HMICFRS

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

National Child Protection Inspection Post-Inspection Quarter 2 Update

The Metropolitan Police Service
April – June 2017

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Contents

Background

HMICFRS's 2016 inspection of child protection services in the Metropolitan Police Service

In 2016, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)[1] carried out an inspection of the Metropolitan Police Service's (MPS's) approach to child protection. This was part of HMICFRS's rolling programme of child protection inspections.[2]

HMICFRS used its standard child protection methodology to assess the service that the MPS provides to children in the Greater London area. This involved examining the effectiveness of the force at each stage of its interactions with or for children, from initial contact through to the investigation of offences committed against them. It also scrutinised the treatment of children in custody, and assessed how the force is structured, led and governed in relation to the provision of its child protection services.

In November 2016, the report of that year's child protection inspection was published. [3] It concluded that there were fundamental (and widespread) deficiencies in the way that the MPS understood and dealt with the needs of, and risks facing, children in Greater London, and that, as a result, children were being adversely affected. A summary of the findings is at annex A.

The 2016 report made nine recommendations (see annex B). Four of these required immediate action by the MPS, specifically in relation to:

- establishing governance and oversight of child protection practices;
- improving the response to children who go missing from home;
- increasing the force's understanding and awareness of risks to children; and

[1] This inspection was carried out before 19 July 2017, when HMIC took on responsibility for fire & rescue service inspections and was renamed HM Inspectorate of Constabulary and Fire & Rescue Services. The methodology underpinning our inspection findings is unaffected by this change. References to HMICFRS in this report may relate to an event that happened before 19 July 2017 when HMICFRS was HMIC. Citations of documents which HMIC published before 19 July 2017 will still cite HMIC as the publisher.

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

[3] *National Child Protection Inspections: Metropolitan Police Service*, HMIC, November 2016. Available from: www.justiceinspectorates.gov.uk/hmicfrs/publications/metropolitan-police-service-national-child-protection-inspection/

- improving the management of those posing a risk to children.

The remaining five recommendations required action to be taken within either three or six months. Specifically:

Three months

- improving the planning and initial response to child abuse and protection matters; and
- improving the investigation of child protection matters.

Six months

- reviewing the management of resources to better meet the demands of child protection matters;
- conducting, with children's social care, a review of practices in the detention of children; and
- auditing the skills and experience of staff involved in safeguarding investigations.

This report uses these nine recommendations as the basis for HMICFRS's assessment of the MPS action plans, and to describe some of the outcomes arising from the force's recent activity to improve its child protection service.

About this report

On 20 June 2017, HMICFRS published the first of its four quarterly reports,[4] which provided HMICFRS's preliminary assessment of whether the force's action plans demonstrated an appropriate level of focus and prioritisation of activity to improve its child protection services. At that stage, it was too early for HMICFRS to assess the effectiveness of these changes. However, the report (referred to hereafter as Quarter 1 Report) set out in some detail the changes that the MPS planned to implement by spring 2017.

This is the second of HMICFRS's quarterly reports and provides a review of the force's continuing progress against the recommendations of the 2016 report and the force's own action plans.

[4] *National Child Protection Inspections Post-Inspection Quarter 1 Update –The Metropolitan Police Service*, HMIC, March 2017. Available from: www.justiceinspectorates.gov.uk/hmicfrs/publications/metropolitan-national-child-protection-inspection-quarter-one-update/

In this quarter, HMICFRS inspectors have reviewed specific documents provided by the MPS which are intended to begin to demonstrate some of the outcomes of the force's improvement activity. HMICFRS has also assessed internal auditing and self-testing carried out by the force and combined this with evidence from the continuing discussions with MPS staff.

Quarter 2 assessment

The MPS's action plans

Following the recommendations of the 2016 report, the force provided HMICFRS with two action plans: one relating to child protection and one focused on children who are missing and absent. For each of HMICFRS's recommendations, the relevant plan sets out:

- the objective to be achieved;
- the actions required to meet that objective, including the timeframe and the member(s) of the force responsible; and
- a summary of the current position in working towards the objective.

For this second report, HMICFRS began to assess the effectiveness of the activity undertaken by the force to respond to the recommendations made in our 2016 report. We assessed whether the MPS's action plans were now beginning to translate into improved protective practices and whether (based on that assessment) they remain fit for purpose.

