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

# National Child Protection Inspection Post-Inspection Quarter 4 Update

The Metropolitan Police Service
October – December 2017

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# Contents

# Summary

## About this report

In 2016, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)[1] published a highly critical report of the Metropolitan Police Service's (MPS') child protection practices. This included a series of recommendations aimed at improving the service provided to children in the London area.

Because of the severity of the failings we found in 2016, the Home Secretary commissioned us to publish quarterly reports over the course of 2017, setting out the progress made by the MPS in improving its practices.

In this, the fourth of these quarterly post-inspection review reports, we make our final assessment of the force's progress since the original 2016 report was published.

### Methodology

This report draws together findings acquired over the course of 2017. Annex C sets out the approaches taken in the first, second and third quarters of the year. Additional post-inspection review activity in the fourth quarter included: an examination of MPS policies, strategies and other documents; interviews with officers and staff; and an additional audit of child protection cases.

### Findings

As in 2016, we found some committed and dedicated officers and staff operating in an increasingly complex and demanding environment, investigating cases which are seldom straightforward. We acknowledge and commend the work they continue to do to keep children safe.

HMICFRS also acknowledges the difficulties inherent in effecting significant changes in policing practice in respect of the 31,000 police officers working in the force. Despite the demands of policing the capital – which in 2017 included responding to three terrorist attacks and the Grenfell Tower fire – we found that the force has made progress in a number of areas relating to child protection, and continues to do so.

[1] The original MPS child protection inspection began 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.

In 2016 we reported that the MPS was failing to monitor and manage child protection cases to ensure consistently good standards of service in London. In particular, we highlighted a lack of strategic oversight, with no single chief officer in overall charge of child protection matters across the force. From our 2017 fieldwork we found that a significant amount of change has taken place at a strategic level within the MPS; there is now a named chief officer lead, and a team currently dedicated to checking regularly and reporting on the nature and quality of decision-making in child protection cases.

Since the 2016 inspection, the force has also made significant changes to how it disseminates the data to officers and staff which it collects on child protection performance, to improve their awareness and assist in decision-making. Police data that is available currently across all safeguarding areas has been used to develop and populate a new safeguarding performance dashboard, which went live in July 2017. While this is relatively new (and therefore we are unable to comment upon how effectively it is being used), it represents a real step change in the availability of data for officers and staff at all levels.

We were pleased to find that officers are now made aware of registered sex offenders living in their areas through the introduction of Operation Beat, an internal briefing system containing details on offenders categorised as of high- or very high-risk.

Senior leaders have invested time and energy into overseeing these changes and communicating to all officers and staff the importance of improving child protection practices. This reflects the clear commitment of leaders, both in the force and the Mayor's Office for Policing and Crime (MOPAC), to act on the results of our 2016 inspection to improve outcomes for children.

However, progress in other child protection areas is slower and inconsistent. For instance, in 2016 we reported on failures in partnership working (which is an essential element in helping to improve outcomes for all children). In 2017 we found that although the force is working with partner agencies at a senior level, and that there are some strong and effective joint-working arrangements in place, many of the urgent improvements needed for those critical functions are being delayed. We recognise the complexity of working with the large number and range of partners in London, however an acceleration of progress in this area is needed.

During the post-inspection review, we were told about a wide range of initiatives aimed at improving the service the MPS provides to children. However, many of these were still embryonic, and had yet to translate into consistent improvements at the frontline, and so had not yet improved outcomes for children.

We also found limited evidence of the MPS effectively bringing about a shared and consistent understanding of the appropriate action required at practitioner-level when officers and staff encounter vulnerable children. This is evident in the outcomes of

our review of 214 child protection cases. The majority of these cases (191) were found to demonstrate policing practice that we judged either as ‘requiring improvement’ or ‘inadequate’.

We also found that, in some areas, the volume of work is contributing to delays and drift in child protection investigations. This is exacerbated by a lack of effective supervision, and is leading to inconsistencies in investigations and the absence of appropriate oversight.

These weaknesses are compounded by the fact that the findings of the internal case audit process developed by the MPS are not yet being used to make the required changes to its processes or practice. Together, these weaknesses have demonstrably adverse effects upon the provision of the MPS’ safeguarding services, and may leave some children vulnerable.

## Conclusion

The MPS has demonstrated a strong commitment to protecting children. This is evident particularly among senior officers, and is demonstrated through the new and improved governance structures. The force has taken some steps to translate this commitment into improved services for children, however many of these changes are more recent and their effectiveness is yet to be fully assessed and understood.

Overall, despite the progress made in areas such as the provision of training, the development of new governance structures, and the efforts of senior leaders, consistently good outcomes for children in London are still not being achieved; often they are being compromised by poor investigations and ineffective supervision. It is therefore incumbent upon the MPS to ensure that the current focus and momentum is accelerated in some areas and maintained in others to address the inconsistencies and deficiencies in the provision of its services to those children in London in need of help and protection.

## Next steps

We recognise that the force should be given the time and space to introduce and embed the arrangements that they have been working to put in place over the past year. However, in light of our findings and our continuing concerns about the outcomes for children in London, we intend to re-visit the force at least once over the next 12 months to review progress. In particular, we will seek demonstrable improvements in relation to frontline practice and outcomes, and clear evidence of the effectiveness of the new safeguarding structures being implemented.

