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Dear **local partnership**

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

Between 18 June 2018 and 22 June 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 Medway.[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 Medway.

This joint targeted area inspection (JTAI) included an evaluation of the multi-agency 'front door' for referrals about children who may be in need or who may be at risk of significant harm. In Medway, this is made up of single point of access (SPA), which receives contacts, and a multi-agency safeguarding hub (MASH), which undertakes further enquiries. These teams also consider whether children's needs can best be met through the provision of early-help services. Alongside this inspection of 'front door' arrangements, which had an emphasis on referrals relating to children and young people living with domestic abuse, inspectors undertook a 'deep dive' into the

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

effectiveness of services for a group of children and young people living with domestic abuse. Inspectors also evaluated the effectiveness of the multi-agency leadership and management of this work, including the role played by the local safeguarding children board (LSCB).

Multi-agency working in Medway is not consistently effective in ensuring that the right children receive the right services quickly enough; some children are left in situations of unassessed risk. This is true both for individual children and at a strategic level in how partner agencies work together to plan and commission services. Although inspectors met staff who are committed to doing their best for vulnerable children, including those living with domestic abuse, and found that this strong commitment was shared at a strategic level by senior leaders from all agencies, this has not translated into similarly strong services being provided for all children. There are a number of examples of good practice. These include the weekly 'one-stop-shop', which provides open access to a broad range of services for victims of domestic abuse each Tuesday morning, and the practice of holding weekly multi-agency risk assessment conferences (MARAC), which helps ensure the timely and joined-up provision of services in many higher-risk situations. Overall, however, risk is not consistently recognised and responded to in a timely and coordinated manner.

The local partnership is at an important stage, with a strong shared commitment to developing an effective MASH and to tackling the impact on children of domestic abuse, but with services lacking coherence and not consistently effective. Developments such as new early help arrangements, agreed commissioning intentions, plans to implement Operation Encompass and a new multi-agency governance structure for tackling domestic abuse are all positive. However, at this stage, most plans are either not yet in place or are too new to have had an impact on improving outcomes for children.

Area for priority action

- The partnership must ensure that when children about whose welfare there are concerns are referred to their SPA and MASH multi-agency front door, the right information is gathered to sufficiently understand their circumstances and that decisions about next steps are timely and consistently well matched to need and risk.

Areas for improvement

- The partnership has not ensured that that the new multi-agency front-door arrangements of the SPA and MASH, introduced in April 2018, consistently gather the right information quickly enough and make swift and appropriate decisions about children. This means that some children are left in situations of unassessed risk. This is particularly true when risks to children are chronic rather than acute. For a few of these children, this has meant waiting for several days before risks are adequately assessed. Although there are plans in place to review the effectiveness of the new arrangements, the partnership has not had effective systems in place to oversee and performance manage work in the MASH. As a result, managers and leaders across the partnership were not aware of the situation until it was identified by inspectors, and so were not able to act to address it.

- The MASH is generally good at responding quickly and robustly to acute situations of high risk. However, when risk is chronic, and the result of long-standing patterns of concern, whether related to domestic abuse or other factors, it is less well identified. In these situations, threshold decision-making is inconsistent because it is not always well matched to risk. Professionals, both in the MASH and in wider services, often respond to the presenting or most recent concern and so do not recognise and respond well enough to the cumulative impact on children and young people of living with domestic abuse or other neglect and abuse.

- When inspectors observed situations in which professionals had not fully understood the impact on children, this lack of understanding was most often associated with a lack of professional curiosity or an insufficient focus on children's lived experiences. In many of these situations, professional thinking was driven by an over-reliance on parental self-reporting and an over-optimism about outcomes in the face of longstanding histories of concern. For example, inspectors saw one child's case where the risk to the child was assessed as medium rather than high because the boxes ticked in a risk assessment form indicated this. Rather than the risk assessment form being used to inform professional judgement, it had in fact constrained it. The outcome recorded on the form had not taken account of the wider context of current and historic harm. If it had, and there had been a sharper focus on the impact of domestic abuse, then an appropriate professional judgement of high risk is likely to have led to the swifter intervention and a better outcome. In another child's case, inappropriate advice from the Kent police staff within the Central Referral Unit (CRU) not to

make a referral because the child did not engage with the risk assessment process and did not want to make a statement against her father resulted in no domestic abuse notification (DAN) being sent to the SPA, despite obvious risk of harm to the child.

