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Dear **local partnership**

Joint targeted area inspection of the multi-agency response to abuse and neglect in Haringey

Between 4 and 8 December 2017, Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS) and HMI Probation (HMI Prob) undertook a joint inspection of the multi-agency response to abuse and neglect in Haringey.[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 Haringey.

This joint targeted area inspection (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 who 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 identification, assessment and service provision for children living with neglect in Haringey are too variable, and some practice is ineffective in improving the child's

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

day-to-day lived experience. Although some good practice is evident, this is often due to the commitment and skills of individual professionals rather than sound practice underpinned by robust management oversight and quality assurance systems. There has not been a coherent commissioning of services for children living with neglect. Too many children are subject to social care assessments that do not lead to the provision of appropriate services, and cases are closed too early without sufficient progress being made. Some children are therefore referred and assessed again as they did not receive effective help before their case was closed. There are not enough parenting programmes or other interventions to support long-term change for children experiencing neglect. Children who would benefit from counselling support have to wait too long for this service. Early help is underdeveloped and there has been insufficient strategic leadership or prioritisation from the Local Safeguarding Children Board (LSCB) or the partnership to address this deficit. This means that children living with neglect do not consistently receive the right help at the right time.

The LSCB recognises that tackling neglect is a strategic priority, but it has been slow in taking action to achieve it. Auditing of cases undertaken by the LSCB and local authority is leading to increased self-awareness of the scope and scale of the issue. The partnership has a robust understanding of the deficits about both the front door service, and the response to children living with neglect, some actions have been taken to improve this. However, the pace of improvement is too slow. There has been a lack of effective business planning, which has not enabled effective monitoring and implementation of actions. Partners have not been fully held to account by the LSCB for their role in the safeguarding of children, and there is an over-reliance on children's social care.

It is good that the partnership has invested resources into the multi-agency safeguarding hub (MASH). However, the partnership has not enabled the full potential of the MASH to be realised. Partners are not involved in decision-making; most decisions are made by children's social care, or when there is a strategy discussion between the police and children's social care.

It is good that children's social care has implemented a clear model of practice and that training has been delivered across the partnership. Leaders recognise the challenges of embedding this model in practice. The relationship, engagement and support of schools are a strength in Haringey. This was reflected in the proactive approach to safeguarding issues that inspectors identified in cases.

The interim director of children's services has developed a clear vision to enable children to access help at an earlier stage and to use resources more effectively. There is significant energy being invested in creating momentum for this change with increasing urgency, and some early positive signs of improvement were observed. Neglect workshops have been arranged as well as workshops on thresholds in the

MASH. 'Bite size' learning modules have also been developed. There have also been improvements to the MASH. Plans have been developed to address the main deficits identified during this inspection. The local authority has set up an improvement board to improve early help and children's social care.

Key strengths

- There is multi-agency representation in the MASH to ensure that information is shared effectively. The appointment of a full-time health representative in the MASH, with support from safeguarding advisers at times of absence, is a positive development. This ensures that there is some continuity of health oversight for referrals, and, when the referral is notified to the health representative, information can be obtained and records updated accordingly. The role of the disclosure officer is well placed to quickly and effectively respond to information received from the community rehabilitation company (CRC) and probation. The disclosure officer is able to identify situations where further exploration and a referral are required.
- There have been some improvements at the front door. For example, performance data is now available daily and gives information on the previous seven days' activity. Thus ensures that managers have oversight and are able to maintain workflows. The managers meet with the team daily to ensure that work is progressed.
- The majority of parents spoken to by inspectors from families where older children are living with neglect are positive about their social workers and the way in which they are engaging and communicating with them.
- Auditing has led to the LSCB and local authority having a good understanding of the deficits at the front door and in relation to the response to children living with neglect.
- There is evidence in Merlin[2] reports of police officers speaking and listening to children who come to their notice. Investigations reviewed by inspectors show officers both listening to and acting on the views of children. There are examples of well-planned enquiries, with thoughtful updates of the risks to children and their brothers and sisters based on current circumstances, including the neglect they are experiencing and their previous histories.
- When a specialist police officer from the child abuse investigation team (CAIT) is dealing with an investigation, there is better partnership work; this was evident in strategy discussions and joint child protection investigations.

