HMICFRS

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

National Child Protection Post-Inspection Review

Metropolitan Police Service
8–19 October 2018

Contents

Summary

About this report

In 2016, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) published a highly critical report of the Metropolitan Police Service's (MPS's) 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 the fourth of these reports (published February 2018), we concluded that progress had been made in some important areas – but this had not translated into consistently good outcomes for children in London. We therefore committed to further reinspection activity in 2018.

This report summarises what we found.

Findings

Progress since 2016

Since the 2016 inspection, the MPS has taken significant steps to improve its safeguarding practice for vulnerable children. This has been achieved in the context of an extremely demanding policing environment, and despite the complexity of the different partnership arrangements for protecting children across the 32 London boroughs.

In 2016, we highlighted a lack of strategic oversight in the force, with no single officer in overall charge of child protection matters. This was immediately addressed by the MPS, which gave that responsibility to an assistant commissioner. This assistant commissioner is now supported by a head of profession for safeguarding (introduced in 2017), whose responsibilities include setting standards and improving performance in relation to child protection. We found that senior level oversight is now in place. Overall, this has resulted in better and more effective oversight of child protection practices across the force.

In our 2018 inspection, we found that the force has continued to review and refine the structures, systems and processes it has introduced to monitor and manage child protection work. Some of this is linked to a force-wide restructuring programme that will see the force replace the 32 borough operational command units (BOCUs) with 12 basic command units (BCUs). Each BCU will have a dedicated superintendent safeguarding lead, and the MPS intends this and other elements of the restructuring programme to support further significant improvements in outcomes for vulnerable

people, including children, who come into contact with the police. Evaluation of the first pilot BCUs did, however, show some initial dips in performance. While the MPS has made some changes to the wider restructure as a result, it should ensure that it has robust plans to monitor and mitigate any negative effect on the experiences of children who need police protection while the new BCUs are bedding in.

A dedicated inspection team (DIT), which the MPS established to review child protection cases after our 2016 inspection, continues to be a strength. It now provides an effective and established assurance role to senior leaders, and accurately assesses the responses to vulnerable children in the cases it reviews. However, the MPS still needs to ensure that the inspection team's assessments are shared quickly and efficiently across the organisation (not just with the local area where the case was managed) and, most importantly, are acted on. Many aspects in those cases that we and the DIT judge as requiring improvement or inadequate were similar to those seen in 2016. The MPS must act more quickly to translate its better understanding of the nature and quality of decision making into tangible changes on the front line.

We found evidence that the MPS is continuing to make changes and improvements. For example, in 2018, the force produced a safeguarding framework, which clarifies roles and responsibilities and outlines its approach to partner engagement, risk and performance management, and internal audit and improvement. We are encouraged by this work, which, when implemented, should provide the means for the MPS to scrutinise performance, identify gaps in service, share effective practice and achieve good outcomes for children. Equally, we are encouraged by other changes we have seen implemented since the last time we inspected (in 2017), details of which are provided in this report.

However, some of these improvements are still relatively new and need more work to make sure that they operate effectively. For example, it is positive that the force now has a 'safeguarding dashboard', which gives an overview of child protection cases across London. This provides managers with a good sense of what officers and staff are dealing with. But the force must now focus on ensuring that it reviews the type and quality of data on this dashboard, and clearly defines how it is used to improve practice (and therefore outcomes for children), so that the information is put to practical use.

As we found in 2017, the MPS has acted swiftly on some of the 2016 recommendations, and improvements are therefore more evident in those areas of practice. But in other areas progress has been slow. We remain particularly concerned about how the MPS responds to indecent images of children (IIOC) and online child sexual exploitation (CSE) cases, and its management of registered sex offenders (RSOs). The force's performance in these areas has in some respects deteriorated since our 2016 and 2017 inspections. For instance, in some areas, sex offender managers are managing more than 100 offenders each. This is significantly more than we found in 2016 (when they were managing between 50 and 60 offenders each). Further work is required (in the case of online abuse, as a matter of particular urgency) to ensure that children are effectively protected from those who pose a risk to them.

Significant concern: online child sexual abuse and exploitation

We found that the current arrangements for investigating online cases involving IIOC and sexual exploitation are not working. We reviewed 34 online cases. Twenty-nine of these were assessed as either inadequate or requiring improvement, 15 of which were sent back to the force because we considered they contained evidence of a serious problem – for example, a failure to follow child protection procedures and/or a child potentially at risk. There are continuing resourcing problems and backlogs. We also have significant concerns that cases that are dealt with by non-specialists result in notably poorer outcomes than those that are dealt with by specialist teams.

In addition, we found that the processes the MPS has in place for examining devices that are suspected of containing IIOC are ineffective. For example, because of the limited capacity of the digital examination team, only two devices can be sent for full examination. But, because non-specialist investigators have limited access to digital triage (which provides an initial assessment of whether IIOC are present), they must make uninformed decisions about which devices they should send. In addition, because of the volume and backlogs in the digital examination team, some devices are returned without being checked at all. As a result, investigations may be poor, victim confidence undermined and safeguarding opportunities missed.

This significant and concerning risk has been recognised by the force and several internal recommendations have been made to address the issues. These should be acted on swiftly to reduce the current risk. We acknowledge that the increase in online exploitation of children is a national problem. However, because of our acute concerns, we have made a further recommendation in this report about the improvements that are required.

Case file results

During this inspection, we examined 303 cases where the police had identified children at risk. We assessed the child protection practice as good in 93 (31 percent) cases, requiring improvement in 127 (42 percent) cases and inadequate in 83 (27 percent) cases. Many of the elements that required improvement or were inadequate were like those identified in 2016.

While fewer cases in the file sample were graded inadequate, proportionately we still referred the same percentage of cases back to the force (17 percent) during this inspection as we did in 2017. We do this if we think cases we are examining potentially contain evidence of a serious problem – for example, because child protection procedures have not been followed or a child has been left at risk of potential harm.

Overall, these results indicate that consistency of effective practice remains weak. We found that opportunities to act quickly and decisively to protect children and to prevent offending are still being missed. We found that lack of supervision along with the high workload of investigators is contributing to drift and delays in investigations. These inconsistencies are affecting the development of effective and timely protective plans. This is not in the best interests of victims and means that children may be left at risk.

Conclusion

There has been a clear commitment by leaders both in the MPS and the Mayor's Office for Policing and Crime (MOPAC) to respond to the findings from our 2016 and 2017 inspections. Some very positive progress and improvements have been made as a result, against an extremely challenging policing backdrop. However, the improved leadership and better understanding of child protection cases across London must translate more quickly into significant and sustained improvements in the experiences of children who need help and protection.

One of our main ways of assessing the experiences of children is through case file reviews. Approximately two-thirds of those cases we reviewed did not meet the required standard. While we judged fewer cases to be inadequate than in previous inspections, many of the problems we identified remain constant. For instance, we continue to find poor-quality supervision of child protection cases, which has been an enduring problem for the force since we first reported. A recent decision not to proceed with providing training to improve frontline supervision is therefore disappointing.

We also found that the management of RSOs and the response to online child sexual abuse and exploitation has in some respects deteriorated since we last inspected. This is of significant concern.