- DANs from the police are not routinely of a sufficient quality to support decision-making in the SPA and MASH in a consistently effective manner. This has a negative impact on the capacity of local authority staff in the MASH to process referrals about children in a timely manner. Police currently share all information regarding domestic abuse with the SPA and MASH by cutting and pasting a copy of the crime or incident report into the DAN form. This means that salient information relating to the child can get lost among the wider, adult-related, information. Domestic abuse, stalking and harassment and honour-based violence risk assessments (DASH) are often vague and do not always address the presenting risk. There is confusion about what should be sent to the SPA in relation to standard-risk DANs and there is some duplication of DANs and child protection referrals sent by the police. This puts further pressure on capacity in the MASH. DASH risk assessments with an outcome of 'standard' risk do not result in a DAN being sent to the MASH when children are over one year old. This approach means that information that may help to identify chronic risk, when placed in the wider context of available information, is not being made available to support decision-making in the MASH for these children. When records within the CRU are marked 'DASH awaited', there is no formal system for following up to ensure that these are completed. For some children, this has meant that known risk was not shared with those making decisions and planning next actions for them within the MASH.

- Police processes within the CRU are not well integrated or aligned with the MASH. The way that information about non-acute risk is recognised, assessed and shared by the police with the MASH, and with key partners more broadly, is inconsistent. It is not routinely supporting effective or efficient joint decision-making at the point of referral. The impact of new structures and processes on the development of protective plans is not regularly monitored, so that senior leaders are unable to ensure that all information about risk which requires referral is meaningfully assessed and shared in a timely way.

- Detailed strategic assessments of need have ensured that the partnership has a clear understanding of both the level of need in relation to domestic abuse and of gaps and other areas for development in current services. This has informed new commissioning plans and a well-considered re-structuring of early help services.

However, progress has been slow since the local domestic abuse needs assessment of 2015. The newly re-structured early help services have the capacity to enhance early intervention and support child-focused domestic abuse services. However, they are relatively new, and domestic abuse-specific staff, although recently appointed, are yet to take up their posts. Work to create a new domestic abuse strategy is underway, led by Kent police, but is not yet complete. Similarly, plans are yet to be implemented for Operation Encompass, the nationally established system for notifying schools the day after a domestic abuse incident in a home where a child is living. Services remain fragmented and lack capacity, particularly child-focused services, early intervention and services for un-convicted perpetrators.

- Both individually and collectively, partner agencies are not making consistently good use of performance information to understand the impact of their services, to identify areas of weaker performance and to drive and monitor progress. Through the partnership's domestic abuse sub-group, which reports to the Community Safety Partnership (CSP) and the Kent and Medway Executive Group for Domestic Abuse and Sexual Violence, partners have recognised this as an area for development. However, work to agree a shared process for analysing the impact of domestic abuse services is yet to conclude. The local authority has put in place a thorough framework of performance meetings. Monthly performance and quality meetings are particularly well attended, from frontline to senior manager level, and they provide an appropriate forum for considering performance and focusing on areas for development. However, performance reports, such as the 'MASHboard', that support such meetings, do not consistently contain sufficient depth or a sharp enough focus on impact within their analysis. The focus of police performance management is currently on measures of quantity and timeliness. These are important, but there is not a similarly strong focus on measures and processes to enable senior leaders to assure themselves about the quality of decisions that officers are making about vulnerable children and young people. Health performance data is not consistently available or accurate, and so cannot provide a clear picture of the quality and impact of service delivery within Medway. Health providers do not have a collegiate approach in place to ensure effective performance monitoring of risks and outcomes and that relevant performance data is shared across the wider partnership.

