Hounslow Safeguarding Children Partnership Meeting
Monday 25th January 2021
3.00pm – 5.00pm
Virtually, via MS Teams

Attendees		
Name	**Agency**	**Designation**
Hannah Miller	Hounslow Safeguarding Children's Partnership	Independent Advisor
Jo Leader	Hounslow Safeguarding Children's Partnership	Business Manager
Janet Johnson	Hounslow Safeguarding Children's Partnership	Training & Development Manager
Councillor Tom Bruce	Education and Children's Services	Councillor
Steven Forbes	Hounslow Safeguarding Children's Partnership	Executive Director of Children's & Adults' Services
Martin Forshaw	London Borough of Hounslow	Interim Assistant Director – Children's Safeguarding & Specialist Services
Elizna Visser	London Borough of Hounslow	Interim Head of Safeguarding & Quality Assurance
Amanda Lowes	London Borough of Hounslow	Assistant Director: Homelessness, Independence and Preventative Services
Vicki Taylor	London Borough of Hounslow	Interim Assistant Director Education & Skills
Kerry Jacks	Feltham YOI	Head of Safeguards
Pauline Fletcher	North West London CCG	Associate Director for Safeguarding Children
Sarah Green	Chelsea & Westminster Hospital	Consultant Midwife for Public Health and Safeguarding
Tony Bowen	HRCH	Named Nurse Safeguarding Children
Emelia Bulley	CCG	Designated Nurse Safeguarding Children
Dr Nirmala Sellathurai	CCG	Designated Doctor Safeguarding Children
Ian Berryman	Woodbridge Park Education Service	Principle (Nominated Special Schools Rep)
Sapna Dhall	ARC	Senior Practitioner
Parminder Sahota	West London NHS Trust	Director of Safeguarding Children and Adults
Sharon Brookes	Police	Detective Superintendent

Michael Michaelides	West Thames College	Executive Director Resources & Student Experience
Phil Hopkins	London Borough of Hounslow	Head of Adolescent Services
Guests Attendees		
Nicki Pettitt	-	Independent Reviewer
Jordan Clover	NWL CDR	CDR Team Manager
Apologies		
Steve Calder	London CRC	Partnerships & Contracts Manager
Graeme Baker	West Thames College	Head of Quality & Standards
Thomas Webster	West London NHS Trust	Named Nurse Safeguarding Children and Young People
Clare McKenzie	London Borough of Hounslow	Children's Commissioning Manager, Public Health
Sarah Shingler	HRCH	Director of Nursing
Annita Cornish	London Borough of Hounslow	Interim Assistant Director Special Educational Needs and Disability
Ruben Seetharamdoo	ARC	Service Manager
Not Attended		
Kevin Prunty	Cranford Community College	Executive Headteacher (Nominated Secondary School Rep)
Karen McLean	Homestart	Voluntary Sector Representative
Kamm Grewal	Springwell School	Headteacher (Nominated Primary School Rep)
Josephine Daly	Oak Heights School	Independent School Rep
Clea Barry	CAFCASS	Service Manager
Lizzette Ambrose	HM Prison & Probation Service	Head of Service Delivery – Hounslow, Kingston and Richmond

1) Introductions & Apologies

Partnership members introduced themselves to the meeting. Apologies of members unable to attend were noted.

2) Minutes of the last meeting & matters arising

The minutes of the last meeting were agreed and no matters arising were discussed. The action log was updated.

3) Child Sexual Abuse Audit (CSA) Findings Presentation

Nikki Pettitt gave a presentation summarising the full report which was circulated to members prior to the meeting and welcomed comments and questions.

Following the Children's Commissioners report in 2019, Ofsted undertook a series of Joint Targeted Area Inspections (JTAI) with the focus on Intrafamilial Sexual Abuse and the overview report was published in February 2020 outlining how effectively professionals and organisations worked together in cases of sexual abuse from a national perspective.

The partnership undertook a CSA audit in October 2020 to baseline Hounslow's position in identifying and responding to children who have experienced or may be at risk of sexual abuse within their family. Ten children from different families were considered, aged between 6 to 17 years old and who were from different ethnic backgrounds. All of the children were currently or had

previously been subject a Child Protection (CP) Plan, Child in Need (CIN) Plan and some were now Looked After Children (LAC). The audit benchmarked local practice against the findings of the JTAI and the Children's Commissioners Report.