# Background

## The 2016 inspection conducted by HMICFRS of child protection services in the Metropolitan Police Service

In 2016, HMICFRS 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 was providing 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.[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 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
- 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:

[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] www.justiceinspectorates.gov.uk/hmicfrs/publications/metropolitan-police-service-national-child-protection-inspection/

**Within three months:**

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

**Within 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 original report, HMICFRS wrote to the Commissioner of the Metropolitan Police Service 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.

Concurrently, on account of the significant failings 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.

## About this report

The reports for quarters 1 and 2 (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 two action plans. The report of the third quarterly assessment (published in October 2017) set out the findings of the audit we completed in August 2017, in respect of 135 MPS child protection cases.

This final quarterly review report outlines the progress the force has made against the recommendations of the 2016 report. It also provides further detail of the current barriers to improvement, and provides an overall assessment of how effective the MPS is in safeguarding children at risk across London.

Additional post-inspection review activity for this final quarter included: an examination of MPS policies, strategies and other documents; interviews with officers and staff; and an additional audit of child protection cases.

# Post-inspection review findings

## Leadership, management and governance

### Recommendations from the 2016 inspection report

We recommend that the Metropolitan Police Service should immediately 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.

We recommend that within three months the Metropolitan Police Service should develop a performance framework to report on the results of the service it provides to children.

We recommend that within six months 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.

### Review findings

Despite the demands faced by the force of scale, complexity and multi-agency input, progress has been, and continues to be, made in a number of areas relating to child protection; we found that the MPS is committed to improving its services for children. There are examples of visible leadership, such as a concerted drive to provide more focus on child protection, in addition to efforts to work closely with fellow safeguarding agencies at a pan-London level to protect children better. This is demonstrated by the membership and attendance of partner agencies at a number of the force's internal meetings.

There is an unambiguous recognition by senior officers of the scale of work required to influence and effect change within the 32 London boroughs, each with different and complex partnership arrangements, and at a time of exponential growth in demand. To overcome some of these difficulties, the MPS has sought to improve its leadership arrangements through the recent introduction of a single head for safeguarding (at commander rank), supported by lead officers responsible for 12 streams of work.[4]

[4] The 12 streams 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

This structure may provide the necessary cohesion between the 12 work-steams to improve the force's safeguarding services, and it seems to be a sensible approach to this broad area of policing. However, given the complexity of partnership arrangements across London, continuing support and scrutiny is required at executive level to ensure this approach is successful.

Senior leaders (some of whom are either new in post or have been made lead responsible officers for policing areas, such as child sexual exploitation) were candid about the difficulties they face and acknowledged that approaches are inconsistent and sometimes disjointed. However, they were clear about what needs to be done to address the current problems, and were able to explain how they will provide the necessary leadership for that to be achieved.

Previously, we found that child protection matters received less consideration compared to the attention given to measuring and monitoring the MOPAC 7 crime types.[5] Since then, there has been a rebalancing of priorities within the MPS; the Mayor of London has removed the previous targets and, in the latest police and crime plan, has replaced them with three priorities, one of which is keeping children and young people safe. This shift has resulted in the force focusing on its service in its four primary policing functions, namely safeguarding, investigation, response and neighbourhoods.

The MPS has also undertaken a risk and harm assessment to prioritise and focus activity effectively through the design of its control strategy.[6] One area assessed as a threat is child safeguarding, which includes child abuse, sexual exploitation and online abuse. This area is now within the MPS' control strategy; it has provided senior officers with a framework through which they have been able to prioritise the allocation of resources for the protection of children. In 2016 we concluded that there was an absence of strategic oversight of child protection. We were pleased to find that the force has since reviewed its governance arrangements, restructuring them to provide oversight of its approach to child protection. This is now led by an assistant commissioner, supported by a deputy assistant commissioner, and by head of profession at commander-level for safeguarding. Their work is supported by an external advisory panel of individuals and organisations, which includes representatives from the voluntary sector and academia.

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harassment; modern slavery and human trafficking; vulnerable adults (including elder abuse and abuse of disabled people); and staff engagement, i.e., 'wellbeing and morale' and 'making safeguarding everybody's business'.

[5] Previously Mayor's Office for Policing and Crime had established seven principal neighbourhood (or 'MOPAC 7') crime types as particular priorities for the MPS: burglary, criminal damage, robbery, theft from a motor vehicle, theft from a person, theft of a motor vehicle and violence with injury.

[6] A police control strategy sets out the operational priorities for a police force, including for crime prevention, intelligence gathering and enforcement.

Oversight of the force's response to the child protection recommendations from 2016, and the associated force action plans, is managed through a safeguarding board chaired by an assistant commissioner and a gold group[7] chaired by a deputy assistant commissioner. Activity against the 2016 HMICFRS recommendations is tracked, and is managed by a detective superintendent via the child safeguarding delivery group (CSDG)[8], reporting into the gold group.

The Mayor's Office for Policing and Crime has also convened a child protection improvement oversight group whose purpose is to scrutinise, on behalf of the Mayor of London, the MPS' response to HMICFRS' recommendations and the force's overall progress.

The new safeguarding model (implemented in early June 2017), the introduction of the safeguarding work-streams and the newly-structured borough safeguarding pilot sites (Islington, Camden, Barking & Dagenham, Havering and Redbridge), while all in the early stages of development, demonstrate a recognition and firm commitment by the force to provide a more co-ordinated approach to child protection and wider safeguarding. The intention is that these measures will provide greater consistency in the service to safeguarding cases across London. However, at this stage it is too early to assess their effectiveness and potential to improve outcomes.

In 2016 we established that information on victims, offenders and risk was kept in isolated pockets across the force, with officers and staff carrying out their own analyses of demand and trends.

