HMICFRS

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services

National Child Protection Inspection – assessment of progress

Metropolitan Police Service

11 January–12 February 2021

Contents

Introduction

This report sets out findings from our 2021 assessment of the progress made by the Metropolitan Police Service (MPS) against recommendations and findings from our 2016, 2017 and 2018 child protection inspections.

Our 2016 inspection

In 2016, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) inspected the MPS's approach to child protection and the service it provides to children in the Greater London area. This was part of our rolling programme of child protection inspections.

In November 2016, we published our findings. We concluded that there were fundamental and widespread deficiencies in the way the force understood and dealt with the needs of and risks to children. As a result, children were being adversely affected.

Our report set out a series of recommendations for improving child protection practice. Four needed immediate action by the force. These were to:

- establish governance and oversight of child protection practices;
- improve the response to children who go missing from home;
- increase the understanding and awareness of risks to children; and
- improve the management of people posing a risk to children.

We recommended that within three months, the force should improve:

- the planning and initial response to child abuse and protection matters; and
- how it investigates child protection matters.

And we recommended that within six months, the MPS should:

- review how resources are managed to better meet the demands of child protection matters;
- review, with children's social care, practices used to detain children; and
- audit the skills and experience of staff involved in safeguarding investigations.

Our 2017 quarterly assessments

Because the failings we found in 2016 were serious, the Home Secretary commissioned us to publish quarterly reports in 2017 about the force's progress against our recommendations.

Our quarter 1 report (published 20 June 2017) assessed the action and improvement plan produced by the force. The quarters 2 and 3 reports (published August 2017 and November 2017, respectively) assessed progress against the action and improvement plan. And our quarter 4 report (published February 2018) assessed the effect of improvements that the force had made on the service provided to children.

Overall, although the force had increased its efforts to make progress, we were concerned that some of the changes were failing to improve outcomes for children. And we were still finding many of the same problems in case files as we had found in 2016.

So we recommended that the force continue with our 2016 recommendations, making sure to review the effectiveness of the changes they were making (which included some major reforms of safeguarding structures). We also said the MPS should act immediately to improve its frontline services in protecting children. We also said it should put in place arrangements for scrutinising, challenging and analysing how well it was responding to children in need of help and protection.

The 2018 post-inspection review

In October 2018, we assessed the force's progress in a post-inspection review. We looked for evidence of improvements in the nature and quality of frontline practice and outcomes for children. We wanted to see evidence that the new safeguarding structures put in place were effective.

Our findings, published in March 2019, assured us that there continued to be a focus on child protection matters and that long-term planning was in place. But we remained concerned that the responses provided to children weren't consistently effective.

We also had significant concerns about the force's ability to effectively investigate offences involving online child sexual abuse and exploitation. This prompted us to make a further recommendation for the force to urgently improve practice in this area. As a result, we committed to revisiting the force to assess its progress again. This report sets out our most recent findings.

The 2021 assessment

We started this inspection in early 2020, but the COVID-19 pandemic meant we had to postpone some of our work until 2021. We adapted the methodology for a remote inspection, using video calls for discussions with police officers and staff, their managers and leaders, together with online reviews of incidents and investigations.

During this inspection we:

- examined force policies, strategies and other documents;
- interviewed senior leaders, managers and frontline officers and staff, in some planned and some unannounced sessions; and
- audited 170 child protection cases. We graded 54 (32 percent) cases as good, 63 (37 percent) as requiring improvement and 53 (31 percent) as inadequate.

Summary of findings from the 2021 assessment

Senior leaders want to respond well to children who need safeguarding

Since our first child protection inspection, governance, performance management and oversight arrangements in this area have continued to evolve. Changes made immediately after the 2016 inspection didn't result in the consistent improvements we would have liked to see. This problem was compounded when the introduction of the new basic command unit (BCU) model led to some dips in performance.

But now there is a real sense that leaders want to engage staff at all levels in the force to make and influence the changes needed for better outcomes for children. Staff we spoke to knew about the recent changes and that public protection senior leadership was scrutinising specific areas. They also commented on a new energy and focus on child protection.

The current oversight arrangements are clearly defined and supported by an improvement plan with five clear main operational areas (capacity, capability, leadership, governance and partnership). There are also milestones and examples of success.

The public protection plan and a management board chaired by an assistant commissioner give senior officers a strong foundation to make improvements. The plan sets clear priorities. The board structure helps the force to understand progress against each area of activity and the associated outcomes (qualitive and quantitative) and risks. It also gives an opportunity to challenge and direct more scrutiny, analysis and action.

The size of the organisation and diverse arrangements for working with other organisations across London have previously been cited by the force as obstacles to an effective service. Some of these arrangements will continue to present challenges. But it is evident that, despite this, change is happening, and the force is making improvements for children who are vulnerable or at risk.

Police officers and staff on child-related investigations are committed to their roles

During our inspections, we continue to see examples of good work by individual frontline officers responding to incidents involving children. We also found highly committed specialist child protection staff. Some of them do their best to keep children safe and deal with some very complex investigations in an increasingly demanding and changing environment.

