HMICFRS

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

National Child Protection Inspection Post-Inspection Quarter 3 Update

The Metropolitan Police Service
July – September 2017

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Contents

Background

The 2016 inspection conducted by HMICFRS 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') approach to child protection. This was part of HMICFRS' 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 was structured, led and governed in relation to the provision of its child protection services.

In November 2016, we published a report of our findings from the 2016 inspection.[3] This set out fundamental and widespread deficiencies in the way that the MPS understood and dealt with the needs of, and the risks facing, children in Greater London. We concluded that children were being adversely affected as a result. A summary of the findings is at annex A.

The 2016 report contained 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 also 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

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

Six months

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

HMICFRS' 2017 post-inspection activity

In December 2016, following publication of the 2016 report, HMICFRS wrote to the Commissioner of the Metropolitan Police requesting an update on progress following the immediate recommendations and an action plan setting out how the MPS would respond to all the recommendations. This is standard procedure following all HMICFRS national child protection inspections.

At the same time, and because of the significant concerns set out in the 2016 report, the Home Secretary wrote to HM Chief Inspector of Constabulary, Sir Thomas Winsor, requesting that HMICFRS publish quarterly reports detailing the MPS' progress against the recommendations made in 2016. As a result, HMICFRS is undertaking four assessments and publishing four follow-up reports in 2017 (see annex C).

About this report

The quarters 1 and 2 reports (published in June and August 2017 respectively) provided our assessment of the MPS' progress against both the recommendations of the 2016 report and the force's own action plans.

For this third quarterly assessment, we examined 135 MPS child protection cases that had also been assessed by the force's internal auditing team. We also started to assess the extent to which the clear strategic intent to improve (as reported in the

first two quarterly reports) was being translated into tangible improvements in the decisions made to protect children. This assessment will be completed and concluded in the quarter 4 report.

Quarter 3 assessment

Audit of cases

In the quarter 2 report, we reported that we were encouraged to find the force's newly-established internal auditing processes successfully highlighting weaknesses in its child protection practice. However, we found little evidence of senior leaders in the MPS using this information to change its operational practices sufficiently to bring about demonstrable improvements in the provision of its child protection service.

To determine the accuracy of the audit team's work, and whether and to what extent MPS efforts to improve have led to improved outcomes for children, HMICFRS asked the force in June 2017 to select and self-assess the effectiveness of its practice in 135 child protection cases. The cases selected were a random sample from across London, and were either live or completed investigations from within the previous six months.[4] The force used HMICFRS criteria to grade the practice in each case as 'good', 'requiring improvement', or 'inadequate'. HMICFRS also assessed these cases, and compared its results with that of the MPS' self-assessment.

In summary, HMICFRS found that individuals and teams managing the force's child protection cases are still not achieving an acceptable level of good results for children in London; just under 93 percent demonstrated policing practice that either needed improvement or was inadequate.

Whilst we did find improvements in some areas, the self-assessment undertaken by the MPS also identified similar themes found in the original 2016 inspection – and while we do not expect immediate improvement, we would look for signs that the force is using this information to target its activity, and certainly act on cases where the necessary safeguarding has not taken place.

[4] The case types are: domestic abuse; the exercise of powers of police protection under s. 46 of the Children Act 1989; the conduct of s. 47 Children Act 1989 enquiries (including both those of a criminal and non-criminal nature); sex offender management; missing children; child sexual exploitation (CSE); and the detention of children in police custody.

Figure 1: Cases assessed by both the Metropolitan Police Service and HMICFRS inspectors

	Good	Requiring improvement	Inadequate
Force assessment	3	84	48
HMICFRS assessment	10	64	61

The self-assessment undertaken by the MPS was found to be detailed and demonstrated a good understanding of the main weaknesses in each case, supported with clear rationale of the required improvements where its level of service had been deficient. HMICFRS was therefore disappointed to find that in some of these cases, where the force itself had identified weaknesses and had decided on corrective actions, these had not been addressed effectively, with no remedial activity having been undertaken or recorded. Eighteen cases were referred back to the force, with HMICFRS inspectors highlighting the continued presence of inadequate service.