In addition to addressing HMICFRS's recommendations, the action plans also set out intended improvements to other areas of child protection practice. These areas have been identified by the MPS itself, or through consultation with its partners.

Findings

Despite the scale and complexity of the challenges faced by the force, HMICFRS is pleased that progress has been and continues to be made in some important areas. We also note that several of the actions identified will take time to become part of routine practice and demonstrate significant improvements. However, HMICFRS is concerned that in other equally critical areas progress is less apparent, with limited evidence that the activity the force is undertaking is meeting the objectives of its own action plan or leading to tangible improvements in practice.

HMICFRS is somewhat encouraged that the force's newly established internal auditing processes were identifying many of the same issues. However, we were concerned to find little evidence of senior leaders using this information to make tangible changes to operational practices and improve the nature and quality of decisions to protect children.

Recommendations requiring immediate action

Governance and oversight of child protection practices

The force has continued to review and refine its governance and oversight of its child protection (and wider vulnerability) services. In addition to the governance structure in place as reported upon in the publication of HMICFRS's Quarter 1 Report, the force has now introduced further levels of scrutiny and responsibility which include:

- appointment of a commander-level head of profession to lead on safeguarding for children and adults;
- implementation of a new safeguarding board, chaired by an assistant commissioner, which first met on 8 June 2017. The board is intended, through the analysis of performance and risk, to provide oversight of the force's current performance across 12 safeguarding workstreams (see below), and to bring about improvements where needed;
- introduction of lead practitioners at inspector rank, whose purpose is to bridge the gap between policy and process development, in support of the force's frontline service; and
- introduction of 12 portfolio workstreams overseen by chief superintendents or superintendents. These workstreams are:
    - child protection;
    - child sexual exploitation and abuse;
    - domestic abuse;
    - gang exploitation, child criminal exploitation and youth offending;
    - harmful traditional practices ('honour-based' violence, forced marriage and female genital mutilation);
    - mental health, drug and alcohol dependency and suicide prevention;
    - missing people;
    - rape and serious sexual offences;
    - stalking and harassment;
    - modern slavery and human trafficking;

- vulnerable adults (including elder abuse[5] and abuse of disabled people); and
- staff engagement (including wellbeing and morale, and making safeguarding everybody's business'.

The implementation of these new arrangements is very recent and it is therefore not possible to provide an assessment of their effectiveness.

The response to children who go missing from home

Governance and oversight of this area was previously the responsibility of the MPS missing person's diamond group.[6] In HMICFRS's Quarter One Report, we stated that missing children were being dealt with through a separate process and action plan, and that this would be scrutinised in the subsequent quarterly reporting process. The work of this group has now been replaced with the introduction of a force-wide safeguarding board, which is intended to provide consistent governance across all aspects of safeguarding. This is a positive step which provides the force with an opportunity to reassure itself that oversight of the activity undertaken and improvements being made (particularly in relation to children who go missing) are appropriate and effective. Given its very recent introduction we have not been able to test the effectiveness of these new arrangements but future reports will examine whether improvements are evident.

The force has adopted the College of Policing Authorised Professional Practice guidance for missing people,[7] and has begun to provide specialist training to staff within missing persons units across London. Staff receive a five-day course which includes the increased risk of sexual exploitation faced by children who go missing, in addition to the development of multi-agency protective plans and the proper conduct of strategy discussions. At the time of HMICFRS's second quarterly report, 30 staff from the force had received this training, and the force aims to have a further 240 of its staff trained by March 2018. The force is providing this training in a phased way, prioritising those working in missing units who have received no formal training for their role. All new staff joining a missing persons unit will automatically receive this training when taking up their new posting. However, while this is positive, HMICFRS would also like to see this training provided to staff within the pathfinder

[5] Elder abuse is defined by the World Health Organization as "A single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person".

[6] A meeting chaired by a senior officer intended to oversee the implementation of a major programme of change within a particular practice area across the force.

[7] Authorised Professional Practice – Missing Persons, College of Policing, 2016. Available from: www.app.college.police.uk/app-content/major-investigation-and-public-protection/missing-persons/

sites[8] being trialled in two areas of London. The new structures and processes at these sites bring together the management of neighbourhoods, response, investigation and protection of vulnerable people (including child protection) into one department. A failure to provide the appropriate training to these staff (who will be managing the response to those who go missing) will mean staff may not have the appropriate skills and experience to effectively respond and safeguard children who go missing.