For context, at the time of the audit there were 231 children on a CP Plan in Hounslow with only 5 children on a CP Plan under the category of sexual abuse. There was an acknowledgement that the number of children on CP Plan and section 47 enquires in relation to sexual abuse was low. The audit found that there were only three cases which required improvement in safeguarding. The audit recognised strengths and areas of improvements. It was a reflective process, exploring practice and the effectiveness of systems when children are at risk of or are being sexually abused.

Partner agencies completed good quality audits using the Ofsted grading of Outstanding, Good, Requires Improvement, or Inadequate. The panels were well attended by multi-agency practitioners who were directly involved in the case including Police. The panels generated dynamic discussion and valuable learning was generated in real-time which members found useful and were committed to sharing it within their organisations. Professionals gave positive feedback that the learning identified was to improve practice and it was not viewed as a judgemental process.

The audit identified the following learning points:

1. Working with children who have or may have been sexually abused is complex work that has an emotional impact on the professionals involved.

2. Professionals need to be able to 'think the unthinkable'.

3. Working with child sex abuse is complex, as children are unlikely to make an outright disclosure of what has happened.

4. Professionals need to be curious about a child's behaviour and identify other indicators that they may be a victim of sexual abuse.

5. Even when a child has made a disclosure it is not always easy for the perpetrator to be successfully prosecuted.

6. Professionals should be clear about the decision made and why no further action is being taken. They should challenge the police/CPS if required.

7. A system which waits for children to tell someone they are being sexually abused cannot be effective. Behaviours, family history and professional observations should be considered within the context that sexual abuse may be happening.

8. The opportunity to build a relationship with a child when a professional has concerns or a 'gut feeling' about sexual abuse is important.

9. The importance of information sharing of the history and current concerns.

10. Therapeutic support can be provided without delay.

11. Professionals must be proactive in seeking the child's views.

12. Professionals should refer to and use the on-line procedures and seek immediate advice from the MASH when they are confronted with a concern about sexual abuse.

13. Specialist advice should be available and sought when working with CSA cases, particularly regarding the perpetrator.

14. Perpetrators of sexual abuse are known to groom children, family members and professionals.

15. When the issue is a child sexually abusing another child in the family, both the alleged child perpetrator and victim need to be considered as children in their own right.

16. Perpetrators can target vulnerable children because they may believe they are less likely to disclose the abuse or be believed if they do.

17. CSA happens in all communities.

18. Strategy meetings need to include all of the professionals involved in the investigation and reviews need to be held until the investigation is complete.

19. The need to consult with GPs particularly prior to or during strategy meetings.

20. COVID-19 had and continues to have an impact on this area of safeguarding.

Nicki Pettitt recommended that the partnership as a collective and individual organisational leader should ensure that all practitioners were supported adequately to be more confident and skilled in responding CSA. The audit findings were reflective of the national picture, but Hounslow had the skill and resources to respond well and achieve good outcomes and it was positive that professionals had the right attitude towards addressing the risk.

The below recommendations were identified to respond to the findings:

Recommendation 1:
The HSCP ensures there is a focus for the whole system which ensures the development of staff to enable them to work with cases where sexual abuse is an issue. The work is complex and different to other child protection work, so professionals require access to training including around perpetrators within the family environment, supervision and support including consideration of the impact of the work and details of those with particular knowledge and expertise that can be consulted with as required.

Recommendation 2:
The HSCP needs assurance that family history is being considered and shared appropriately in cases where there is risk of sexual abuse and that professionals across agencies are requesting and holding meetings to consider complex cases. This will support new and shared decision making to recognize risk and make appropriate plans to deliver support.

Recommendation 3:
The HSCP needs to seek assurance that there are improvements being made in reconvening strategy meetings to consider the results of all child protection investigations, including medicals, ABE interviews, significant updates in a criminal investigation and so on. They should be attended by all the professionals involved and chaired by a professional with suitable experience and objectivity.

Recommendation 4:
A further audit is undertaken in approximately 24 months, in order to consider progress in this area.

Dr Nimmi Sellathurai commented that it was good audit and reiterated that pediatricians should be involved in the initial strategy meetings which could have a better outcome for the child. All CSA examinations were currently being undertaken at the Haven because Hounslow did not have a local service. The expectation was that examinations would be undertaken at the North West London Safeguarding CSA Hub. Nicki Pettitt agreed that having the expertise at initial strategy meetings would be vital.