Officers and staff want to address promptly the areas of concern we identified during this inspection. This is positive, as is their recognition of the need for both individual and collective organisational learning.

We saw some examples of effective and engaged supervisory oversight, good joint working and safeguarding plans put in place with other organisations. These cases gave the best chance of a positive outcome for the child and of reducing future demand (for instance, by helping to stop a child going missing repeatedly).

But some staff said they are under significant pressures. They identified workloads, staff capability and supply of detectives with the right experience as contributing factors. It was evident that some of these pressures affect both staff welfare and their investigations.

In some areas, the force is seeking to manage the high workloads. We have also seen investment to address capacity issues, which has helped to ease some of these problems.

The force continues to improve its understanding of its service provision to children

The force uses themed audits by a dedicated inspection team and other assurance work to assess how its staff respond to children at risk, the effectiveness of service provision and the quality of its investigations.

But it could do more to use this understanding of good practice and development needs to inform both immediate and ongoing staff training. The force also needs to ensure all teams involved in such work are consistent in both approach and method.

Progress in some areas remains slow

Senior safeguarding leads show focus and oversight in improving child protection across London, but we haven't yet seen sustained improvements in all areas of work or decision making.

Despite our earlier recommendations, we are still concerned about how the force:

- manages registered sex offenders;
- carries out online abuse and exploitation investigations;
- uses the child abuse image database; and
- examines digital devices.

The force should act immediately to determine the level and extent of risks to children that these failings cause and act to mitigate them.

Online investigations remain an acute concern

Overall, we found that investigations of the viewing and sharing of indecent images of children do not focus enough on quickly identifying and protecting any children at risk from the offender. We saw cases where investigators delayed alerting children's social care to the fact that children were living in a house with someone who was potentially uploading images of child abuse because they did not want safeguarding to jeopardise the investigation. This potentially leaves children at risk.

We also found concerning delays in uploading images of child abuse to the national child abuse image database (CAID). We do not underestimate the size of this task. For instance, in one case, there were millions of images to review, classify and upload. But delays in this process mean delays to all parts of the system designed to tag new photos, identify them on online platforms and remove them. It also potentially means victims are not identified and safeguarded as quickly as they should be.

This is a national problem, which we intend to inspect in more detail.

Next steps

The pace of change since we first reported our findings in 2016 has at times been slow. But the force has now made progress in some areas and recognises there is more to do to achieve consistently better outcomes for children.

We will continue to evaluate the force's performance as part of our routine monitoring and will instigate closer scrutiny if we think it is needed.

2021 findings: Initial contact

Recommendation from the 2016 inspection report

The force should immediately put in place an action plan to make sure it improves practice in cases of children who go missing from home. As a minimum, this should include:

- improving staff awareness at all levels in the central communications command (CCCs) of the need for better risk assessments and for 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 using the 'absent' and the 'missing persons' categories;
- improving staff awareness of the links between children going missing from home and risk of sexual exploitation, especially with repeat episodes; and
- putting arrangements in place with partner organisations for sharing information and making trigger plans (which determine the main actions to be taken if a person is reported missing again, such as checking in certain places or talking to particular friends) to forestall further episodes after repeat 'missing' or 'absent' episodes.

2018 findings

Staff in the CCCs had received training on safeguarding and vulnerability. But some children were still being assessed as being at no apparent risk when reported missing, despite risk factors being identified.

The use of trigger plans to help find as quickly as possible a child who repeatedly goes missing had improved significantly but the force needed to do further work.

2021 findings

The initial categorisation for children reported as missing has improved

Children, specifically looked after children, who are reported missing are no longer classed as being absent with no apparent risk. Now all children get a police response, irrespective of their circumstances or background.

Staff are aware of potential links between children going missing and the risk of exploitation

Call handlers in the CCC told us how they take time to establish the circumstances of a child reported missing. Staff have received training about missing, safeguarding and the THRIVE risk assessment model. They have a good understanding of the links between going missing and being at risk of exploitation. As an extra support, a single point of contact for safeguarding is also attached to each CCC team to give training and advice.

The investigative response doesn't always match the identified level of risk

In most cases we reviewed, the risk grading and rationale for each missing report was appropriate. But the investigative response doesn't always match the identified level of risk and history of the child.

In the first 48 hours of a missing investigation, local teams mainly make telephone and office-based enquiries, with limited proactive work in the local area.

Supervisory input and oversight in some cases is generally restricted to approving the risk assessment rather than directing the investigation. This means that the missing persons units that take over the inquiry after 48 hours have to make basic enquiries that haven't been done by local officers.

But in high-risk cases that the criminal investigation department or public protection teams manage, we saw effective fast-track activity and joint work across specialist teams to find the child.

The force doesn't always use trigger plans to help direct investigations to find a child

Our 2017 quarter 4 report identified that there were only 32 trigger plans in place across London. We encouraged the force to examine the reasons behind this. In the 2021 inspection, the force provided current data showing that there are now 339 plans in place. This is a significant change from 2017.