The MPS told us that it anticipates work to ensure that children receive consistently improved responses will take a further two years. Senior leaders must assure themselves that this timescale is justifiable, given the extreme vulnerability of many of the children who come into contact with the force. We would also now expect to see clearly articulated time frames and milestones that are agreed and established, and can be closely monitored to give the force and others overseeing this work clarity on exactly how and when improvements will be achieved.

The MPS should maintain, and in several areas accelerate, its responses to improve outcomes for children. It knows where practices are weak and it must act swiftly now to strengthen these areas by improving practices on the front line. In addition, we remain deeply troubled by the capacity of staff to manage RSOs, and we recommend that the force should review its current structures for responding to online cases as a matter of urgency.

Next steps

We are assured that there has been, and continues to be, a focus on child protection matters, and that long-term planning is in place. However, we remain concerned about the consistency of decision making and whether children benefit from effective or improved outcomes when they require the help and protection from the MPS.

We will revisit the MPS, no more than 12 months after publication of this report, to assess progress. This will allow the force to complete its major restructure and to continue work to address our previous recommendations.

In line with the force's own plans, we would expect to see a step change in the quality of outcomes being provided for vulnerable children.

1. Background

The 2016 inspection

In November 2016, HMICFRS[1] published a highly critical report of the Metropolitan Police Service's (MPS's) child protection practices.[2] This included a series of recommendations aimed at improving the service provided to children in the London area. Four of those required immediate action by the MPS in relation to:

- establishing governance and oversight of child protection practices;
- improving the response to children who go missing from home;
- increasing the MPS's understanding and awareness of risks to children; and
- improving the management of those posing a risk to children.

The remaining five recommendations (see Annex A) required the MPS to act within either three or six months.

Specifically, we reported that the MPS was failing to monitor and manage child protection cases to ensure consistently good standards of service for children in London. We highlighted a lack of strategic oversight, with no single chief officer with overall responsibility for child protection.

Because of the severity of the failings we found in 2016, the Home Secretary commissioned us to publish quarterly reports[3] over the course of 2017, setting out the progress that the MPS had made in improving practice.

The 2017 quarterly findings

The reports for quarters one and two (published in June and August 2017, respectively) provided our assessment of the MPS's progress against both the recommendations of the 2016 report and their action plans. In quarter two, we stated that we were concerned that the changes made in some principal areas were failing to improve outcomes for children.

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[1] The original MPS child protection inspection began before 19 July 2017, when HMIC also took on responsibility for fire and 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] *National Child Protection Inspections: Metropolitan Police Service*, HMIC, November 2016

[3] Available from the HMICFRS website.

The quarter three report (published in October 2017) set out the findings of 214 cases that we had reviewed. They confirmed that there were still significant weaknesses in practice in relation to child protection. We judged that 191 cases (89 percent of those reviewed) were either requiring improvement or inadequate.

In the quarter four report (published in February 2018), we stated that the MPS had increased its efforts to improve the awareness of officers and staff about vulnerability and wider children's safeguarding. We found examples of good work by individual officers and staff, supporting children and listening to their needs and wishes.

However, the new governance and oversight structures had not produced a sufficient improvement. The consistency in practice, which had been stated as a clear expectation set by senior officers, was not being realised. Moreover, many of the weaknesses seen were similar to those we reported in 2016.

We therefore recommended that the MPS should continue to implement all the recommendations we made in 2016, and that it should act immediately to improve practice by its frontline services in the protection of children.

The 2018 post-inspection review

During August and October 2018, we conducted a post-inspection review to assess the force's progress.

The review included:

- an examination of documentation, including policies and training materials;
- interviews with officers, managers (including senior managers) and staff; and
- an audit of 303 child protection cases.

2. Post-inspection review findings

Leadership, management and governance

Recommendations from the 2016 inspection report

> Immediately 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 MPS 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.
>
> Within three months the Metropolitan Police Service should develop a performance framework to report on the results of the service it provides to children.
>
> 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 to bring about improvement.

In 2017, we found that, despite the demands faced by the MPS of scale, complexity and the need to collaborate with a network of other agencies such as local councils and the health service, the MPS had made progress in several areas of child protection. Lead officers and staff involved in safeguarding were also candid about the difficulties they faced, and acknowledged that methods were inconsistent and sometimes disjointed.

Review findings

The protection of children is a priority for the MPS. There are now clear governance structures in place to support improvements in operational practice and provide oversight of performance. Senior leaders and their staff are committed to providing improved services to children.

The MPS now has a strong strategic vision, supported by the evident commitment and desire of its senior leaders to improve practice and the outcomes for children.

The MPS has strengthened its senior level oversight of child protection and is embedding this oversight into daily work. It has produced a safeguarding framework, which outlines the long-term approach for partner-agency engagement, risk and performance management, and internal audit and improvement, together with clarity of roles and responsibilities.

There are clear governance structures both within local policing (with identified lead responsible officers and dedicated safeguarding superintendents) and central specialist services.

Several forums provide oversight. These include Frontline Executive (FLEx)[4] meetings, a quarterly force-wide safeguarding board, the Enablers[5] meeting and the London Child Protection Improvement Oversight Board, chaired by the Deputy Mayor for Policing and Crime.

In 2016, we highlighted a lack of strategic oversight, with no single officer in overall charge of child protection matters. An assistant commissioner now spearheads the MPS's response to child protection. A head of profession (at commander rank) for safeguarding is responsible for setting standards, improving performance, and managing risk and vulnerability. These people are supported by lead responsible officers and subject matter experts for 12 safeguarding strands relating to vulnerable people.[6] This now provides the MPS with better strategic oversight and a better grip on child protection practices across the force.

The Metropolitan Police Service should ensure that its new structure realises the anticipated improvements in outcomes for vulnerable people, including children

The MPS's plans for restructuring its arrangements for local policing, including child protection, are now well under way. The force is replacing the 32 borough operational command units (BOCUs) with 12 basic command units (BCUs) through the 'One Met Model' transformation work. This structural change is expected to be completed by March 2019.

As part of the restructured governance arrangements, the MPS has considered the importance of engaging with and influencing partners across the different local authorities to achieve greater consistency. The head of profession engages at a national and cross-London level, and safeguarding superintendents engage with their local partnerships.

Each new BCU has safeguarding expertise that combines the specialist centralised child abuse and sexual offences (CASO) teams,[7] and incorporates the child abuse referral process into the multi-agency safeguarding hubs (MASHs).

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[4] Frontline Executive (FLEx) meetings have replaced previous Crimefighters and are performance meetings that include thematic discussions on safeguarding performance, provision of safeguarding and emerging problems.

[5] The Enablers meeting to support the introduction of child protection improvements is attended by senior MPS safeguarding leads and external interested parties. These include representatives from the Association of London Directors of Children's Services and the London Safeguarding Children Board chairs.

[6] There are 12 safeguarding strands: child abuse; online child sexual exploitation and abuse; rape, serious sexual offences and sex-workers; young offenders; child sexual exploitation; hate crime; domestic abuse, stalking and harassment; harmful traditional practices ('honour-based' abuse, forced marriage and female genital mutilation); mental health, drug and alcohol dependency and suicide prevention; missing people; modern slavery and human trafficking (including child criminal exploitation); abuse and neglect of vulnerable adults.

[7] CASO consisted of the child abuse investigation team (CAIT) and the sexual offences team (Sapphire).

