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Dear **local partnership**

Joint targeted area inspection of the multi-agency response to abuse and neglect in Bristol City Council

Between 16 and 20 October 2017, Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMICFRS) and HMI Probation (HMI Prob) undertook a joint inspection of the multi-agency response to abuse and neglect in Bristol City Council.[1]

This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Bristol.

This JTAI includes an evaluation of the multi-agency 'front door' for child protection, when children at risk become known to local services. In this inspection, the evaluation of the multi-agency 'front door' focused on children of all ages who are being or have been neglected. The JTAI also included a 'deep dive' focus on children between seven and 15 years old who have been neglected. This group of children will be referred to as 'older children' for the purpose of this letter.The partnership has a strong commitment to protecting children in Bristol, with solid foundations for further improvement. It is evident that self-awareness in the partnership is improving and that the vast majority of the areas for improvement identified during the inspection had already been identified, with action being taken to address these deficits.

[1] This joint inspection was conducted under section 20 of the Children Act 2004.

There is significant good practice in Bristol, for example the schools' role in safeguarding children is prioritised and supported by the partnership. This is making a real difference to children experiencing neglect. Early help work is given appropriate priority for resources, leading to children and families often being well supported, with increasingly effective multi-agency working. However, some of the basics of multi-agency practice in relation to the 'front door' and children living with neglect are not yet sufficiently in place.

In June 2017, the Bristol Safeguarding Children Board (BSCB) undertook an audit of children subject to child protection plans under the category of neglect in response to children staying on those plans for long periods of time. The audit highlighted a number of deficits:

- insufficient consideration of the voice of the child;
- an approach that is too adult focused and 'incident-led', leading to the cumulative impact of neglect not being recognised;
- a lack of specificity in planning; insufficient understanding of the impact of children living with domestic abuse and substance abuse;
- and a 'misinterpretation of the current strengths-based model of practice'.

These factors led to drift and delay for some children, as well as 'start again syndrome'. Progress is being made to address these deficits. A number of the same issues were identified during this inspection.

The partnership recognises that not enough priority has been given to neglect and is determined to develop a robust multi-agency neglect strategy to support improvement.

Key Strengths

- The multi-agency partnership has a strong commitment to the protection of children in Bristol. There is a developing culture of learning, demonstrated throughout the inspection by partners looking for opportunities to improve. During the inspection, the partnership put learning into practice by making immediate improvements where possible. Strong foundations to further improve are in place and there is significant evidence of the partnership agencies in Bristol being able to work together effectively.
- BSCB has delivered training on neglect, and this has been integrated into all child protection courses. The training is valued by staff across agencies. BSCB is continuing to develop its evaluation of training to measure the impact on practice. There is good dissemination of lessons from serious case reviews, which are incorporated into training. Learning and development is a strength of BSCB.

- There is increasing evidence of a responsive and self-aware BSCB. For example, an audit was undertaken in response to children staying on child protection plans for too long. Significant deficits were identified during this audit, and they are being addressed. Another example saw the BSCB responding to data on the low proportion of contacts that resulted in children receiving a service. This led to an audit in which poor quality referrals and information sharing from partner agencies were identified as deficits. An action plan is in place and work across the partnership is being done to improve the quality of referrals. This includes a new quality assurance process for referrals.
- The voice of the child has a strong influence on BSCB. Bristol Safeguarding Children Shadow Board includes young people from across health, social care, city council and voluntary sector participation groups. This has enabled the voice of adolescents who have experienced neglect to inform policy development. The shadow board devised and presented a safeguarding audit across secondary schools. They are also supporting the work of the participation group, which has developed a range of education resources designed by young people who have experienced sexual exploitation. The BSCB Annual Conference (2017) highlighted the importance of young people's participation. The conference was co-chaired by the members of the shadow board, who spoke about the need for interventions designed to meet the individual needs of young people as well as the impact of neglect and abuse on adolescents. Young people are involved in the development of policies such as the new safeguarding disabled children policy.
- Good prioritisation and commitment in relation to early help by the local authority has led to increasingly effective multi-agency work with children and their families. The local authority has commissioned a cohesive package of early help services that covers a broad spectrum of needs. This includes: youth services operating from targeted to open access; two national charities that, between them, provide a strong framework for delivering joined-up services for troubled families and early help that includes an evidence-based model for assessing and delivering services to children experiencing neglect; and specialist services for children who use drugs or alcohol or live with parents who do. This thorough package of early help support means that children who are experiencing lower levels of neglect have access to a range of services that are well tailored to their needs at an early stage. Eighty per cent of children and their families who receive an early help service do not return to early help or statutory services within 12 months of their case being closed. The Bristol partnership recognises the challenges of some caseloads in the early help teams being too high and the increasing complexity of some cases.
- Innovative use of data is enabling a better understanding of need and an earlier response. A predictive analytics tool is being developed by the police and local authority, which will have both a multi-agency element and a single-agency element. This is already being used by the early help service and the police. The early help service use the tool to ensure that intelligence about families is shared