Parminder Sahota asked about the voice of the child in the recommendations and how to ensure their voice is heard.

Nicki Pettitt responded that the voice of the child was captured in the single agency audits and discussions were held regarding how difficult it was for children to make a disclosure. The audit identified learning but not a recommendation as this was already a recommendation from a previous review undertaken by the partnership.

Pauline Fletcher recommended that the actions undertaken for the cases that required improvement or had been inadequate should be included in the report. The Chair and all members agreed that assurance should be sought from all agencies who worked with the families were the grades applied had either been inadequate at a point in the safeguarding process or were it had remained as requires improvement or dropped in a grade.

Action: Jo Leader to request assurance from all agencies where the cases audited had either been inadequate at a point in the safeguarding process or were it had remained as requires improvement or dropped in a grade.

Cllr Tom Bruce said that he assures his colleagues and the wider community that children are safe in Hounslow through the work of the partnership including audits and commented that the CSA audit was positive. A few years ago, steps were undertaken by the government to robustly respond to and raise awareness about Child Criminal Exploitation (CCE) and questioned whether a similar approach could be undertaken by the partnership to effectively respond to CSA both from a professional and a wider community perspective. Nicki Pettitt said that the community plays a key role in identifying children at risk and agreed that it was everybody's business. The Chair recommended that this was considered further in the Safeguarding Effectiveness Sub-Group as part of the development of the strategy.

Action: For the Safeguarding Effectiveness Sub-Group to consider raising awareness regarding CSA to practitioners and the wider community as part of the strategy.

Janet Johnson said that it was important that professionals responded proactively to CSA. Historically the Hounslow Safeguarding Children Board (HSCB) had undertaken preventative work in awareness raising, such as the PANTS campaign which was ongoing across primary schools and includes the engagement with parents. Professionals have said that if they anticipate a concern about CSA does not meet the Children Social Care (CSC) threshold, they will not make a referral and would not know what to do. Professionals were not confident in speaking to children about CSA and the training that was being developed by the partnership would support them in having conversations with children in those circumstances.

Ian Berryman said that the conversation between CSC, schools and partner agencies was positive and professionals being able to talk about emerging issues, themes and referrals was a positive step that should be reinforced, strengthened and maintained. This would encourage professionals in schools to have discussion about the vague areas and seek professional support and advice.

The Chair commented that although there was still a lot of work to be done, the audit was reassuring, and partner agencies were proactive. The Chair thanked Nicki Pettitt for her presentation and agency leads for their contribution and allowing professionals to attend the panels.

Members acknowledged that this was a good quality multi-agency audit and accepted the report, findings and recommendations.

4) CDOP Annual Report 2019/20

Jordan Clover, Child Death Review Team Manager, summarised the report which was circulated to members prior to the meeting and welcomed comments and questions.

The North West London Child Death Review (CDR) Statutory Service took over the responsibility of Child Death Reviews in April 2020. In 2018-2019, there were twenty-one notified child deaths in Hounslow and an additional eight in 2019-2020. There was an increase in neonatal deaths and there were five unexpected deaths out the twenty-eight notified. The age range was high with neonates with a low number of deaths above the age of one year. There was a consistent number of deaths in April to August and a slight peak in September and March. The majority of the deaths happened in the labour ward with very few deaths at home. Only 4% of the Hounslow cases had modifiable factors which was extremely low against the national average of 32%. Hounslow CDOP was very efficient in closing cases and on average they were closed in 179 days compared with the national average of 274 days.

There was one case in Hounslow that highlighted good practice in the form of a comprehensive child death review template used at the meeting. One case highlighted concern regarding a delay in Adults Services notifying the death of a young person in their care and one case was felt to have modifiable factors that could have prevented the death of the child which was highlighted in the perinatal mortality review.

Sarah Green asked whether there had been an increase in modifiable factors because of Covid-19. Jordan Clover responded that there had been a reduction in number of deaths but there had been more Joint Agency Reviews (JARS) so potentially there was an increase in the severity of cases with modifiable factors. A scoping exercise was being undertaken to explore the impact of Covid-19 on child deaths, and the more severe cases had been seen. A key point already identified as a contributory factor was a delay in accessing treatment. Parents were anxious about the virus and seeking treatment earlier would potentially have a different outcome.