- The LSCB has been influential in building good working relationships and a shared sense of purpose between partners. This has been important in ensuring that domestic abuse is a shared priority and in creating a culture in which partners

have come together to create the MASH. However, the board's role in providing monitoring, scrutiny and challenge to partners is under-developed and lacks a sufficiently rigorous focus on impact. For example, the LSCB data set lacks both depth of relevant data and analysis. It is unlikely to provide the board and agencies with a sufficient understanding of areas of good and poor practice, the reasons for this, and where best to direct scrutiny and improvement actions.

- Systems to ensure swift and appropriate information sharing across the partnership are not effective enough. This means that, in too many instances, agencies are working with children and families in isolation and important information about domestic abuse or other risks and vulnerabilities is not shared. For example, the Community Rehabilitation Company (CRC) has no formal links or information sharing channel to the MASH. Health information systems are not compatible with each other, nor do they support effective information sharing across the partnership, such as when children have had multiple missed appointments. Information held by hospital staff, GPs, child and adult mental health and substance misuse services is not consistently swiftly and effectively shared to inform decision-making within the MASH. Delays by the local authority in sharing important information with partner agencies, such as the outcome and agreed actions from child protection strategy discussions, mean that professionals across the partnership are not always clear about children's current circumstances or about what actions may be expected of them and by when.

- Although information from health agencies is almost always included in child protection strategy discussions, most only have the direct involvement of the police and the local authority, limiting the extent to which discussion and decision-making can be informed by all relevant agencies. Similarly, strategy discussions are only initiated by local authority professionals, limiting the extent to which decision-making is owned and informed by all agencies.

- The role of the MASH health professional is underdeveloped. There is a lack of capacity, as well as a lack of clarity of roles and access to all relevant recording systems. This means that the contribution of this role, and of health agencies more broadly, is not currently adding the value it could to assessment, decision-making and planning for children within the MASH.

- Weaknesses in the information recording system that supports health practitioners within the acute emergency department setting mean that practitioners are not routinely informed if an adult or child is a victim of domestic abuse who has been discussed at MARAC. As a result, practitioners cannot

consistently consider the vulnerability of adults or children who have been victims of domestic abuse.

- Legacy problems with the quality and availability of some community health records are limiting the capacity of the new provider, Medway Community Healthcare (MCH), to provide a complete picture of the needs and experiences of children. Although inspectors were assured that all records relating to children in need and those on a child protection plan have now been transferred to MCH, not all children's health records have been transferred. This remains a significant risk and has been recognised as such on relevant organisational risk registers.

- Both MCH and Medway NHS Foundation Trust (MFT) have processes to support practitioners to identify and respond to domestic abuse. However, neither organisation has a strong model for measuring activity or the impact of their work. The recording of practitioner activity related to domestic abuse at MCH is variable and, at MFT, although the standard operating procedure for domestic violence is comprehensive, monitoring of activity is not taking place.

- Staff at Turning Point, the local organisation providing services to adults with drug, alcohol and substance abuse problems, are generally not aware of risk assessments or safety plans in place for parents with whom they are working. This limits their ability to recognise and report on the progress that parents are making to achieve their individual treatment aims. While Turning Point's assessment and care planning documentation recognises the importance of checks for domestic abuse and parental responsibility, case-recording and analysis in this service do not have a strong focus on the voice of the child.

- With high turnover and vacancy rates, the local authority faces a significant challenge in recruiting and retaining a sufficiently skilled and stable workforce to ensure that children receive a consistent standard of service. Created in response to this, the local authority's 2018–20 children's services workforce development strategy is thorough and well focused. It contains a broad range of measures to recruit, develop and retain a suitably experienced and capable workforce. For example, the local authority's recent decision to create 10 new social work posts shows a real commitment to tackling this situation at a time of significant pressure on local authority budgets. However, although these challenges have existed for some time, many of the measures to address them are relatively new and have not yet had a significant impact. As a result, workforce pressures relating to vacancies, turnover and reliance on temporary agency staff remain serious. Many social workers in assessment teams have high caseloads and, for

some, they are excessive. These problems mean that it is difficult for children to build a trusting relationship with a single consistent social worker.