[2] Merlin is a database run by the Metropolitan Police that stores information on children who have become known to the police for any reason. A report is generated by the police at each incident.

- Neglect is recognised by the police as a crosscutting issue in child protection and is referenced in strategic documents, for example the child risk-assessment model guidance. In addition, guidance to officers on the Merlin child referral mechanism has a clear focus on the identification of neglect.
- There is an increasing and strong commitment to partnership working between children's social care and the police. For example, the arrangement to co-locate a social worker with the police between 3pm and midnight, seven days a week, has been agreed in order to support more timely assessment and response of the risks to children suffering neglect and other forms of abuse outside office hours. In addition, the police are embedding a greater number of police officers in the MASH, which is a positive development.
- Senior leaders in the Metropolitan Police Service (MPS) have recognised the importance of obtaining the voice of the child at incidents involving risk. For example, the most recent guidance documents on how officers should deal with incidents involving children at risk clearly highlights the importance of the voice of the child.
- Frontline resources, including detective constables, have been given safeguarding training on two occasions in the last nine months. The identification and response to neglect is a consistent theme in the training. This training has been delivered in partnership with national charities. Frontline police officers reported a clear understanding of their powers to protect children from significant harm, as a result of attending this training.
- In child and adolescent mental health services (CAMHS), evidence was seen of age-appropriate approaches used by staff to engage young children experiencing neglect, through drawings. Such approaches support child-centred practice and gather the views of children. In adult substance misuse (ASM) services (ASM), CAMHS and the 0—19 service, evidence of supervision and case discussion was seen in records to support practitioners' decision-making. However, actions were not always measurable to evidence progress.
- There is effective safeguarding practice, including the identification of neglect, in the community dental service.
- The relationship, engagement and support of schools are a strength in Haringey. This is reflected in the practice seen by inspectors in the children's cases reviewed. There is a proactive approach to safeguarding linked to the LSCB priorities. Designated staff for safeguarding have worked with schools to develop a neglect toolkit, which has been piloted and found to be effective. The toolkit will be rolled out to all schools in 2018 and monitored through the advisory service. Neglect is a significant part of the training for school staff, who receive regular updates on best practice regarding safeguarding. Schools report that this is an effective resource for their work. School staff know their children well, are committed to keeping children in school and provide pastoral support for children and their families.

- Schools effectively monitor the well-being of children who are living with neglect. Inspectors observed some good examples of school staff listening to and engaging with children. Overall, the engagement by schools with parents is positive. In the cases evaluated by inspectors, there are a number of examples of effective engagement with families, resulting from close contact with children and their families.
- Inspectors observed the positive use of interpreters for families that require this service. In some cases, there is good consideration of cultural practices and of how these affect children's identity in their families, with peers and in the wider community. Diversity is well recognised by police officers, and interpreters are provided where required for victims, witnesses and suspects. Schools are well aware of the cultural diversity found within their communities. They often use creative solutions, and staff support young people and their families with translation.
- There is evidence in assessments undertaken by the national probation service (NPS) and CRC of the impact of parents offending on older children living with neglect.
- In the youth justice service, there were two examples in which the 'Voice of the Child' self-assessment tool was used as part of the 'Asset Plus' assessment and the views of the child were incorporated into the assessment. The youth justice service has also developed its own 'My Plan' document, which enables the child to identify their own targets and to use it to address their offending behaviour effectively.
- The youth justice service undertook a review of the 20 most prolific offenders, focusing on their life histories. It found very high levels of neglect, and the effect of trauma the cumulative consequences of neglect have in the young people's lives. The service has disseminated the findings of the review widely and is currently seeking funding to develop a trauma-informed practice model. The youth justice service is represented at the LSCB and has taken important issues relating to young people to the Board, including the issue of young people in both police and prison custody.
- North Middlesex University Hospital emergency department (ED) makes good use of child protection alerts, and ED attendances are checked against the national child protection information system (CPIS) to ensure that risks, including those of the neglect of older children, are managed effectively. Information is shared appropriately with all health professionals involved.
- A gangs youth worker team is based at the North Middlesex University Hospital ED, to which young people at risk can be referred to help to meet their needs and encourage them to escape gang influences. This positive engagement with young people is also an opportunity to assess the risk of child sexual exploitation and neglect.

