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Dear **local partnership**

Joint targeted area inspection of the multi-agency response to domestic abuse in Durham

Between 9 and 13 July 2018, 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 domestic abuse in Durham[1]. This inspection included a 'deep dive' focus on the response to children living with domestic abuse.

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 Durham.

The inspectorates recognise the complexities for agencies in intervening in families where there is more than one victim and where, as a consequence, risk-assessment and decision-making have a number of complexities and challenges, not least that the impact on the child is sometimes not immediately apparent. A multi-agency inspection of this area of practice is more likely to highlight some of the significant challenges to partnerships in improving practice. In a significant proportion of cases seen by inspectors, there were risk factors in addition to domestic abuse, and this reflects the complexity of the work.

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

Increasingly strong commitment from partners is leading to a clearer vision for responding to children living with domestic abuse. This strong strategic intent is yet to have an impact on improving practice and reducing delay. However, partners have a good understanding of capacity issues and deficits in practice, and have made appropriate plans, which are being implemented. The partnership needs to ensure as a priority that strategy meetings are timely and effective.

Key Strengths

- Strong commitment to a multi-agency approach at a strategic level can be seen through the investment from agencies into the multi-agency safeguarding hub (MASH) and a commitment to commissioning a range of services for adult and child victims and perpetrators of domestic abuse.

- Awareness-raising of domestic abuse by the partners is embedded and visible and leads to increased confidence in victims reporting domestic abuse. Commitment to protecting victims and their children is also seen through Clare's law[2] being well used to protect potential victims of domestic abuse.

- The 'remain safe' scheme is an effective jointly funded project with Public Health, County Durham Stronger Families Programme and Housing Solutions that improves the security of properties of victims so that they feel safer in their homes.

- The local safeguarding children board (LSCB) has surveyed practitioners across the partnership and responded to the findings of this survey. Actions include revision of the guidance on thresholds and training on this revised guidance, as well as the introduction of a new referral form.

- The LSCB is currently undertaking a significant number of serious case reviews. The LSCB has used a multi-agency challenge meeting to identify themes for learning at an early stage. Some of these themes were identified as part of this inspection.

- There is an increasing emphasis by the partnership on evaluating the impact of services on the lives of children and their families. Evaluation is built into a number of newly commissioned projects.

[2] Clare's Law: a disclosure under this scheme is the sharing of specific information about an individual with the person making the application or a third person, for the purposes of protecting a potential victim from domestic violence.

- Inspectors observed a session for younger children who had experienced domestic abuse that was run by a charity commissioned by the partnership. The children were well engaged, were enjoying the session and they felt safe. This meant that they were able to speak about their experiences of living with domestic abuse. The children said they had found the sessions helpful.

- Children's services have experienced, and continue to experience, significant change. There has been a restructure of teams, with the aim of reducing the numbers of changes of social workers for children in the longer term. There has been an increase in capacity for senior leaders and three heads of service are being recruited. A new electronic system is being introduced, as well as a new model of social work practice. Changes are also taking place to improve the recruitment and retention of social workers. Although these actions have yet to have a significant impact, this is laying the foundations in order to create a better environment for social work to flourish.

- An improved approach is being developed by the local authority to understand performance. For example, there is recognition that teams are applying different thresholds for child protection investigations.

- It is good that children's services are prioritised by the council and that the improvement journey is being supported by council and corporate services. There has been investment in a new electronic recording system and in an additional social work team in order to improve capacity.

- The council is undertaking significant work to increase capacity through recruitment and retention, with the aim of reducing caseloads. A social work academy has been developed to support the learning and development of newly qualified social workers. Social workers were positive about the support that they received from the academy. The front-line programme is being expanded, and a return to social work programme and an apprenticeship programme are in place. To increase capacity in the short-term, an agency has been commissioned to work with 180 cases.

- Inspectors received positive feedback from some parents who were spoken to. For example, one father told us that social workers had been 'brilliant', as had everyone who had tried to help his son, including doctors, schools and probation. Another parent described the social worker working with them as 'absolutely brilliant'.

- We have seen, in most instances, schools building strong relationships with children and parents, which helps to keep children safe. In the absence of other

therapeutic input, schools also provide opportunities for children to talk safely about the domestic abuse that they have experienced.