Since the 2016 inspection, the MPS has made significant changes to the methods of disseminating to officers and staff its data on child protection matters, to improve their awareness and assist in their decision-making. Police data that is currently available across all safeguarding areas has been used to develop and populate a new safeguarding performance dashboard, which went live in July 2017. While this is relatively new (and therefore we are unable to comment upon how effectively it is being used), it represents a real step change in the availability of data held on police systems for officers and staff at all levels. This has been achieved despite the current IT difficulties the MPS is seeking to overcome through its introduction of the new Met Integrated Policing Solution (MIPS) system – anticipated for 2018 and intended to integrate the current seven databases.

Due to the relatively recent introduction of the performance dashboard, the force has yet to fulfil HMICFRS' recommendation about the use of a performance framework to inform resourcing and planning decisions.

[7] 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.

[8] The CSDG is made up of senior officer leads and subject matter experts.

Over the last year, territorial policing crime fighters' meetings[9] have shifted explicitly towards scrutinising safeguarding by the force as well as volume crime,[10] and have moved away from the previous focus on the MOPAC 7 crime types. Since July 2016, these meetings have covered a wide range of areas, including domestic abuse, managing sex offenders, missing persons, child sexual exploitation (CSE), indecent images of children and sexual offences. These meetings now provide a forum in which senior officers can be briefed and discuss current aspects of child protection and other matters affecting the force, examining and reassuring themselves of what is happening locally within their own boroughs.

The change in governance structures, adjusted priorities, new internal media campaign and the obvious re-focus upon children (the latter of which is now explicit in the force strategy, police and crime plan and within crime fighters' meetings) should be providing a 'golden thread' from strategy to operations. However, we have concluded that gaps remain between the force's strategic intent to improve and its practice on the ground. As is set out below, we continue to be troubled by the standards of action and investigation in the cases that were examined, and by the absence of appropriate and timely responses to those investigations referred back by the dedicated audit team for remedial action. This is despite our finding that the officers and staff we spoke to who manage child abuse investigations are committed and dedicated, often working in difficult and demanding circumstances.

A number of factors that continue adversely to affect outcomes for children were reported to HMICFRS by officers and staff during the post-inspection review. These include the limited capacity and capability of those officers and staff tasked with responding to incidents and undertaking investigations, as well as the inadequate supply of officers and staff appropriately skilled to conduct this type of specialist work.

[9] Monthly performance meetings.

[10] Volume crime is any crime (such as street robbery and burglary) which, through its sheer volume, has a significant and adverse effect upon the community and the ability of the local police to tackle it.

# Initial contact

### Recommendations from the 2016 inspection report

We recommend that The Metropolitan Police Service should immediately 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.

### Review findings

In 2016, we reported on the absence of designated professional development days (PDDs) for the training of officers and staff within the three MPS command and control centres[11] (CCCs). This remains the current position, namely that officers and staff remain reliant on 15-minute briefings and emails to receive necessary information. During the post-inspection review, we were informed that the MPS is working to implement a new shift pattern in 2018 to facilitate the provision of PDDs. Until then, briefings have been provided on matters of missing and absent people and domestic abuse, however this has not yet been extended to include CSE.

CCC officers and staff making assessments on vulnerability and risk have access to a number of standing operating procedures,[12] in addition to prompts and briefings.

[11] These are the MPS' three communications centres, based in Bow, Lambeth and Hounslow. They are responsible for handling emergency and other incoming calls to the MPS, and despatching officers to deal with incidents across the capital.

[12] These set out activities necessary to complete a task in accordance with MPS standards.

These include areas such as recognising vulnerability, Operation Makesafe,[13] sexual offences, and missing and absent people.

CCC officers and staff are responsible for categorising a child as either missing or absent at the time of receiving such a report. In 2016, we highlighted to the force its misuse of the absent category (typically intended 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). However, we found that the category is still being misused by the force in relation to some children.

The Authorised Professional Practice (APP) on missing person investigations, which provides national guidance to police services, was published by the College of Policing in November 2016. This states that all reports of missing people sit within a continuum of risk from 'no apparent risk (absent)' through to high-risk cases that require immediate, intensive action. In May 2017, the MPS held a workshop in which it was decided to adopt the changes within the APP. However, the new national guidance, and associated training that will be required, is yet to be implemented across the MPS.

Since August 2017, the force has been trialling an interim missing persons' protocol on the pathfinder sites.[14] This seeks to use a proportionate and risk-based approach (i.e., using alternative methods to despatching officers). The pilot has yet to be evaluated.

In addition to the missing cases we reviewed, a small sample of absent cases were also examined by HMICFRS for the period 8 to 11 September 2017, all of which involved looked-after children. From this we found an inconsistent approach to categorising such cases: of the 12 examined, 5 were classified inappropriately as absent (as opposed to being categorised as missing), and therefore received no investigative police action.

In 2016, HMICFRS recommended that the force put in place arrangements to ensure that for children who repeatedly go missing, trigger plans[15] are implemented to forestall further such episodes. As an initial response to this recommendation, the MPS developed 'intelligence passports' to record relevant information on those who repeatedly went missing, to assist in locating them as quickly as possible.

[13] The Operation involves working with hotel staff, taxi drivers and licensed premises to identify potential victims of child sexual exploitation.

[14] The MPS pathfinder sites are pilots to test the effectiveness of moving from a policing model based on 32-boroughs to one comprising a smaller number of larger units (i.e., the basic command unit (BCU) model). This is currently being tested in two areas.

