the MPS and the Central Police Training and Development Authority (Centrex, which was established under Part 4 of the Criminal Justice and Police Act 2001)

National Crime Agency

non-ministerial department established under the Crime and Courts Act 2013 as an operational crime-fighting agency to work at a national level to tackle organised crime, strengthen national borders, fight fraud and cyber-crime, and protect children and young people from sexual abuse and exploitation; provides leadership in these areas through its organised crime, border policing, economic crime and Child Exploitation and Online Protection Centre commands, the National Cyber Crime Unit and specialist capability teams

National Police Chiefs' Council	organisation which brings together the 43 operationally independent and locally accountable chief constables and their chief officer teams to co-ordinate national operational policing; works closely with the College of Policing, which is responsible for developing professional standards, to develop national approaches on issues such as finance, technology and human resources; replaced the Association of Chief Police Officers on 1 April 2015
notification requirements	set of instructions with which registered sex offenders must comply when placed on the Sex Offenders Register; examples include the requirement to notify the police, within three days of conviction (in person, and at a prescribed police station) of their name, address, date of birth, passport details, credit card and bank details, and national insurance number; further detail in the Sexual Offences Act 2003 (Notification Requirements) (England and Wales) Regulations 2012
partnership team	MPS team within the SOECA command; responsible for working with partner agencies and different organisations to improve the care of victims and the welfare of children who need safeguarding; also identifies opportunities to prevent child abuse and sexual offences
PCSOs	police community support officers
perpetrator	someone who has committed a crime
police community support officers	uniformed staff whose role is to support the work of police officers within the community

police officer	individual with warranted powers of arrest, search and detention who, under the direction of his or her chief constable, is deployed to uphold the law, protect life and property, maintain and restore the Queen's peace, and pursue and bring offenders to justice
police protection powers	powers exercisable by a police officer to remove a child to a place of safety if the child is considered to be at risk of significant harm; established by section 46 of the Children Act 1989
predatory offenders unit	MPS team within the SOECA command; specialises in combating the activities of those who manufacture and distribute indecent images of children; also tackles child abuse on the internet by targeting the activities of paedophiles on line, including the grooming of potential victims
professional lead	nominated senior organisational lead for a particular discipline
protecting vulnerable people lead	person responsible for the oversight of all public protection matters
rape and serious sexual offence unit	rape and serious sexual offence unit
RASSO	Crown Prosecution Service team; responsible for providing specialist legal advice and support to victims, and dealing with cases of rape and serious sexual offences, including child sexual abuse
risk assessment	assessment intended to assist officers in deciding appropriate levels of intervention for victims

safe and well check	interview carried out by a police officer with a missing person when they are found or return to ensure that he or she is safe and well
safeguarding	term which is broader than 'child protection' and relates to the action taken to promote the welfare of children and protect them from harm
Sapphire team	responsible for the investigation of rapes and other serious sexual offences
section 47 enquiry	enquiry under section 47 of the Children's Act 1989, which relates to a child 'in need' of protection rather than 'at risk of harm'
sexual assault referral centres	specialist units providing forensic medical examinations and immediate aftercare for both adults and children who have been raped or sexually assaulted
sexual exploitation team	MPS team within the SOECA command; responsible for reviewing all CSE concerns after the initial assessment team has recorded, assessed and categorised them on the Crime Report Information System
sexual harm prevention order	order imposing (sometimes wide-ranging) prohibitions on an individual who has been convicted of an offence listed in either Schedule 3 or Schedule 5 to the Sexual Offences Act 2003 (either in the UK or overseas, and who the court believes presents a risk of sexual harm to the public; an individual may be prohibited from working with children, for instance, or from engaging in particular activities on the internet
Sexual Offences, Exploitation and Child Abuse Command	MPS command including teams involved in child protection work

sexual violence	any act, attempt, or threat of a sexual nature that results, or is likely to result, in physical, psychological and emotional harm
SOECA	Sexual Offences, Exploitation and Child Abuse Command
trigger plan	force document outlining the plan to locate a child quickly when he or she goes missing
vulnerable person	individual who is in need of special care, support, or protection because of age, disability, or risk of abuse or neglect, or is a ward of court (child or young person for whom a guardian has been appointed by the court or who has become directly subject to the authority of that court)

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 assist forces in improving their 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*, published in March 2015. 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 focus on the experience of, and the results for, children, following their journey through the child protection and criminal investigation processes. They assess 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. The inspections consider how the arrangements for protecting children, and the leadership and management of the police service, contribute to and support effective practice on the ground. The team considers how well management responsibilities for child protection, as set out in the statutory guidance, have been 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; and
- Examination of service statistics, reports, policies and other relevant written materials.

The purpose of the self-assessment is to:

- raise awareness in the service about the strengths and weaknesses of current practice (this forms the basis for discussions with HMIC); and
- initiate future service improvements and establish a baseline against which to measure progress.

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 about children potentially at risk of harm;
- the exercise of powers of police protection under section 46 of the Children Act 1989 (taking children into a 'place of safety');
- the completion of section 47 Children Act 1989 enquiries, including both those of a criminal nature and those of a non-criminal nature (section 47 enquiries are those relating to a child 'in need' rather than 'at risk');
- sex offender management;
- the management of missing children;
- CSE; and
- the detention of children in police custody.