- The police team in the MASH manages large volumes of information, and in the high-risk domestic abuse cases seen by inspectors, this was done quickly and efficiently. However, in most medium-risk cases, there were delays in officers and staff making assessments and onward referrals.

- There is evidence of police leaders working to ensure that risk can be identified and responded to more effectively. The police have made a significant investment in their IT system and have recently implemented the THRIVE[3] risk-assessment process to support more effective and timely decision-making.

- Police leaders in Durham are innovative and recognise the benefits of developing approaches that address lower level risk. MATAC, the Checkpoint programme, provides the force and partners with an opportunity to address lower level domestic abuse with both the victim and perpetrators and mitigate the impact of escalating and cumulative risk factors in a timely way.

- A more proactive approach has been developed for victims of domestic abuse. When there are three medium-risk cases within three months, and the victim has declined outreach support from a charity commissioned to work with victims of domestic abuse, the third case automatically leads to contact being made by the charity. Inspectors found examples of this working well, with engagement with families leading to reduced risk.

- Domestic abuse innovation officers based in geographical areas in the safeguarding hubs are responsible for safeguarding medium-risk victims of domestic abuse. Their role is primarily to prevent further incidents of domestic abuse. They are also responsible for managing victims at medium risk, and the integrated offender management unit is responsible for the management of risk of the perpetrator. Despite this process being in its early stages, the focus on medium-risk victims and perpetrators of domestic abuse is reducing risk in some cases.

- The Clinical Commissioning Group's (CCG) focus on domestic abuse has ensured that this is a priority area of activity for GP practices in Durham. For example, a recent round of level three safeguarding training was tailored to domestic abuse, with specific focus on MARAC and the impact of domestic abuse on children. Nearly 90% of the GPs in the county attended this training. A parallel programme

[3] THRIVE is a risk-assessment tool that considers six elements to assist in identifying the appropriate response grade based on the needs of the caller and the circumstances of the incident, namely: threat; harm; risk; investigation; vulnerability; and engagement.

of training aimed at practice non-clinical staff was also provided to support reception and administrative staff in identifying and responding to vulnerable people who present for consultations. Inspectors saw an example of where this has had a positive impact in identifying adult victims.

- There has been a significant investment by the CCG in improving safeguarding performance across primary care. This has included, for example, the appointment of three named GPs with safeguarding leadership responsibility for each of the primary care localities, the implementation of the widely used 'Childsafe trigger tool' and the teleconferencing pilot to enable GPs to participate in strategy meetings and child protection conferences. This has led to an improved understanding of safeguarding children among GPs, including raised awareness of children living with domestic abuse. For example, there are good safeguarding systems in the practices, which ensures that safeguarding information is shared appropriately across health services with health visitors, school nurses and midwives.

- The CCG ensure that learning from serious case reviews is embedded in practice. For example, new 'was not brought' policies have been developed with providers and GPs. Practitioners in health providers as well as GPs have greater insight into the risks associated with children who are not brought to medical appointments.

- Referrals made from maternity services provided by the County Durham and Darlington NHS Foundation Trust (CDDFT), the 0–19 universal health services provided by Harrogate and District NHS Foundation Trust (HDFT) and by GPs to children's social care were of good quality. We noted clear articulation of current risk and potential impact.

- The CDDFT maternity and HDFT 0–19 services work well together where risks have been identified, undertaking joint visits to further investigate risk and to ensure that joined up support plans are in place for families.

- The newly developed Vulnerable Parent Pathway (VPP) is a positive service offer to additionally support families who have enhanced health visiting, where additional vulnerabilities have been identified in the antenatal stage. The council's One Point early help service provides additional family support, including access to family centre activities to support these families.

- Managers and leaders in the National Probation Service (NPS), Community Rehabilitation Company (CRC) and the Youth Offending Service (YOS) have a good strategic understanding of the impact of domestic abuse on children. This has resulted in the development of targeted and specific services for perpetrators and victims.

- Leaders in the NPS use their detailed understanding of need to commission appropriate services to address domestic abuse. The one-to-one perpetrator programme is an example of this. Partnership work with housing providers has resulted in the development of project Beta. This project gives people the opportunity to apply for housing before they are released from prison. This means that risk can be better managed by the NPS and support services can be arranged because there is a known address prior to release.