This new BCU model seeks to produce multi-functional investigators who have the skills and knowledge to investigate any type of crime in this area. The MPS is trialling this model in north London with the aim of building expertise by enabling specialist trained staff to share their skills and knowledge with non-specialists who work in child protection, supported by relevant training.

Six BCUs have been established, but the child abuse and sexual offences teams are only in place in the two original pathfinder sites (Central North – boroughs of Camden and Islington, and East Area – Barking and Dagenham, Havering and Redbridge). The effect of this is that, although some of the BCUs are using the new model, the planned resources to implement it are not all in place. Therefore, the amount of work, and the capacity of the teams to do the work, continues to be a problem.

The movement of specialist CASO posts from the centre to the BCU pathfinders has resulted in an investment of specialist staff into the local policing structures. However, there are still vacancies for safeguarding jobs at both pathfinder sites. BCUs are going live with more vacancies than expected and there is also a shortfall of qualified detectives. The impact of this is that staff who are not experienced in this field, and who have not received specialist child abuse investigation training, are conducting some investigations (such as those of online sexual exploitation and IIOC) without the necessary support and skills.

MOPAC reviewed and evaluated the two BCU pathfinders and reported its findings in January 2018. The report says that the cultural and operational changes resulting from the transformation work are challenging, and that both pathfinder sites suffered from initial dips in performance. These are now reported to have stabilised and performance in the east area has improved.

The MPS anticipates that these initial dips in performance will be repeated in other BCUs as they go live. In response, it has changed the design for the new BCUs and is working to better match resource to demand in the safeguarding and criminal investigation departments. It has also introduced local resolution centres, aimed at resolving non-crime incidents without the need for the immediate deployment of officers.

However, we remain concerned about the effects of the restructure, at least initially, on the experiences of those children who need the police's protection while the new BCUs are bedding in. The MPS should ensure that it fully understands the reasons behind these performance issues and has plans to mitigate them, using the evidence gained from the review of the pathfinder sites.

Decisions about children at risk are still being compromised by factors such as the capacity and capability of staff and poor supervision

The MPS is trying harder to make officers and staff more aware of vulnerability and their safeguarding responsibilities. For example, 20,000 officers and staff have received safeguarding awareness training since April 2017.

Throughout the inspection, the officers and staff we spoke to who manage child-related investigations were evidently committed and dedicated to their work. However, they said they were under significant pressures, with factors such as the capacity, capability and current vacancy levels affecting their ability to provide a

consistently good service. For example, in one missing persons unit we visited, there were 77 missing people that day and 57 of them were children. Three staff were on duty. They said they could not manage the workload and had no capacity for any proactive work.

It is evident that these pressures are affecting the service that the MPS is providing to children. Some staff continue to report that they have not had specific training to undertake their role. See 'Initial contact'.

In the cases we reviewed, we found good examples of officers and staff managing specific concerns about children, but the effectiveness of supervision by first- and second-line managers requires significant improvement. Management oversight is not rigorous enough in some areas. The rationale for making decisions by officers and staff is not always clear in cases, and supervision does not consistently challenge the progress of investigations or the pursuit of identified lines of enquiry. This is leading to drift, delays and missed opportunities in those cases.

As we mentioned earlier in this report, we found that a lack of supervision was compounded by high workloads. Supervisors also have very limited capacity to better support and direct their staff.

We reported on problems with supervision of child protection cases in 2016 and 2017. Our case file review shows that these problems have not been resolved. The force is planning activity to improve supervision, although much of this is recent and unevaluated. It includes:

- developing leadership across the MPS through the 'Leading for London' programme. The main aims are to have staff in leadership roles (from sergeants and police staff equivalent to chief officers and directors) who can produce consistent operational results and performance, and set high standards;
- use of a new targeted supervision approach, which enables supervisors to use their discretion as to which officers or staff require limited supervision, compared with those who are either new to the role or require additional oversight of their work. This is intended to alleviate some of the demand and capacity pressures on supervisors; and
- as a short-term measure, a template that outlines the minimum expectations from both investigators and supervisors in relation to child sexual exploitation (CSE) cases. The MPS intends to measure the use of this template through dip sampling.

In addition, the MPS identified a requirement for a supervisors' course to improve the supervision of investigations, resulting in the design of a week's course to tackle this problem. We have been told that the course has been cancelled because of the cost of sending all frontline supervisors on the course. Without an investment in the training and development of supervisors, the force will continue to experience the shortcomings we have identified.

Performance information to understand outcomes for children requires further development

The information that the dedicated inspection team produces by undertaking audits of cases continues to provide effective assessments of the quality of investigations. The team disseminates those findings to senior officers and staff in the areas where the investigations took place.

However, performance management remains a weakness in terms of understanding outcomes. The performance dashboard gives managers a good sense of what staff are managing, including the timeliness and numbers of investigations, as well as providing senior officers and staff with a clearer understanding of performance for which they are held accountable. Although the type and quality of data are evolving, information in terms of understanding the quality of investigations and outcomes for children requires further development to help improve future practice.

The outcomes from the cases we reviewed during the inspection have shown that the MPS is still missing opportunities to act quickly and decisively to protect children and to prevent offending. Although the protection of children is a priority, and senior leaders are committed to this, decisions about children at risk are still not consistently better.

We acknowledge that the MPS has undertaken significant transformation of its safeguarding structures, including its joint working at a senior level with partners. However, there remains a concern about the extent to which the structural changes have been translated into a step change in the quality of response for those children who are vulnerable and in need of help and protection from the MPS each day.

As stated earlier, we found that strategic oversight is now in place, with a better grip on child protection practices across the force. This should be providing the means for scrutinising performance, identifying gaps in service and sharing effective practice, leading to improved outcomes. Currently, this is not yet being seen consistently in child protection cases and the rate of improvement is still slow.

Initial contact

Recommendations from the 2016 inspection report

> Immediately 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:
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> - 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.

In 2017, we found that the MPS had not yet implemented the new shift pattern in command and control centres[8] that would allow it to provide training days for staff within the centres. We also found that the force was inappropriately categorising some children as 'absent', rather than 'missing'. This meant that children were assessed as being at no apparent risk – which was not appropriate, given their age and other vulnerabilities – and that there was no proactive police work to find them. Finally, there was still only limited use of trigger plans for children who repeatedly went missing.

Review findings

Staff within the Metropolitan Police Service command and control centres now have access to professional development days to receive training

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. In the quarter four 2017 report, we reported that the MPS was working to implement a new shift pattern to facilitate the provision of PDDs. We are therefore pleased to find that PDDs are now in place. As a result, by July 2018, officers and staff working in command and control centres (contact centres) had received training on safeguarding and vulnerability.

Some children are still being assessed as being at no apparent risk (absent) when reported missing, despite identified risk factors

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. We previously reported that the MPS had not implemented the new APP in terms of adopting those risk categories. This remains the case.

Command and control centre officers and staff are responsible for categorising a child as either missing or absent when they receive such a report. In 2016, we highlighted to the MPS its misuse of the absent category. This is typically intended for a person who is not at a place where they are expected or required to be but is assessed as being at no apparent risk. Following further sampling and the auditing of cases, we have found that the category continues to be used inappropriately in relation to some children.

[8] These are the MPS's 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.