The next annual report would be focused on North West London CDOP as a collective and would include wider themes and trends for child deaths. The CDR team was committed to working with partners locally to improve the understanding of local trends and respond to wider themes.

Sarah Green informed that there was a decrease in women presenting for antenatal care which was of concern and suggested more joined up work with the team to explore further. Jordan Clover said that the team had identified the theme of the use of interpreters and language barriers. This would be included in their newsletter on the importance of using interpreters where English is not someone's first language to ensure that they understand the risks during pregnancy if treatment is delayed.

Pauline Fletcher said that anecdotally, Covid-19 appeared to have had a significant impact on an increase of injuries sustained by children across North West London and NHS England.

The Chair thanked Jordan Clover for his report and members accepted the report.

5) HSCP Escalation Policy

Jo Leader presented the updated escalation policy, which was circulated prior to the meeting and welcomed comments and feedback.

The escalation policy was briefly updated as part of the development of partnership arrangements in 2019 and had been due a full review in 2021. JL explained that the policy had been revised to be more specific, much clearer and in line with best practice models used by other partnerships and recommended by the London Safeguarding Children Partnership. A step which included a conflict resolution panel of senior partnership members had been included which was a method that had been tried last year and had worked effectively.

Jo Leader informed that once members had agreed escalation policy, a flowchart would be created as a quick guide for practitioners and both would be published on the HSCP website.

The Chair asked members whether they wanted to agree the policy at the meeting or whether they required more time to review the policy and provide comments and feedback to JL. Emelia Bulley said that she had feedback and comments which she would provide to JL after the meeting.

The meeting agreed that comments and feedback should be sent to Jo Leader within two weeks so that the policy could be agreed and published.

6) Police Protection Audit Findings

Elizna Visser gave a verbal update on the findings of the Police Protection audit.

Following the last Ofsted Children Social Care (CSC) Focus Visit and a conversation with the previous, Detective Superintendent, the Police and CSC undertook a joint audit to specifically explore the use of Police Protection in practice. The audit did not identify any new areas of concern that Police and CSC were not aware of and there were three areas of learning that needed further embedding:

1. Contingency planning to support decision making before Police Protection was initiated.
2. To share the Section 20 legislation and guidance with Police, to support their knowledge in that area.
3. The use of strategy meetings was not consistent

Recommendations:

- To put together a pack with contingency plan for Police specifically for Adolescents.

CSC have made changes to the strategy meeting multi-agency guidance to include expectations around Police Protection.

Progress against the actions will be monitored through the Safeguarding Effectiveness (SE) Sub-Group and all partner agencies, particularly CSC would be requested to submit quarterly assurance reports to the SE Sub-Group for oversight. There had been good improvements made with strategy meetings which needed to be sustained.

The full report was being updated to provide assurance on the activity which had taken place in parallel to and since the audit took place, for example the cases that were looked at predated the work undertaken with strategy meetings. The report would be shared with the Chair of the partnership for oversight and assurance.

7) CCG Annual Report 2019/20

Emelia Bulley summarised the report which was circulated to members prior to the meeting and welcomed comments and questions.

The safeguarding annual report was produced in collaboration with all eight CCGs serving the boroughs of Brent, Ealing, Harrow, Hammersmith and Fulham, Hillingdon, Hounslow and Kensington and Chelsea & Westminster. This report provides assurance that they are fulfilling their statutory safeguarding duties in relation to safeguarding the population they serve.

The Executive lead for NWL CCGs is the Chief Accountable Officer which is delegated to the Chief Nurse and Director of Quality. In 2019, two Associate Directors were appointed for safeguarding Children and Adults to strengthen the safeguarding leadership and have oversight across the eight CCGs. The roles of Designated Professionals such as Designated Nurses and Doctors and Named GP for safeguarding was to deliver the functions set out in the NHS Safeguarding Accountability and Assurance Framework. The Designated leads have been working with the partnership to provide safeguarding input and oversee the health element of all safeguarding statutory and non-statutory reviews and support GP practices with their safeguarding systems, processes and level three training requirements. The CCG was working towards a 'Think Family' approach.