- The NPS has been able to deliver good-quality work on a consistent basis. In cases sampled, we found domestic abuse issues were quickly identified, thoroughly analysed, and that there was effective planning to manage serious harm. Restrictive controls, such as curfews and exclusions, approved premises and breach and recall were used effectively to protect the victim.

- Consideration is routinely given, by the YOS, CRC and NPS, to the delivery of appropriate interventions designed to reduce the incidents of domestic abuse. The CRC deliver two domestic abuse programmes to perpetrators: the accredited Building Better Relationships (BBR)[4] and a newer, one-to-one programme, delivered by the same tutors. This is in response to analysed need. There are few delays in accessing these programmes. The CRC also have a team that works directly with women, and this is reducing risk.

- The YOS has a range of services and interventions for victims, including parenting support and restorative justice. The YOS also has access to a range of interventions to reduce the potential for young people of using violence in relationships. The 'clear cut communication' programme has been developed to help young people understand and express themselves clearly, reducing the need for expressive violence. Good work has been undertaken to reduce the impact of domestic violence perpetrated by young people on their brothers and sisters.

[4] The Building Better Relationships programme is an accredited group work programme for men who have been violent in their relationships, which can be imposed as part of a sentence.

Practice study: highly effective practice

The voice of the child makes a difference to developments in Durham.
Young people's voices influence the role of the LSCB. For example, young people with whom the LSCB consulted explained that they felt that there was a need to increase their own knowledge about indicators of domestic abuse and controlling relationships. The LSCB responded to this by developing and piloting an interactive education package for young people that is being rolled out to a variety of setting, such as schools, colleges and youth centres.

The CCG have collaborated with the local authority to support the contribution of children and young people to service design. The 'Investing in the children' project is aimed at raising awareness among children and young people about the impact of domestic abuse. One success of this group is in improving the child-focused facilities for contact centres. The group are also developing an education programme for 14–17 year olds on early signs of domestic abuse and what a healthy relationship looks like. This has been evaluated effectively by a group of young people it has been shared with.

Areas for priority action

- This is a multi-agency area for priority action. Strategy meetings are not always being held where the threshold is met due to the lack of effective risk-assessment by all agencies and the lack of understanding of thresholds. Where the threshold is recognised, there is significant variation in terms of timeliness and attendance. In some cases, there are delays in strategy meetings, and sometimes weeks between the incidents occurring and the strategy meeting being held. Agencies with critical information fail to attend some strategy meetings or to provide relevant background information. Action and minutes are not always shared, and this impedes effective multi-agency decision-making. This means that some children are not adequately safeguarded in a timely way.

Areas for improvement

- When professionals make decisions on thresholds, children's history and cumulative risk are not fully considered. A number of children have a history of a significant number of re-referrals and numerous assessments because of a repeated pattern of abuse. There is often an over-optimism of all agencies in relation to the assessment of the future risk of domestic abuse, and this includes a lack of professional challenge as well as a lack of awareness of disguised compliance from parents. The cumulative impact for children experiencing

domestic abuse is often not recognised early enough, with intervention only happening after a significant incident is reported. In the cases of some of these children, there are delays in recognising that the threshold for a multi-agency child protection plan may have been reached.

- The quality of auditing and monitoring of work has not been sufficiently robust. This has been recognised, and a new model of auditing has now been developed. The monitoring across the partnership of decision-making about next steps for children in need of help and protection has not been robust and therefore deficits in practice have not been sufficiently identified. There has been a lack of challenge about the operation of the MASH, which has not ensured effective and timely multi-agency decision-making.

- There is insufficient challenge and scrutiny from the LSCB in relation to monitoring and challenge of children living with domestic abuse and the response to children at the 'front door'. Partners are not consistently held to account for their safeguarding responsibilities.

- Referrals are not always sent through to children's social care in a timely manner in order to ensure that the risk to children is responded to effectively. This is due to a number of reasons, including a lack of understanding of thresholds, and is exacerbated by children's social care services failing to progress referrals appropriately.