The following case is an example of one which the MPS assessed as inadequate (as did HMICFRS), but we found no evidence of action taken in response to the concerns raised.

A 15-year-old girl, who was a looked after child at the time of the incident, had been reported missing. She was 'found' at the address of a registered sex offender (RSO). Numerous other children, all known to children's social care services and at risk of child sexual exploitation (CSE), were also present.

Children's social care services requested two strategy meetings in relation to the CSE concerns, but the force did not attend to share relevant information and contribute to the safety plans for those at risk. There was no record of any discussion with the management of the residential unit where the RSO resided to discuss wider safeguarding issues, even though the investigating officer had noted that action needed to be taken to prevent female children visiting the unit.

On 19 July 2017, the MPS' audit highlighted these failings. By 14 August 2017, when HMICFRS reviewed the case, there had been no documented response to the recommendations made by the MPS. This case was referred back to the force.

Recommendations requiring immediate action

Governance and oversight of child protection practices

Governance and oversight of child protection in the MPS are now established, with clearly identified roles and responsibilities for senior officers, and the associated meetings. The MPS has allocated:

- an assistant commissioner specifically responsible for matters relating to the of safeguarding children;
- a deputy assistant commissioner to oversee actions aimed at addressing HMICFRS recommendations;
- the child safeguarding delivery group (CSDG), reporting into the deputy assistant commissioner's gold group;[5]
- a commander head of profession leading on both adult and child safeguarding; and
- 12 portfolio work-streams overseen by chief superintendents or superintendents who have all been appointed, reporting into the assistant commissioner's safeguarding board.

The Mayor's Office for Policing and Crime (MOPAC) also has a child protection improvement oversight group to scrutinise, on behalf of the Mayor of London, both the MPS response to the recommendations made by HMICFRS and its overall progress.

In addition, the MPS continues to undertake and develop its work in partnership with numerous external agencies and boards across London to improve its child protection service.

We intend to speak with safeguarding partners to establish their views of the work undertaken by the MPS, and will report on these in the fourth quarterly report.

The response to children who go missing from home

The audit of cases in this quarter revealed some improvement to the force's approach to children who are reported missing:

[5] A 'gold group' is a meeting that brings together skilled and qualified people to ensure the effectiveness of the police response to a specific incident, crime or other matter.

- 'form 124M'[6] (as reported upon in quarter 2) has created a good structure for investigation, including the necessary checks, risk assessments and actions to be completed; and

- responses to high-risk cases were good; well-organised, well-supervised and with pro-active enquiries being undertaken.

However, we found evidence in the case files of numerous aspects of the MPS' management of such cases that still require improvement. These included:

- the 'absent' category (typically used for a person who is not at a place where they are expected or required to be and is assessed as at no apparent risk) was still being used for some children who should have been categorised as missing;

- evidence in three cases of lengthy delays in the force's initial response, ranging from six hours in one case to three days in another;

- no recorded communication with children's social care services during live missing episodes – even when the child was known to children's social care services, the subject of a child protection plan, or subject to child sexual exploitation (CSE) intervention;

- enquiries made into missing children assessed as medium risk appeared to be mostly desk-based (i.e. phone calls and other checks), with insufficient proactive investigation, such as address checks, location visits and briefings to patrols;

- an inconsistent approach to investigations, generally;

- some recorded evidence of members of the force making inappropriate comments in relation to missing children – for instance, "It's what they always do" – indicating a lack of recognition of the additional risks associated with children who frequently go missing; and

- 'safe and well' checks[7] lacked structure, with completion delays ranging from one day to more than a month.

[6] The form 124m is a template/aide memoire for responding to those who go missing. It provides staff with information to support and guide their enquiries at an early stage.

[7] Safe and well checks are conducted by the police when a missing person is found to manage any safeguarding risks

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

In the quarter 2 report, HMICFRS set out details of the quarterly professional development days (PDDs), introduced by the MPS to increase the workforce's awareness of matters relating to child safeguarding across its London boroughs. PDDs are intended to train all of the force's frontline officers and staff in critical areas such as CSE, mental health and missing children. To increase understanding and awareness of child protection across the force, a recently-launched internal communications plan has been implemented; it complements the provision of child protection presentations which have been used to inform MPS senior officers and borough commanders of the matters of significance and risks for specific themed areas, such as missing children.