We found that trigger plans are completed for the most vulnerable children.
But generally, they aren't used effectively to inform investigations. trigger plans are often mentioned in the police record, but their information didn't always feature in the lines of enquiry used to find a child. So the force may be missing early opportunities to quickly find a child and make sure they are safe.

Once the child has returned, police conduct a preventative interview to ensure they are safe and well. We found these generally focus on checking that the child has returned and establishing where they have been. These are both important things to check, but the force should also explore more widely any particular factors that led to the child going missing and any ongoing risk. In addition, some of the interviews take place by phone, which means officers can't see a child's demeanour or physical state.

Follow-up interviews when the child has returned home, which are the responsibility of the local authority, don't always result in extra information being passed to the police.

This limits opportunities to inform investigations and decision making in any future missing events and can inhibit long-term safety planning.

Missing persons co-ordinators are continuing their work to reduce repeat missing episodes

We found that missing persons co-ordinators have improved their involvement with other organisations and that long-term problem solving (to help prevent children going missing again) was better as a result. The force has also introduced the Philomena Protocol, a police project to increase the involvement of other organisations and information sharing. The aim is to make sure the police get an accurate report of risk when a child goes missing, which helps to inform their response.

2021 findings: Assessment and help

Recommendation from the 2016 inspection report

The force should put in place an action plan to:

- reinforce 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;
- record and communicate any concerns or incidents appropriately, flag them and submit them promptly on Merlin forms;
- review together with children's social care its responsibilities for attendance at and contribution to strategy discussions and child protection conferences; and
- provide guidance on what information (and in what form) this should be recorded on systems so that it is readily accessible in all cases where there are concerns about children.

2018 findings

The force designed an established child protection internal communications campaign called 'Spot it, Stop it' to raise awareness among staff about their safeguarding responsibilities.

Most cases where there were concerns about a child's welfare or vulnerability resulted in a referral to children's social care services. But there was often no follow up to these referrals to check the response or the decision making by other organisations.

Access for officers to internal safeguarding advice and guidance had improved, with toolkits and extra guidance to help them in their duties.

2021 findings

Information sharing is seen as an administrative process rather than an important way of protecting children

Exchanging information with other organisations takes place through the multi-agency safeguarding hub (MASH) process. We found police sergeants in the MASH haven't been trained for their role and don't have a background in child protection or detective experience.

The force uses the Merlin IT application to record details of vulnerable children. Merlin forms refer a child for assessment when officers are worried about a child's safety or wellbeing. There are no police referral backlogs in any of the London safeguarding hubs, but this is because the force sends most Merlin information forms as a notification rather than a referral. That means the force passes on the forms but does not expect any particular action by children's social care services. Current processes don't show clearly if the force is referring a case to children's social care services because officers are concerned that a child is (or is likely to be) suffering significant harm. If the force shares a Merlin form with a local authority as a notification only, there is no statutory requirement for that authority to tell the police what action and decisions it has taken. Also, unless a child abuse investigation team (CAIT) is handling the case, the force doesn't prompt strategy discussions when officers are concerned about a child. This means the force can't challenge decision making or make sure other organisations are safeguarding children.

Officers don't always recognise when they should have strategy discussions for the cases that fall outside the remit of specialists. They rely too much on the CAIT referral desks being able to meet the demand for strategy discussions. These happen in cases involving children that are missing, exploited or living with domestic abuse.

Attendance at initial child protection conferences is good

Police consistently attend initial child protection conferences, with most areas reporting almost 100 percent attendance. Between January and November 2020, there were 4,711 initial conferences and the force attended 4,621. This involvement supports good information sharing and contributes to risk assessment and safety planning for the child. The force sends reports to support most review conferences.

2021 findings: Investigation

Recommendation from the 2016 inspection report

The force should make sure 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.

The force should act to improve child protection investigations by making sure 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 force receives is allocated to people 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 be needed;
- it regularly audits practice, including assessing the quality, pace and supervision of investigations; and
- it works with the Crown Prosecution Service to monitor and improve the pace of case management.

2018 findings

The police response often focused solely on dealing with children's immediate behaviour. Officers and staff didn't always analyse historical factors or use multi-agency information to help them understand a child's situation, their vulnerability or the causes.

We found that officers and staff didn't always speak to children. As a result, opportunities to hear children's views or help them disclose abuse or neglect can be missed.

Often, the reasons officers made decisions in cases aren't clear and supervisors didn't consistently challenge investigation progress or how officers followed up lines of enquiry.

The structure for investigating cases involving online offences and indecent images of children wasn't working in 2018.

Recommendation from the 2018 inspection report

The force should act to improve the quality and pace of investigations of online child exploitation and abuse. Specifically, this should include:

- reducing or eliminating delays in investigating online abuse;
- making sure that it promptly shares information about children at risk of online abuse with safeguarding organisations and that it develops appropriate protective plans;
- allocating investigations about online abuse or exploitation to teams with the skills and experience to manage them effectively; and
- examining seized devices (using triage technology for non-specialists) and that only devices known or suspected to contain indecent images are sent for further examination.