- General practitioners (GPs) receive good support from the named GP for safeguarding in Haringey. This includes regular safeguarding updates on both local and national issues, including neglect, as well as child protection training. This means that they are supported to identify risks and report it accordingly, and this was evidenced in cases reviewed by inspectors.
- In cases reviewed in which children are living with neglect, GPs demonstrate good professional curiosity and appropriate flagging of concerns to the relevant agencies. GPs evidence a good understanding of neglect of older children that enables effective identification and response to these children.
- The named doctor for Whittington Health has provided training in relation to health and neglect to social workers and CAIT officers. This includes key messages about neglect and the importance of making a referral for a medical assessment in which neglect is indicated. This demonstrates good multi-agency practice to recognise risk and refer accordingly for appropriate care and support for older children experiencing neglect. Further training is planned during 2018.

Case study: highly effective practice

Liam is a 12-year-old child who has experienced significant neglect throughout his childhood, which has had a detrimental impact on his emotional and psychological development and his relationship with his mother. Liam's presenting behaviours have impacted on his ability to engage with education. Through strong, committed and tenacious multi-agency working across the partnership, Liam has been supported to engage with CAMHS, the school nursing service and, with the provision of suitable education, has made a successful return to mainstream schooling. Psychological assessments and extensive psychotherapeutic intervention have addressed the underlying attachment issues impacting on Liam and his mother's relationship and parenting. Children's social care has led and managed a holistic package of support for Liam and his family, which has resulted in Liam having a better understanding of his behaviours and an increasing ability to regulate them. The outcome of the multi-agency interventions is that the local authority is now seeking to achieve permanence for Liam.

Areas for improvement

- Practice at the front door is not sufficiently robust. Pathways are not clear. In some cases, there are duplication and delay in MASH checks being undertaken when it is clear that an assessment is required. Agencies focus too much on sharing information rather than on evaluating the information to inform decision-making about the most appropriate help to meet the needs of children and their families. The quality of information and referrals from agencies is too variable. There are delays in some referrals being made and a lack of clarity regarding the outcome requested. Research is not carried out by the police prior to an initial referral being made, and when information is shared it is excessively detailed and some of the information is not always relevant. CRC and probation staff are not always clear about the difference between a check and a referral and, therefore, information is not always shared appropriately. In addition, parental consent is not consistently sought where appropriate. All these factors impact on the capacity of the front door. The front door focuses too much on process and gatekeeping, rather than ensuring that children have access to appropriate help and support. This leads to a high proportion of contacts and referrals for which it is decided that there should be no further action, and to some families not accessing the right help at the right time.
- The full potential of agencies working together in the MASH has yet to be realised. The role of agencies is limited to information sharing; thus, the skills and knowledge of all agencies in the MASH are not being harnessed to enable joint decision-making.
- Thresholds are not consistently understood and applied across all agencies.
- Historical information about children and families is not consistently taken into account to enable needs and risks to be considered and understood, which does not support effective decision-making. The voice of the child is not consistently evident in referrals and therefore does not influence decisions made about their lives. There is insufficient professional curiosity in some cases.
- Outcomes of referrals are not consistently shared with partner agencies, and minutes of meetings are not always evident in all agency records.
- Pathways to early help are not well understood among agencies, which leads to low numbers of contacts, referrals and assessments that progress to early help support. This means that families are not consistently receiving help at an early stage. Parents spoken to by inspectors stated that there is insufficient early help, and that too much onus is put on statutory social work services. Early help assessments lack focus on the child's needs, and the format used makes it difficult to follow progress to address needs and risks. There is limited analysis in

the documents to demonstrate the impact of interventions and the next steps required.