HMICFRS notes that the force is yet to complete its skills audit in respect of the officers and staff responsible for conducting safeguarding investigations; this may also be a contributing factor to the disappointing quality of investigations and outcomes in the 135 cases audited.

Following the recent appointment of a commander as head of profession to lead on child (and adult) safeguarding, the MPS has also commissioned the lead officers responsible for each strand of safeguarding to conduct a training-needs analysis for their respective areas. This is a sensible approach, and HMICFRS acknowledges that this analysis, and the development of its consequential training, will take time and therefore cannot be expected to contribute support to any short-term remedial action required of the force. However, we also note that the force has been aware of the lack of appropriate training for its staff since our 2016 inspection fieldwork (which concluded in May 2016).

Improving the management of those posing a risk to children

The cases audited relating to individuals who present a risk to children demonstrated some positive practice, including:

- some evidence of the use of the MPS' proactive assets, such as surveillance, to manage registered sex offenders (RSOs) effectively; and
- some evidence of good joint-working with external agencies to ensure children are safeguarded.

However, we also found areas that still require improvement, including the fact that there are disparate working practices across borough Jigsaw teams.[8] The examination of these cases also showed:

[8] Jigsaw teams are officers and staff dedicated to multi-agency public protection arrangements aimed at managing known registered sex offenders (RSOs) and other dangerous individuals.

- a failure to submit MERLIN PAC notifications[9] in relation to some children, with information being recorded in the ViSOR[10] system only. For those MERLIN notifications submitted, there was little information as to any further safeguarding activity generated;
- limited evidence of strategy meetings being held following the identification of children at risk from those offenders being managed;
- a lack of effective supervision over records and investigations;
- poor record-keeping;
- evident delays in responding to information about RSOs, with some offender managers being unaware of the conditions imposed on some offenders through sexual harm prevention orders or sexual offences prevention orders; and
- a general failure to record the views or concerns of a child.

Recommendations requiring action within three months

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

In August 2017, the MPS launched its internal 'Spot It to Stop It' campaign, with the strapline 'Think Child, Think Safeguarding'. This was developed using information from the force's first safeguarding staff survey (a positive development which we described in the quarter 2 report).

The campaign is intended to run for 12 months, and focuses on four themes: child sexual exploitation; child abuse; missing children; and child criminal exploitation. The aim is that it will become a recognisable brand in use across the whole organisation and that it will support a behavioural ('hearts and minds') change such that, whatever their role, every officer has the duty to protect children at risk of harm and to safeguard them. A clear and comprehensive communications plan, with detailed objectives, underpins the campaign.

The force is planning to use a variety of methods to evaluate the success of the campaign. These include measuring hits on intranet stories, podcast downloads and the interaction of staff through intranet comments and feedback.

[9] Merlin PAC (pre-assessment checklist) is used to refer safeguarding concerns for further assessment.

[10] 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.

While this is encouraging, the evaluation framework in its current form focuses on the success of the communication strategy rather than assessing improvements in practice. We would expect to find evidence of both as the campaign continues.

Improving the investigation of child protection matters

As set out above, HMICFRS was pleased to note that the force's self-auditing of the quality of its investigations was detailed and demonstrated a good understanding and grasp of the notable problems in each case. However, it was disappointing to find that in some cases in which the MPS itself had identified weaknesses, the force had not responded effectively.

The rest of this section gives an overview of the common themes from the case audit, which involved HMICFRS examining 135 MPS child protection cases that had also been assessed by the force's internal auditing team.

- Section 47: cases in which a child has been identified as in need of protection, i.e. is suffering or likely to suffer significant harm.
    - There were examples of good, child-centred investigations which were well-recorded and conducted in the best interests of the child.
    - Strategy discussions were often held in a timely manner, although details from those discussions were frequently limited and did not include information shared by external agencies.
    - Minutes of strategy discussions were not appended to the CRIS[11] record.
    - Recording on the force's systems was poor and failed to document significant activity required or undertaken.
    - Ancillary victims, perpetrators, siblings and family members of affected children were not always named on the force's systems; further incidents may not highlight previous history and therefore risk may be assessed incorrectly.
    - The lack of awareness of child protection by some frontline officers and staff was evidenced through the absence of a MERLIN notification in some clear cases of neglect.
    - Some crimes were not being recorded, or there were delays in recording crimes.
    - The views or concerns of a child were not consistently recorded.

