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Dear local partnership

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

Between 17 and 21 October 2016, Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMIC) and HMI Probation (HMI Prob) undertook a joint inspection of the multi-agency response to abuse and neglect in Lincolnshire.[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 Lincolnshire.

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. We anticipate that each of these JTAIs will identify learning for all agencies and will contribute to the debate about what 'good practice' in relation to children living with domestic abuse looks like. In a significant proportion of cases seen by inspectors there were risk factors in addition to domestic abuse, which reflects the complexity of the work.

Strategic arrangements for the management and oversight of domestic abuse in Lincolnshire are well developed, based on a good understanding of the extent and

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

nature of domestic abuse and are having an impact across services to improve responses to children who have experienced domestic abuse. There is good awareness and ownership of the domestic abuse joint protocol by front line staff across agencies. There has also been a strong focus on equipping frontline staff and their managers with the knowledge and assessment tools required to better understand and tackle domestic abuse. This includes a good range of methods of engaging with children and these are being used well by many professionals, helping them understand children's experiences and supporting work with children to address the impact of domestic abuse. The clear drive and commitment from partners is evident but there is more to do to ensure consistency and effective joint working at all stages of engagement with children and their families.

A number of areas for improvement have been identified to support more effective and timely information sharing. Agencies do not always share the full range of information known to them so that a full consideration of risks to children living with domestic abuse can be undertaken at the earliest opportunity. Systems within the police are not effective in ensuring that when there are incidents of domestic abuse where children are present or in the household, information is shared in a timely way with professionals working with the family. The current backlog of work in the police Central Referral Unit means that referrals to children's social care services concerning children experiencing domestic abuse do not contain all the relevant information. Recording systems in some areas of health provision do not currently support effective information sharing, and more needs to be done to ensure the full engagement of NHS Adult Mental Health services and Addaction (drug and alcohol abuse service) in child safeguarding work.

While some agencies have a very strong child centred approach to addressing domestic abuse, others such as the Community Rehabilitation Company need to ensure that they are pro-active in identifying family members and the involvement of children's agencies with adults with whom they are working. Further training needs have been identified in the inspection, including the need for all professionals to understand the impact on children of repeated incidents of domestic abuse and additional training for police staff, including those who make decisions about when to refer cases to children's social care.

Gaps in the provision of services for perpetrators of domestic abuse who have not received a conviction have the potential to undermine the good work that is in place, promoted through the Local Safeguarding Children Board (LSCB) to prevent domestic abuse.

Key Strengths

- The local partnership has a clear and collective determination and drive to engage agencies in delivering a coherent approach to tackle domestic abuse. Strategic action plans are well considered and comprehensive, and are underpinned by a strong shared vision and ambition to reduce incidents of domestic abuse and prevent their reoccurrence. Senior leaders across the range of Adult and Children's Safeguarding Boards, the Public Protection Board and the Community Safety Partnership have a detailed understanding of the prevalence of domestic abuse and the impact on children in their area.

- The partnership in Lincolnshire has an effective domestic abuse strategy and a comprehensive joint protocol developed by the Adults' and Children's Safeguarding Boards and the Domestic Abuse Strategic Management Board (DASMB) to guide all professionals working with those affected by domestic abuse. Hundreds of frontline professionals attended the launch of the strategy and protocol at a learning event in August 2016. This, together with a wide range of training, means that many staff across agencies have the knowledge and assessment tools required to better understand and manage risks related to domestic abuse. Practitioners across the partnership were aware of the protocol and many were using the resources to good effect. For example, routine enquiries about domestic abuse, stalking and honour based violence (DASH) assessments are now well-embedded in the practice of frontline staff in all three NHS trusts with strong links to multi-agency risk assessment conferences (MARAC) in maintaining a vigilant approach to the management of high risks.

- The strategic overview of domestic abuse in September 2015 undertaken by the Community Safety Partnership provided an analysis of patterns and trends of domestic abuse across Lincolnshire, enabling senior leaders across the range of Adults' and Children's Safeguarding Boards and the Community Safety Partnership to have a detailed understanding of the prevalence of domestic abuse and the impact on children in their area. The resulting action plan, together with review and update of progress in June and October 2016, has enabled the partnership to review progress against the plan and monitor the impact of the domestic abuse joint protocol. This has provided a sound basis to clearly define current priorities and integrate learning from domestic homicide reviews. As a consequence, frontline practice across the partnership has been strengthened in a number of areas, for example work undertaken with district nurses to ensure that they identify domestic abuse in older people.