at the referral stage. The tool has been used for young people at risk of child sexual exploitation to ensure an early response and offers a more practice-based approach to identifying risk and need. It also allows for older children who are experiencing neglect to be identified.

- Very good engagement with and support for schools through the safeguarding in schools team and early help managers have helped schools identify and respond to neglect effectively. This is further supported through a safeguarding audit of schools and a BSCB sub-group that focuses on safeguarding in education. School staff are universally positive about the quality of the safeguarding training they receive.
- The strong work in schools to support children who are identified as suffering from neglect means that concerns about individual children and families are identified at an early stage. The work of the learning mentors, family support workers or home-school workers is, in many cases, highly effective in identifying and monitoring older children who suffer from neglect. School budgets also fund therapies such as art and play, which can help to meet the needs of children and so prevent the need for a referral to children's social care. The good relationships between school staff and children's social care staff mean that support and guidance is available to support the referral process. School staff's knowledge of children and their families in their community is a great strength in enabling support for older children experiencing neglect.
- A strong commitment to the local authority's preferred model of working is leading to a clear framework for multi-agency practice. Significant training has been given across early help and statutory services. There remain inconsistencies both in practice and the implementation of the model by practitioners, and we found that the lack of effective implementation led to risks not being sufficiently reduced for some older children experiencing neglect. The commitment to the model and to continuously learning how to improve its effectiveness provides a sound platform from which to improve work with older children experiencing neglect.
- Social workers are positive about working for Bristol local authority and value the support and training they receive. Workforce stability is strong, with a very low vacancy rate. Workers speak highly of the social work unit and 'trio' system[2]. They receive regular supervision and say that when their immediate supervisors are absent, they are able to quickly gain support/guidance from other consultant social workers. Many had attended area neglect workshops. They can talk about how they have reflected on learning and how this has influenced their practice.

[2] The system in which a small group of social workers work closely together with a 'practice lead' who has a close working knowledge and oversight of their work. Social work units are grouped in threes as 'trios', with practice leads in each unit being readily available to social workers to provide management guidance and oversight.

- There is good management oversight of contacts to the first response team (FRT). Initial screening and information gathering is carried out by workers without a social work qualification. Managers, who are all qualified social workers, oversee all referrals and final decision-making. The symptoms of neglectful parenting are often identified in cases, but neglect is not consistently identified as the cause of these symptoms.
- Inspectors saw examples of sensitive and creative direct work helping children to build trusting relationships with their social workers. The 'three houses' tool is increasingly well used by social workers. However, the work to gather the views of the child does not always inform assessments and plans.
- In partnership with the local authority, the police have developed a screening tool to improve their ability to identify and assess vulnerability and risk. There is evidence from the cases sampled that this has started to improve the focus of frontline officers in identifying and responding to neglect and capturing the voice of the child. However, the tool does not currently support officers to reflect on the 'lived experience of children', which is particularly important in situations of chronic neglect. Therefore, the impact of chronic risk indicators for children is not clearly articulated when information is shared with the FRT.
- The significant investment by the police in the multi-agency safeguarding hub (MASH), lighthouse[3] and safeguarding coordination unit (SCU) to support safeguarding in a climate of financial challenge demonstrates commitment and provides an opportunity to enhance systems and structures to support the delivery of improved outcomes for children. The police recognise that opportunities exist to further improve police practice within the SCU and MASH.
- Police leaders have recognised the critical importance of effective and integrated joint working arrangements when seeking to identify, assess and respond to the risks faced by children at risk of neglect and other forms of abuse. The police, with partners, have invested significant time and resources in the development of innovative approaches such as the 'One Team' (a pilot in south Bristol in which families are visited within 24 hours of a domestic abuse incident) and Operation TOPAZ (a proactive approach to identifying and engaging with children at risk of, or subject to, child sexual exploitation and the identification and disruption of perpetrators). These approaches are leading to earlier identification and response to neglect and vulnerability.
- The National Probation Service (NPS) has an understanding of the signs and impact of neglect for children, and there is evidence that staff assess these when they see offenders with their children, for example on home visits or when families are in probation reception areas.