[11] Crime Recording Intelligence System.

- In several cases high workload was recorded as the cause for delays in investigative action.
- In most investigations reviewed, no achieving best evidence (ABE)[12] interview was conducted.

- Domestic abuse: cases involving referrals relating to domestic abuse incidents or crimes.
  - The initial response and attendance by officers was generally quick.
  - Where appropriate, positive action such as an arrest was taken and consideration given to the effects upon children living with domestic abuse.
  - There was evidence of children being spoken with by officers and of their comments being recorded on MERLIN PACs (when they were the victims of assault).
  - In cases involving CAIT,[13] good support and safeguarding were provided to victims.
  - There was a lack of consideration given to the use of wider safeguarding tools, such as domestic violence prevention orders.
  - There was a general lack of referrals made to MARAC 14 and, for referrals which were made, there was a lack of recorded discussions and agreed actions.
  - There were cases where consideration of a prosecution without witness testimony would have been appropriate, but there was a lack of recorded rationale as to why unsupported prosecutions had not been pursued by investigators.
  - In risk assessments, there was a general lack of consideration given to cumulative risk and therefore to MARAC/IDVA[15] referrals.

[12] Achieving Best Evidence (ABE) refers to good practice in relation to the interviewing of and giving of evidence by vulnerable witnesses both children and adults.

[13] Child Abuse Investigation Team.

[14] A MARAC is a locally-held meeting of statutory and voluntary agency representatives to share information about high-risk victims of domestic abuse, at which any agency can refer an adult or child whom they believe to be at high risk of harm. The aim of the meeting is to produce a co-ordinated action plan to increase an adult or child's safety.

[15] An IDVA is an independent domestic violence advocate whose purpose is to address the safety of both victims and their children at high risk of harm

- Although the multi-agency safeguarding hub (MASH)[16] provided the information contained on the MERLIN PAC to children's social care services, there was limited evidence of this leading to strategy discussions/meetings or of safeguarding actions being undertaken.
- For some cases in which there was an investigation plan that directed ABE interviews and joint visits, these were not being conducted.

- Other referrals: these are cases involving referrals to the police arising from incidents other than domestic abuse.
  - Officers failed to cross-reference reports. As a result, connected subjects and individuals were not always linked, making searches of police systems more difficult.
  - Some members of the force failed to record sufficient details on MERLIN, which compromises the quality of risk assessments being made in respect of some children.
  - There was a general failure to record the views, and observations in relation to the demeanour, of the child within the MERLIN PAC adequately and accurately, despite officers seeing and speaking with these children.
- CSE: cases in which children are at risk from CSE arising from local contact (i.e. not from the internet).
  - Risks were accurately identified by frontline officers and staff, and they mainly provided a good response to such incidents.
  - There was good evidence of frontline officers and staff seeking advice from specialist teams such as CAIT or Sapphire[17] before taking action.
  - The initial assessment team conducted daily searches to identify CSE incidents requiring assessment, and made good use of action plans which are added to each report to assist the investigating officer.
  - There was an inconsistent approach to the practice of recording investigative activity on CRIS, and there were often delays in updating reports.

[16] This is a hub in which public sector organisations with responsibilities for the safety of vulnerable people work together. It has staff from organisations such as the police and local authority social services, who work alongside one another, sharing information and co-ordinating activities, to help protect the most vulnerable children and adults from harm, neglect and abuse.