- Effective governance structures and agency attendance at a wide range of boards provide further evidence of a collective commitment to work together in tackling

domestic abuse. The National Probation Service and Youth Offending Service (YOS) are well engaged in the partnership and represented on key strategic boards; the youth offending manager has a high profile, for example chairing one of the current domestic homicide reviews. District councils are key strategic players in supporting community safety arrangements. Social housing staff clearly recognise their safeguarding responsibilities and actively contribute to safety planning, enabling improved outcomes for children in a number of cases.

- The LSCB effectively monitors and evaluates the work of the statutory partners, with a range of examples of real impact that is making a difference for children. For example, the approach to preventative work with children in Lincolnshire, managed and promoted through the LSCB, is a particular strength. Links between schools and the LSCB are strong, with a multi-faceted approach to promote awareness of domestic abuse and to support children to stay safe in Lincolnshire. There are termly safeguarding briefings for schools and 'It's That Easy' workshops supported by the police are provided in schools to raise awareness across a range of issues, including domestic abuse. The LSCB e-safety officer visits schools, works with parents, children and teachers and provided guidance to 11,000 pupils in 2015/16. During November 2016, the LSCB is running a campaign on domestic abuse and will provide resource packs to all schools to use in assemblies and provide information on services and support available. There will also be a communications campaign using social media to reach parents and young people.

- A wide range of training is provided by the LSCB on domestic abuse, with good take up across partners including adults' services. For example, over 1500 professionals undertook e-learning courses on domestic abuse from April to September 2016.

- A further strength is the range of multi-agency audits by the LSCB, the most recent of which focused on domestic abuse. Feedback from parents and carers is an integral aspect of these audits and demonstrates the commitment of the partners to understand and listen to children's experiences.
- The commitment of the partnership to provide high quality services to children is evidenced in agencies' investment in services to ensure that staff have the resources they need to undertake this complex area of work. In the vast majority of cases seen during this inspection, children were receiving some direct support to help them address the impact of domestic abuse. Social workers and early help workers have a wide range of resources to support them in working directly with children who have experienced domestic abuse, and this was seen to be making a positive difference to many children. The council commissions a good range of services for victims of domestic abuse, including those assessed as lower risk. These services are used well by families and were seen to be making a positive difference in many cases.

- The YOS has invested in the 'Status' programme for young perpetrators of abuse, with effective partnership work at the scoping stage of the project to support an informed understanding of the extent of the issue and the needs of young people. The YOS was assisted in the design of the programme by an experienced group worker from the Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company (CRC), who has undertaken similar work with adults. YOS practitioners are well supported by a Lincolnshire Partnership NHS Foundation Trust clinical psychologist to help them assess and deliver effective interventions to reduce risk in these young people's lives.

- The YOS undertakes effective assessments to identify where young people have been victims or perpetrators of domestic abuse. The co-location of YOS services across Lincolnshire with Early Help and FAST teams, the child sexual exploitation multi-agency team and with the police, along with their access to the children's social care information recording system, supports timely information sharing.
- The police promote prevention and the early identification of risk. The investment in training frontline officers to utilise the 'Signs of Safety' tool, the translation of domestic abuse literature and risk assessment forms into different languages and the investment in a dedicated team to engage with emerging communities are evidence of this commitment. The increase in referrals from newly-arrived communities as a result, is evidence of the positive impact that this can have.
- There is strong and effective leadership in children's social care and a clear approach to developing innovative and child-focused practice to support children living with domestic abuse. Performance management and a wide range of audit activity are well embedded, leading to identification of areas for improvement as well as informing service development, such as the need for work with young people who perpetrate domestic abuse. Engagement with children and families is routine in audit activity and represents a commitment to participation by children and families in service improvement.
- Police leaders are committed to the partnership and have prioritised the protection of children living in homes where domestic abuse occurs. There is a clear determination to reduce the risks to those identified as being vulnerable and there was evidence of police leaders aspiring to develop a culture of continuous improvement to enhance decision making and protective practices.
- When a referral is accepted by the customer service centre, the case is referred in a timely way to the relevant family assessment and support team (FAST). Customer services advisers are clear about their roles and responsibilities and receive training and updates to assist them in their work. They have aide memoirs to assist them in asking relevant questions, including in relation to domestic abuse, and have information regarding local groups and resources to pass on.