The MPS has also developed a template/aide memoire (known as 124m) for staff responding to those who go missing, and has tested its effectiveness in the borough of Croydon. The template provides staff with information to support and guide their enquiries at an early stage. The force reported that the child safeguarding delivery group's dedicated audit team (formerly Operation Benson) has identified, in the small sample of cases examined, improvements in those missing children investigations in which the template was used. For example:

- there was an improvement in early decision-making, which assisted staff later;
- there was less of a need to rectify problems as a result of missed enquiries during the initial response; and
- supervisory reviews were better informed as a result of a more thorough and detailed initial response.

Based on these positive outcomes, the force intends to use this form across all London boroughs. This may coincide with the introduction of electronic tablet devices for all frontline staff (the plans for which were set out in the first of these quarterly reports – approximately 17,000 by July 2017) which, together, are intended to improve quality and consistency in the response to and management of missing children investigations.

In a positive response to our Quarter 1 Report, the force has indicated that it will incorporate its review of improvements to the response to missing children into the single improvement process to ensure it co-ordinates its activity and that it oversees this activity consistently.

Increasing the force's understanding and awareness of risks to children

The MPS has now introduced quarterly professional development days (PDDs) within territorial policing, aimed at increasing staff awareness of child safeguarding issues across its London boroughs. The first quarter of PDDs is underway, and 6,500 officers have so far received this training. This is positive. Moreover, the child safeguarding delivery group (CSDG) is currently preparing the PDD package for the

[8] The pathfinder sites are a proposed restructure of local policing from a borough-based policing model to basic command units (BCUs). This is occurring in two areas, bringing together Barking & Dagenham, Redbridge and Havering boroughs, and Camden and Islington boroughs.

second quarter. The force expects this to cover 'peer-on-peer' abuse, tackling online offences and the child safeguarding process. The force has also considered feedback received following PDDs in the first quarter of 2017/18 and, in response, PDDs in the second quarter of 2017/18 will also include 'what good service looks like' using exemplar case studies. The training provided in quarter two will be face to face (rather than electronic) and will involve external partnership input.

The provision of training and communication of best practice is fundamental to MPS plans to improve the capability of its workforce to respond effectively to child safeguarding concerns. However, the current approach (whereby the CSDG designs and implements the training) was only intended to be a temporary measure to address an immediate need. Its implementation and development is undertaken in isolation, outside of the MPS corporate training structures. The force has identified weaknesses in this approach, which include inconsistent evaluation, supervision and monitoring of attendance, and was undermining efforts to improve practice. Notwithstanding this investment, HMICFRS is concerned that, unless these weaknesses are addressed, the provision of much-needed child protection training which leads to sustainable improvements may not be achievable in the long term. It is encouraging that the force has identified these gaps and we recommend prompt remedial action. HMICFRS will assess this further in future reports.

A further area of concern described in HMICFRS's 2016 report related to command and control centre staff having no designated training days. The approach instead was to rely upon 15-minute briefing and de-briefing periods at the start and end of the working day, combined with email updates and electronic learning packages. The force recognises the need for staff to have better opportunities to learn within the organisation but at present HMICFRS finds no evidence of meaningful improvements being made in the quality or availability of training. The CSDG has also conducted reality testing within the force's three communication centres and found that while staff have a general understanding of missing and absent categories relating to children, they could not recall receiving any specific training on the links between missing children and child sexual exploitation (CSE). Further, the force itself has found that staff were uncertain about what a child protection plan was and how it should be considered when assessing risk.