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

    - There was a general absence of meaningful supervisory review and oversight.
    - There was an inconsistent approach in the practice of recording any joint-working or strategy discussions.
- CSE online: cases in which children are at risk from CSE arising from the internet.
    - Unnecessary delays were evident during the initial stages while investigative ownership was passed between various teams. In the interim, vulnerable children were not being contacted and, potentially, not adequately safeguarded.
    - Investigations were not always child-centred.
    - For cases in which a child refused to engage with police or children's social care services, there was no apparent re-evaluation of risk.
    - There was evidence of some officers failing to speak with children who were victims of an offence, or of failing to conduct ABE interviews.
    - There was a general absence of concerted effort to locate suspects whose names had been identified, and delays in making such arrests.
    - There was a general lack of technical knowledge in the collection and preservation of evidence, and a reluctance to seize devices that were likely to contain evidence, especially mobile phones from children.
    - Supervisors generally failed to supervise investigations, and failed to ensure compliance with previous supervisory reviews. Reviews often contained brief comments, such as "officer in the case to update", rather than details of specific activities that needed to be undertaken.
    - The risks to children were assessed on a case-by-case basis, but the risk to suspects did not seem to be fully understood by officers and staff when dealing with offenders who have a sexual interest in children.
- Police Protection Orders: cases involving officers using their powers to take children to a place of safety under section 46 of the Children Act 1989:
    - Decisions to take a child to a place of safety were generally well-considered, although there were cases audited in which the initial risk to children was not assessed with the urgency required.
    - There were instances of missed opportunities by the force to conduct investigations into potential offences (relating to the circumstances under

which their police protection powers were needed), due to failures to gather evidence.

- There were instances in which police protection powers failed to be managed effectively and, as a result, elapsed.
- Although every incident that results in the use of police protection powers should result in the submission of a MERLIN PAC (to prompt a strategy discussion in which joint plans can be created to mitigate risk), information, particularly in relation to strategy meetings, safeguarding plans and contact with children and families, was frequently incomplete or missing.

Recommendations requiring action within six months

Resourcing and demand management for child protection matters

In the quarter 2 report, HMICFRS set out the extensive work MPS had conducted to develop a safeguarding performance framework (HMICFRS recommendation 5). This has now been launched.

The new framework was intended to provide a useful source of valuable information for the MPS across a broad range of child protection areas. However, at the time of the quarter 3 inspection, the performance framework's use to inform resource-allocation and planning decisions to bring about improvements (HMICFRS recommendation 7) remained outstanding within the force's action plan.

Two specific measures by the plan to evaluate success in the delivery of recommendation 7 are:

- a data set that is routinely available at MPS tasking meetings and other operational forums; and
- that this data set should be available to decision-makers to enhance the allocation of child safeguarding resources across London to address specific geographic pressures.

HMICFRS now expects prompt action to be taken and progress to be made against the positive aspirations set out in the action plan.

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

HMICFRS was pleased to note that the force has established a multi-agency working group to improve practice in the detention of children. The purpose of the group is to consider the following:

- the provision of accommodation (secure and non-secure) for children detained in police custody;

- the provision of appropriate adults; and
- the associated criminalisation of some children in the care system and other pan-London matters, such as attendance at strategy meetings.

The formation of this group is still recent. However, HMICFRS considers that it represents a real opportunity for the force to understand the weaknesses in its current custodial system from a multi-agency perspective, and to seek solutions to the problems in the post-charge detention of children and their timely access to appropriate adults.

The cases audited relating to the force's management of children detained in custody demonstrated some improvements.

- Officers made timely requests for alternative accommodation post-charge.
- In most cases, MERLINs and pre-release risk assessments were completed.
- Of the cases reviewed, all detention certificates were completed.

However, they also highlighted crucial aspects of the force's approach which continue to be weak.

- For numerous cases where officers requested local, non-secure accommodation for children, only secure placements were offered by local authorities.
- Children were regularly detained in custodial cells, because of a shortage of detention rooms.
- Detention reviews were rarely used to obtain updates on the progress of investigations.
- Where review times coincided with the child being asleep or in interview there was a lack of evidence to indicate that the child was subsequently informed of these reviews
- There were long delays in appropriate adults attending custody to support children; in numerous cases the appropriate adult was absent when the child was charged and, in some cases, strip searches of children took place without the presence of an appropriate adult.

Auditing the skills and experience of those officers and staff undertaking safeguarding investigations

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

However, HMICFRS notes that the force was yet to adhere to the recommendation to undertake a skills audit (within six months) to establish that its officers and staff dealing with child protection matters, including abuse and CSE, are appropriately trained to carry out their duties.