[15] A trigger plan is a police force document outlining the plans to locate a child quickly when he or she goes missing.

Unfortunately, these were found to be under-used, with only 32 in place. The MPS has therefore decided to withdraw this approach and develop an intelligence-style report to record such information.

Other disruption tactics, such as the use of Child Abduction Warning Notices as part of a comprehensive risk-management plan (the purpose being to sever contact between children at-risk and those who may seek to exploit them), are being used, but in low numbers. In the 12 months from September 2016 to August 2017, just 111 such notices were issued across London by the MPS.

## Assessment and help

### Recommendations from the 2016 inspection report

We recommend that the Metropolitan Police Service should immediately 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.

### Review findings

The assistant commissioner lead for child protection has published a series of messages communicating the fact that child protection is a priority for the MPS. These have been used to support the development of PDDs across territorial policing, which have been designed to improve awareness and understanding of child protection.

The quarter 1 PDD dealt with safeguarding children and young people, and was provided to 13,524 officers. The force does not have information on the number of officers that did not receive this training, and there are no plans to provide it in the future to those who did not attend. Moreover, the force has advised that in the future

it will no longer collate attendance data on training due to costs. This decision will limit the MPS's ability to conduct a skills audit of what training their staff have received, in order to determine whether this is adequate for their roles.

To support enhancing its approach to children at risk, the MPS launched its internal media campaign, 'Spot It to Stop It' (with the strapline 'Think Child, Think Safeguarding'), in August 2017. This was developed using information from the MPS' first ever safeguarding staff survey. The aim for the campaign is to develop a recognisable brand across the whole organisation, and for it to support a behavioural ("hearts and minds") change reinforcing that, whatever their role, every officer has the duty to protect children at risk of harm and to safeguard them. Although senior leaders spoken to during our post-inspection review were aware of the campaign, this was less evident among frontline officers and staff, despite the campaign posters within police buildings.

We reported in quarter 3 that, in its current form, the evaluation framework for the Spot it to Stop it campaign focuses on the success of the communication strategy rather than assessing improvements in practice. The force needs to ensure both forms of assessment are in place as the campaign continues.

This campaign is also being used to support a new safeguarding page on the MPS intranet to help with matters of child protection and associated decision-making. It has dedicated links to the 12 safeguarding work-streams and their associated toolkits, to provide guidance to officers and staff.

Attendance at initial child protection conferences is now good (in the Islington and Camden boroughs it is 100 percent at the time of writing). However, many review conferences are not attended by force representatives, rather a report is sent instead. We were informed that, despite the MPS having dedicated police liaison conference officers, current demands and staffing resilience within child abuse investigation teams (CAITs) is adversely affecting the force's attendance at review conferences.

The MPS is working with external safeguarding agencies to review the arrangements of the London multi-agency safeguarding hubs (MASHs), demonstrating its commitment to evaluating and seeking to improve its wider processes of joint-working. The review has the support of the pan-London local safeguarding children's board, and will include examining practice in relation to information-sharing, workflows (such as referrals), as well as data and performance. The first meeting of the group of agencies, including the force, took place in September 2017 to examine and agree terms of reference. The report on the findings is expected March 2018.

# Investigation

### Recommendations from the 2016 inspection report

We recommend that within three months 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.

We recommend that within three months 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.

### Review findings

To understand whether the MPS has improved its approach to and investigation of child abuse, child sexual exploitation and missing children, we reviewed a total of 214 cases. While we did find individual areas of good practice, the overall findings were that 191 (89%) of those cases either required improvement or were inadequate. This is despite the training that has been provided and the procedural guidance made available to officers and staff. In addition, the force has yet to conduct a skills audit to ensure that officers and staff dealing with child protection matters are appropriately trained and competent to undertake such investigations.

Our audit revealed that cases are sometimes compromised due to both poor investigations and an absence of robust supervision. The weaknesses we found in these cases were similar to those detected by the MPS dedicated inspection team, whose purpose is to examine and evaluate investigations. Although the team has been conducting reviews since June 2016, in a number of cases the response of those officers assigned to undertake remedial action has been neither effective nor timely.

A 13-year-old girl had previously sent a picture of herself naked from the waist up to a 12-year-old boy; subsequently, he threatened to distribute it more widely if she did not send more images. The girl rang the police but was not seen by the force for 11 days. The case file demonstrated extremely limited investigative action and no evidence of multi-agency work. The MPS' own review of its work in this case judged it to be inadequate, and listed a number of actions to be taken. However, in respect of these we have found limited response by the force.

A 17-year-old girl reported to the force that she had been raped by a number of men after they had given her alcohol. Specialist officers were allocated to both the rape and CSE elements of the investigation, however there was no strategy meeting in relation to either. This indicates that partner agency information (which could be used to address wider safeguarding needs) is not being shared. The omission in safeguarding this child was highlighted during the MPS' own audit in July 2017, and an action was raised for a strategy meeting to take place. At the time of the HMICFRS' review of this case, a strategy meeting had still not been conducted.

Samples from the internal reviews conducted by the MPS are also presented before a child safeguarding scrutiny panel (CSSP), which comprises senior police officers as well as representatives from children's social care services, the Crown Prosecution Service (CPS) and the National Society for the Prevention of Cruelty to Children (NSPCC). Learning acquired from the panel is passed to the borough commanders, as well as to the MPS' crime fighter meetings.