- The MASH and the First Contact are under-resourced. The volume of contacts is high and has increased recently. This is leading to delays in decision-making about suitable interventions to improve children's outcomes. The pressure to make decisions quickly, together with the high volume of work, results in incorrect categorisation of some referrals. Some checks undertaken by social workers in the First Contact service are too superficial, and result in children not receiving the right support at the right time. Examples were seen of referrals incorrectly graded as needing early help when in fact they required statutory intervention such as MASH work or allocation to a social worker. Managers took action during the inspection to send these referrals to the MASH.

- The backlog of medium-risk domestic abuse referrals from the police in the MASH means that there is a delay in taking action to safeguard children who are living with domestic abuse. Children are not being included on safeguarding referral forms, which means that there are missed opportunities to safeguard them. Backlogs of work at different points in the First Contact and MASH processes lead to delays in children's services assessing the needs of vulnerable children. There is insufficient capacity to manage the current demands on the service.

- Police risk-assessment processes focus on the victim and perpetrator and place insufficient focus on the long-term impact on children. In some of the cases reviewed, this has resulted in an under-recognition of risk and a failure to consider and respond to the long-term impact on children who are exposed to domestic abuse at the earliest opportunity.

- Children's voices are rarely recorded in cases where the police attend a domestic incident. There are instances of reports being made by children who have been assaulted and neglected not resulting in a criminal investigation. This means that the opportunities to protect children and help them feel safe are missed.

- Some cases are incorrectly graded by the police as standard risk when they should be graded as medium risk and are therefore not shared with children's social care. This means that there are missed opportunities to assess risk and reduce risk to children living with domestic abuse. In other cases, domestic abuse referrals graded by the police as medium too often require an urgent response once they are reviewed against the multi-agency threshold of need, and taking into account information held by children's services. These children experience additional delay in having their needs, including their need for protection, assessed.

- Information gathering and sharing in the MASH is hampered by some specialisms not being represented. This includes adult and youth criminal justice services (CRCs, NPS, the YOT), and some health services available to children and families in Durham. This means that key information about risks to children and their families is missed. However, a process is in place that ensures that a flag is put on the 'front door' database indicating YOS involvement. This supports information sharing.

- Decision-making within the MASH about next steps, once all known information has been collated, is not undertaken jointly with other agencies. This has inherent weaknesses, for example in non-health staff interpreting health information, levels of risk not being agreed on a multi-agency basis, and partners not being part of discussions about levels of risk and suitable interventions.

- A lack of understanding from partners about the distinct roles and statutory responsibilities of the NPS and CRC has implications at strategic and operational levels. This leads to a lack of effective information-sharing, which impacts on agencies' ability to monitor and manage risks to victims of domestic abuse and on the management of risk posed by perpetrators to adult and child victims. Information relating to adult offenders is not consistently directed to the right organisation by the MASH. This means that information is not effectively shared,

which leads to missed opportunities to manage the risk of perpetrators effectively. This includes delays in information-sharing when perpetrators attend court.

- The MASH does not have access to the NPS or the CRC databases, and all referrals from these two services to the front door are categorised as 'probation'. It is therefore difficult to monitor the numbers and quality of referrals from each organisation.

- Only referrers receive information about the decisions made on referrals. Other partner agencies who have significant involvement with the child and family do not receive feedback, which means that they cannot challenge decisions made.

- Unborn children in families with known risk factors are not considered at a sufficiently early stage on a multi-agency basis.

- Operation Encompass[5] is not yet fully effective because there are too many children living with domestic abuse for whom no information on incidents is shared with the school. In addition to standard-risk[6] cases not being shared, medium-risk cases are not shared in cases where there is a delay. This also means that some children are not being identified as needing access to available support services to meet their emotional needs within the school or elsewhere, and it also restricts the school's ability to effectively contribute to multi-agency planning and decision-making. The partnership has recognised this and is putting plans in place to address these areas for improvement.

- There are delays in police attendance at domestic abuse incidents. This leads to a delay in the submission of safeguarding referrals, which means that these medium-risk cases are not being shared via Operation Encompass and there are delays in sharing them with the MASH.