The MPS' action plan in relation to this particular recommendation sets out the following specific activity:

- to conduct a skills audit of officers and staff within the child abuse investigation teams (CAIT) who are not accredited by the specialist child abuse investigation development programme (SCAIDP), to understand their training needs;
- to provide the relevant and appropriate training to all officers and staff requiring it, informed by the skills audit;
- to conduct a skills audit of non-SCAIDP-accredited officers and staff within other specialist and borough units investigating child protection matters; and
- to deliver the appropriate training to relevant officers and staff, informed by the skills audit.

Although the force's action plan documents that these actions were to be completed within the six-month timeframe set by HMICFRS (i.e. by summer 2017), none of them has as yet fully concluded. The 2016 report highlighted that the MPS' training deficiencies were inhibiting staff and officers' abilities to protect children effectively; that their training needs remain outstanding is a problem that needs to be remedied urgently.

Conclusion

Despite the scale, complexity and multi-agency challenges facing the force in delivering change, progress has been, and continues to be, made in numerous areas regarding child protection. This has been achieved through the force's governance arrangements which, since 2016, have been re-structured to provide oversight of improvements to the MPS' response to child protection and wider safeguarding.

In the quarter 2 report, HMICFRS noted that the MPS' commitment to improving the provision of its services to children had resulted in demonstrable progress in some important areas. The report also stated that, notwithstanding the force's efforts, HMICFRS was worried by early signs that the changes made in some principal areas were failing to improve outcomes for affected children.

As we outlined earlier in this report, while the CSDG's dedicated inspection team (DIT) has demonstrated a good understanding and grasp of the notable problems identified in cases assessed as inadequate or requiring improvement, the

weaknesses found in these cases have not been effectively and consistently responded to, despite being referred back to officers for action. Such continuing failure indicates that the changes expected by the force are not yet a routine part of everyday practice.

The HMICFRS review conducted on 135 MPS child protection cases has identified that there are still significant weaknesses in the force's current practice in relation to child protection. This is rendered more troubling by the fact that such changes and insufficient improvement have been implemented under the new governance and oversight structures that the force has put in place. The improvements and consistency in practice that have been articulated clearly in the expectations set by senior officers via numerous forums, including the force's action plan, are not yet being realised. As a result, improved outcomes for children at risk are not consistently being achieved across all the nine areas examined during the case review.

Throughout the inspection we have continued to liaise with the force ensuring that our emerging findings are shared in a timely manner to support prompt and effective action. However, while the DIT has identified the weaknesses in cases it has reviewed, setting in place a number of remedial actions, we identified some indications of a lack of empowerment to effect change or to hold officers to account, particularly when necessary action is not taken to address the failings highlighted in the cases reviewed.

Moreover, the number of weaknesses uncovered in too many of the cases examined in this quarter continues to reflect those which we reported in 2016. HMICFRS will continue to scrutinise the force's response to these findings, and expects the MPS to take prompt and effective action to improve outcomes, particularly for those cases which are currently being investigated by its officers and staff.

Next steps

In its fourth quarterly report, HMICFRS will outline the progress the force has made over the past year in relation to the recommendations of its 2016 report. We shall also explore in more detail the current barriers to improvement and provide an overall assessment of how effective the MPS is in safeguarding children at risk across London, and undertake further audits and sampling of cases. Finally, the report will describe how the force has responded to the weaknesses identified through these quarterly reports, and will set out our plans for any further inspection activity.

Annex A – Summary of findings from HMICFRS' 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 (published 20 June 2017)

HMICFRS assessed whether the action plans demonstrated a sufficiently clear understanding of the weaknesses to its practice and the recommendations made in its 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 set 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, provided the starting point for tracking the force's progress over the course of the year. It clearly indicated which actions had been planned and which had been completed.

Quarters 2 and 3: Assessments of progress against the action and improvement plan (Quarter 2 report published 10 August 2017; Quarter 3 report – this report)

HMICFRS is reviewing the force's progress against the recommendations of its 2016 report, and against the force's own action plans. Inspectors have been carrying out a combination of interviews with senior leaders, insight work and meetings, and incorporating 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 2017/18)

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, officers 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 the 2016 report. This final quarterly report will also include details of any further inspection activity.