[3] Lighthouse is a team of staff from the police and victim support organisations, working together to guide, advise and support victims and witnesses.

- The Community Rehabilitation Company (CRC) has a women's centre where specific interventions are available for female offenders, many of whom have multiple needs. Several of these women have dependent children. These interventions support some parents whose children may be experiencing or at risk of neglect.
- The Youth Offending Service (YOS) regularly conducts home visits. As a result, children and their parents are seen in context, and therefore neglect is more likely to be identified. They engage parents well in discussions and planning, and children complete self-assessments, meaning YOS practitioners have a good knowledge of the children and their families. Trauma recovery model training for practitioners in YOS supports the understanding and recognition of neglect, including the impact of neglect on young people.
- When progress in a YOS case is not being made, children and adolescent mental health service (CAMHS) professionals meet with a YOS case holder and others to review cases, which helps to identify the impact of neglect and develop appropriate plans to support the young person to make positive progress.
- A speech, language and communication needs (SLCN) therapist now works within the YOS, which means that older young people with SLCN within the justice system are more likely to be identified by YOS practitioners due to the practitioners' increased knowledge and awareness. Evidence was seen in a neglect case of a YOS practitioner considering and identifying SLCN.
- The 'connecting care' electronic system enables health services to view key records and information about children and families that are derived from health records. This has proved particularly useful in ensuring that multi-agency decision-making at the 'front door' is better informed by health information. It is good that plans to fully integrate this with the child protection information system will facilitate an exchange of information across local authority borders.
- Active leadership from the named general practitioners (GPs) and the designated professionals at the CCG has strengthened safeguarding performance by the GPs we visited. The establishment of regular network meetings for safeguarding link GPs enables good practice and learning to be shared, while the arrangements with other health services for sharing information about families are improving across primary care. In one practice, arrangements for sharing information with health visitors and community midwives were very well developed, with a strong focus on understanding families of children who were repeatedly 'not brought' to immunisation and other health appointments.
- GP practices in Bristol are known as 4YP practices, where children and young people under 16 can attend and speak to a doctor or practice nurse within an hour of presenting at a practice. GPs routinely complete child sexual exploitation risk assessments for each consultation, which means that young people can receive a confidential service subject to there being no safeguarding concerns identified.

- Health agencies provide good support to their staff through a variety of different supervision models. For example, health visitors receive three-monthly one-to-one supervision from dedicated safeguarding supervisors. This provides the medium to promote their critical thinking in complex cases, including those in which the indicators of neglect may be difficult to identify.

Case study: highly effective practice

This case study reflects strong partnership working and effective intervention to tackle neglect and promote positive outcomes for an older child living with neglect.

Good assessment with clear analysis, well-focused planning and proactive intervention has prevented drift and delay in the case of Mark. This means that for Mark, the impact of previous neglect is being reduced and his welfare has improved.

Mark's case demonstrates effective partnership working between a number of professionals and highlights effective information sharing and risk management by the adult substance misuse service and social care. The substance misuse service took a proactive approach to verify Mark's mother's account of her drug use when there was suspected disguised compliance[4]. Extensive checks were made and there was close liaison with both the social worker and extended family, to reduce the impact of Mark's mother's substance use. Mark built trusting relationships with professionals and this has enabled him to express his feelings about his mother's presentation and articulate his wishes for the future.

Good liaison between probation and the social worker at the pre-sentence report stage meant that risks to Mark and his brothers and sisters from the mother's substance misuse were identified, well considered and available to inform sentencing and case allocation.

Mark's school has provided effective one-to-one support for him, which has shown clear impact: his attendance has improved significantly and now he is making progress with his academic work. His behaviour and attitude have improved, as have his social and physical presentation. This shows real impact in reducing the impact of neglect for Mark.

[4] Disguised compliance involves parents giving the appearance of co-operating with agencies to avoid raising concerns.