The CCG have the responsibility of gaining assurance that the services they commission have appropriate arrangements in place to safeguard adults and children. The mechanisms available include the Safeguarding Health Outcomes Framework (SHOF).

Between January and March 2020, Designated Professional and Children Looked After (CLA) Provider Teams held Task and Finish Group meetings to agree standard CLA KPI's to monitor across all CCG's across NWL in line with Statutory Guidance and local need.

The Liberty Protection Safeguard (LPS) will replace the Deprivation of Liberty Safeguards (DoLS) but this had been delayed until April 2022 because of Covid-19. The Designated professionals would continue to work with the health economy and Local Authority to ensure systems and processes were in place to deliver the new Liberty Protection Safeguards (LPS).

In February 2020, the CCG held a safeguarding conference with over 200 participants and the topics were County Lines and self-harming/suicide prevention.

The Hounslow CCG have undertaken work alongside the partnership to implement the changes in the Sir Alan Wood Review.

In terms of Covid-19, NHS England gave an indication that practitioners in non-patient facing roles were asked to support clinical practice in the NHS and as a result staff were redeployed to support frontline work.

The report highlighted achievements in local areas including Hounslow;

- In September 2019 an evaluation of the health arrangements in Feltham Young Offending Institute was undertaken by Hounslow CCG. An action plan was developed and was progressing.

- In May 2019, the Designated Nurse for Hounslow supported Chelsea and Westminster Foundation NHS Trust (ChelWest) to undertake a safeguarding children deep dive audit. This

was to provide additional assurance to the CCG that ChelWest was delivering and meeting their safeguarding responsibilities.

- The Hounslow CCG have untaken work with the FYOI Sub-Group.

Members accepted the CCG Safeguarding Annual Report.

8) Sutton LSCP Management of Young People who Self-Harm or have Suicidal Ideation Protocol

The Chair summarised the protocol which was circulated to members prior to the meeting and welcomed comments and questions.

Sutton Safeguarding Children Partnership have developed a self-harm protocol with the addition of young people who have suicidal ideation to ensure that both local and national learning from Serious Case Reviews (SCRs), Local Child Safeguarding Practice Reviews (LCSPRs), learning reviews and audits were embedded across their partnership. The Chair asked members if it would be helpful to develop a similar protocol in Hounslow. Jo Leader commented that this was being explored through the Adolescent Safeguarding Strategy and a conversation would be held with the Joint Commissioning Manager, Ellie Tobin to understand Hounslow's position in relation to suicide.

Sarah Green suggested that it would be useful to request data from the Emergency Department at West Middlesex University Hospital (WMUH) regarding the number of young people who present with self-harm or suicidal ideation which could inform some of the work in Hounslow.

Kerry Jacks said that young people in FYOI do commit self-harm but would not always present to hospital and was happy to provide the partnership with data.

Janet Johnson informed that the partnership had done a lot of training on self-harm and suicidal ideation and there was a lack of clarity and anxiety amongst professionals regarding support available including referrals to CAMHS and therefore strongly recommended a protocol for Hounslow.

The Chair asked that members reviewed the document and a further conversation would be held with Public Health regarding the protocol and would come back to the meeting for further discussions.

Part B Agenda – Confidential

9) Notification of Hounslow's Involvement in Case Reviews in Other Areas

Standing Agenda Items

10) Covid-19 Update – All

The Chair requested an update on Covid-19 from each agency.

Children's Social Care

Martin Forshaw gave a verbal update on Covid-19.

In January 2021, Children Social Care (CSC) saw a small spike in infections amongst professionals with a few positive tests and professionals isolating. Staff had started to return to work and CSC

continued to maintain a 'business as usual' response to safeguarding children and young people in Hounslow.

Police

DS Sharon Brooks gave a verbal update on Covid-19.

Police have seen a number of positive cases throughout the Metropolitan Police force with a number of Officers self-isolating, however this had not had a detrimental impact on service delivery. Police continued to maintain 'business as usual' which was positive.

FYOI

Kerry Jacks gave a verbal update on Covid-19.

The establishment had 165 staff self-isolating due to Covid-19, which had impacted the regime for young people. Education was still being delivered to young people. Staff had started to return to work and the establishment continued to manage well which was positive.

Early Intervention, Education Special Needs and Children with Disabilities

Steven Forbes gave a verbal update on Covid-19 in absence of Vicki Taylor.