The force's inconsistent investigative practice is evident below:

- In domestic abuse cases the force has a good initial response to such incidents, but fails to consider using wider measures, such as civil orders. In the 12 months from September 2016 to August 2017, a total of 154 Domestic Violence Prevention Orders (DVPOs) were granted and only 110 disclosures made under the Domestic Violence Disclosure Scheme (also known as 'Claire's Law').

- In general, initial strategy discussions take place following referrals. However, there are occasions when officers are unable to attend strategy meetings or joint initial visits with children's social care services due to the level of demand.

In February 2017, a 7-year-old boy reported to staff at his school that he had been assaulted by his parents. The child was on a protection plan with a history of neglect, together with the presence of substance misuse and mental health problems in the family home. The matter was referred to the force and a strategy meeting took place. It was decided that the matter should be carried out as a single agency investigation, despite there being other significant factors (namely that the child had not been spoken to and access to his siblings in the house had been denied), which clearly indicated that police involvement in a joint statutory investigation would have been the correct approach.

There is no evidence of investigation by the force despite a disclosure and significant causes for concern in respect of the child. Supervisory oversight by the force failed to result in any positive action being taken or the relevant children being safeguarded appropriately.

It was only following a further assault on the child by his mother, reported in June 2017, that a joint investigation involving the force took place, and which resulted in the affected children being safeguarded through placement with other family members.

Examination of cases involving CSE revealed the presence of delays in the initial stages, during which the investigative responsibility passed between teams before being resolved. During such periods of delay, the force fails to contact victims, who therefore are potentially not being safeguarded.

In May 2017, the National Crime Agency reported to the MPS that two indecent images had been uploaded onto the internet. Following a delay of five days, the force established an investigation plan and conducted research revealing that the suspect had an 8-year-old daughter. A further 15 days elapsed until a search warrant was executed and the suspect arrested.

A Merlin referral to children's social care services was not made until four days after the arrest, in which it was stated there were no immediate concerns for the children involved, despite the suspect admitting to the offences for which he was under investigation. This was subsequently rectified by staff within the MASH.

There is a general reluctance demonstrated by the force to seize devices, especially mobile phones from children; some officers lack the confidence to seize these devices without the owner's permission, even when it is known they contain evidence of indecent images of children.

For cases clearly defined as child protection matters from their outset, officers are generally good at making decisions about taking children into police protection. Those cases we reviewed where the police used their powers to take a child to a place of safety were generally well-considered and in the best interests of the child.

An 11-year-old boy was known as at risk of harm from his mother, following a disclosure to the force that he had been subjected to a continuing period of physical violence from her. The force demonstrated an effective initial response by correctly taking the child into police protection. Investigators were sensitive to the child's needs as they sought to obtain information from him at his school about the abuse he had suffered. The child's views and wishes were acquired and recorded from the outset and, through finding a safe address at which the child could be accommodated, measures for his longer-term safeguarding were put in place.

The use of police protection powers should result in the submission of a Merlin pre-assessment check (PAC) in order to prompt the taking place of a strategy discussion involving partner agencies. However, HMICFRS found that information, particularly in relation to strategy meetings, safeguarding plans and contact with children and families, was frequently incomplete or missing from police records.

The MPS described to us its relationship with the CPS as positive, particularly through the implementation of a pilot scheme for early investigative advice: as soon as an investigation is considered ready for case-building, a joint strategy is established between the force and CPS (in relation to matters such as third-party material and forensic evidence).

The force and CPS have also developed processes to enable the MPS to obtain post-trial feedback to inform learning; to examine matters such as whether a CPS case conference was held before trial, along with comments which are provided as feedback to the investigating officer. The force also has a mutually-established process with the CPS to escalate matters from either organisation where required, and this is supported by regular meetings.

# Decision making

### Recommendations from the 2016 inspection report

We recommend that within six months 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.

### Review findings

The final recommendation in the 2016 report was specifically in relation to conducting a skills audit to assess the training required for those officers and staff undertaking child protection work, and to establish whether they are appropriately trained to carry out their duties (which we found to be a problem in 2016). We are therefore disappointed by the fact that very little progress has been made in respect of this recommendation. Although the lead officers responsible for each strand of safeguarding are due to conduct a training-needs analysis for their respective areas in the near future, this analysis and the subsequent development of training will take time and therefore cannot contribute to the current improvement activity nor support any of the short-term remedial action required of the force.

The provision of training, together with the development and communication of best practice across the force, is fundamental to MPS' plans to improve the capability of its workforce, in enabling it to deal effectively with the demands of safeguarding children.

# Managing those posing a risk to children

### Recommendations from the 2016 inspection report

We recommend that the Metropolitan Police Service should immediately 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 (RSOs) is made available routinely to local officers.

**Review findings**

In our 2016 inspection we established that the MPS' procedures for the investigation of crimes involving the possession of indecent images or videos of children failed to consider sufficiently the safeguarding needs of children within the suspect's family.

Although the force has reviewed its procedures and drafted new ones, they have yet to be formally endorsed by senior leaders although they have been put into effect. However, the new model continues to raise questions as to the effect of the force's approach: indecent images of children cases in which there are children present in the suspect's home now go to an already overburdened child abuse investigation team (CAIT), a problem we highlighted earlier in this report. This process is used irrespective of whether there is any evidence of familial abuse taking place. We found that, as a consequence of the demands it faces the CAIT team passes some of these cases to the criminal investigation department (CID).