Areas for improvement

- Strategy discussions are taking place, but there are examples of significant delay in children being seen when a joint visit involving children's social care and the police is required. Action was taken to address this during the inspection.
- Strategy discussions do not always include professionals involved with the child other than children's social care, police and community paediatricians. While community paediatricians are routinely involved, they are not always the health professional best placed to make the most effective contribution. Consequently, the most appropriate health professional does not consistently participate in, and receive information from, strategy discussions. Recording of strategy discussions is not consistently clear or complete; this includes the rationale for decisions and agreed actions.
- The quality of referrals to children's social care from partner agencies is variable. This is a result of the majority of police referrals lacking focus on concerns regarding children and some health referrals having insufficient detail and analysis of concerns. This impacts on the partnership's ability to make timely decisions and leads to barriers for FRT to assess and prioritise responses based on clear, assessed risk and need, and is particularly pertinent to neglect, where individual incidents are considered rather than the pattern of neglect.
- FRT does not consistently provide a clear response to referrers about actions taken following a referral. There have been recent improvements in some responses to referrers but this is still not consistent.
- The purpose of the MASH meeting is not clearly understood by all workers as a result of a lack of clarity about when a MASH meeting should be a strategy discussion, and this leads to delay. Guidance was issued during the inspection to address this.
- Overall, there is insufficient focus on neglect across the partnership and BSCB, particularly for children in need. The impact of this can be seen in the lack of practice tools, lack of data and inconsistent recognition of and response to neglect issues. Professionals do not consistently identify the underlying causes of neglect. This is improving in relation to child protection plans, where a focus on neglect has led to a significant increase in the proportion of children subject to child protection plans.
- Thresholds are not consistently well understood across the partnership, which is particularly apparent for neglect cases. BSCB has recognised this and is using the opportunity to review the threshold document to enable more consistent understanding and application of thresholds, particularly in relation to neglect.
- Lack of effective design of the 'front door' combined with ineffective performance information have led to insufficient priority being given to seeing children at the

front door in a timely way. Decisions about responding to referrals are not consistently being made within 24 hours, which is the statutory timescale. Referrals are left open while 'further enquiries' are being made, but are not allocated at the point of referral by the priority decision team. Some of these referrals were received up to two weeks before the inspection. Different workers gather further information and the case is not allocated until a visit to the family has been arranged. There needs to be greater clarity about when information is being gathered and an assessment is being undertaken. Some children experience significant delays in being seen and being assessed. In some cases this leads to further delay in action being taken to reduce risk. Senior leaders have identified this and are taking action to improve the effectiveness of the 'front door'.

- Agencies effectively identify acute and immediate risks to children and refer these cases to FRT in a timely manner. However, there is less consistency in identifying the risks to children that arise from chronic neglect. Schools, however, do effectively identify indicators of neglect for older children. When children who are suffering the impact of chronic neglect are referred to FRT, the child's experience of neglect is not always identified as quickly or effectively as it could be and in some cases repeat referrals over a considerable period of time are made in relation to the same issue.
- Older children's involvement in child protection conferences and other meetings about them is very limited. Advocacy is not routinely considered and where it is in place, it is not always used to good effect. This is not effectively challenged by child protection chairs.
- Consideration of diversity is not strong, and while inspectors did see examples of better practice overall, issues of diversity are not well reflected in assessments and do not inform planning and interventions sufficiently.
- Families and professionals wait too long to receive minutes and plans from strategy discussions, conferences and other meetings about older children experiencing neglect. Families and professionals are not always clear about what is expected of them, and this can cause delay and a lack of clarity about how to protect and meet the needs of these children.
- Child in need and child protection plans and health needs assessments generally detail relevant actions but are not consistently specific, with clear timescales for completion, and are not well used as a tool to drive and monitor progress. Health needs assessments were delayed in some cases. The lack of goals, outcomes and timeframes in plans result in some cases drifting and a focus on incidents, rather than the overall impact for children living with neglect
- There was limited evidence of constructive challenge between partners to either inform or improve decision-making or where the child's situation was not improving quickly enough, with schools being the exception. Escalation procedures are not consistently used when there is a disagreement between

agencies. This leads to delays in taking action to improve the child's lived experience.