On the 21st January 2021, Hounslow Schools had 39,640 on roll and 3,078 pupils were attending school.

The breakdown of the cohort was:

- Pupils on an Education Health and Care Plan (EHCP) – 489
- Pupils with an allocated Social Worker - 206
- Pupils receiving Free School Meals (FSMs) - 729
- Pupils of critical workers - 1876

The approximate split of the cohort across settings were 68% Primary, 23% Secondary and 9% Special School/AP Provision.

Safeguarding Vulnerable Pupils:

- Schools were keeping in touch with vulnerable pupils who were not attending and were updating the designated Social Worker of any concerns.
- Education Welfare Service were keeping in touch with families and sharing information and concerns with CSC.
- Elective Home Education (EHE) had increased to 391 which was a 95.5% increase since August 2020 and was split 60% across Primary school and 40% across Secondary school. The department has increased capacity within EHE to ensure contact was made.
- For young people accessing Virtual College, Social Workers were following the risk assessment protocol for all those not attending. The team gathered weekly data of pupils who were not attending school and the list was forwarded to social care team managers weekly.

Cllr Tom Bruce reported that Hounslow bought 750 laptops and 150 dongles for pupils in Hounslow who could not access face-to-face education due to Covid-19.

HRCH

Tony Bowen gave a verbal update on Covid-19.

HRCH continued to maintain a 'business as usual' response to safeguarding children and young people. The organisation has a redeployment hub that meets three times a week to review the needs of the service across the organisation. Very few staff had been redeployed. Community staff nurses have been redeployed from the school nurse and health visiting service into community nursing to support. This was being monitored and Tony Bowen who would provide an update to the partnership if there were any changes.

West London NHS Trust

Parminder Sahota gave a verbal update on Covid-19.

The Trust continued to deliver 'business as usual'. There were three members of staff in Children's and Adults that were supporting the vaccination hub however safeguarding remained their priority. The priority of the Trust was to support service users, and members of staff were moved around to achieve this. Partner agencies continued to work together to safeguard children which was positive.

CCG

Emelia Bulley gave a verbal update on Covid-19.

Due to the pandemic, staff had been redeployed to frontline roles to support the vaccination programme. There had been no indication on the redeployment of Designated professionals.

Dr Nimmi Sellathurai informed that the number of Child Protection medicals completed had been low in the last few weeks.

Chelwest

Sarah Green gave a verbal update on Covid-19.

The Safeguarding team continued to maintain 'business as usual' and were working closely to support each other during the pandemic.

The Covid-19 Serious Case Panel had been published and the focus was the death of children under 1 year old were significant and the concerns around face-to-face or telephone appointments for midwives or health visitors. The report was circulated to staff and staff where encouraged to see patients when possible instead of phone calls which was well received. A few midwives raise a concerned that health visitors were not undertaking face-to-face visits particularly for new births and vulnerable families and clarity was needed around this.

Tony Bowen had not been made aware that face-to-face visits were not being undertaken. The health visiting service was undertaking a blended approach to visits with face-to-face and virtual contact. The Covid-19 risk assessments would be completed before face-to-face visits were undertaken. Tony Bowen would follow up with the service manager to confirm and would inform the partnership and Sarah Green.

Emelia Bulley informed the meeting that the Practice Briefing report was published in December 2020 by the Safeguarding Practice Review Panel and therefore recommended that the CCG and the SE Sub-Group were given the opportunity to have a look at the reports.

11) AOB

Steven Forbes reported that the infection rate in Hounslow has begun to drop. The infections in schools were less than they had been. There was hesitation for the take up of the vaccination across BAME communities and there was preference to the Oxford vaccination as suppose to the Pfizer. The communication team was liaising with Public Health and North West London Sector and the intelligence would be used to sign post people to the right place to minimise hesitancy.

Sarah Green raised concerns regarding the abortion clinic and would email Pauline Fletcher and Emelia Bulley to further explore this and update the partnership.

Safeguarding children within organisations presentations

Following 1:1 Board member conversations with the Chair, which were ongoing, members suggested that it would be useful to include on the Board agenda presentations from each partner agency to understand safeguarding children in their services. The presentation should include individual organisations key statutory roles, safeguarding functions, responsibilities and assurance around their own performance in order to ensure that there was a good understanding and respect for each agency's role. Members agreed it would be helpful.