- A broad range of training for social workers is provided by both the local authority and the LSCB. The local authority's foundations of practice programme, although relatively new, is comprehensive and well-focused. It includes training in systemic approaches to social work and in the use of assessment tools. Training is generally well matched to areas of practice which need strengthening. Some training, such as recent training for social workers in working with domestic abuse perpetrators, is sharply matched to specific identified need. However, the partnership is not yet consistently evaluating the impact of training and development, thus limiting senior leaders' understanding of how well it is improving practice.

- Difficulties faced by the local authority in recruiting and retaining a suitably skilled workforce are shared by the National Probation Service (NPS). Some staff within NPS are relatively new to the role, and so ensuring that there is a sufficient body of child-safeguarding knowledge and expertise within the workforce remains a challenge. Attendance at LSCB training by the CRC is improving but remains low, with just under half of CRC staff having attended training. This means that most CRC staff have not gained the benefit of multi-disciplinary safeguarding and domestic abuse training.

- When children and their families are receiving a service from the local authority's assessment service, the quality and pace of this work is variable, with a good standard only being achieved in a minority of cases. Although children are generally seen regularly, there is often too long a wait between allocation and the first time a social worker visits a child. Gaps and delays in case recording, along with a lack of chronology for most children, mean that children's stories are not always clear from case records and that an understanding of their history does not always inform assessments. When issues of diversity, such as race, culture or sexuality, are of importance to understanding a child's experience, these are mostly commented on, but they are rarely well considered within assessments or used to inform planning. About half of assessments require improvement to be of a good standard. Better assessments seen by inspectors contained a clear sense of children's history, of their voices and lived experience, and stronger analysis, underpinned by a sharp focus on key risk and protective factors. Such better assessments support more informed and child-focused planning and interventions.

- Recording of social work supervision and management oversight, including the rationale for decisions, is not consistently evident in children's electronic case records. This means that senior managers cannot always be confident that critical decisions are given the level of managerial scrutiny and oversight needed and that work with children is being progressed effectively.

- When the NPS conducts child-safeguarding and police call-out checks to assist the courts in making safe and appropriate sentencing decisions for adults whose domestic abuse offending may pose a risk to children, information from the police is often received too late to inform sentencing decisions. Although discussions are underway to resolve this, a solution has not been reached and this remains a weakness in information sharing.

- A re-focusing on vulnerability within Kent police is leading to a greater awareness of the risks faced by vulnerable children and a shift in thinking towards the wider context of domestic abuse. The investment of additional staffing, 350 officers across the wider Kent force, in a climate of significant financial challenge, is demonstrative of the commitment of force leaders. Despite their clear strategic leadership and direction, this increase in staffing has not yet been translated into consistent improvements in operational delivery or better decisions being routinely made to protect vulnerable children at risk of domestic abuse. For example, officers do not routinely ask parents for consent to share relevant information or offer early help services to families experiencing lower level domestic abuse, and so miss some opportunities to offer intervention before concerns escalate. Officers rarely describe or record the wishes and feelings of children and their lived experience of domestic abuse within initial risk assessments.

Case study: areas for priority action and improvement

Amelia is a 12-year-old girl who has been living with domestic abuse for a very long time. The way the agencies involved have worked with Amelia, her family and each other has been poor. Weaknesses in their practice include agencies working in isolation, work taking place without an up-to-date comprehensive assessment, poor planning, drift and frequent changes of social worker. Professionals involved with Amelia have not focused enough on the risk to her from living with domestic abuse, or its impact on her emotional well-being. There has been limited direct work with her and a lack of purposeful visiting that has focused on assessing and reducing the risk of domestic abuse. Consequently, there has been insufficient focus on Amelia's voice, her wishes, feelings and what living with domestic abuse has felt like for her. Insufficient intervention with her family and a lack of focus on the perpetrator has meant that little has changed because of agencies' involvement. There have been too few multi-agency meetings to plan work or track progress, little management oversight and, importantly, no safety plan is in place.