- The current threshold to access the Multi-agency Risk Assessment Conference (MARAC) is inconsistently applied, meaning that cases that meet nationally agreed high-risk criteria are not benefiting from the multi-agency information-sharing and action planning that MARAC provides. There is insufficient quality assurance of the decisions. In addition, it was a concern that agencies are not referring significant high-risk domestic abuse cases to MARAC appropriately. GPs are not

[5] Operation Encompass is a project whereby schools are informed by the police of incidents of domestic abuse that relate to their pupils.

[6] The police assess the risk at each domestic abuse incident which determines next steps. The police categorise incidents as standard, medium or high based in their assessment of risk. This determines next steps. The current policy in Durham is that only incidents that are considered medium or high are shared with the MASH.

currently asked for information to contribute to MARAC and this means that decisions are made without the benefit of this information.

- In some cases, children were removed from homes and placed with other individuals without recourse to police protection powers (PPP). This means that checks were not always carried out and the processes afforded to support PPP, such as a strategy meeting and joint plan for the children, did not take place.

- While flags are visible in systems to alert frontline staff across agencies to changing risk, these are not always being used to aid decision-making about the extent and severity of risk to children. For example, in one case it was found that critical information, such as the minutes of MARAC and initial child protection meetings, was not readily accessible to frontline staff and was held within standalone systems. In addition, flags did not inform the full extent of risk to those involved. In the other cases, while flags were visible to staff, they were not used to understand known risks to the children linked to the adult.

- For some children, there is an over-reliance by agencies on adult victims of domestic abuse to keep their children safe. Written agreements are ineffective because they place unrealistic expectations on the mother, such as expecting her (the adult victim) to prevent the perpetrator from attending the home. These agreements do not take into account the power relationship or focus sufficiently on the perpetrator who needs to change their behaviour.

- Across agencies, case planning is not effective. Children's multi-agency plans are not well shared and do not identify key actions and activities against their plans. The majority of child protection plans are of poor quality and are not always sent to partner agencies. The result of this is reduced effectiveness in ensuring that agencies and families are clear about what the risks are to children and what needs to happen to keep them safe. Outcomes and goals do not sufficiently identify what needs to change to protect children from experiencing domestic abuse. Some do not mention domestic abuse and others are adult-focused.

- Seniors managers are clear about the priorities for children's social care to: improve recruitment and retention of social workers; ensure that caseloads are manageable; reduce delay; and improve the quality of practice. Actions taken have yet to have sufficient impact, and there remains significant deficits in practice and multi-agency working. In addition to this, children experience too many changes of social workers.

- Some cases seen show that children's views have not been taken into account by professionals across all agencies when assessing their vulnerability and risks. Where children have a consistent social worker, the child is well engaged and

their voice is heard. However, the voice of the child is rarely visible in most cases seen and their views are not routinely sought to influence practice.

- Some social workers' caseloads are higher than the local authority's preferred maximum, making it difficult to allocate incoming work. The 'duty inbox' system results in some children experiencing additional changes of social worker.

- Coercive control and disguised compliance is not as well understood by social workers and managers as other aspects of domestic abuse.

- Children's social care assessments vary in quality and a consistent deficit is that they do not summarise children's history effectively in order to inform analysis of risk.

- Schools are not routinely putting individual risk assessments in place for children, when staff become aware of domestic abuse and the risks that perpetrators and other family members may pose to children. Instead, they are relying on existing security arrangements at the school.

- Audit activity is under-developed in the health providers visited by inspectors, which does not support consistency of practice or learning from domestic abuse-related safeguarding casework.

- Management oversight of safeguarding caseloads in the health services visited by inspectors is under-developed. Some cases sampled showed drift and delay, and there was limited supervision or tracking of these cases. Supervision arrangements need further consideration to ensure that they are fit for purpose, easy to access and meet the specific needs of the local teams in Durham.

- Cases sampled highlighted a lack of professional challenge and escalation when health staff disagreed with decisions being made about children and their families.

- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) has not undertaken audit activity to support learning from domestic abuse-related safeguarding casework. The leadership focus on domestic abuse is not evident in case recording, and there is limited monitoring of domestic abuse interventions or their outcome.

- There are capacity pressures in the safeguarding specialist support function in the substance misuse service provided by Humankind. As a result of some recent support staff absence, the safeguarding database used by the lead practitioner has not been updated since May 2018 and so the monitoring of recent safeguarding activity is not taking place.