- Neglect is not being consistently identified by agencies. The focus is on the presenting issue rather than the underlying cause of the young person's behaviour. Neglect tools are not used routinely to assist in the identification of neglect.
- Overall, engagement with parents and children is weak. There is a lack of work with parents of older children living with neglect, which does not support the young person making positive progress. A consistent practice approach across the partnership has been to assess and make decisions about older children living with neglect based on the child's presenting needs and behaviours. Agencies are not consistently identifying and assessing the day-to-day experience of older children living with neglect and the impact of this on their behaviour. Interventions across the partnership with parents and children in cases seen have been reactive to the issues presented at a time of crisis.
- The combination of an insufficient focus on effective interventions with parents and lack of effective outcome-focused multi-agency planning and monitoring of progress has led to drift and delay for older children living with neglect. There is a lack of challenge by professionals where insufficient progress for the child is being made or there is disagreement about decisions being made. The LSCB escalation process is not consistently used by professionals.
- Consideration in meeting the diverse needs of the families is variable. Some partners have well-established processes to meet the diverse needs of families, whereas in some cases there has been little consideration to individual needs. In cases where the children's ethnicity is Gypsy Roma, professionals lack cultural competency and there is a lack of resources available in the borough to meet the needs of this group of children.
- Systems in individual agencies are not robust enough to ensure effective information sharing. Not all agencies are complying with their own policies to undertake safeguarding checks at key points of assessment and planning. Information sharing between different health services and between health and other agencies is poor.
- Professionals from all partnerships do have access to neglect training. However, training and learning have not led to sufficient knowledge across the workforce in relation to identifying, assessing and intervening cases in which older children are living with neglect.
- The LSCB has not challenged partners to ensure that there is timely action to address deficits identified in the response to children living with neglect. An effective action plan with clear timescales has now been developed, and this will be monitored by the LSCB.

- A backlog of approximately 200 cases is awaiting a full risk assessment by the police in the MASH due to issues of capacity. The case that has been longest in the queue is three weeks overdue. These cases have been initially graded as lower-risk cases and, although they have reduced from the backlog of 800 in September 2017, there may still be unmitigated risk in these cases. The MPS is increasing police capacity to address this shortfall.
- A significant intelligence gap exists in relation to the submission of Merlin reports handled by the police in the MASH due to an absence of police national database (PND) checks being conducted prior to a referral being made. The reason for this is that at the time of the inspection there were no staff trained in the MASH to access this information. Previous backlogs have been managed through a decision to file approximately 600 Merlin reports without sharing them further, on the basis that the child had not come to notice for six weeks following the original Merlin submission. Concerns are compounded as managers and senior leaders were unaware of this gap until it was highlighted by inspectors. The failure to identify this at an earlier stage means that risk is unknown and therefore unmanaged in a proportion of police notifications that were relevant to children for whom a PND check would have been required. The number of those referrals over and above the 600 mentioned for which PND checks have not taken place is also unknown. Thus, the scale and level of unmanaged risk cannot be determined. The MPS is immediately addressing this issue by ensuring that a trained staff member conducts PND checks in relation to referrals when necessary and also by training existing staff to perform this function.
- Police officers regularly submit Merlin reports about children who come to their notice. In most cases reviewed, there was some delay in police notifications being sent to children's social care, which adversely affects the timeliness of assessment and decision-making at the front door. There is no training available for new police MASH staff. Furthermore, in cases examined there had been a lack of understanding of police intelligence and information, resulting in the risk not being identified. The initial assessment and cumulative risk of neglect were being missed, which was resulting in children and families not being referred for help.
- Police officers generally fail to recognise the cumulative risk of other factors, such as domestic abuse, in families in which older children are known to be living with neglect. This additional information is not consistently used to inform decision-making. In the cases reviewed by inspectors, police officers did not take timely action, which included delays in investigations linked to children suffering from neglect.
- The good practice that inspectors have seen of police officers listening to children was not seen in all cases. Inspectors found that police officers generally focus on the presenting issue and behaviour, which means that they will tend to assess a violent child committing crime, rather than a neglected child. In these cases, parents may be more likely to be seen as victims of their child than the child being seen as having experienced neglect. In investigations, there was some

evidence of supervision. However, supervision did not consistently challenge the decisions already made, which resulted in drift and delay in some investigations and decisions being made in the absence of complete information in others.