Some cases of the missing children we sampled involved vulnerable looked after children, who should have been categorised as missing rather than absent because of the presence of more than one risk factor. Officers and staff should consider the history of each child in deciding what category to apply, rather than looking in isolation at the details of the individual report in front of them. Officers and staff in the command and control centres have a template stating that more than two missing reports are a reason to consider using the absent category. We found that cumulative risk is still sometimes not being considered, with some officers and staff considering frequent 'missing' episodes as normal behaviour for that child.

When we spoke to officers and staff within the command and control centres, they stated that the absent category was used predominantly for children who were in the care of either the local authority or foster parents if there was no clear additional risk. Some supervisors were of the view that it was not the police's responsibility to mitigate or prevent missing episodes – they saw this as the role of children's social care services. Another supervisor described a culture in which some officers and staff still considered missing children to be a nuisance rather than vulnerable. Such an approach demonstrates a lack of awareness and recognition of the wider risks to these children and their vulnerability, thereby limiting the opportunity for early intervention and protection.

Absent children generally do not have prevention interviews when they return. This means that officers and staff may be missing opportunities to gather valuable information on risks such as where the child has been, and with whom, which could allow them to better safeguard the child and respond appropriately if they go missing again.

Some officers and staff have received training on missing people – but not all, including some in important roles

We previously reported that the MPS had developed a missing persons five-day training course for staff working within missing persons units. The course has been attended by 201 people, but 45 of the staff who have still not been trained are working in missing persons units. We saw one unit where all the staff were waiting to go on the course. This means that some of the officers and staff whom the MPS most needs to be fully effective in responding to missing people are not yet trained.

The MPS recognises this risk. Further training is planned for early 2019. The 45 missing persons unit staff will receive this, together with officers and staff who conduct CSE investigations.

The use of trigger plans has improved significantly but further work is required

In 2016, we recommended that the force put arrangements in place to ensure that trigger plans were developed for children who repeatedly go missing (in line with the College of Policing APP for missing persons). These plans should outline key actions to be taken if a person is reported missing, in order to assist in finding that person as quickly as possible.

At the time of the 2018 inspection, there were 109 'live' trigger plans in place. This is a significant improvement on the 32 plans we reported on in our quarter four report. However, we found that some officers and staff were still confused about when they should be used. Four areas (Sutton, Tower Hamlets, Brent and Hackney) did not have any plans in place. The MPS should review why there are no plans established in those areas, so as to ensure that practice is consistent across London.

Further work is needed to ensure that officers and staff know about trigger plans and their value in providing early information to find a child who has been reported missing. We spoke to officers and staff within the command and control centre and in local policing who said that either they did not use them or they had not heard of them. The effect of this is that information on trigger plans is not being considered when those children go missing again, which means that early opportunities to quickly find a child and ensure that they are safe may be missed.

Assessment and help

Recommendations from the 2016 inspection report

Immediately 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;[9]
- 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.

In 2017, we found that the MPS had launched an internal communications campaign: 'Spot it Stop it'. This aimed to reinforce the message that, whatever their role in the force, every officer had a duty to protect and safeguard children at risk of harm.

Attendance at initial child protection conferences had improved and was good, and the MPS was working with external safeguarding agencies to review the arrangements of the London MASHs. We said that this demonstrated the force's commitment to evaluating and seeking to improve how it worked with partners.

[9] The Merlin pre-assessment checklist form is used to record and refer incidents for further assessment when a child or young person comes to the notice of the police and there are concerns about their wellbeing or safety.

Review findings

The Metropolitan Police Service has an established child protection internal communications campaign

'Spot it Stop it' is now a recognised brand. The communications strategy behind it has been split into four strands, focusing on improving officer and staff understanding of their responsibilities in relation to online child abuse, CSE, criminally exploited children and missing children.

There is currently no form of assessment in place to identify whether the campaign is having an impact on, and ultimately improving, practice.

The review of the London multi-agency safeguarding hubs finds high levels of information sharing

We previously reported that the London Safeguarding Children Board was commissioning a review of the arrangements of the London MASHs in six boroughs. In September 2018, the review report was published. Its findings included the following:

- There was a high level of awareness across agencies that have safeguarding responsibilities (including the police) that they should report concerns about children.
- On average, 37 percent of all referrals came from the police.
- However, more than a third of contacts that resulted in no further action originated from the police.

These findings highlight that MPS officers and staff, like their partner agencies, are aware of the need to report and share concerns about children with the MASHs and are submitting a large volume of referrals. This is positive. However, the MPS needs to ensure that these referrals meet the thresholds[10] for requiring additional help and support, as part of their work to understand why more than a third resulted in no further action.

Access to internal safeguarding advice and guidance has improved

A 2017 staff survey identified that some officers and staff did not see safeguarding as part of their role or did not think it was a priority for the MPS. The survey also highlighted that officers and staff said that they would not be able to recognise child protection issues and that they had difficulty accessing supporting guidance.

In response, the MPS has created an online safeguarding hub on the intranet. This gives officers and staff easy access to safeguarding toolkits and policies. As a result, officers and staff told us that access to information has improved. There have been around 2,500 visits a month to the hub since August 2017.

The MPS repeated the staff survey in June 2018 with 10 percent of officers and staff completing it (1,130 fewer responses than in 2017). Responses showed that officers and staff now see safeguarding as a priority, and more respondents reported that they

[10] London Child Protection Procedures and Threshold Document, September 2018.

were confident that they can recognise risk to children and act to safeguard them. While this is positive, only 47 percent of respondents agreed with the statement: "The training I have received in the Met has equipped me to understand risks and effectively safeguard children and young people."

The MPS has also developed a separate training exercise for senior leaders in the police and partner agencies. This uses the 'immersive hydra'[11] model to train these leaders on their collective and multi-agency responsibilities to safeguard and protect children from harm. Six events have taken place, attended by both senior officers and partners from health, local authorities and charities. The MPS reports that feedback from attendees has been positive.

Notable practice – The Lighthouse

In 2016, we reported on proposals to introduce a 'child house' for children and young people who have experienced sexual abuse. We considered this would provide a major improvement in providing support for such children.

The Lighthouse in Camden is the UK's first child house. It provides a co-ordinated approach to providing medical, advocacy, social care, police and therapeutic support to children and young people living in five London boroughs – Barnet, Enfield, Haringey, Camden and Islington.

The development of this child house has taken multi-agency commitment and investment to establish. Although it is too early to assess impact, the model is firmly rooted in the child's voice and experience. This is a positive development of notable practice for children and young people who have experienced sexual abuse, including exploitation.

Investigation

Recommendations from the 2016 inspection report

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.

Within three months the Metropolitan Police Service should take action to improve child protection investigations by ensuring that:

- it provides guidance to staff which identifies the range of responses and actions that the police can contribute to multi-agency plans for protecting children;
- every referral which the police receive is allocated to those with the skills, capacity and competence to undertake the investigation;

[11] Hydra is immersive learning used to simulate live incidents. It enables participants to experience the decision-making process and complex issues facing the police and partner agencies when dealing with critical incidents.

- 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.

In 2017, we reported that we had reviewed a total of 214 cases. While we did find individual areas of good practice, the overall findings were that 191 (89 percent) of those cases either required improvement or were inadequate.