High- and very high-risk cases in which there are no children living in the suspect's home, or for which the suspect has no children in the family, are investigated by the predatory offender unit;[16] as a result the team deals only with a fraction of the overall referrals. Medium-risk cases where there are no children present go to borough CID to be investigated by officers who often have received no specialist training. Moreover, these officers are being supervised by managers with limited knowledge of the work and who are unable to offer investigative advice or set parameters in limiting the quantities of indecent images viewed by the officers.

Furthermore, the Operation Bellona[17] team deals with all levels of risk in cases originating from within this operation, irrespective of whether or not there are children in the suspect's family. This creates a situation of trained specialist officers investigating low-level, low-risk cases purely because they originated via the

[16] The predatory offender unit specialises in combating the activities of those who manufacture and distribute indecent images of children. It also tackles child abuse on the internet by targeting the online activities of paedophiles.

[17] Operation Bellona is a proactive investigation into the sharing and distribution of indecent images of children.

operation, while untrained, inexperienced borough officers investigate medium- and high-risk cases (i.e., in which there are children in the family), on the sole basis that the offence was identified through different means.

We are also troubled by the force's decision-making process for cases investigated under Operation Bellona in which there are children in the suspect's family or in which the suspect has access to children. In these cases, we found the force fails to make timely referrals or share information with children's social care to ensure risks are mitigated and children are safeguarded appropriately (for example, refraining from doing so until after a search warrant is executed). The approach is not child-focused; the force's priority to collect evidence for criminal investigations is effectively prioritised over the safeguarding of children.

Through Operation Bellona, the force identified an address in which child abuse images had been accessed. A warrant was executed with all the occupants (a married couple and their son) denying responsibility. The force discovered that four children, all aged below 14 years, in the family visited their uncle (one of the occupants) at that address. A decision was made that the seized devices would be examined for child abuse material before making any referral in respect of the children. Although such images were found later that same day, it was not until the following day that the force arrested the uncle, following which he made admissions to having accessed child abuse material. It was at this stage that the force made the relevant child referrals and disclosures. This delay caused by the force's poor decision-making placed the children visiting the address at risk from the uncle.

Officers and staff in the Jigsaw[18] teams are clear about their responsibilities to protecting children and are aware of the processes for making referrals to fellow safeguarding agencies. However, HMICFRS found that these referrals are not always being made by the Jigsaw teams

During a home visit, a registered sex offender disclosed to officers a breach of his sexual harm prevention order (SHPO) as a result of contact with a 7-year-old girl. The officers were unaware of his SHPO conditions, which they should have been before the visit. He was subsequently interviewed under caution five days later, on the same day that the Merlin PAC was submitted to children's social care services. The force's five-day delay in making the relevant referral left the child at risk during that period.

[18] Jigsaw are teams dedicated to multi-agency arrangements managing known registered sex offenders and other dangerous individuals.

In 2016, HMICFRS reported that the force's performance management processes were inconsistent and underdeveloped. We were therefore pleased to find that the MPS has introduced a performance spreadsheet, which is starting to make a positive difference to the quality of its work. For example, Jigsaw teams spoke about an uplift in resources and, in one borough, officers had received an email from a senior manager acknowledging their improved Active Risk Management System (ARMS)[19] completion rates for offenders. However, there was less evidence that managers are using the spreadsheet to direct activity.

There has been a significant improvement in the levels of ARMS compliance across the MPS, with an average completion level of 75 percent. However, the figures vary substantially between boroughs, with the lowest being 54 percent in Croydon, up to 95 percent compliance in Hackney. Although these assessments are now being used by the force proactively to monitor and manage risk, supervisors reported problems in relation to completing ViSOR[20] supervisory tasks (as a result of there being no cover for when they are away from the office). Most teams have one sergeant in post only and, in the areas we visited, the detective inspectors responsible for Jigsaw were not ViSOR-trained.

Across the force the caseloads being dealt with by borough Jigsaw units vary widely: in Barnet each member of the team deals with approximately 95 offenders, whereas in Kensington and Chelsea the number is 45. Only three of the Jigsaw units have a ratio below what is considered nationally reasonable, of 50 offenders per team member.

Additionally, despite the improvements in the completion of ARMS assessments, there are very low numbers of offenders actually subject to reactive management,[21] with only 60 (i.e., one percent of offenders) being managed as such across the MPS. Current difficulties with the force's IT systems, including in flagging offenders, has led to manual checking by offender managers to identify trigger points for moving an offender from reactive to active management; this presents a potential gap in the MPS' ability to transition to 'true' reactive management. We found a range of differing

[19] ARMS is a structured assessment process for the 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.

[20] ViSOR is the Violent and Sexual Offenders' Register.

[21] The management of sex offenders focuses on available information that assists risk management planning and will determine whether offenders are actively or reactively managed. Those not being actively managed may move to active management by the force reacting to new information that may raise the risk level of an offender.

approaches by officers and staff to overcoming this problem, with some teams still checking offenders individually on a weekly basis, while others have developed an automated daily check.

The force's multi-agency public protection arrangements (MAPPA)[22] attendance has been set by the MPS at chief inspector-level for level 3 cases and at inspector-level for level 2 cases.[23] We were pleased to find that the level of appropriate representation and attendance by the MPS exceeded its 90 percent target for level 2 cases at 95 percent (805 out of 844), and that at 90 percent (75 out of 83) it met its target for level 3 cases.

In 2016 we established that local officers were often unaware of registered sex offenders (RSOs) in their areas and missed opportunities to gather intelligence on those posing a risk to children. We were pleased to find that officers are now made aware of RSOs living in their areas through the introduction of Operation Beat, an internal briefing system containing details on offenders categorised as being high- or very high-risk. Operation Beat has been implemented on boroughs, and despite some logistical delays (such as training dedicated ward officers and producing slides for the system), the feedback from local officers is generally positive; we were provided with examples of submissions of intelligence on particular offenders leading to their re-assessment for risk.