- The FAST team deals swiftly and effectively with referrals for children at risk of harm in the vast majority of cases. Clear, robust management oversight within the customer service centre and the FAST team in most cases ensures that, when risk is first identified, action is timely and well planned. Strategy meetings seen were appropriately attended by children's social care, police and health; children were seen the same day to establish current and future risk. All section 47 investigations seen evidenced liaison with partners to address risks and concerns.
- Assessments within children's social care are detailed and, include information from other agencies such as health and schools. The 'Signs of Safety' approach is used effectively to consider what is working well, what the concerns are and what needs to happen. Danger statements are used within assessments, and make the presenting risks, including from domestic abuse, really clear. The voice of the child is well represented and where the child is pre-verbal, developmental milestones and attachment are carefully considered through observation and health reports. Direct work with children informs assessments and plans, for example one young person clearly indicated that she needed an adult with her when she saw her father 'Because my dad needs to earn (my) trust', resulting in plans for appropriate contact arrangements.
- The co-location of health professionals from LCHS and LPFT at Grantham police station enables a co-ordinated approach to the sharing of intelligence between these agencies about children who may be at risk of harm. This helps ensure that frontline health professionals in the Lincolnshire Community Health Services NHS (LCHS) and Lincolnshire Partnership NHS Foundation Trust (LPFT) are promptly informed about the outcomes of strategy discussions and of required actions. Safeguarding leads within LCHS, LPFT and the United Lincolnshire Hospital Trust NHS (ULHT) provide good oversight and support continuing improvement of safeguarding practice to ensure that, where there are risks to children and young people due to domestic abuse, these are promptly identified.
- Midwives appropriately identify, assess and manage safeguarding risks to unborn or new babies, including risks of domestic abuse. Assessments seen were holistic and included information gathering from other agencies to support a comprehensive understanding of risk at the earliest opportunity. Ante-natal records provide information about Lincolnshire domestic abuse services, ensuring all pregnant women are provided with this information regardless of their history.
- Frontline staff within the 0-19 community health service recognise the importance of engagement and continuity of professional input to support parents and their children when there are concerns about domestic abuse. Local managers ensure that the most appropriate health professional remains involved with the children and their family through key stages of child in need and child protection processes, and clear chronologies of significant events enable health staff to ensure appropriate assessment of risks. The leadership and impact of the domestic abuse lead nurse in driving improvements to enhance practice were evident, for example in robust quality assurance of DASH assessments.

- A Polish support worker, employed to work with health visitors and school nurses, encourages access to services by the Polish community. DASH and MARAC assessment forms have been translated into Polish and workers have easy access to face to face interpreting services as required. The needs of the traveller communities are also well identified and supported.

Case study: highly effective practice

The importance of direct work to support children who have experienced domestic abuse is well understood in Lincolnshire. Social workers and early help workers are skilled in the use of the 'Signs of Safety' approach and are effective in utilising age-appropriate tools in their direct work with children in order to understand their wishes and feelings. This means that they are better able to understand the range of risks that children face and the impact that domestic abuse is having on them. They use this information to better protect children and provide appropriate support for their individual needs. Children are sensitively supported to develop safety plans through the use of their own words and pictures, which help to protect them while also enabling them to make sense of their lived experience. Clear messages are given to children through this work that the abuse is not their fault but that if they are at risk there are things they can do to help them to stay safe.