Review findings

The police response often focuses solely on dealing with children's behaviour, not on understanding their vulnerability

Our case file review continues to find that officers and staff do not always understand or recognise what is happening to vulnerable and 'at risk' children. Case files do not always show how the work that officers and staff are doing is effectively meeting a child's needs, reducing risk and improving outcomes. Officers and staff are not always analysing historical factors or using multi-agency information to help them understand a child's situation. The focus is often on the immediate behaviour, not on understanding the vulnerability or the causes.

The dedicated inspection team continues to provide the Metropolitan Police Service with a good insight into the quality of investigations

Some of the weaknesses we found in these cases were similar to those detected by the MPS's dedicated inspection team. As we have previously reported, the assessment of cases by that team continues to be effective and detailed. The assessments demonstrate a good understanding of both strengths and weaknesses in each case, clearly identifying where the level of service has been deficient and setting out what needs to happen as a result.

We reported in our quarter four 2017 report that the MPS should ensure that it has processes to disseminate the good practice and learning gathered by the dedicated inspection team, so that they can have the best effect. However, in the 2018 staff survey, only 19 percent of respondents stated that they were aware of the dedicated inspection team and the quality assurance process that they undertook.

Given the consistent and persistent problems in investigating child protection cases, the MPS should act quickly to improve its processes for flagging up poor practice to practitioners and supervisors, sharing best practice, and identifying and acting to improve underlying common causes of poor practice. This information needs to be shared quickly and efficiently across the organisation, not just locally where the case is managed.

Case reviews

During this inspection we reviewed a total of 303 cases. Although we did find individual areas of good practice, the overall findings were that 93 cases (31 percent) were good and 210 (69 percent) either required improvement or were inadequate (see Figure 1).

Figure 1: Cases assessed by HMICFRS inspectors

Case type	Good	Requiring improvement	Inadequate	Total
Referrals relating to domestic abuse	20	11	6	37
Referrals other than domestic abuse	22	18	5	45
Enquiries under section 47 of the Children Act 1989	13	13	20	46
Children taken to a place of safety by police officers	7	11	9	27
Sex offender management	9	10	3	22
Children at risk of child sexual exploitation non-internet	8	15	4	27
Children at risk of child sexual exploitation online	5	11	18	34
Children missing	9	17	9	35
Children in police custody	0	21	9	30

Officers and staff do not always speak to children

We found that officers and staff do not always speak to children. As a result, children's views and disclosures of abuse or neglect are not always appropriately pursued. When concerns regarding a child cannot be substantiated, potential risks to the child are not always being considered and addressed.

Management oversight is not rigorous enough

The rationale for the decisions officers and staff are making is not always clear in cases, and supervision does not consistently challenge the progress of investigations or the following of identified lines of enquiry. This leads to drift and delays in investigations, resulting in cases not been progressed effectively.

> A 16-year-old girl was assessed as being at high risk of CSE and was in contact with men in risky situations.
>
> There was good multi-agency work to try and reduce the risk to the girl, including several strategy meetings. However, although there was supervision of the case, it was not effective. There were delays in updating police IT systems and several actions had not been completed. The officer dealing with the CSE case at the time of the audit had not met the child, and it was unclear what investigative work had taken place to identify the men the child had been meeting.

Most cases resulted in a referral to children's social care services

Most cases where there were concerns about a child's welfare or vulnerability resulted in a referral to children's social care services. However, frequently officers are not following up these referrals to check the response or the decision making, or to ensure that children's social care services are aware of any safeguarding plan. Children's social care services should give feedback about the decisions they have made, including reasons why a case might not meet the statutory threshold for referral (i.e., if they decide to take no further action). This is not happening consistently.

Strategy discussions should, as a minimum, involve social care, police and health services. When these discussions did take place, most of them involved only the police and children's social care. In a number of cases we examined, there was no evidence that a strategy meeting had been held. This was despite the fact in some cases that supervisors had specifically directed officers to arrange them. This inhibits information sharing and the creation of multi-agency plans. When discussions did take place, it was not always clear what the joint safety plan was in relation to ongoing investigations.

We found some good examples of investigating officers and staff using an appropriate mix of investigative and protective approaches

> The mother of three young children was suffering from mental health problems, a situation that was putting her children at risk. Officers used police protection powers appropriately, made the children safe and arrested the mother for neglect. They recorded the incident on their body-worn cameras.
>
> The safeguarding of the children was at the centre of the investigation, which had a clear plan and included child protection medical examinations. The decision was appropriately made to take no further action in relation to the criminal investigation, and there was a clear understanding with children's social care services about how the children would continue to be safeguarded.

Decision making

Recommendations from the 2016 inspection report

> 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.

In 2017, we found that very little progress had been made in conducting a skills audit to assess the training required for officers and staff who undertake child protection work.

Review findings

A skills audit has been completed to understand what training staff have received

A skills audit to assess the training required for those officers and staff who undertake child protection work has now been conducted for all 12 BCUs. This identifies which staff in safeguarding have received training, including the specialist child abuse investigations development programme and the achieving best evidence interview course. While this is positive, the MPS must now ensure that it uses this information to target required training for those officers and staff undertaking child protection work.

Some of the officers and staff in the new safeguarding teams have not received the training required to carry out their roles

The MPS recognises that officers and staff investigating child protection matters need training and appropriate skills. However, not all the officers and staff within the new BCU safeguarding teams have received the training they need to carry out their roles. This means that some officers and staff are conducting investigations even though they are not experienced in this field and do not have specialist child abuse investigation training.

In response, the MPS intends to train 3,000 staff in safeguarding, although the timescales for this are unclear. There is currently a one-week safeguarding course in place providing training on the basic elements of safeguarding, designed for those currently deployed in a safeguarding team. Since April 2018, 93 officers have attended the course. It is scheduled to provide training to 1,101 members of staff, which will be 40 percent of staff deployed in those teams. There is currently no plan to train the remaining 60 percent.

Managing those posing a risk to children

Recommendations from the 2016 inspection report

Immediately the Metropolitan Police Service should act 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.

In 2017, we found that there had been a significant improvement in the levels of ARMS assessments completed across the MPS. We were, however, concerned by the force's decision-making process for cases of online child sexual abuse and exploitation. We found the force frequently failed to make timely referrals in these cases, or to share information with children's social care services to ensure that risks were mitigated and children safeguarded appropriately. The approach was not child focused, with the collection of evidence for criminal investigations prioritised over the safeguarding of children. We were pleased to find that the levels of representation and attendance by the MPS at multi-agency public protection arrangements (MAPPA) meetings were appropriate.

Review findings

Jigsaw officers are managing significantly high numbers of registered sex offenders

The ratio of offender managers to offenders within the Jigsaw[12] teams remains a concern. Officers are now managing 6,199 active RSOs in the community. We found that the number of offenders whom officers were responsible for managing varies, but in five areas there are more than 100 offenders to manage per offender manager. These ratios have deteriorated from what we reported on in 2016. At that time, staff managed between 50 and 60 offenders each. The MPS has recently (September 2018) started to collect centrally a new set of data to help monitor Jigsaw's performance. This includes civil orders, number of visits conducted, timeliness of visits and ARMS compliance. This should provide managers with the necessary information to identify areas of underperformance or risk, so that they can act to understand and address them.

[12] Jigsaw teams are dedicated to MAPPA, aimed at managing known RSOs and other dangerous individuals.

We reviewed 22 RSO cases and assessed 13 as either inadequate or requiring improvement. In some of these cases, the force was not proactively sharing information with children's social care services on RSOs as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children. This affects the MPS's ability to put effective safeguarding arrangements in place.