HMICFRS's 2016 report highlighted the force's inability to appropriately 'flag' risks and vulnerabilities (relating to both child victims and perpetrators) on force systems This was of particular concern because it prevented officers attending incidents involving children from making the most informed and comprehensive assessment of risk. The force now recognises the weakness of its internal systems and has taken steps to address this. For example, the absence of any link between ViSOR[9] and

[9] The violent and sex offender register (Visor) is a secure database of risk assessment and risk management information on individual offenders who are deemed to pose a risk of serious harm to the public.

other MPS information systems meant that information about sex offenders (or children exposed to them) would not be known by officers responding to calls for service. The introduction of Operation Beat (briefing, engagement and active tasking) represents a positive step by the force to address this gap in the knowledge of local policing teams. The initiative provides briefings to local teams about high and very high-risk sex offenders. However, while this is positive, officers attending calls report that this information is still not being provided routinely unless they request that additional checks are made before their attendance. The force has also implemented a new 'flagging' system in relation to vulnerable children. This is intended to ensure that 'flagged' incidents involving vulnerable children are prioritised by staff to ensure officers are provided with all necessary information before they arrive. Although this is a positive step, the CSDG stated that it is not yet confident that staff gathering this information know or understand well enough what information they should include in child protection plans,[10] and how to assess the relevance of this information for officers responding to incidents involving at-risk children. This means that the quality of risk assessments could be compromised. The effectiveness and consistency of this process will be further scrutinised in HMICFRS's subsequent quarterly reports.

In addition to the steps described above, the CSDG is exploring opportunities for using the force's computer aided despatch (CAD) system – the force computer system used for recording each of its reported incidents – to highlight important information relevant to certain incidents involving vulnerable children. However, this approach relies on manual inputs by specialist staff responsible for managing registered sex offenders and child abuse detectives (dealing with children subject to protection plans). The inability to automate this process is a risk. In addition to the opportunity for human error, the requirement for specialist staff to prioritise this task in the face of many competing demands means that the consistency of the approach cannot be guaranteed.

Improving the management of those posing a risk to children

The MPS has reviewed its approach and taken steps to improve its processes for mitigating the risks posed by those offenders who represent the greatest risk of harm to children.

The MPS intends that its introduction of Operation Beat will bridge the gap between its safer neighbourhood officers and its specialist teams managing registered sex offenders (RSOs); specifically through the provision of briefings relating to high and

[10] A child protection plan assesses the likelihood of a child suffering harm and considers ways the child can be protected, as well as setting out the responsibilities and actions to be undertaken and by whom.

very high-risk RSOs. In September 2017, the force is scheduled to undertake an initial review of Operation Beat to assess its impact and effectiveness. It has scheduled a further final review for March 2018.

The force reports that there are approximately 6,000 RSOs in the 32 London boroughs. The MPS is the lead agency for 4,434 of these and therefore responsible for completion of their active risk management system (ARMS)[11] assessments. The remaining RSOs are on licence and under responsibility of the National Probation Service (NPS), although the MPS provides support during their assessments.

Currently, the force reports it has completed an ARMS assessment for 2,682 RSOs (i.e. 60 percent of those RSOs for which it is responsible). The force stated that by December 2017 it expects to have increased this completion rate to 95 percent.

Recommendations requiring action within three months

Improving the planning and initial response to child abuse and protection matters

The MPS recently conducted a survey across the whole organisation to assess the understanding of officers and staff about child protection matters, as well as seeking responses as to how the MPS could improve its engagement with children. The force intends to use the information gained from this survey to improve its internal communications strategy and to inform the development of future training for staff. While this is positive, HMICFRS notes that less than 10 percent of the organisation (9.6 percent or 4,203 people) responded.

Analysis of the results from the survey has identified three notable outcomes:

- all ranks within the MPS agree that safeguarding children and young people is of high importance;
- officers and staff across all areas of the force felt confident in their ability to recognise and effectively respond to risks to children in most situations. However some staff indicated that they felt insufficiently trained to understand some of the significant factors that relate to some specific areas of child protection such as grooming or radicalisation;

[11] ARMS is a structured assessment process to assess dynamic risk factors known to be associated with sexual re-offending, and protective factors known to be associated with reduced offending. It is intended to provide police and probation services with information to plan management of convicted sex offenders in the community.

- staff valued the benefits of face-to-face training and continuous professional development; and
- improving the investigation of child protection matters.

The purpose of CSDG's dedicated audit team (DAT) is to inspect, examine and evaluate investigations. However, it also supports and encourages learning within the force to bring about improvements in child protection investigations. This is achieved through identifying to leaders and managers where improvement is required or best practice is evidenced.

The DAT currently audits case files in the following areas of child protection:

- CSE borough investigations;
- child sexual exploitation team (CSET) investigations;
- indecent images of children (IIOC) investigations;
- missing person enquiries involving children; and
- section 47 Children Act 1989 investigations.