- Although there is evidence of a shift in the emphasis of the MPS towards a more explicit focus on the reduction of risk and vulnerability, this has not yet been translated into consistent improvements in improving practice where the police come into contact with older children living with neglect in Haringey. Some areas of the work to improve this are yet to be implemented or are at a very early stage, and, as a consequence, these areas are not yet fully realising the intended benefits. For example, the introduction of the dedicated inspection team (DIT) is a positive step; however, the findings from audits show that the majority of investigations are below the expected standard. This qualitative process is not yet effectively informing practice and training to ensure that gaps in knowledge are addressed.
- There are an insufficient number of trained officers in the CAIT. Steps have been taken to mitigate this by the introduction to the team of seven police constable investigators. These officers should only be assisting with tasks such as statement taking and conducting some enquiries; however, they are carrying out investigations concerning children. Despite some mentoring being in place, they have not had any specialist training to carry out this level of complex investigation.
- Some police officers see children solely as perpetrators of offences rather than considering their needs arising from neglect. Inspectors saw children living with neglect spending significant overnight periods in custody and being released without a recorded risk assessment or support. Significant delays were seen in cases in which children were detained in custody for long periods before an appropriate adult attended. The reason for delays in an investigation while children are detained in custody is not evident from the custody record. In addition, there was no alternative accommodation offered to a child who was detained in custody.
- Health services under-utilise record-keeping systems that aid the identification of vulnerable children. Dedicated alerts, safeguarding templates and chronologies are not always completed or updated with the most recent risks. This prevents practitioners from having access to highly visible information that can help to identify children living with neglect.
- In health agencies, the quality of recording in some records is weak. Assessments are not comprehensive or are sometimes missing from records. In adult mental health and adult substance misuse services, risk assessments are not always updated or carried out fully. In school nursing, assessments are not underpinned by the use of tools to assess risks of neglect and do not demonstrate sufficient evidence of professional curiosity.

- In adult substance misuse and adult mental health services, the 'Think Family' approach is not fully embedded, which means that there is an insufficient focus by these services on children living with neglect. The adult substance misuse service does not have robust guidance in place to help safeguard children who may come into contact with adults receiving opioid substitution treatment. The service is not commissioned to carry out home visits. Checks on the safe storage of this medication rely on what the parent/carer reports rather than actual checks at the family's home. Therefore, the service cannot be assured that children are being adequately safeguarded.
- Information sharing between health services is not always effective to support the early identification of risks to children, including unborn children. Links between midwives and health visitors are not always robust to support the early identification of safeguarding risks. This hinders the provision of universal and targeted health visitor antenatal contacts. Links between adult mental health, adult substance misuse and the community dentist to the 0—19 team are not well developed to support information sharing. This limits opportunities to work jointly at the earliest opportunity to improve outcomes for children. Electronic records used by some health services and providers, such as the RIO (electronic healthcare record system) are not linked. This prevents access to a complete record of children's care.
- There is insufficient capacity in the school nursing service, which impacts negatively on the older children living with neglect. The resourcing of school nursing is on the trust risk register, but it is not clear whether this has taken into account the impact on children and their families. Managers reported that there is no established standard provision or offer to children and young people who are home educated or not accessing education. The current school nursing service offer to children, young people and families is, on the whole, reactive in nature. This limits opportunities to consider health needs or identify unmet needs of school-aged children and intervene early when children are experiencing neglect.
- School nurse records reviewed by inspectors demonstrated poor recording, lack of recognition and analysis of neglect and risk, delay in assessment and lack of specific, outcome-focused plans to meet the needs of these older children. Chronologies are not used consistently or effectively in the school nursing service, which would help practitioners to highlight patterns of neglectful behaviours, including missed appointments or unmet health needs. Thus, the school nursing service is not proactive in identifying neglect for older children. In three cases that were evaluated by inspectors, the course of action taken did not demonstrate sufficient evidence of knowledge and understanding of how to respond to neglect. These cases were not prioritised and there were delays seen of between six and nine months at the time of the inspection. The school nursing service was not invited and therefore did not contribute to multi-agency assessments and decision-making for these children.

