Community Safety Select Committee

A meeting of Community Safety Select Committee was held on Thursday 25 September 2025.

Present: Cllr Mrs Ann McCoy (Chair), Cllr Katie Weston (Vice-Chair), Cllr Bob Cook, Cllr John Coulson, Cllr Jason French, Cllr Ray Godwin, Cllr Shakeel Hussain, Cllr Barbara Inman, Cllr Alan Watson

Officers: Richard Bradford, Mandy MacKinnon, Marc Stephenson (A,H&W); Aishah Waithe, Gary Woods (CS)

Also in attendance: Cllr Norma Stephenson OBE (SBC Cabinet Member for Access, Communities and Community Safety); Sarah Massiter (Harrogate and District NHS Foundation Trust); Beth Swanson (North Tees and Hartlepool NHS Foundation Trust); Gemma Sharpe (Tees, Esk and Wear Valleys NHS Foundation Trust); Lindsay Britton-Robertson (University Hospitals Tees)

Apologies: None

CSS/19/25 Evacuation Procedure

The evacuation procedure was noted.

CSS/20/25 Declarations of Interest

There were no interests declared.

CSS/21/25 Minutes

Consideration was given to the minutes of the Community Safety Select Committee meeting which was held on 31 July 2025 for approval and signature.

AGREED that the minutes of the Committee meeting held on 31 July 2025 be approved as a correct record and signed by the Chair.

CSS/22/25 Stockton-on-Tees Community Safety Strategy

The Committee received a briefing on the ongoing refresh of the local Community Safety Strategy (the current version was due to expire at the end of 2025).

Community Safety Partnerships (known locally as the Safer Stockton Partnership (SSP)) had statutory obligations under the Crime and Disorder Act 1998 to prepare a strategy to reduce crime and disorder, reduce reoffending, and reduce the harm caused by drugs and alcohol. A clear process was set out in the Act in terms of developing a strategy, the main requirement being a significant strategic assessment of data and information in relation to crime and disorder locally (this set the framework of the priorities for the Borough, though many of these were mandated nationally).

A draft '*Community Safety Plan: Stockton-on-Tees 2025-2027*' was provided in advance for the Committee's consideration. Introduced by the Stockton-on-Tees Borough Council (SBC) Assistant Director – Regulated Services and Transformation, and supported by the SBC Cabinet Member for Access, Communities and Community Safety and the SBC Civic Enforcement Manager, content included:

- Introduction (SBC Cabinet Member for Access, Communities and Community Safety)
- About Stockton Borough
- What do we know about crime in Stockton-on-Tees?
- Keeping Stockton Safe 2025-2027
- Priorities underpinning the strategic approach for the next three years
    - Managing the impact of serious and organised crime
    - Crime and disorder linked to drugs and alcohol
    - Anti-social behaviour (ASB) and feelings of safety
    - Reducing the offending rates of the most prolific offenders
    - Domestic Abuse
    - Prevent
    - Diverse Communities Feeling Safe
    - Welcoming Town Centres
- Operation Shield: A Unified Approach to Town Centre Safety
- Achieving our Mission

Reminding the Committee that this was a partnership plan as opposed to a SBC one, each of the proposed priorities for the 2025-2027 period were detailed. In terms of consultation to inform the preparation of this document, it was noted that meetings had taken place with young people involved with the Council's Bright Minds Big Futures (BMBF) initiative, as well as Cleveland Police's independent group on diversity. Once approved, an Action Plan relating to the strategy would be completed and available for scrutiny.

In response, the Committee referenced the perception of crime (often raised in discussions around community safety) and asked how this strategy would be communicated to the public. Members were informed that, despite successes in tackling local crime and disorder, perceptions remained an issue, and that a communications drive would be undertaken by all partners to reinforce messaging. It was important to ensure the voice of businesses / traders was heard, something which had already been aided by the *Operation Shield* initiative. Getting back to basics around resident engagement was also vital in understanding concerns and subsequently address these.

Drawing attention to the statement (within the 'What do we know about crime in Stockton-on-Tees?' section) that '*Domestic abuse overall is showing a downward trend; however, incidents involving children present in the household are beginning to rise*', the Committee noted its ongoing review of Children affected by Domestic Abuse, and requested any data and / or accompanying narrative which could contribute to the evidence for this work.