- Improvements in safeguarding practice in maternity services provided by CDDFT have not been effective in one of the localities in the south of the county. There are still some poor approaches to safeguarding the unborn, adults and linked older children. Routine enquiry of domestic abuse is not embedded or well considered, even when there are known risks. Assessments lack professional curiosity, which impedes the timely identification of, and effective response to, risks.

- The safeguarding practices in the Urgent Care Centres and the Emergency Department (ED) provided by CDDFT are significantly under-developed. These shortfalls in both the effectiveness of safeguarding screening processes and the knowledge and understanding of staff have not been identified by the trust, either through supervision or audit activity. This means that risks to vulnerable children and young people who visit the service, or children who are associated with adults who present with risky behaviours, are not identified.

- 'Think family' is not fully embedded across health services. The impact of the adults' behaviour on children is not identified, so children do not receive the support they need. For example, in the adult mental health service provided by TEWV, the adult substance misuse service provided by Humankind and in some GP practices, assessments focus too much on the adult. This does not enable the effective or timely identification of the impact of adults' behaviour on children. Cases sampled in the ED highlighted significant concerns that ED staff are not recognising risks to children. Therefore, CDDFT cannot assure itself that children and adults leaving the ED are safe.

- While the police have developed some additional training, which is positive, inspectors found that some of the cases tracked and sampled show that inconsistencies remain in the quality of decision-making at the front line. Incidents are often dealt with in isolation rather than consideration being given to the previous history of incidents and the wider context of risk and vulnerability.

- At the time of the inspection, domestic violence call-out information from the police was only provided to NPS if the index offence was domestic abuse-related. People appearing at court with other types of charges did not have a routine domestic violence call-out check with the police. Court staff could only use the self-reported information from the offender in order to identify whether there were risks to children or risks of domestic abuse. Therefore, limited information was passed on to prisons and the CRC, and this hampered efforts to manage risk.

- Work to assess and respond to domestic abuse within the CRC is variable, ranging from good assessment and appropriate planning to delayed information sharing and planning. There is not a sufficient focus on risks to children.

- The YOS manages some children who pose a significant risk to others. There are evident difficulties in assessing and managing these risks when children are working on a voluntary basis with the YOS. In one case, there was a missed opportunity to respond to a serious assault as restorative disposal, which did not support the YOT in working with the young person.

- There is a missed opportunity to utilise information gathered by the NPS, which is adult-orientated and has safeguarding concerns because the systems rely on knowing the specific details of children or adults close to the child.

- NPS at court need to have access to risk information in domestic abuse cases so that it can be shared with prisons immediately post-sentence. This then enables prisons to take steps to manage the risk in order to protect the victim.

Practice study: areas for priority action and improvement

Several missed opportunities for partners to share information and analyse cumulative risk for Jill, a child aged 14, means that not all risks have been identified and that her needs have not been met. Partners held lots of information on the child's history and current family circumstances, yet they continued to view her case through a single agency lens and did not consider her as a child in need of protection.

Jill was displaying increasingly challenging and concerning behaviours, including significant violence towards her younger sister and criminal damage, all in the context of a complex family background which included domestic abuse and substance misuse.

Failure to convene a multi-agency strategy meeting to share information, despite the involvement of police, the school and children's social care following the most recent domestic abuse incident, resulted in her arrest. During her 20 hours in custody, Jill was assessed by a CAMHS liaison and diversion nurse, who identified significant mental health concerns and took swift action to ensure that these were assessed further. Jill was discharged home and although seen by a social worker, she was not given the opportunity to speak with them on her own. Jill is a child in need; however, partners' continued view of her as a perpetrator and not a victim of abuse has not reduced risks and some of her needs remain unmet. The partnership has reviewed this case and put a list of actions in place to meet Jill's needs and reduce risk. This includes initiating a strategy discussion.

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 Durham and Durham Constabulary. The response should set out the actions for the partnership and, where appropriate, individual agencies[7]

The director of children's services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 3 December 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**
Yvette Stanley National Director, Social Care	Ursula Gallagher Deputy Chief Inspector
HMI Constabulary	**HMI Probation**
Wendy Williams Her Majesty's Inspector of Constabulary	Helen Davies Assistant Chief Inspector

7 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