The wife of a RSO who had previously been convicted of possessing IIOC contacted the MPS because she found more such images, which he admitted to.

There was a 29-day delay before the MPS submitted Merlin forms for the children in the family, who were then placed on a child protection plan. Because of the delay in submitting the Merlin reports about the children, the risk posed to them was not effectively addressed early enough, leaving them exposed to potential risk.

In addition, the offender manager for the RSO had raised the risk from low to medium because of the concerns but had not completed a new ARMS assessment or a risk management plan. This did not comply with national guidance and the manager did not consider the fact that there had been a significant change in the case.

National guidance states that ARMS assessments should be reviewed every year or if any new relevant information comes to light. This is to ensure that risk assessments remain current and that the associated risk management plan can be updated if it needs to be. We found that this is frequently not happening. The annual assessments are seen as health checks, ensuring that there is no information that would change the level of risk. We also found many risk management plans that were out of date or had not been re-assessed when new information came to light.

During a routine visit, an RSO with convictions for gross indecency with a child was found to have been associating with young children. The RSO was arrested and subsequently charged.

Officers submitted Merlin reports promptly and shared them with children's social care services, ensuring the safety of the children. Two children then disclosed further offences, which led to a further arrest and a charge for offences of inciting a child to engage in sexual activity and indecent images.

The Merlin form that the officers submitted asked for a multi-agency planning meeting to discuss the concerns with other professionals, but there is no record showing whether or not this took place.

The MPS is also responsible for managing British sex offenders who are deported to the UK after committing offences against children in other countries, and who then settle in London. The central Jigsaw team has developed an efficient process for dealing with these cases and has arrangements in place with several countries to ensure that they are alerted in reasonable time that offenders are due to land back in

the UK. As a result, officers meet offenders at the airport and in most cases a notification order[13] is obtained that day.

The MPS also has a MAPPA agreement with housing services in all 32 London boroughs. This ensures that these cases are given priority and that accommodation is identified, which is notable practice. It makes sure that suitable accommodation is found for the offender, helping them to quickly resettle and so preventing homelessness. This is an important factor in managing risk and may help reduce re-offending.

Information on high- and very high-risk registered sex offenders is made available to local officers and staff

In 2017, the MPS introduced a new system for briefing officers and staff about high- and very high-risk RSOs in their local areas. This is positive and addresses, in part, our 2016 recommendation that the force should "ensure that appropriate information on RSOs is made available routinely to local officers". However, these officers and staff remain unaware of the majority of offenders (i.e., those categorised as medium and low risk) in their areas.

By their very nature, high- and very high-risk RSOs are more closely and robustly managed by Jigsaw teams. As low-risk offenders are generally managed reactively (i.e., without formal visits), it is important that local officers are aware of these RSOs' presence in their areas because they are more likely to have contact with offenders through routine neighbourhood policing. This is a missed opportunity to use frontline staff in the wider collection of intelligence on those medium- and low-risk offenders who might pose a risk to children.

Notable practice – ViSOR record created at point of charge

The MPS Jigsaw teams create a record on ViSOR when a person is charged. Although this is not a mandatory requirement and is not set out in the College of Policing's APP or ViSOR standards, it is an action that the MPS includes within its processes. The practice allows for the case to be tracked through the court process, and ensures early identification of risk and appropriate interventions when necessary.

The current structure for investigating cases involving online offences and indecent images of children is not working

The increasing use of social media platforms and channels to distribute, share and view child sexual abuse images on a global scale poses a significant and complex challenge for policing. This is a national problem, requiring a co-ordinated response at a national level, including internet companies, to understand and exploit opportunities to reduce the access to, and availability of, such images.

[13] A notification order puts an offender on the sex offenders' register, requiring them to notify certain information to the police as if they had been convicted in the UK.

We reviewed 34 online cases during the inspection, of which 29 were assessed as either requiring improvement or inadequate.

Operation Bellona cases

Operation Bellona targets those who distribute IIOC online. In 2016, we reported that managing the significant demand caused by the increasing scale of online offending was a serious problem. This situation has not improved and the MPS continues to struggle to ensure that investigations are undertaken in a timely way.

At the time of the inspection, there were 20 investigations ready for allocation, 41 cases awaiting research and 42 cases waiting for data from internet providers about the identity of those suspected of distributing or viewing indecent images. Approximately 100 new investigations are generated each month.

In August 2017, the police traced an offer of supplying IIOC back to an IP address (a unique electronic address for a particular computer). However, no further research to identify and locate the suspect took place until May 2018.

Once checks to confirm the suspect's address had been completed, there was a further delay of two weeks before a search warrant was executed.

When the warrant was executed, officers discovered that the suspect at the address had previously taken images of his six-year-old daughter. He was charged and remanded in prison. His daughter was safeguarded and remained with her mother.

This highlights the significant risks to children that can remain when delays occur during investigations.

Child Exploitation and Online Protection referrals

During our inspection, the MPS was also dealing with more than 800 referrals from the Child Exploitation and Online Protection (CEOP) command of the National Crime Agency (NCA).

Between January 2017 and August 2018, the MPS created 1,387 crime reports from NCA referrals.[14] Of these, 77 percent (1,065) were allocated to non-specialist frontline officers, 17 percent (235) to the child abuse team and the remaining 6 percent (87) to central specialists to investigate. This shows that non-specialist officers and staff, who may not have the necessary skills or experience to carry out investigations effectively, are dealing with the vast majority of referrals.

[14] NCA referrals include cases involving the sexual exploitation and abuse of children using the internet.

We found a significant difference in the outcome of CEOP-referred cases, depending on which team investigates the case:

- When frontline police conducted the investigation, 86 percent of cases resulted in no further action, 3 percent were recorded as 'no crime[15]' and 11 percent of cases resulted in a positive outcome (such as a suspect being charged).
- When specialist officers conducted the investigation, 29 percent of cases resulted in no further action, 12 percent were recorded as 'no crime' and 59 percent resulted in a positive outcome.

The main reason documented for frontline policing investigations to be closed with a no further action category is that there were evidential difficulties, even though the suspect had been identified and the victim supported police action.

The number of referrals from CEOP is expected to continue to rise as the police become more effective at identifying the online exploitation of children. It is therefore critical that the MPS addresses these problems.

There is a clear recognition by the MPS that the current structure for investigating IIOC is not working, and is leading to delays and poor investigations. This has resulted in a recent decision to create dedicated teams within each of the BCUs. The MPS is planning further work to identify where the necessary staff will be drawn from within each BCU, the level of training required and the availability of triage[16] equipment. This area of significant risk should be addressed without delay.

The MPS received a referral from CEOP in 2018 stating that an indecent video of children had been uploaded onto the internet in May 2017. Research by the police indicated that the account holder was a 45-year-old female with four children aged between 12 and 17 years.

The case was allocated to a child abuse investigation team but was subsequently closed three weeks later by a supervisor. At this time, no investigation had taken place to establish if the children in the house were linked to the video, no visit was made to check on the welfare of the children and no referral was passed to children's social care services.

This decision by the supervisor left these four children potentially exposed to risk of harm, with no consideration of their welfare or opportunity to put in place safeguarding measures with partner agencies to protect them.

This case was returned to the force for further review.