Although the introduction of Operation Beat has been positive in facilitating briefings for local officers in relation to high- and very high-risk offenders, these officers remain unaware of the majority of offenders (i.e., those categorised as medium- and low-risk) in their areas. This is a significant problem; by their very nature, high- and very high-risk RSOs are more closely and robustly managed by Jigsaw teams. As low-risk offenders are moved towards reactive management, local knowledge will become even more important, as ward officers are more likely to have contact with offenders as a result of routine neighbourhood policing.

[22] MAPPA is a system whereby safeguarding agencies co-ordinate their response to the potential risks posed by an offender.

[23] MAPPA cases are managed on three levels: level 1 applies to cases managed by the agency responsible for supervision of the offender; level 2 are cases for which the active involvement of more than one agency is required; and level 3 is for cases that require close co-operation between agencies at a senior level due to the complexity.

# Police detention

### Recommendations from the 2016 inspection report

We recommend that within six months 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.

### Review findings

In direct response to the recommendations in HMICFRS' 2016 report, in July 2017 the force established a working group to review the treatment of those children brought into police custody. Specifically, this group is responsible for examining: the provision of accommodation for children detained following charge; the provision of appropriate adults; and the criminalisation of children in the care system.

Attendance at the working group is made by representatives from the MPS, directors of children's services and two national charities. This group has met twice, the first time being in July 2017. While the group's formation is still relatively recent, it represents a significant step towards establishing the necessary strategic collaborative links between the force and local authorities to enable them to meet their statutory obligations in providing alternative accommodation for children.

Between January and August 2017 in London, 12,324 children were taken into police custody. From this total, 2,679 were charged with an offence, of which 898 (aged between 11 and 17 years-of-age) were detained after charge; in only 21 cases was the child placed into local authority accommodation.

These numbers show that too many children who are charged and refused bail remain in police custody when they should be moved to alternative accommodation.

In cases of post-charge detention, the local authority is responsible for providing appropriate accommodation if a child is to be detained overnight; it is only in exceptional circumstances that the transfer of the child to alternative accommodation would not be in their best interests. In rare cases (for example, if a child presented a high risk of serious harm to others), secure accommodation might be needed.

HMICFRS was informed that the force has begun to disseminate data on child detention cases to local authorities across London, however, there is no evidence either of such cases being escalated in a timely way or of the value provided by the force's monitoring and oversight of these cases. We were told that there are practical difficulties still to overcome, specifically information-sharing practices and the provision of secure email.

HMICFRS examined 25 cases of children in detention ranging from 13 to 17 years-of-age. Out of the 25 cases examined, HMICFRS assessed the force's practice in 23 as either requiring improvement (17 cases), or as inadequate (6 cases). In only two (relatively straightforward) cases was the practice of the force assessed as good.

We examined the methods by which officers recognised, assessed and recorded the risk relating to children's detention, and found them to be inconsistent. Detention certificates (which outline to a court the reason for a custodial remand) are essential for police accountability, and enable forces to monitor how well they are discharging their responsibilities under the Police and Criminal Evidence Act 1984. We found that detention certificates were completed for all the cases examined, and that officers working outside of custody were regularly submitting Merlin reports to refer matters of safeguarding for further assessment. However, we found that officers and staff in custody suites did not reflect this good practice and are not routinely submitting referrals when, for example, self-harming incidents occur. The failure to record or consider such assessments also restricts the ability of custody officers and staff to take previous risks into account, and results in poorer decisions which are not always in the best interest of children.

A 16-year-old boy had been arrested by the force for a racially-aggravated public order offence and for possession of drugs. He was detained in custody for 38 hours, 12 of which were after charge. There are entries on the custody record indicating that throughout his stay in custody the child felt suicidal, had self-harmed and reported hearing voices; he saw the nurse in custody seven times, and went to hospital twice. During his period in detention an officer entered the cell to find him with a t-shirt around his neck; this incident was recorded as a behavioural problem rather than an attempt to self-harm. As a result, the risk assessment was not updated and no marker was created for self-harm. A pre-release risk assessment was completed which stated the child was "fit and well for transfer to court". On the submitted Merlin referral, both the child's mental health problems and attempts to self-harm were not recorded.

HMICFRS found that the force has an over-reliance on the use of templates for completing the authorisations, extensions and reviews necessary when an individual is detained in police custody. This requires improvement, particularly in the context of recording important information, such as establishing the legal grounds for the serious step of detaining children, the rationale for refusing bail, and for providing explanations for not transferring children to local authority accommodation.

The force has made little progress to improve the provision of appropriate adult services for children in custody. We also found that local safeguarding agencies are not aware of these problems.

There is a legal requirement upon custody officers and staff to identify and contact an appropriate adult as soon as practicable and without delay, so that all children have one with them during the custody process and any police interviews. In the 2016 inspection, our examination of custody records for children suggests that many waited a number of hours for an appropriate adult to attend. Custody sergeants explained to us that they could not always access family members and that the local authority appropriate adult service did not turn out on a 24-hour basis. In our post-inspection review, we still found that the responsibility for making the request often rests with the investigating officer rather than with custody officers and staff (contrary to Code C of the Police and Criminal Evidence (PACE) Act 1984); this is a continuing weakness that was reported upon in 2016. The requests made for appropriate adults therefore continue to be dependent upon times of interviews, rather than for their (intended) purpose of supporting children in detention.