2021 findings

The force is working to improve the quality of investigations involving children

The force, the Mayor's Office for Policing and Crime (MOPAC)[1] and an external supplier have jointly introduced Operation Aegis in the South BCU (Bromley, Croydon and Sutton). The purpose of this pilot operation is to improve safeguarding and outcomes for children through its child protection investigations. The operation seeks to improve the investigative skill and knowledge of police officers and police staff through advice and guidance provided by experienced practitioners. It also uses audits to understand the impact of this approach. While the force reported that areas involved in the pilot saw better investigative results, the review of cases and incidents we undertook did not show any significant difference in these areas when compared across all BCUs. This model will be expanded across the force, but it will take time to make sure the early successes reported in the South BCU are sustained during the change.

Public protection investigators should hold no more than 14 active investigations at a time. But there are different levels of investigation and timeframes involved, depending on the complexity of the crimes within each strand of public protection. Also, levels of demand and the current multi-skilled approach mean that the number of investigations held by officers can and does differ significantly across different teams.

In community safety units (CSU), we were told that temporary detectives often have high workloads, with more than 16 cases each.

[1] Through MOPAC, the Mayor and Deputy Mayor are responsible for oversight of the Metropolitan Police Service's performance and setting the strategic direction of policing in London.

Shift patterns can make investigating child protection cases difficult

The corporate shift pattern for all staff across the force doesn't allow for the demands of working with other organisations. In some cases it has made joint working harder, leading to delays or isolated working. In response, individual BCUs have established their own local agreements. That way, specialist officers work variations of the shift pattern so they can attend meetings with partners or conduct joint visits to see children either at home or school during an investigation.

Limited supervisory oversight is leading to drift and delays in some investigations

Supervising officers now provide better supervision of and input into specialist teams on child protection investigations. But in many cases supervisors don't challenge the progress of an investigation or whether teams follow up on the identified lines of enquiry. This means cases don't progress effectively and risk can be left unmanaged.

Detective inspectors told us it is difficult to complete meaningful reviews on time because supervisors are having to oversee significant numbers of investigations. And more complex cases, particularly those involving historic allegations of intra-familial sexual abuse, tend to drift as priority is given to cases with current safeguarding risks.

The THRIVE+ project is an evidence-based decision-making tool designed to help officers determine and prioritise actions in primary and secondary investigations. It isn't designed to reduce workloads, but is intended to increase efficiency and help officers make decisions.

Child exploitation and online protection referrals

The management of investigations involving referrals from the National Crime Agency (NCA) is clear. There is a central team and an additional 12 newly established online child sexual abuse and exploitation (OCSAE) teams responsible for these referrals, one in each BCU. But there are still legacy cases open outside these teams and backlogs in NCA referrals dating back to August 2020.

The creation of BCU OCSAE teams is a positive step since our last inspection. So too is the use of digital triage to detect indecent child images, new hardware for viewing and grading images, and training and guidance documents. This is improving how BCUs approach investigating medium and low-grade image cases. Enhanced occupational health support is now available for staff.

The central OCSAE team deals with the very high and high-graded NCA referrals. The team is also responsible for peer-to-peer investigations and undercover operations.

Online investigations focus on evidence collection to the detriment of early safeguarding action

Not all officers working in this specialist online area see themselves as child protection officers. Similarly, the intelligence team working on these cases doesn't see itself as responsible for safeguarding. These stances affect decisions about when the force safeguards a child and when it notifies children's social care services.

Safeguarding is considered in terms of what risk the offender poses, rather than whether specific children are at risk and need safeguarding from the offender. In some cases, this is despite officers knowing early on that a child may live at an address where images are being downloaded or shared.

The force does not establish early contact with children's social care services before police enforcement activity so it and other organisations can work together to plan the approach to safeguarding the children identified. This is because officers believe that social care services will affect the investigation, for example, by approaching the family before the police are ready to act. Consequently, Merlin submissions, safeguarding and engaging with a local authority designated officer are delayed until the force arrests the offender or executes a search warrant.

The OCSAE training course and toolkit both contain modules on safeguarding. The toolkit says safeguarding is a main consideration but doesn't encourage early direct contact with children's social care services before arrest. The toolkit doesn't include working with safeguarding bodies to explore the needs of the children. Nor is there any explanation of how child protection procedures work, which would help staff members' understanding in this area (as many have no child protection background).

A partnership approach that places the needs of the child at the forefront of joint decision making without diminishing the police response is needed. This would create an environment where officers can work directly with other organisations to discuss individual cases and agree a way forward.

Our examination of cases in this area also showed significant delays. Most cases don't get the interventions they need when they should, as set by the force. Some staff cited workloads as one problem. Delays in getting an appointment with the courts to obtain a search warrant (this usually takes 3–5 weeks) is another. Supervisors generally aren't actively addressing some of these problems.