- GPs have good relationships with health visitors in Haringey, and regular practice meetings take place. However, relationships with school nurses remain under-developed. Information sharing, specifically between school nurses and GPs, is weak.
- The paediatric dentistry referral form does not support the identification of children for whom there are known safeguarding concerns. This limits the opportunity to identify children living with neglect.
- Health leaders across Haringey provide senior leadership and there is a strong presence and engagement on the LSCB and subgroups. However, there is further room for all partners to be considered as equal partners. The complexities of the health landscape are not fully understood by the multi-agency partnership. Across primary care, acute, mental health and community health services, the important contribution that health practitioners make to the multi-agency safeguarding of children needs to be better understood by partner agencies and considered more appropriately. For example, health practitioners are not part of strategy discussions, referrals are not shared with the health professional in the MASH and health are not currently involved in decision-making at the front door.
- Most assessments undertaken by children's social care include key information and are mostly analytical. However, there is not always recognition of neglect for older children, and information gathered is not always used to inform plans. There is very limited use of tools to support assessments.
- Plans are not child- or outcome-focused and they are not always multi-agency. Actions are not consistently focused on the neglect experienced by the older child. This leads to a lack of timely and effective multi-agency intervention for older children living with neglect.
- Social workers receive regular supervision by managers, but this is not always effective in progressing cases and improving outcomes for older neglected children. Gaps in supervision have resulted in cases being 'stuck' and delay and drift occurring for older children living with neglect.
- The local authority faces significant challenges in relation to the retention and recruitment of experienced social workers. There is a high staff turnover and use of agency staff. This leads to challenges in enabling consistent social work practice. The local authority has recognised this. It has made the retention and recruitment of social workers a priority, and plans are being developed to support this.
- High demand has created significant capacity issues at the front door. This means that children are not consistently seen in a timely way. The performance indicator for seeing a child within 10 days of the start of an assessment does not support the importance and urgency in seeing children. Delays in seeing children and their families lead to challenges in engaging them and a delay in assessing risk.

- Probation staff undertake safeguarding checks at court, but due to practical issues, such as stand-down reports, the information is not always returned prior to sentence. There is a national policy that allows for cases to be sentenced without a safeguarding check, and it is down to professional judgement as to whether this would make a substantial difference. The consequence in Haringey is that an inappropriate sentence can be given to parents of children living with neglect because the safeguarding check has not been undertaken.
- The CRC has largely withdrawn from strategic engagement with local safeguarding partnerships as it rebuilds the organisation. It has developed proposals for future engagement and has discussed them with the local partnership. The CRC is in the process of implementing a new IT system that will include child safeguarding prompts. It intends to deliver two-day in-house safeguarding training for all of its staff in 2018. It does not intend to take up places on local partnership training in the near future, as that would require staff to exceed their allocation of training days. The combination of these factors means that the multi-agency involvement of CRC in safeguarding children living with neglect is significantly underdeveloped, which does not support effective practice.

Case study: area(s) for improvement

Partnership working has focused on the presenting issues of domestic abuse in a family in which children have suffered from years of neglect. The cumulative impact of that neglect has not been recognised. As a consequence, decision-making and planning have been driven by events, hampered by delays in information sharing that was not consistently robust across all agencies, and a failure to recognise the escalating risk.

John a child in this family was offered an appointment following a CAMHS referral. However, when he did not attend, professionals did not follow this up and were unclear about the status of the CAMHS referral. As a result, no further attempts were made to arrange an assessment to explore John's emotional well-being and the impact of suffering neglect. Thus, interventions and plans were not effective in improving John's situation. Although there was imminent high risk of domestic abuse following an incident, there was a three-week delay in a police officer attending to take a statement, and a strategy meeting took six weeks to be convened. This left the family unsupported and unprotected. The impact of this for John and his mum was that they were left without intervention following the incident, which potentially gave a message that they and their concerns were not important to professionals and resulted in both of them refusing to engage with the investigation.

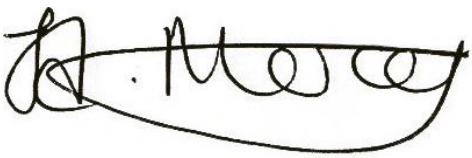
John has since been remanded to local authority care and placed in residential provision. There has been a lack of effective multi-agency work to safeguard the child. This was not recognised in management oversight until the partnership undertook an audit of the case as part of the inspection. An effective plan is now in place.

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 Haringey and the MPS. The response should set out the actions for the partnership and, where appropriate, individual agencies.[3]

The director of children's services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 11 May 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	 Ursuala Gallagher Deputy Chief Inspector
HMI Constabulary	**HMI Probation**
 Wendy Williams Her Majesty's Inspector of Constabulary	 Helen Mercer Assistant Chief Inspector

[3] 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.