The MPS uses the KIRAT risk-assessment process for IIOC investigations. KIRAT very high- and high-risk cases are allocated to specialist teams, together with Operation Bellona cases. Medium- and low-risk cases are allocated to the BCUs, whose staff do not currently have access to training in relation to the investigation of IIOC offences.

[15] 'No crime' is used when the police obtain information that shows that an incident previously recorded as a crime was not in fact criminal.
[16] Triage is used to determine whether a device should be prioritised for further investigation.

The MPS has produced a draft toolkit to give advice and guidance to officers and staff investigating IIOC offences. This comprehensive document covers the following areas: definitions, legislation, investigation, safeguarding, welfare and digital forensics, as well as the viewing and grading of IIOC including victim identification and information sharing. Although the toolkit is clear about the priority of safeguarding when officers and staff are taking enforcement action, it does not give guidance about making referrals to children's social care services if there is likely to be a delay in this action. The toolkit also outlines that all seized items will be subjected to a digital triage process. However, this does not currently happen.

Our review of online child sexual abuse cases (not involving CEOP referrals or Operation Bellona cases) again found a significant difference in outcomes, depending on which team in the MPS was in charge of the investigation. The vast majority of cases allocated to central specialists resulted in a positive outcome (91 percent), while those allocated to BCU or child abuse team investigations achieved this in less than a fifth of cases (17 percent). Our concern is compounded by the fact that 88 percent of all cases were dealt with by either a BCU or CAIT team.

Part of the reason why there is a poor outcome in so many cases is that non-specialist staff cannot access digital triage. Specialist central investigators apply digital triage techniques to all devices seized during their investigations. This ensures that they only submit items for further forensic work if the presence of indecent images has been confirmed. Other staff in the MPS have no such access to digital triage and can only submit two items for examination.

The proliferation of digital devices increases demand for digital forensic examinations of these devices. The MPS said that each investigation will typically result in the execution of a search warrant, with officers seizing an average of ten devices. This means that, for each investigation carried out by non-specialist staff, eight of the devices seized cannot be submitted for further examination – but these officers and staff do not have access to digital triage to ensure that they are choosing the right devices to send.

The MPS reported that 50 percent of the items seized and submitted during non-specialist investigations do not have IIOC on them. This is resulting in the MPS discontinuing a high number of cases and returning seized digital media to the suspect. There are significant risks that the MPS has itself identified because of this, suggesting that it may be returning devices containing IIOC to suspects and missing evidence, and therefore not safeguarding children appropriately or bringing offenders to justice.

At present, because of the incompatibility of the MPS's IT systems, the force cannot use all the functions and capability of the child abuse image database (CAID)[17]. This means that officers and staff cannot routinely upload all the details of child victims and relevant images onto the system to help with future investigations. This undermines the ability of the police to quickly identify victims. It also means that opportunities to reduce the amount of time officers and staff must spend viewing and grading images are being missed.

[17] The child abuse image database (CAID) helps investigate online child sexual abuse offenders and helps identify and protect victims.

Because of these findings, we have significant concerns about the MPS's response to cases involving online child sexual abuse and exploitation. We have therefore made a new recommendation aimed at ensuring that the force improves as a matter of urgency.

Welfare support for staff investigating cases of indecent images of children is good for those specialist teams but it is not consistent for all staff

MPS officers and staff have viewed and graded more than one million images and videos in the past year. In 2016, we reported that the provision of welfare support for non-specialist staff who were investigating cases IIOC was inconsistent compared with those in specialist teams. This remains the same. Specialist staff undertake mandatory psychological questionnaires and meet a clinical psychologist. This facility is not open to BCU staff who undertake IIOC investigations. The MPS has responded to this issue by creating a new online psychological screening form, 'Looking after yourself', for those staff. This is, however, only a short-term solution.

Police detention

Recommendations from the 2016 inspection report

> 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.

In 2017, we found that, while a working group had been established to review the treatment of those children brought into police custody, limited progress had been made to improve the provision of appropriate adult services for children in custody. We identified that children were not always informed of reviews regarding their detention that had been conducted in their absence (i.e., when the child was asleep or being interviewed) and were not given the opportunity to make representations about their detention. Too many children who were charged and refused bail remained in police custody when they should have been moved to alternative accommodation.

Review findings

The MPS ensures that all new custody officers and staff working within Met Detention[18] receive safeguarding awareness and mental health training. This is positive. Custody inspectors also receive training on their safeguarding responsibilities, which includes guidance on when it is appropriate to ask the local authority for secure accommodation for children detained in custody.

Children in custody are not provided with early access to an appropriate adult

Children who come into police custody are not provided with early access to an appropriate adult. Generally, officers and staff do make efforts to ensure that they tell appropriate adults about the arrest of a child when the child arrives in custody. However, in many of the cases we reviewed, there were delays in the adult's arrival at the custody suite, which often coincided with the time of the interview. This prioritises the needs of the investigation and the management of demand over the welfare of children in custody, and means that children remain in custody without having an independent person to give them support and advice. It is the responsibility of the appropriate adult provider to work with the MPS to ensure that there is effective provision of appropriate adult services for children.

In cases where an officer of inspector rank reviewed the detention of a child, we found some evidence that they had noted that an appropriate adult had been required but had not yet arrived. However, there was limited evidence of intervention or escalation in these cases.

In the cases we reviewed, the statement of rights and entitlements that officers and staff should give to a child in the presence of the appropriate adult had not always been countersigned by that adult. Therefore, it was not clear that officers and staff had repeated the rights and entitlements in the adult's presence once they had arrived, as the law requires. It was also not evident in some cases whether an appropriate adult was present when children were charged with an offence, because this was not always documented in the detention log.

Officers and staff had carried out and documented risk assessments in all the cases we reviewed, and generally set the appropriate level of observations (i.e., how often a child should be checked) when the custody staff were made aware of the risks from the child.

Strip-searching of children in custody[19] was only seen in two of the cases we reviewed. In the first case, the search was delayed while the child was kept under constant observation pending the arrival of the appropriate adult. However, in the second case, the search was carried out without an appropriate adult, with no supporting rationale as to why the search was urgent. This is a breach of the Police

[18] Met Detention is the police custody command for the Metropolitan Police Service.
[19] Code C, Annex A of the Police and Criminal Evidence Act 1984 applies to all circumstances where children are strip-searched.

and Criminal Evidence (PACE) Act 1984[20] and the code of practice that governs the treatment of those in police detention.

Officers and staff are not informing children of reviews authorising continued detention when these are carried out in the child's absence

In 15 of the 30 cases we assessed, officers and staff had conducted the first custody PACE review (an assessment of the need for continued detention without charge) in person. However, we also identified cases where officers and staff had conducted reviews in a child's absence (i.e., when the child was asleep or in interview). While the reviewing inspector placed an entry in the detention log stating that officers and staff were to tell the child about the review, there was no recorded evidence that this had in fact happened, nor if the child had been given the opportunity to make representations about their detention.

In most cases, officers and staff completed Merlin forms for children detained in police custody and submitted them to the youth offending team (YOT)[21] via the local MASH. The use of the Merlin form enables a force to share information effectively with its partners, and to make joint decisions and plans for safeguarding when necessary.