Professionals from the agencies involved with Amelia are not communicating effectively. For example, it was only during an inspector-led multi-agency meeting held as part of the inspection that several historic and more recent instances of domestic abuse were shared between those involved. Amelia had phoned the police herself on several occasions to report domestic abuse of her mother by her mother's partner, most recently on her birthday earlier this year. Professionals from health agencies have not been involved with her, nor have they been kept informed. Amelia was held in custody for significant periods of time on two occasions following shoplifting offences. This information was not shared with her school. The experience of being held in custody for many hours caused Amelia extreme distress, she was very scared and broke down in front of staff on her return to school.

Amelia told inspectors that what she found most difficult about having all the different professionals involved in her life was the frequent changes of social worker. She said, 'All the social workers I have had means I get mixed up, so I don't want to talk to them.'

Key strengths

- There is a shared commitment across the partnership to tackle domestic abuse. A 2015 needs assessment, followed up by a new 2018 domestic abuse joint strategic needs assessment, provides a clear understanding of the level and profile of need, and highlights gaps in service provision. Although there is an overall lack of coherence, and gaps in provision remain despite plans to enhance provision, local services do show examples of good practice and innovation. Weekly multi-agency risk assessment conferences (MARAC) are well attended by partner agencies, with good information-sharing leading to effective action to reduce risk. The completion of actions is tracked between meetings, and inspectors saw that when children have child in need or child protection plans, these are mostly informed and strengthened by the work of the MARAC. This helps ensure that the MARAC is an effective forum for reducing risk to the most vulnerable. A well-used, weekly 'one-stop-shop' service provides good advice, support and intervention for families in which domestic abuse is a concern. A wide range of agencies attend on a weekly basis and an effective triage system ensures that users are directed to the most appropriate help. A new monthly domestic abuse board, although still developing, is helping to provide a more joined up response for children and families when risk is below the high-risk threshold for the MARAC.

- When there are clear and immediate risks to children, the SPA and MASH act swiftly and effectively. Inspectors saw examples of swift and appropriate information sharing and joint working with the youth offending team (YOT) and NPS. The MASH team manager attends monthly YOT risk meetings and the staff from the YOT attend MASH panel meetings. This, along with the YOT having access to the local authority's electronic case recording system, has ensured good communication and information-sharing about children between the YOT and the MASH.

- Although at an early stage of development, some elements of the new MASH structure have had a positive impact since their introduction in April. For example, the co-location of an early help coordinator in the MASH is promoting more effective information sharing and co-ordination of the step-up and step-down process between early help and a statutory social work service. This means that

children and their families are more likely to experience continuity of support when moving between statutory social work and early help services and are less likely to experience gaps or inconsistencies in the services they receive. Twice weekly multi-agency allocation meetings are also ensuring a more joined-up initial response to referrals. The co-location of the education safeguarding officer and a police officer within the MASH is helping to enhance inter-agency communication. Staff from a range of partner agencies spoken to by inspectors described recent improvements in communication and feedback about referrals since the new arrangements have been in place. Case records clearly show that parental consent to make enquiries and to share information is routinely sought and recorded.

- Within the wider context of the LSCB's drive for closer working between schools and partner agencies, the appointment of a dedicated education safeguarding officer in September 2017 has also had a positive impact. Training on domestic abuse is now offered at a whole-school level. School safeguarding staff have a good understanding of domestic abuse and the impact this has on children in their care. Because of her co-location within the MASH and attendance at MARAC meetings, the education safeguarding officer has been a catalyst for improved communication and coordination between schools and other agencies about the most vulnerable children and young people. The local authority has worked hard to engage with schools and to support them in enhancing their understanding and responses to safeguarding concerns, including those related to domestic abuse. Inspectors found that when schools are aware of domestic abuse, they generally make prompt referrals and provide a good range of support to children, for example by helping them build their resilience through accessing emotional well-being and counselling services.