The DAT reported it had audited 170 cases, 97 of which were sent back to the officer dealing with the case for further action. Of those, 33 had an outstanding matter to be resolved and seven were reopened for investigation.

Following HMICFRS's 2016 report findings on the assessment of cases, the DAT conducted a phase 1 audit of those cases examined by HMICFRS during the 2016 inspection. Since the start of the phase 2 audits, the percentage of cases returned to officers for further action has been consistently between 50 and 60 percent.

The general findings reported by the force from the audits are:

- CSE investigations:
    - investigating officers for individual matters are not communicating effectively with each other; and
    - often there is confusion regarding which aspect of a case is the most significant, which has in turn resulted in missed or delayed actions.
    - significant delays in officers visiting the victim and maintaining contact throughout the course of the investigation;
    - lack of joint working with children's social care services;
    - no record made of a formal strategy discussion or agreed actions on the crime reporting information system (CRIS);

    - a lack of conducting intelligence research, assessing risk and considering wider safeguarding measures (such as referrals to children's social care) in relation to victims and/or their associates;
    - a lack of investigation to trace suspects or others potentially linked to enquiries, sometimes resulting in a decision to close before such enquires are completed;
    - improvements needed to the consideration of wider safeguarding measures, particularly in relation to online child abuse;
    - crimes not being recorded as per the Home Office Counting Rules for underage sexual intercourse; and
    - inconsistencies relating to both supervision of investigations and reports being inappropriately closed by supervisors prior to the completion of all agreed actions and/or in the absence of a closing plan.
- CSET investigations:
    - there is a general lack of intelligence research conducted into the victim's family and other associates; and
    - inconsistent frequency of formal strategy meetings with children's social services.
- Missing person's enquiries involving children:
    - initial investigation stage usually lacks any face-to-face contact with the person reporting the incident;
    - limited initial enquiries to establish the basic details;
    - frequent delays in the investigation and enquiries to trace children; and
    - grades of risk relating to missing persons do not reflect all the factors relevant to children.
- Section 47 Children's Act investigations:
    - limited information recorded on CRIS from strategy discussions;
    - joint visits with children's social care are not always made; and
    - decisions to make cases a 'single agency investigation' have been made based on insufficient information.

In addition to the findings above, HMICFRS has noted that the records of case conferences show an inconsistent picture of attendance by MPS staff across the 32

London boroughs, at both initial and review conferences (although attendance at initial conferences is generally better).

At present, these findings do not indicate that any significant improvement has occurred in the in the quality of investigations or the nature of decision making. This is of concern. HMICFRS acknowledges the progress made by the force to analyse and understand its own practice more effectively and identify areas for further improvement. We also recognise the challenge of making improvements across all areas of child protection in a force of the size and complexity of the MPS and that such change cannot be expected immediately.

However, HMICFRS does expect to find evidence of these findings being used to inform demonstrable changes across all boroughs. For this to work effectively, the governance arrangements should support effective oversight of local practice, which is the escalated to a sufficiently senior level to address any blockages or facilitate any improvements. This should be supported by a process that ensures lessons learnt are disseminated across the force effectively, and that checks are in place to monitor the implementation and progress of such changes.

As noted previously in this report, HMICFRS remains troubled by the presence of outstanding matters on some cases, and that the force cannot reassure itself that the appropriate and necessary action is being taken following reviews of its own practice.

Recommendations requiring action within six months

Resourcing and demand management for child protection matters

The MPS has undertaken extensive work to develop a safeguarding performance framework, which is due for implementation in July 2017. The data include information on both adults and children, and cover the 12 workstreams previously mentioned, including: missing persons, CSE, child protection and domestic abuse. The force also intends that it will enable officers to access and understand safeguarding data and trends at force, borough and ward levels. This is to be achieved through the collation of data on child abduction warning notices, child protection plans, domestic violence prevention orders and repeat victims and offenders, which collectively enable officers to examine trends, locations of concern, victims and offenders.

This new ‘dashboard’ is a potentially useful source of valuable information for the MPS across a broad range of vulnerability and safeguarding areas. Its success will be determined by how effectively it is used to improve performance and, ultimately, outcomes for children.