Aron is a 12-year old boy who lives with his mother, who is from Europe, and his sister who is seven years old. There is a history of domestic abuse and his mother is now separated from his father. All of the family were frightened by Dad, who was misusing drugs and had frequently come to the family home shouting abuse and demanding to be let in. Aron has been supported to develop his own safety plan and was able to tell inspectors how this, combined with work undertaken with his mum and sister, made the family feel safer. Mum is now supported by a social worker who speaks her language and an Independent Domestic Violence Advocate, who is supporting her to think about the legal options; his sister also has direct work with her to address the impact of abuse. In addition, work is underway with Aron on improving his self-esteem and understanding of what makes healthy relationships, in order to support him to make decisions about his own future relationships.

Areas for improvement

- Although there is clear evidence of strategic leadership and direction, this has not yet been translated into consistent improvements in operational delivery across all services and there remain a number of significant areas for improvement in some services.
- The police in the Central Referral Unit (CRU) are not risk assessing and progressing all incidents of domestic abuse in a timely way. All high risk cases are referred immediately to children's social care with a copy of the DASH assessment completed by the police. When cases are initially risk assessed as 'standard or medium risk', a daily record of all those cases where children are present or living in the household is sent to children's social care. However, this record only contains basic details of dates of birth and names and does not contain full details of the incident, nor have the police undertaken checks on their own systems to identify any previous concerns.
- In standard and medium risk cases, if officers have a concern about a child, they are expected to submit a 'Stop Abuse' form, which should then be reviewed by the CRU and, if deemed appropriate, a referral is made to children's social care. However, at the time of the inspection, there was a significant backlog of work in the CRU which means that the standard and medium risk cases had not been fully risk assessed. Almost 500 incidents where children were present or living in the household, the oldest of which dated back to 18 August 2016, had not been risk assessed, although not all featured domestic abuse. This means that standard and medium risk cases, including those with 'Stop Abuse' forms, have not been appropriately risk assessed in a timely way, meaning that children's social care may not have all of the information they require to make an accurate assessment of risk and need. In addition, administrative processes such as linking people and addresses to incidents of domestic abuse had not been completed in a large number of cases so that officers attending an incident may not having a complete picture of the domestic abuse history. The police have given assurances to inspectors that they will immediately address the backlog of notifications and have increased capacity in the CRU to manage demand.
- Additionally, police staff within the CRU do not refer all 'Stop Abuse' forms to children's social care, but make an assessment of whether the threshold is met for children's social care intervention. Staff have not received any formal training to help them undertake this work, nor do they make any enquiries with any other agencies at this point. There is no audit or oversight of this decision making and a small number of cases were identified by inspectors that should have been referred to children's social care. The police are introducing a new automated system to link notifications and 'Stop Abuse' forms and cross reference domestic

abuse incidents, and recognise the need to provide training and management oversight to support more effective decision making.

- In a small number of the cases tracked and sampled for this inspection it was clear that, while each agency held some information about risks to children and victims and acted upon that information, agencies were not sharing the full range of information known to them. This meant that full consideration of risk did not always take place, and this resulted in delays in interventions to reduce risk. This is one of the key areas for development from this inspection. A number of examples were seen,involving a range of agencies where information to inform the assessment of risk to children should have been shared but was not. This means that in a small number of cases the full range of risks to children was not understood.
- Community health services such as health visitors and midwives are not routinely informed when the police attend domestic abuse incidents where children are present or living in the household. This limits the health professional's ability to understand and prioritise risk and the needs of victims and their children. Clear examples were seen during the inspection where this lack of information sharing meant that health professionals could not make a fully informed assessment of risk.
- Health visitors are not always involved in the discharge planning meetings for new-born babies where there are concerns about domestic abuse, and may not have access to the most up to date information to help them understand the risks. Midwives and health visitors report that they are not always involved in pre-birth planning discussions in cases where children's social care is involved. Where cases have been discussed at MARAC and identified as greater risk, information is shared effectively, but where risk is considered to be at a lower level, information is not routinely shared with midwives and health visitors.
- Currently the LSCB cannot be assured therefore that all agencies understand and apply statutory guidance and information governance protocols, so that where there are risks to children, information is shared promptly and effectively to fully inform decisions about risk and need.
- Decision making in most cases seen was appropriate and timely, but this was not consistent in all cases. For example, while police manage the immediate response to incidents of domestic abuse well to ensure that the victims and children are safe, the police do not always use the full range of powers available to them to deal with cases of domestic abuse to protect victims and their families, such as domestic abuse prevention orders and restraining orders. For example, in one case when the father's behaviour clearly constituted harassment, he was arrested for being drunk and disorderly. This approach was a short term measure which did not address the impact on the family, and limited police powers in setting bail conditions.