Central OCSAE online investigations

The central team has five main functions. These are day-to-day tasking of OCSAE operational teams; dealing with high and very high-risk online investigations and referrals; providing specialist digital forensic examination; identifying victims in indecent images; and covert policing operations. But the lead responsible officer is not responsible for the performance of OCSAE investigations across the force. Oversight, governance and resources for the BCU OCSAE teams sit locally with BCU safeguarding superintendents. And the lead officer has no authority to, for example, move officers or staff to address an imbalance in workloads and performance across London.

Like the work on BCUs, the central teams' decision-making process for investigations doesn't focus on identifying and protecting children at an early stage. None of the investigations we reviewed had documented evidence of contact with the MASH or children's social care services before the operational element of the investigation. And in some cases, there was very clear and present risk to children.

The force also doesn't proactively use intelligence from the peer-to-peer file sharing child protection system (CPSys) to target opportunities to identify children who may be at risk through online abuse. Only one member of staff (of three who have licences) accesses this system's notifications, meaning they identify very few individuals who share indecent images of children.

The decision to act on intelligence is left to the individual.

Schools' officers are responsible for dealing with youth-produced sexual imagery

Although not all schools' officers have a specialist investigative background in child protection, this is mitigated by their training on youth-produced sexual imagery and their close contact and relationships with schools. This results in good information exchange with school safeguarding leads and quick identification of children involved in sharing images.

Schools' officers are generally good at recording their interactions with children. Their records give a good understanding of the views of the child.

These officers have a clear understanding of outcome 21 (used when an investigation isn't in the public interest), the need to record crimes when children send indecent images of themselves and the need to safeguard instead of criminalising children where appropriate. But we found that these investigations are generally poorly supervised, with oversight absent for weeks or months as an investigation progresses.

We saw a good focus on the welfare of children in investigations, but there were examples of missed opportunities to progress a case. This included not seizing phones when there are aggravating factors such as wider distribution of images or broader risks to the child from perpetrators who might be adults or not connected to a school.

Connectivity problems still affect the child abuse image database

In our 2018 inspection, we reported IT problems with CAID. Effective use of CAID helps to identify and protect victims of child abuse and provides evidence to support investigating and prosecuting suspects. In 2018, we also found that details of child victims and images weren't being uploaded to the system to help future investigations identify and safeguard children. These problems remain. At the time of our 2021 inspection, the last time officers uploaded images uploaded on to the CAID system was September 2020.

Digital Policing, the force's technology function, doesn't support either the IT systems used to centrally investigate images or CAID. Staff in the central team who know about the systems, including those in the high-tech crime unit, provide support where needed, but don't have the technical ability to address the wider CAID

connectivity problems. That is because CAID is a national system separate to the MPS's IT infrastructure. In response, a separate standalone database has been set up for local searches. But other law enforcement agencies or police forces can't use it.

When digital forensic hubs examine an item (such as a phone or hard drive) and identify indecent images of children, a pack of these images is created for an officer to grade and categorise. We found that there were 310 grading packs to be uploaded to the system and around 20 new packs generated each week. The size of cases in terms of the numbers of images involved varies, but one had 7.5 million images. This growing backlog of packs will need to be uploaded to the system at some point and this will create capacity issues in the central team.

There were also around 200 scene and facial comparison photographs waiting to be searched against the database. These photographs are used to provide investigators with opportunities to identify victims and interpret any similarities or differences against known locations or individuals.

These delays weaken the effectiveness of CAID as a whole. Officers in other forces are potentially viewing and verifying images that MPS officers have already dealt with but not yet uploaded. The images awaiting upload may also contain pictures of victims who could be identified and safeguarded if they were on the database.

There is also an impact outside policing. Online providers use the unique 'hash' identifier from CAID (which is essentially the digital fingerprint of an image) to scan their media platforms for known child sexual abuse imagery, so they can remove those images, prevent further sharing and alert police forces. Delays in uploading images means delays in sharing these hash identifiers and so delays in online providers being able to identify and remove pictures.

These are significant problems that affect not only the force but the wider police service and other industries. So the force needs to undertake urgent remedial action.

Digital forensic examination capability and capacity are still a problem

The volume of referrals from the NCA and wider reporting and identification of online offences have resulted in more demand for investigations. The force is seizing more devices that need processing and examining. These factors, and the growth in device data and its complexity, have resulted in delays in digital forensic examination.

After triage, force policy allows a maximum of two devices (three on the central team) per case to go for examination at one of the nine digital forensic hubs, irrespective of how many devices contain indecent images. This may result in unmanaged and missed risk in terms of first-generation images and abuse in a family being identified. The force advised us that this policy is flexible to allow additional devices to be submitted for examination if required. And at triage, images aren't checked against CAID so new images won't be uploaded on to that system. We were told that restrictions on submissions are to help manage demands and workload. Each case is considered individually by a digital strategy advisor.