- In most areas of practice, and apart from the urgent need to improve decision-making within the MASH, identified during the inspection, the local authority has a good awareness of its strengths, key challenges and areas for development. It uses dialogue with partners, learning from inspection and peer review to inform its service development planning. This is reflected not only in its work with schools, but also in its workforce strategy and recent re-structuring of early help, youth and early years services. The local authority's own recent workforce survey, the social work 'health check', shows that social workers are generally more positive about working for the local authority than they were a year ago and that they believe they work in a 'learning culture'. The new early help arrangements provide a clear and coherent structure which has the capacity to support an enhanced offer, including a stronger focus on earlier intervention and prevention

for domestic abuse. Two new dedicated domestic abuse early intervention staff have been appointed but are not yet in post.

- Health leaders are actively addressing areas where current service capacity does not meet demand or deliver expected outcomes. Recent developments, such as increased school nurse capacity, therapeutic provision and the expansion of the health visitor role, are providing more opportunities for targeted work with children and co-working with partner agencies. Feedback from children, their families and partner agencies has shaped recent changes to the young people's mental health and well-being service. This is helping to ensure that children who self-harm or are exposed to domestic abuse receive a timelier response. Learning from a recent serious case review has led to action to address gaps in children's safeguarding arrangements in primary care. New named GPs, together with a designated nurse, are working closely with general practices to embed shared systems and practice tools that support effective identification, information sharing and tracking of children about whom there are welfare concerns.

- Domestic abuse training is prioritised by all local health agencies, and specialist domestic abuse leadership roles are well established. Their advisory role is highly valued by frontline staff and is helping to improve both the identification of and the provision of support. This includes, for example, the MCH domestic abuse nurse specialist who offers expert support and advice, which is valued by staff, and the training to undertake DASH assessments that Turning Point adult substance misuse practitioners, adult mental health practitioners and health visitors have received. This is informing both initial advice to victims and timely referrals to MARAC.

- Midwives at MFT are equipped with the knowledge and tools to identify and support women who are victims of domestic abuse. Their work is supported by the multi-agency monthly midwifery safeguarding hub meeting. This is an effective forum for discussion about how best to support and protect both pregnant women and unborn babies. Well-established joint clinics between Turning Point and midwives at MHFT provide an effective forum to enhance information sharing and coordination of actions to safeguard pregnant women and their unborn babies.

- NHS Medway Clinical Commissioning Group (MCCG) leaders, and those from public health, have effectively embedded a focus on safeguarding children within wider commissioning and governance arrangements. New contracts and assurance processes provide tighter scrutiny of levels of identification and

workforce training in relation to domestic abuse. The risk of serious and long-term harm to the health and development of children and adult victims is clearly recognised within new approaches to tackling health inequalities associated with domestic abuse.

- The prioritisation of vulnerability and significant increase in dedicated staffing by Kent police has not only brought with it a significant increase in capacity, but also reflects a positive shift of culture. Police leaders are seeking to innovate and work to promote the development of child-centred policing practice across all areas of the force. The development of dedicated vulnerability investigation teams and investment in training frontline officers in safeguarding responsibilities demonstrate senior leaders' commitment to developing more nuanced and sophisticated safeguarding approaches. Although practice remains inconsistent, frontline officers have an improving knowledge of how adverse childhood experiences affect the long-term health and well-being of children. Risk assessments carried out by officers in situations involving children are appropriate in most children's cases.

- Several agencies, including the CRC in its work with adult women offenders, the YOT and Medway young persons' well-being service, are developing the use of trauma-informed practice. This is a positive development that has the capacity to enhance services to child and adult victims in Medway.