The effects of this weakness were evident in the cases assessed during the post-inspection review, namely:

- in nine cases, charge sheets had not been signed by an appropriate adult, suggesting that one had failed to be present when the child was charged (or, if they had been, there was no endorsing signature to that effect); and

- in five cases, the child had been strip-searched in the absence of an appropriate adult. Although conducting a strip-search is a practice which should only take place when there is a serious risk of harm to the child or another, in only one case did the record demonstrate the required urgency for conducting such a search.

We were pleased to find that in none of the cases we inspected, had custody PACE reviews (i.e., an examination of the need for continued detention without charge) been conducted over the telephone. However, we identified 17 reviews that had been conducted in the child's absence (i.e., when the child was asleep or in interview), only one of which contained a further update indicating that the child had been informed of the review and given the opportunity to make representations about their detention. In three cases, the child spent their entire detention in custody without seeing an inspector.

In relation to the detention of children under section 136 of the Mental Health Act 1983, it is positive to note that the force continues to refrain from taking any children into custody as a place of safety. HMICFRS did examine a small number of cases in which children detained for criminal matters had subsequently required a mental health assessment; in one of these cases the child had remained in custody for four days, and in another case for five days. A major factor for the lengthy durations in police custody was time spent waiting for an available mental health bed, despite repeated efforts by the MPS to secure one. Local authorities and health services have duties to meet such requests from the police.

Custody officers and staff have designated PDDs during which they receive training in safeguarding and CSE. The force reported that, at the time of our post-inspection review, 85 percent of those working in the force's custody facilities had received such training.

## Results of case file reviews

As reported on in third quarter, in June 2017 HMICFRS asked the force 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. HMICFRS also assessed these cases; we found that just under 93 percent demonstrated policing practice that either required improvement or was inadequate.

HMICFRS then selected and examined a further 79 cases; just under 84 percent again demonstrated policing practice that either required improvement or was inadequate.

**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 |

**Figure 2: Additional cases assessed only by HMICFRS inspectors**

| | Good | Requiring improvement | Inadequate |
|---|---|---|---|
| **HMICFRS assessment** | 13 | 32 | 34 |

In July 2016, the MPS began a review of its child protection cases, to assess and understand the outcomes in these investigations. This approach was undertaken in three phases, namely:

- phase 1, known as Operation Benson, commenced in July 2016: reviewing cases identified by HMICFRS in 2016 as either inadequate or requiring improvement. This phase concluded in September 2016, with the findings compiled into an internal force report;
- phase 2 commenced in October 2016: sampling 266 cases comprising missing children, CSE, indecent images of children, child abuse and section 47[24] cases. This phase concluded in June 2017; and
- phase 3 commenced in June 2017: reviewing 135 cases as directed by HMICFRS. This phase concluded in July 2017, following which an internal panel conducted a quality assurance process through dip-sampling some of the cases.

This three-phase review, together with the additional cases HMICFRS examined, established similar themes to those found in the original 2016 inspection. Although we do not expect immediate improvement, we would anticipate signs that the MPS is using the information it has gleaned from this review and our subsequent examination to target its activity to bring about improvements.

[24] Section 47 of the Children Act 1989 is relevant to matters in which a child is suspected to be suffering, or likely to suffer, significant harm.

As stated previously, the assessment of cases by the dedicated inspection team was detailed; it demonstrated a good understanding of the main weaknesses in each case and where the level of service had been deficient. Therefore, it is worrying that despite the findings that the MPS has itself collated, improved outcomes for children are not being demonstrated consistently.

## Conclusion

The MPS has increased efforts to make progress in improving the awareness of officers and staff in relation to vulnerability and wider child safeguarding; this is supported by the recent internal media campaign and related training. We also found some examples of good work by individual officers and staff; supporting children and listening to their needs and wishes.

In both our reports for quarters 2 and 3, we stated that despite the activity undertaken by the MPS, we were troubled that the changes made in some principal areas were failing to improve outcomes for children.

The examinations conducted on child protection cases during this post-inspection review have reinforced our concerns; there are still significant weaknesses in current practices in relation to child protection which are not being effectively and consistently addressed, despite being referred back to the force for action. This is made 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 has been stated clearly in the expectations set by senior officers via numerous forums (including the force's action plans) are not yet being realised. We accept that it will take some time to embed a consistently good practice across the force but would expect to see greater signs of improvement.

Moreover, the presence of weaknesses uncovered in too many of the cases examined in this quarter were disappointingly reflective of those which were reported on in 2016, with a lack of structure to support the collection and dissemination of good practice and learning.

**Recommendation**

- Owing to these findings, we therefore recommend that the MPS continues to implement all the recommendations made by HMICFRS following our child protection inspection in 2016, ensuring that it reviews their effectiveness. It should also take immediate action to improve the practice by its frontline services in the protection of children, in particular that it has in place arrangements for the necessary scrutiny, challenge and analysis. Equally important is how the force reassures itself of its approach to children who are presently in need of help and protection.

## Next steps

In light of these findings and our continuing disappointment in relation to the outcomes for children, recognising that the force should be given an opportunity to embed its plans, we intend to re-visit the force at least once in 2018 to review its progress. In particular, we will seek evidence of demonstrable improvements in the nature and quality of frontline practice and outcomes for children, and clear evidence of the effectiveness of the new safeguarding structures currently being implemented.

# 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.