There are still significant delays in forensic examinations after devices are submitted to hubs. The current wait time is 6–9 months, with a backlog of 1,277 submissions.

The central team has its own examination hub, with a shorter wait time of 2 months. In all forensic examination hubs, most submissions relate to indecent image inquiries.

Prioritisation assessment

The force considers the increasing number of referrals to be unmanageable. It understandably wants to target the people who have a sexual interest in children and can cause the most harm.

The force uses a prioritisation assessment tool to select cases for no further action and it is designed to prioritise incoming referrals for action. This process relies on assessing the content of the downloaded or shared material, rather than ensuring officers identify and assess any connected child in terms of risk and safeguarding. Neither does it seek to identify who the individual that has accessed or shared the image is and their background in terms of access to children. The force advised us that this new process is being reviewed and an external force will also peer review it. As part of that work, the force should consider how it identifies children and assesses and responds to any risk those children may be exposed to.

2021 findings: Decision making

Recommendation from the 2016 inspection report

The force should undertake a skills audit to:

- assess the training needed 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 trained for their duties; and
- determine how well staff understand child sexual exploitation, including its potential links with missing and absent children.

2018 findings

Each BCU did a local skills audit to assess the training needed for officers and staff doing child protection work. But some of the officers and staff in safeguarding teams hadn't been trained for their roles.

2021 findings

Some officers and staff don't have the right experience and haven't had specialist child abuse investigation training

The 2016 recommendation was specifically about auditing skills to assess the training needed for officers and staff doing child protection work and establish whether they are trained for their duties.

Training, including through developing and communicating good practice across the force, is fundamental to the force's plans to improve workforce capability. This is what will help it to deal effectively with the demands of safeguarding children. The force knows that it doesn't hold accurate data about which staff have done what training and this represents a significant risk.

Recent checks by the force showed only six officers in the organisation have current accreditation for specialist child abuse investigations.

In several BCUs, direct entry officers are moved between departments to gain experience. We were told that relatively inexperienced officers teach some temporary detectives. This lack of experience in, for example, the CSUs was seen in the cases we audited. There was a focus on prisoner processing and limited understanding and activity around addressing child safeguarding or wider risks.

To mitigate some of these problems, the MPS has continued to provide a range of safeguarding and child protection-related courses for staff, but attendance for some courses is low. This is something senior leaders are aware of and they are placing a greater focus on improving attendance figures.

There should be a central skills audit to find out what training staff have had and what training they need

We were told that the force has recently decided to fund and implement a learning management system. We were told this will create a single training record for all officers and staff to help the force target training on an individual or organisational basis, as well as being able to proactively reduce current and future skills gaps.

Although funding is now agreed for this system, it will take time before this can result in sustained improvements in the specialist training and development that officers and staff working in public protection urgently need.

These problems compound some of the immediate challenges for the head of profession in recruiting and moving trained staff and in training, accrediting and retaining specialist detectives. These sit against the broader organisational demands from all business areas for training, which are increasing exponentially.

2021 findings: Managing those posing a risk to children

Recommendation from the 2016 inspection report

The force should:

- 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 in their own family;
- reduce the delays in visiting registered sex offenders and improve the management and response to them;
- review officer attendance at multi-agency public protection arrangements (MAPPA) meetings, making sure attending officers are 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
- make sure that appropriate information on registered sex offenders is made available routinely to local officers.

2018 findings

We found that the teams dedicated to MAPPA (for managing known registered sex offenders and other dangerous individuals) were managing significantly high numbers of registered sex offenders. These teams are known as Jigsaw teams.

Information on high and very high-risk registered sex offenders was being made available to local officers and staff. But they remained unaware of most offenders (that is, those categorised as medium and low risk) in their areas.

There were also some areas of good practice, such as:

- the force created Violent and Sex Offender Register (ViSOR) records at point of charge. This allowed the case to be tracked through the court process and helped ensure risk and appropriate interventions were identified early; and
- an agreement was in place with housing services in London to find suitable accommodation for offenders to prevent homelessness, which is an important factor in managing risk.

2021 findings

The approach to managing those who pose a risk to children continues to develop

The force has increased staffing levels in the Jigsaw teams to help the police-led management of the 4,247 registered sex offenders in the community. We were previously worried about ratios of more than 100 offenders to a manager. The increased staffing has seen the ratio move to a manageable 1 manager to 48 offenders, which is positive.

There is now a ten-point plan in place for performance. This is clearly providing a focus for performance management, but is having some unintended consequences, with staff focused on hitting a target rather than managing risk. For example, the force is meeting the requirement to see an offender within 7 days of conviction, but managers view and record this as simply an administrative visit. So managers don't fully explore the risk the offender poses and what can be done to manage or reduce that risk.

Examining records and speaking to staff has shown us there is a lack of understanding about using the active risk management system (ARMS). This assesses risk factors associated with sexual re-offending and protective factors known to reduce offending, and should feed into a bespoke risk management plan (RMP). Staff members are putting RMPs into the ViSOR database, stating 'added for admin purposes', with no outline of a plan to manage the risk. Case audits also highlighted examples of plans being drawn up before the offender manager has seen a sex offender. The force needs to address this.