At present, the force does not collect performance information relating to its attendance at strategy meetings in cases of CSE, missing children, domestic abuse or Sapphire investigations.[12] The force is now taking steps to address this deficit of information and as an interim measure the requirement for such meetings is being emphasised through training, such as the new missing person co-ordinator awareness course.

Reviewing (with children's social care services) the detention of children

The MPS has been gathering data regarding children detained in custody after charge. It reviewed such data for the four-month period of January to April 2017 to determine the reasons for children being detained, and the compliance of detention officers and local authorities with the requirements of accommodating a detained child. During this period, some 1,356 children were charged and, of those, 454 were detained after charge.

The Police and Criminal Evidence Act 1984[13] requires children who have been charged and denied bail to be transferred to more appropriate local authority accommodation, with a related duty under the Children's Act 1989[14] for local authorities to accept these transfers. Despite this, the MPS's internal review has revealed that, in some cases, these statutory responsibilities are not being met by either the force or local authorities and that children continue to be detained unnecessarily in police custody after charge.

In April 2017, 109 children were charged and detained. Of these, 58 were recorded as requiring either secure or non-secure alternative accommodation, which was consistently recorded as being unavailable (six children were offered secure accommodation in Bristol or County Durham but this was declined due to the distance). Of the 109 cases, 29 contained no record of the local authority being contacted and only 47 in total were described as being completed.

From the review, the responses of local authorities following requests for accommodation reveal a worrying lack of knowledge and understanding of their legal responsibilities. However, the review did not assess whether detention officers were requesting the correct accommodation in every case. Neither did the review consider whether issues relating to the availability of accommodation had been escalated to senior leaders. HMICFRS acknowledges that the responsibility to accommodate a child refused bail after charge is not one that rests with the police. However, the force is responsible for requesting that the absolute duty of local authorities to

[12] Sapphire is the team that investigates rape and serious sexual offences.

[13] Section 38(6) of the Police and Criminal Evidence Act 1984

[14] Section 21 of the Children Act 1989

provide accommodation is discharged, challenging and escalating on those occasions when it is not and working with local authorities and other partner organisations to address concerns.

HMICFRS's 2016 report set out the numerous weaknesses identified in the force relating to the detention of children. In addition to the issues described above, HMICFRS identified poor standards of record-keeping and the general failure of senior officers to engage with safeguarding partners to develop solutions. Therefore, HMICFRS continues to be disappointed and troubled to see that many of these deficiencies are still apparent with no evidence of efforts being made to remedy them. This is particularly the case in relation to its engagement with its partner organisations.

Auditing the skills and experience of those staff undertaking safeguarding investigations

Following HMICFRS's 2016 report, the MPS has made a clear and concerted effort to improve the training, support and supervision provided to those staff responsible for making critical decisions about the safety and protection of children in London.

Currently, the force's child abuse investigation teams (CAITs) consist of 372 police officers (up to and including detective inspector rank), 202 of whom have completed the SCAIDP[15] course. However, HMICFRS was concerned to find discrepancies between force records and College of Policing records in relation to the remaining 170 officers. This means that the force cannot be certain whether officers are suitability trained for their roles.

Conclusion

In our Quarter 1 report HMICFRS acknowledged the clear evidence that the MPS had understood the recommendations within our original 2016 report, and the weaknesses which underpinned them. HMICFRS also concluded that the force's action plans were sufficient to provide the force with an adequate framework through which it could make improvements.

It is evident that progress has been, and continues to be, made in some important areas. It is also clear that the force remains committed to improvement and is being responsive and flexible in its approach to ensure it can overcome emerging difficulties. However, despite the continuing commitment of senior leaders, there are signs that improvement activity in some principal areas is not leading to better outcomes for children or improvements in practice. HMICFRS, as previously stated, recognises the scale and complexity of the challenges faced by the force and recognises that child protection is not something that one agency can or should do in

[15] Specialist Child Abuse Investigations Development Programme

isolation. HMICFRS will continue to scrutinise the MPS implementation of its action plans; nonetheless, we expect that the force should ensure it responds to its own data about areas for improvement more effectively, by taking prompt and effective action to make the required changes.

Next steps

HMICFRS's third quarterly report will continue to review the force's progress against the recommendations of our 2016 report, and against the force's own action plans. HMICFRS will also review cases assessed by the force.