- The CRC demonstrates a real commitment to changing the behaviour of perpetrators and tackling domestic abuse. It delivers large numbers of domestic abuse programmes to convicted adult offenders. In addition to this, the organisation is using its own resources and expertise to deliver a time-limited pilot programme for un-convicted perpetrators, an area of known under-capacity in Medway.

- The YOT provides a consistently strong service to children with safeguarding concerns and those who are living with domestic abuse. This is supported by a stable and experienced workforce with good access to appropriate training. The re-establishment of a police officer post within the team has also been a positive development. The introduction of a new and more child-centred planning process is an example of such good practice. Plans are developed jointly with children and are themed in line with their interests or hobbies. Plans include questions about what young people want to achieve and how they will show that they have addressed problematic areas relating to their lifestyle and offending which were raised at the initial referral order panel. This encourages them to take ownership

of their sentence plan. The plan is held in a portfolio of achievement that is regularly updated with them. This approach is young-people friendly and strengths-based but can also manage risk and vulnerability well. It uses the 'external controls' component of the national assessment tool appropriately. Inspectors saw how it was used well to engage some harder-to-reach children and young people.

- Police within the CRU currently manage the logistical demands of a high-volume workload well, and there are rarely significant backlogs in reviewing children's cases to share with the SPA and MASH. The CRU has sufficient supervisor capacity to respond in a timely manner to all requests by the local authority for child protection strategy discussions.

- Kent police's new domestic abuse pod provides 24 hour-a-day skills and expertise to advise officers on domestic abuse, risk assessment and safeguarding. The domestic abuse pod has a clear child focus and prompts officers to consider cumulative risk. However, this valuable resource does not currently benefit from the expertise of professionals from other agencies and is underutilised by the force. The CRU recognises the potential to expand the criteria to access this support, including for officers no longer at the scene of the incident, but such developments are not yet implemented.

Case study: highly effective practice

Henry is a two-year-old boy who has been living with domestic abuse. Good multi-agency working has made a real difference for him. There has been a significant reduction in risk and his day-to-day life is now calmer and more stable. The professionals from a range of agencies who are involved with Henry and his family are working well with him, his family and each other. The work, particularly that of the school, has also been important in improving things for his older sisters. His mother is attending the freedom programme and his father attends a perpetrators' awareness course with the CRC. This is helping them both to understand their own and each other's behaviour. It is helping to protect Henry, his sisters and his mother. It is also helping his father to change his thinking and behaviour and so is reducing the risk of him being responsible for further domestic abuse. The professionals involved, and the parents, are clear about what needs to change and why. This understanding about what needs to be different and the plan to make it happen are based on a thorough assessment of the circumstances of the child and his family and the clear identification of risk. The professionals involved have got to know Henry and his family well and this understanding underpins their work. There are regular meetings of the family and the professionals, during which the progression of the plan is monitored and discussed. As a result, things are now much better for Henry, his sisters and his parents.

Both parents speak highly of Henry's social worker. They say that the reasons she has been 'fantastic' are that she is organised, visits regularly, has built a relationship of trust with them and has 'got lots done' in the relatively short time she has been involved. This relationship-building by the social worker has been key to engaging the parents and affecting change. The parents describe a positive impact on the children and themselves, with the children more content and safer from risk of harm and parents better equipped with parenting and relationship skills. This view is echoed by Henry's uncle, who said that before the involvement of the professionals and the child protection plan, it had been like 'children parenting children' but that now the parents have 'done a lot of growing up'.

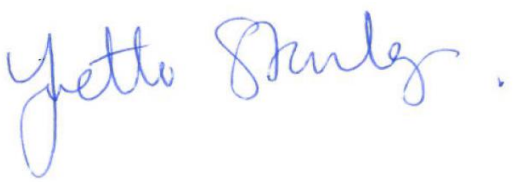
Next steps

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 NPS, CRC, YOT, CCG, health partners and Kent police.

The response should set out the actions for the partnership and, where appropriate, individual agencies.[2]

The director of children's services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 12 November 18. 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

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.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