There are inconsistencies in the recording of whether a child in need has been referred to a healthcare professional

When children in custody disclosed medical issues, these were recorded on the risk assessment and used to inform the level of observation required. This is positive and in line with the PACE codes of practice. However, in some cases we could find no evidence that these children were then referred to or seen by a healthcare professional.

A 15-year-old boy was arrested on suspicion of burglary, being in possession of items suspected of being used in a burglary and carrying a knife. An appropriate adult was contacted promptly but did not arrive for over eight hours.

The police requested a visit from a healthcare professional to examine the boy because of injuries to his wrists following handcuffing. This never took place and there is no record of why not.

The boy was charged and denied bail. Alternative accommodation was requested, but children's social care said they were unable to find accommodation because of the time of night. As a result, the child remained in custody for a further 27 hours before being transferred to court. There was no evidence of any escalation to a senior officer taking place.

Positively, officers did complete a juvenile detention certificate and submitted a Merlin form.

[20] The Police and Criminal Evidence Act 1984 is an Act of Parliament setting out a code of practice governing police powers of investigation including the arrest and detention of people in police custody.
[21] In England and Wales, YOTs are multi-agency and work with children and young people who get into trouble with the law and police.

Children are still being unnecessarily held in police stations when they have been charged with a criminal offence and denied bail

When a child is charged with an offence and the custody officer authorises their continued detention after charge, the PACE Act 1984 places a duty on the police to make arrangements for that child to be taken into the care of a local authority until their appearance in court. This duty applies equally to a child charged during the daytime as well as to those to be held overnight.

Local authorities also have a duty to provide accommodation for children to be transferred out of custody under the Children Act 1989. The type of accommodation provided is a decision made by the local authority and may be secure or non-secure.

In most of the cases we examined, the child was still detained in the police station after they had been charged. We found evidence of requests being made for suitable accommodation to local authorities, which shows that custody staff have a good understanding of the need for children to be transferred out of police detention. The law does not recognise or allow for a situation in which secure accommodation is not required and yet a child remains in police cells. However, children were transferred from custody to non-secure accommodation in only two of the 29 relevant cases we examined. No secure accommodation requests were fulfilled by local authorities.

When officers and staff made appropriate requests for secure accommodation, these were not always ratified by an inspector as required. In addition, when the local authority did not provide accommodation, there was little evidence of escalation to senior officers or of officers making subsequent requests to the local authority during the time the child was in custody. This resulted in children remaining in detention for long periods after they had been charged.

A 14-year-old boy was arrested on suspicion of robbery. Although his mother had been told about his arrest, an appropriate adult did not attend for 16 hours. The boy was later charged with robbery and bail was refused.

During the evening, several attempts to arrange his transfer to non-secure accommodation were made but the local authority said that no accommodation was available. This issue was not escalated to a senior officer, nor were any further attempts to find accommodation made during the ensuing 30 hours the child stayed in police custody. The boy's total time in custody was 60 hours. A juvenile detention certificate and Merlin form were correctly completed and submitted.

The MPS now collects data about every young person detained in police custody. The data is recorded on a stand-alone system and is shared with London councils. One of the reasons that the MPS collects and shares this information is to challenge the lack of accommodation provided by the local authorities. This should provide evidence of the scale of the problem to support discussions and help improve the position.

Innovative work to capture the voice of the child and provide support to those in police custody

We found that the MPS was undertaking some innovative work to better understand the needs of children entering custody. In conjunction with the YOT, a group of young people were invited to a closed custody suite where a police cadet played the part of a detainee and other actors created noise, banging on doors and shouting. The cadet was booked into custody while the group of young people looked on. They subsequently took part in a focus group where they gave feedback about the language used by staff and on forms meant for adults not children. The use of less complicated, more child-centred language, along with explanatory pictures, would help children (many of whom will never have entered custody before) to understand their rights and the support available to them. The MPS is using this feedback in its review of custody policy.

During the Notting Hill Carnival in 2018, for the first time, a juvenile-only custody suite was arranged by the MPS, supported by appropriate adults, outreach workers and the St Giles Trust. This positive approach provided the opportunity to offer support on matters such as alcohol and drug abuse, and knife crime, while those children were being detained.

Next steps

While we are assured that there has been, and continues to be, a focus on child protection matters, and that long-term planning is in place, we remain concerned about the consistency of effective responses being achieved for those children who require the help and protection from the MPS every day.

We will revisit the MPS no more than 12 months after publication of this report in order to assess progress. This will allow the force to complete its major restructure and to continue work against our previous recommendations.

Given the significant concerns we have about the MPS's ability to effectively investigate offences involving online child sexual abuse and exploitation, we are also making a separate recommendation aimed at urgently improving practice in this area.

In line with the force's own plans, we would expect to see continued improvements in the quality of outcomes being provided for those vulnerable children who require the help and protection of the MPS.

2018 recommendations

Immediately, we recommend that the Metropolitan Police Service (MPS) continues to implement all the recommendations made by Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services following our child protection inspection in 2016, ensuring that it reviews the effectiveness of its improvement activities.

Immediately, the MPS should act to improve the quality and timeliness of investigations related to the exploitation and abuse of children via the internet.

Specifically, this should include ensuring that:

- delays in the investigation of online abuse are reduced or eliminated;
- information about children at risk of abuse via the internet is shared promptly with safeguarding partners and that appropriate protective plans are developed;
- investigations about online abuse or exploitation are allocated to teams with the skills and experience to manage them effectively; and
- seized devices are examined (through the introduction of triage technology for non-specialists) and that only those devices where indecent images are known or suspected are sent for further examination.

Annex A: Summary of 2016 recommendations

Immediately

The Metropolitan Police Service (MPS) should put in place arrangements that ensure that it has clear governance structures in place to monitor child protection practices, across both borough teams and specialist units. The MPS should then give officers and staff 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.

The Metropolitan Police Service should put in place an action plan to ensure that 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 people 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 when there are repeat episodes; and
- putting arrangements in place to ensure that, when there are repeat missing or absent episodes, they work with partner organisations to share information and implement 'trigger plans' to forestall further episodes.

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

- reinforces messages to all officers and staff about their individual and collective safeguarding responsibilities, ensuring that they actively assess both any immediate risks or concerns and any wider risks that may affect other children when officers 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 officers should record (and in what form they should record it) on systems to ensure that it is readily accessible in all cases where there are concerns about children.

The Metropolitan Police Service (MPS) should act to:

- review the current standing operating procedures and identified aggravating factors about officers who deal with people who are suspected of possessing indecent images of children, and those suspects' access to children within their own family;
- reduce the delays in visiting registered sex offenders (RSOs) and improve the management and response to them;
- review attendance at Multi-Agency Public Protection Arrangements meetings, ensuring that 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 RSOs is made routinely available to local officers.

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; and
- develops a performance framework to report on the results of the service it provides to children.
- The Metropolitan Police Service should act to improve child protection investigations by ensuring that:
- it provides guidance to officers and 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 officers who have the skills, capacity and competence to undertake the investigation;
- officers supervise and monitor investigations, with supervisor reviews recording clearly any further work that officers might need to do;
- 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

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 to bring about improvement.

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 child sexual exploitation, and of the support children need at the time of detention and on release;
- ensuring the prompt submission of a Merlin form to record a 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.

The Metropolitan Police Service should undertake a skills audit to:

- assess the training required for those who undertake 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 child sexual exploitation, including its potential links with missing and absent children.

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