Annex A – Summary of findings from HMICFRS's 2016 inspection

We found examples of officers and staff throughout the MPS who were working with commitment, dedication and empathy to protect and help children and young people. However, these individuals and teams were not achieving consistently good results for children in London.

HMICFRS found that none of the borough or specialist teams assessed in this inspection was doing a good enough job in protecting children. The way the force handled the cases in almost three-quarters of files (278 of the 374 cases) examined by HMICFRS was found to require improvement or be inadequate. Thirty eight cases had to be referred back to the force, because they represented a continued risk to a child or children.

The MPS had no chief officer responsible and accountable for child protection matters across the force. This absence of oversight of this crucial area is unacceptable and exacerbates the inconsistency we found in dealing with child protection.

In addition to the lack of a single chief officer responsible, other principal areas of concern HMICFRS inspectors identified included the following.

- In 38 cases of missing and absent children, 36 cases were judged as 'requires improvement' or 'inadequate'. Officers and staff need to understand the link between children who regularly go missing and sexual exploitation.
- Of the 38 cases referred back to the MPS because they placed a child or children at continued risk, the force had itself assessed one as 'requires improvement' and three as 'inadequate' and yet had taken no action.
- Of 40 custody cases, 39 resulted in the child being kept in custody, despite the stipulations of the Police and Criminal Evidence Act.
- HMICFRS was told that there was a greater focus on reducing crimes identified as priorities by the Mayor's Office for Policing and Crime (MOPAC), such as burglary and vehicle theft, than on child protection.
- Officers and staff often do not properly assess or speak to children at significant risk of child sexual exploitation (CSE), meaning these children continue to be at risk of abuse.
- Officers were often unaware of registered sex offenders in their area and there were backlogs in visits to some registered sex offenders, including those who pose a very high risk to children.

- Information on child abuse victims, offenders and risks is too often kept in isolated IT systems across the force and so shared properly neither with partners such as local authorities nor even with fellow officers working in the next borough.
- Some staff in important roles, such as borough CSE officers, have limited awareness and had received no training in CSE.

Annex B – 2016 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.

Annex C – Plans for quarterly reporting

Following the publication of the first report in December 2016, HMICFRS wrote to the MPS Commissioner requesting an update on progress following the immediate recommendations, and an action plan setting out how the MPS would respond to all of the recommendations. This is standard procedure following all HMICFRS national child protection inspections. At the same time, and on account of the findings in the 2016 report, the Home Secretary wrote to Sir Thomas Winsor requesting that HMICFRS publish quarterly reports detailing the progress against the recommendations made in 2016.

Quarter 1: An assessment of the action and improvement plan produced by the force

HMICFRS assessed whether the action plans demonstrated a sufficiently clear understanding of the issues identified and the recommendations made in HMICFRS's 2016 inspection. HMICFRS also considered if the action taken is likely to rectify the problems identified, and how the force is testing the effectiveness of its improvement activity.

This report also sets out the breadth of activity planned by the force. Although HMICFRS could not assess at that stage its effectiveness, this list, arranged under the relevant recommendations, provides the starting point for tracking the force's progress over the course of the year. It is indicated clearly which actions are planned and which are completed.

Quarters 2 (this report) and 3: Assessments of progress against the action and improvement plan (planned publication dates: summer and autumn 2017)

HMICFRS will review the force's progress against the recommendations of HMICFRS's 2016 report, and against the force's own action plans. Inspectors shall carry out a combination of interviews with senior leaders, insight work and meetings, and shall incorporate evidence obtained from the relevant parts of the 2016 PEEL: effectiveness assessment (published in March 2017).

Quarter 4: Assessment of the outcomes of improvements made by the force on the service provided to children (planned publication date: winter 2017)

A team of inspectors will spend four weeks in force to assess progress made since the 2016 inspection. As with the 2016 inspection, the fieldwork will focus on a ‘deep dive’ audit of live and recent cases, as well as interviews and meetings with senior leaders, interested parties and staff. HMICFRS shall also review the force’s internal management of performance and its ability to supervise and quality assure decision-making, child protection and investigation standards.

The report produced at the end of the fourth quarter will draw on evidence obtained over the course of the year to provide a comprehensive assessment of the actions undertaken by the MPS in response to HMICFRS’s 2016 report. This final quarterly report will also include details of any further inspection activity.