- When there is a pattern of abusive behaviour, some practitioners do not fully recognise the effect of repeated domestic abuse incidents on children or the victim. A small number of cases were seen where, despite clear evidence of increasing significant concerns about domestic abuse, cases were either not referred or several contacts were made to children's social care before a referral was accepted. This meant that a full assessment of risk and intervention to support children was not put in place at the earliest opportunity. In some agencies, when referrals were made to children's social care and not accepted, professionals did not contact children's social care to discuss the rationale for the decision.
- In a small number of cases, decision making by the multi-agency group working with a family was not always timely to ensure that children's needs for support and protection were in place. In one case, delays in action by the police and children's social care to progress a joint investigation into the assault on a mother and the physical abuse of a child resulted in the mother withdrawing her allegations and no further action was taken at that time. Delays in strategy meetings, or failure to convene strategy meetings in a small number of cases, meant that there were delays in assessing risk and agreeing multi–agency plans to address risk.
- While many strong examples were seen in health and children's social care of practitioners engaging with and listening to children, this was less evident in police records. Frontline officers attending incidents of domestic abuse check that children are safe and well, but the behaviour and demeanour of the child, and what they said, is not routinely recorded. This critical information should be used to inform the initial risk assessment and be shared as part of the force's referral to children's social care.
- The use of written agreements by children's social care places an over reliance on the victims of domestic abuse to manage their own safety and that of their children. Such agreements do not always make clear that professionals take full account of the psychological impact of abuse on victims, the threats to which they are exposed or the heightened risk to victims and children at the point of separation from the abuser. If agreements are to be used they should always make clear the support the victim can expect from agencies, including police use of powers to protect victims and their children.
- The electronic recording system in children's social care does not support effective practice or clear oversight of children's experiences and family history. The system is not efficient and inspectors experienced significant delays in accessing key information from the system for this inspection. This means that social workers are spending unnecessary time on administrative tasks and records do not easily provide a coherent picture of the child's lived experience and background.

- Embedding safeguarding practice into the work of the CRC must be a high priority, for example ensuring vigilance and professional curiosity about children linked to adults under supervision, including through appropriate checks with other agencies. Offender managers do not consistently undertake home visits and as a result, do not routinely assess the family dynamic. CRC offender managers are not proactive in making contact with children's services promptly following allocation of a new case, even when it is made clear that children's services are involved, and they do not maintain regular contact with the police domestic abuse officers to ensure that they are updated in a timely way about any new offences.
- Offender managers within the National Probation Service need further training and support to develop their knowledge and confidence to ensure that they are prepared to challenge and use escalation procedures when they do not agree with children's social care decision making.
- There are significant and serious gaps in the provision of services for adult perpetrators of domestic abuse, other than those who have received a criminal conviction through the courts. This means that, while services may be provided for victims and children to address the impact of abuse, the work to prevent further abuse by perpetrators was seen, in too many cases, to be absent. This has a very negative impact for some children who were seen to be subject to repeated incidents of domestic abuse, or to other children as the perpetrator moves on to live with another family. This gap in service provision, while not unique to Lincolnshire, is a real issue for the partnership and could undermine many aspects of the preventative work that is in place.
- The council commissions a good range of services for victims of domestic abuse, including those assessed as lower risk. These services are used well by families and were seen to be making a positive difference in many cases. However, the funding of such services by Lincolnshire County Council is currently under review. The DASMB has commissioned a consultation on future funding for these services.
- Recording systems within the ULHT do not support effective information sharing between teams in enabling further timely checks about risk of harm to pregnant women. Whilst MARAC alerts are flagged electronically on the Trust's IT system, Emergency Department staff have to check other records for further details, which in a busy department depends on their having the capacity to do so. The midwifery safeguarding data base which contains key information about risks to women is not accessible to other hospital staff who are making decisions about the level of risk and appropriateness of arrangements for discharge home.
- Although safeguarding supervision was regularly offered across a range of health services, the templates in use and the quality of recording of safeguarding supervision seen in midwifery, community health and the 'Addaction' (drug and alcohol misuse) service did not support sufficient analysis of risks, of the impact of action taken, and of work required to improve outcomes for children.