As the RMP doesn't contain a meaningful risk assessment, the offender manager can't rely on it to set an appropriate schedule for visits. So managers must still rely on using the regimen of visits every one, three, six or 12 months for risk levels rather than tailoring them to the offender and their risk.

Some registered sex offenders aren't being seen at home

The force is managing a significant proportion of registered sex offenders by telephone or a doorstep visit to the address. This practice originally developed during the initial stages of the COVID-19 pandemic. At that time, the National Police Chiefs' Council lead issued advice in the light of lockdown restrictions indicating that the need for face-to-face visits may be considered in accordance with each offender's ARMS assessment and risk management plan. This restricts the opportunity to check the home environment and establish any continuing or emerging risks. The offender manager can decide to carry out a telephone visit with no supervisory input.

Notifications are taking place by phone

Under the Sex Offenders Act 1997, all convicted sex offenders must register with the police, in person, within three days of their conviction or release from prison. This notification process is a critical element of managing offenders in the community. It is a legal requirement that provides the police with useful information for assessing and monitoring risk.

Section 87 of the Sexual Offences Act 2003 sets out the method of notification and stipulates that it must take place at a prescribed local police station and involve oral notification to a police officer or an authorised person. But we found that several Jigsaw teams allow notifications over the telephone or by email. This doesn't satisfy the statutory requirements. It follows that a subsequent breach would be difficult to prove, based on information that hadn't complied with the requirements of the Act.

The force needs to improve the methods it uses to brief neighbourhood police teams and enhance intelligence gathering

Operation Beat was introduced in 2017 to brief local neighbourhood officers about high and very high-risk sex offenders living in the communities they police and to help collect intelligence on them.

Some low-risk offenders can be managed reactively (without formal visits). But their details aren't routinely shared with local neighbourhood officers. This is a missed opportunity to use frontline staff to collect intelligence about these individuals through routine policing and help in their management.

We also previously identified difficulties with the force's IT systems. These meant offender managers had to manually check police systems for information or intelligence that would act as a trigger point for moving an offender from reactive to proactive management. We were told that these issues remain and offender managers still need to make manual checks to identify any information that may change the level of risk a sex offender presents. This limits the force's ability to transition to seamless and truly reactive management.

During this inspection we dip-sampled 48 Operation Beat records. We found errors or outdated information in 15 of them. Examples included an offender who was deceased and two people identified as wanted despite already having been arrested and detained. Several records contained out-of-date addresses for offenders.

Jigsaw staff explained that maintaining and updating the Operation Beat briefings is time consuming, which evidently contributes to some inaccurate information being made available to local officers. The findings of the dip-sampling and difficulties reported in maintaining the briefings has highlighted a need for the force to review the current approach to ensure it is effective.

2021 findings: Police detention

Recommendation from the 2016 inspection report

The force, in conjunction with children's social care services and other relevant bodies, 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 child sexual exploitation, and of the support children need on detention and on release;
- making sure Merlin forms are submitted promptly to record the child's detention and help inform future risk assessments;
- assessing early on the need for secure or other accommodation and working with children's social care services to achieve the best option for the child;
- making sure custody staff comply with their statutory duties by completing detention certificates and custody record entries properly when children are detained in police custody for any reason; and
- securing adequate appropriate adult support on time.

2018 findings

Children were usually treated well. But more work is needed so that appropriate adults attend on time, records are consistent and local authorities provide accommodation for children charged with an offence and detained.

2021 findings

Custody staff are better at recognising the needs of vulnerable children coming into police custody

Some of the children coming into police custody have complex or acute needs and need a safeguarding response, in addition to dealing with their offences. Staff in Met detention spoke positively about the training they had received on this. We were also told there is now an emphasis on the importance of recognising those under 18 years old as children, not just offenders, and that assessments of a child include determining and responding to their extra needs while in custody. For instance, we found evidence of the police providing age-appropriate reading material and information and holding post-interview safeguarding conversations.

The force has created a safeguarding dashboard to determine important actions to protect each child in custody across London. This system is also used to give

individual officers feedback and inform developments for the response and treatment of children in custody more widely.

A new Met detention safeguarding team actively reviews the detention and records of vulnerable people, including children, while they are in police custody. Anything that needs closer scrutiny or action is passed to senior officers at the daily pacesetter meetings.

Staff submit Merlin information forms about children who have been arrested to the youth offending teams through the MASH. This allows them to exchange information effectively with other organisations and they use that information to support and inform any joint decisions and plans for safeguarding.

During our inspection, the force was piloting Operation Harbinger. This aims to exchange early information with the relevant local authority when a child is arrested. This can give police a more detailed picture of a child's history and inform their welfare management while in custody. We were told that 16 authorities are supporting the pilot. We haven't evaluated the impact of the work, but it seems a positive step in providing wider support for detained children.