- Evidence-based tools to support practitioners to identify neglect and to support intervention and monitor progress in a family are not consistently in place. Although such tools are used with some children who are receiving early help, they are not routinely used to support referrals or in work with children who are in need or at risk of significant harm as a result of neglect. Inspectors did not see any use of evidence-based tools to identify neglect and underpin assessments or the consistent completion and use of chronologies to help understand patterns of neglect.
- The local authority's preferred model of practice is not being used in a consistent way within assessments to develop plans and focus on outcomes. Assessments are of variable quality. Some contain clear historical information, the wishes and feelings of children and use the model to highlight key concerns, but some do not achieve this standard. There is limited evidence that children or parents are included in scaling exercises, which does not support them in understanding the multi-agency concerns. Chronic risks and the cumulative impact of harm on children are not consistently recognised. The voices of older children who experience neglect are not consistently heard in assessments or meetings about them, and are not reflected in their plans.
- The model of practice is, in a number of cases, used in a confusing or overly mechanistic way, which means that past and present worries and the key areas for concern and action are not always clear. This does not help in the production of robust plans. When plans are not used as an objective measure of progress, partners at core groups and children in need meetings often discuss the immediate presenting issues at that point in time and can lose focus on what overall progress is being made. In situations of chronic neglect, this can lead to drift and delay in taking different or more decisive action to protect children.
- Action to reduce some social work caseloads is starting to be effective, although some social workers' caseloads are too high. This impacts on the effectiveness of their work with children experiencing neglect.
- Although social workers receive regular supervision, only in a minority of cases is effective case direction, monitoring and reflection evidenced in children's case records. In most children's cases, management oversight and supervision is not consistently driving case progression, monitoring action completion or providing guidance to social workers.
- Insufficient capacity in the CRC has an impact on the quality of practice. CRC caseloads are high, therefore management oversight is limited. For example, one frontline manager told inspectors that they were responsible for nearly 1000 low and medium risk offenders. Consequently, there is a wide variation in practice. Some inter-agency work is strong, although at times the CRC is not engaged in

joint work to protect children despite having a court order on a significant adult in a child's life.

- Inconsistent engagement of the CRC at a strategic and practice level does not support effective multi-agency working to protect children living with neglect. CRC and BSCB are still devising an approach to enable the most effective engagement and participation by CRC in the work of BSCB.
- The police have developed some additional training for officers and staff, although inconsistencies remain in the quality of decision-making at the frontline. Incidents are often dealt with in isolation instead of consideration being given to the previous history of incidents and the wider context of risk and vulnerability faced by those affected. The understanding of neglect, the BSCB and the need to make referrals was not clear among non-specialist officers and staff.
- In a number of cases, referrals were not made to children's social care or there were delays due to the police viewing an incident in isolation, being too adult focused and not gathering the views of children or considering their day-to-day lived experience.
- The development of quality assurance processes and a reflective supervision approach within the lighthouse team is positive. However, the cases reviewed highlighted inconsistencies that could have been addressed if the force was better able to test the quality of decision-making at every stage of the team's interaction with a child through similar assurance processes. The absence of this routine scrutiny means that the force is missing opportunities to provide more effective interventions at an earlier stage and results in the possibility that children may be left exposed to unmanaged and/or unidentified risk.
- In the police incident and investigation logs examined, there was very little evidence of a supervisory footprint. Individual officers appear to use their professional judgement about whether a safeguarding referral is appropriate when dealing with an incident, with little evidence of supervisors having oversight or of quality assuring decision-making. Furthermore, incidents reviewed in the SCU did not provide evidence of professional challenge or escalation of issues.
- Information sharing is not robust between health services or with partner agencies where information is not stored within connecting care or if professionals do not have access. For example, the paper-based records systems in use in the community children's health teams do not lead to effective information being shared. School nurses and health visitors do not currently have access to the connecting care system and information held by this service is not accessible to other health professionals or agencies. Furthermore, safeguarding records and documents held by health visitors are not routinely shared with school nurses when a child transitions between the services due the size and bulkiness of the paper record. This means that school nurses do not have a complete record of a child's safeguarding history and some information may be overlooked.