- Addaction's arrangements for safeguarding children, including those at risk of domestic abuse, are not robust. This includes gaps in key procedures and practice in relation to home safety checks, including safe storage of drugs and alcohol in households where there are children. The service has not developed effective arrangements for managing child protection and MARAC alerts and there remain ongoing challenges in relation to operating three different IT systems, coupled with current staffing gaps and redeployment. While the new contract with the Director of Public Health aims to support new ways of working, including stronger partnerships with hospitals and GPs, gaps in legacy arrangements for safeguarding children and hearing the voice of children need to be addressed urgently.
- Effective leadership and support provided by the federated safeguarding team within NHS South West Lincolnshire clinical commissioning group (CCG) on behalf of the four CCG's operating in Lincolnshire helps promote shared direction and delivery of priorities across the local area. However, some key areas of ongoing work with partner agencies have lapsed following workforce changes, or are still at a relatively early stage of development. This includes their contribution to MAPPA arrangements, the development of the safeguarding dashboard to strengthen governance and quality assurance of the work of providers, and provision of regular supervision to named nurses within provider services.
- The recently appointed named GP provides strong direction and challenge in promoting wider use of the DASH risk assessment and 'Signs of Safety' models within primary care practice. It is acknowledged however that further work is required to ensure all local general practices are appropriately engaged in this work.
- There is generally good joint working between child health professionals including midwives, health visitors and school nurses, further strengthened through primary care-led team meetings and safeguarding forums in some localities. However, the routine engagement of NHS Adult Mental Health and Addaction staff is not sufficiently well-secured through regular and effective two-way communication and information sharing.
- The focus of performance measures within the police is currently on the quantity of child protection and domestic abuse incidents and cases. Assessment of the quality of decision making is under-developed and senior leaders cannot be assured that staff are consistently making the best decisions for vulnerable children in all cases. Further work is required by senior leaders to understand the nature and quality of decision making at the front-line.
- There are opportunities within Lincolnshire Police to cascade learning from, for example, domestic homicide reviews and the force makes use of the training offered by the LSCB. However, there was no evidence of dedicated professional development time set aside for officers and staff. The impact of this is that the force relies on 'on the job' training, reducing the opportunities for staff to focus

on professional development. The force has recognised this and is seeking additional funding for bespoke training provision.

Case study: area for improvement

Midwives, health visitors and school nurses are not receiving standard and medium risk notifications from the police when they have attended domestic abuse incidents and children are present. This means that frontline health staff may be unaware of such concerns (which also could impact on them as lone workers) and any additional information they may be able to add or checks they could make are not proactively sought. As a consequence, the area may be missing opportunities to provide early help and to embed a co-ordinated multi-agency approach to securing a timely response to harm reduction.

At a child in need meeting in the summer of 2016, all professionals present were asked to rate the level of their concerns about two young children (aged two and five years) using the 'Signs of Safety' tool. The school nurse rated risks at a level five (relatively low level risk) given the level of information she had. The following month, a multi-agency strategy discussion highlighted that the police had been called out on 11 occasions over the previous four years to deal with incidents of domestic abuse. The school nurse had not been aware of the domestic abuse incidents when she completed her assessment of risks. The children were subsequently placed on child protection plans.

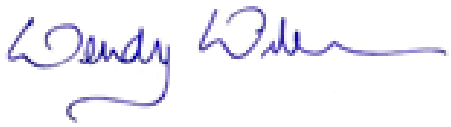
Next steps

The local authority should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving the National Probation Service, the CRC, Clinical Commissioning Group and health providers in Lincolnshire and Lincolnshire Police. The response should set out the actions for the partnership and, where appropriate, individual agencies.[2]

[2] 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.

The local authority should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 7 March 2017. 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	 Alan MacDonald Assistant Chief Inspector