Custody records contain appropriate information

Custody records show that officers and staff clearly explain their decisions about a detained child. They routinely document details of parents and when the force told them about their child's arrest in the detention log.

Although we saw that appropriate adults or parents are informed when a child is arrested, in many cases there were delays (of several hours in some cases) before these adults come into the custody suite. Moreover, their arrival often coincided with the time of the interview. This prioritises the needs of the investigation and the management of demand over the welfare of children in custody, and means that children remain in custody without having an independent person to give them support and advice. It is the responsibility of the appropriate adult provider to work with the MPS to ensure that there is effective provision of appropriate adult services for children, rather than as currently occurs in the majority of cases, where arrival coincides with the time of interview.

More positively, we also saw that officers are completing detention certificates for those being detained and denied bail after being charged.

Inspectors do not routinely carry out reviews face to face

We spoke to inspectors about their reviews of the continuing detention of a child and why they don't always speak directly to the child. They cited significant demands on them, including the need to cover multiple custody suites.

The cases of this kind that we examined included a routine entry by the reviewing inspector on the detention log that the child should be told about the review and decision. But there was no indication on the records that this took place.

In too many cases the force detains children for long periods, including overnight, because it has not allocated an officer to the investigation

We found evidence of unacceptably long delays in interviews and the investigation not getting underway because the force had not yet allocated investigating officers to the case. This means some children are detained overnight, awaiting interview the following day.

Finding alternative accommodation for children refused bail needs to improve

When a custody officer authorises a child to be detained after charge, the police must arrange for them to go into the care of a local authority until their appearance in court (except for breach of bail or those wanted on warrant). We saw evidence of the force making requests for local authority accommodation. This shows a good understanding that children should be transferred out of police detention. An inspector ratified requests for secure accommodation as required.

Although officers made the requests to the local authority, most children in this category stayed in police custody until their court appearance. There was limited evidence of escalating cases to senior officers or of officers making later requests to children's social care while the child was in custody.

Between January and November 2020, the force detained 1,260 children in London after charge: 72 girls and 1,188 boys. It transferred only 98 of those children (five girls, and 93 boys) into the care of the local authority.

Local authorities have a duty to provide accommodation for children transferred out of custody under the Children Act 1989. The local authority decides the type of accommodation, which may be secure or non-secure. The force needs to continue its work with all London local authorities to get the best option for children who are detained after charge.

2021 findings: Leadership, management and governance

Recommendation from the 2016 inspection report

> The force should put in place arrangements that ensure that it has clear governance structures in place to monitor child protection practices across both borough teams and specialist units.
>
> The force should provide officers and staff with a clear understanding of good service and the standards it expects. It should begin to develop a performance management framework that will get consistent standards of service across London.
>
> The force should develop a performance framework to report on the results of the service it provides to children.
>
> It should show how it uses that performance framework to inform resourcing and planning decisions and bring about improvement.

2018 findings

At the time of the 2018 inspection, the force was replacing the 32 borough operational command units (BOCUs) with 12 BCUs.

The new model sought to provide investigators with the skills and knowledge to investigate any type of crime involving protecting children.

But we were still concerned at that time about how much the structural changes had translated into a better response for children. The outcomes from the cases we reviewed showed that the force was still missing opportunities to act quickly and decisively to protect children and prevent further offending.

2021 findings

We previously commented positively on the introduction of the role of head of profession for safeguarding. This individual oversees performance, sets standards and strengthens the priority and focus given to the protection of children. But to change quickly, make practices across London more consistent and move finite resources or reduce staff abstractions to other areas, the head of profession often has to negotiate with each unit commander or central specialist team. And they may have different or competing demands and priorities. This affects both the pace of change and the consistency and quality of responses to children.

The force can learn from the dedicated inspection team and other forms of audit and assurance. It must share these lessons across the force and act on them to target specific areas where necessary, while ensuring consistency of approach and method across all teams involved in assurance work.

Although the force tells BCUs and individual officers about findings, we saw no evidence of a clear method for passing on wider learning and promoting improvement, or assessment of the impact of any learning. Some staff didn't know what the force had learned from the audits. And others didn't know if it was using them to improve operational practice.

Next steps

The pace of change since we reported our first findings in 2016 has at times been slow. But the force has made progress in some areas and recognises there is more to do to achieve consistently better outcomes for children.

We are assured that there are plans, oversight and scrutiny in place to continue making improvements. But some areas still need attention by senior officers. These are:

- the effectiveness of investigation supervision;
- using the active risk management system and risk management plans for registered sex offenders;
- online cases that don't prioritise the early safeguarding of children;
- significant delays in online investigations;
- delays in retrieving digital evidence; and
- uploading data to CAID.

As part of our routine monitoring of all police forces, we will continue to evaluate the force's performance against our recommendations. In particular during our PEEL inspection and ongoing involvement with the force, we will seek further improvements in those areas of ongoing concern highlighted in this report and instigate closer scrutiny if needed.

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