- Information sharing between the Bristol Recovery Orientated Alcohol and Drugs Service (ROADS) and GPs is good. This is not consistent with all health services that are supporting the child, as the details of treatment are not always shared. This means that key professionals may not be fully aware of the current risk a parent may pose to a child, or be fully informed of the impact of their substance misuse on their ability to meet the child's needs. In addition, hard copy safeguarding records, such as child protection conference notes and written records of referrals, are held in a hard copy folder separate from the electronic client record system used by the substance misuse service. Actions and outcomes from supervision are not recorded on the system and in some cases we sampled, safeguarding alerts did not contain up-to-date information. This is a fragmented approach to safeguarding record-keeping systems and limits practitioners' access to important information about risk and harm.
- Some health visitors have very high caseloads and have not been able to achieve all mandatory healthy child programme contacts. The capacity of the frontline management of the service is also stretched and so routine clinical supervision is not offered to staff. This has been recognised, a new management structure has been created and the posts have been recruited to. However, the benefits of this have not yet been realised and this delays opportunities to identify families in which neglect is a feature.
- The capacity of school nurses affects their ability to effectively prioritise their work. School nurses are not commissioned to complete universal health needs assessments on school-aged children that could aid the identification of unmet health needs. In the cases seen by inspectors, there is a lack of direct work with children and young people. Links between GPs and school nurses are underdeveloped, and this hinders any proactive work to identify and respond to neglect.
- Health and developmental checks completed by health visitors and school nurses are not always timely. These delays may prevent the early identification of unmet health needs and possible neglect, thus hindering children's access to an effective early response.
- Dentists in Bristol do not have a lead practitioner for safeguarding with whom they can consult for advice and guidance on safeguarding issues. Furthermore, there are no formal arrangements for sharing information with dentists, which was evident in our visits to dental practices and our review of cases. These visits showed a generally variable understanding among dentists of safeguarding processes, a lack of awareness of the need or means for sharing information, and little or no knowledge of children on child protection or child in need plans they may have on their patient lists.
- Bristol ROADS follows a protocol to ensure that storage facilities for clients who are accessing opioid substitution treatments are viable and enable medicines to be safely kept away from children. The protocol in relation to clients with children

under the age of five relies on a visit and visual check being carried out by associated professionals who report this to the Bristol ROADS shared care worker. However, the service does not monitor whether this check is complied with and so managers cannot be assured that the protocol is met.

- In families in which there are significant histories of parental mental ill health or drug use, multi-agency plans lack sufficient focus on these factors. Children in need and child protection plans do not fully consider the impact of this on parenting and consequently lack actions designed to address these concerns. In most cases where there has been involvement of adult services, the involvement has been limited, and there is little evidence of professionals promoting parents' full engagement in the interventions available.
- When neglect of children is a result of parents' mental ill health, agencies do not always make referrals to adult mental health services. The lack of involvement and information sharing with adult mental health services does not support effective multi-agency working.

Case study: area(s) for improvement

Poor partnership working and interventions leading to drift, delay and the escalating impact of neglect.

A poor assessment, which took seven months to complete, has not been updated for a year, and in light of changing circumstances and escalating need. Consequently, planning and decision-making has been inconsistent, incident-driven and the cumulative impact of years of neglect has not been taken into account. Combined with poor information sharing and a collective sense of impotence among involved professionals, this has meant that Jane has not been protected.

Jane has been in alternative provision since October 2016. There was a delay in the education, health and care plan process beginning, which means that the appropriate support is not in place for this older child. This has resulted in drift and delay, which seriously impairs the likely successful impact on this child's development and future well-being.

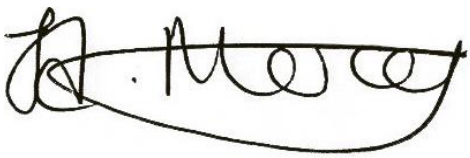
All professionals involved made reference to Jane's mother's struggle with her mental ill health, which was having an impact on her ability to engage with services. However, this was not acted on. There was an absence of a referral to school nursing, despite the school being engaged positively in the child protection meetings.

Next steps

The director of children's services should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving NPS, CRC, the clinical commissioning group, and health providers in Bristol and Avon and Somerset Police. The response should set out the actions for the partnership and, where appropriate, individual agencies.[5]

The director of children's services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 6 March 2018. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

Ofsted	**Care Quality Commission**
 Eleanor Schooling National Director, Social Care	 Ursula Gallagher Deputy Chief Inspector
HMI Constabulary	**HMI Probation**
 Wendy Williams Her Majesty's Inspector of Constabulary	 Helen Mercer Assistant Chief Inspector

[5] The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/uksi/2015/1792/contents/made enable Ofsted's chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.