Praising officers for the continuing community safety-related efforts within the Ropner ward (e.g. Clear, Hold, Build; Project Harmony), the Committee raised the frustration often relayed by residents about failing to receive a response when reporting crime or disorder. Discussion then moved onto isolated incidents which were presented (often via social media) in such a fashion that gave the public the impression crime and

disorder was more prevalent in a particular area than it really was. Despite examples of the Borough's traders transmitting positive messaging about life in Stockton-on-Tees, some people appeared to want to use any single aggravation to portray local towns in a negative light.

Committee comments concluded with a request for engagement with the Stockton-on-Tees Domestic Abuse Steering Group (DSAG) as part of the strategy's compilation and associated actions that may follow its approval, as well as the need for future focus on issues around serious youth violence (an emerging nationally recognised concern). Assurance was given that the SBC Cabinet Member for Access, Communities and Community Safety was part of the DSAG (those leading that group were also part of the SSP), and that serious youth violence was a key issue in terms of local community safety considerations.

AGREED that the draft '*Community Safety Plan: Stockton-on-Tees 2025-2027*' be noted.

CSS/23/25 Scrutiny Review of Children affected by Domestic Abuse

The third evidence-gathering session for the Committee's review of Children affected by Domestic Abuse had a health focus and considered information from NHS Trusts covering health visiting, maternity services, and mental health services for young people. Prior to these presentations, Members were reminded of two health-related publications, links to which had been incorporated into the covering report for this item:

- Home Office: Domestic Abuse – Statutory Guidance (July 2022): Agency Response to Domestic Abuse – Health (pages 91-97)
- GOV.UK: Victims in their own right? Babies, children and young people's experiences of domestic abuse: The role of health services (chapter five)

HARROGATE AND DISTRICT NHS FOUNDATION TRUST (HDFT)

As per the review's focus on children in their early years, health visitors had previously been identified as key contributors to the Committee's work. The HDFT Head of Public Health Nursing and Operations (0-19 Services in Darlington, Stockton and Middlesbrough) was in attendance to present the Trust's response to the following lines of enquiry:

- How do health visitors identify at-risk individuals / families?: Commissioned by Stockton-on-Tees Borough Council (SBC) to provide local 0-19 services, and in the privileged position of being one of a small number of organisations providing support across the ante-natal to pre-school period, HDFT practitioners completed and / or reviewed the holistic health needs assessment at each of the Trust's seven contact points with an individual / family (above the five nationally-mandated reviews for early years) – this included, when this was safe to do so (i.e. no child over the age of 2 was present; individual was alone), routine and selective enquiry regarding any possible domestic abuse. If such an enquiry could not be asked at the previous contact, the plan would be to ask at the next available opportunity.

  If there was any historic or current intelligence shared regarding potential risk, the health visitor would arrange for a contact to take place outside the family home

through discussion and supervision with their line manager and safeguarding colleagues.

0-19 practitioners were made aware of high-risk vulnerable child and adult domestic abuse notifications through the local Children's Hub (CHUB) (indeed, HDFT sat within the CHUB, and liaised closely with SBC Early Help, leading / being involved in multi-agency work), and there were high priority reminders to the child's SystmOne record. HDFT were also notified of domestic abuse incidents through PiTstop (a police initiative).

- How confident do they feel about spotting signs of domestic abuse?: All 0-19 practitioners were trained (Level 3 Safeguarding Children) to be able to recognise signs and indicators of domestic abuse. Even if no disclosures were made, HDFT staff had a safeguarding single point of contact where supervision and advice could be sought in respect of concerns. As previously referenced, the requirement for the completion / review of the holistic health needs assessment also provided opportunities for the identification of domestic abuse-related issues.

- Are health visitors aware of how to report domestic abuse?: Staff were able to contact the HDFT safeguarding single point of contact where supervision and advice could be sought regarding next steps / potential referrals. The Trust had good links with Harbour for advice and support, and also had the DASH (Domestic Abuse, Stalking and Honour-Based Violence) risk assessment tool that staff could be supported with to inform onward referrals.

- How does the Trust promote reporting routes?: Reporting routes were shared via training and during 1:1 safeguarding supervision sessions.

- Who / what is the responsible person / role within your organisation regarding written safeguarding policies / training / submitting referrals?: The HDFT Head of Safeguarding was responsible for the Trust's domestic abuse policy (which was current, accessible and user-friendly). Delivery of training at HDFT was the responsibility of the Specialist Nurses and Named Nurses (in accordance with the Intercollegiate Document), and 0-19 staff could also attend external training delivered by partner agencies. Any staff member within the 0-19 service could make a referral if they suspected domestic abuse.

- Data on the number of domestic abuse-related referrals made by health visitors in the last three years: HDFT did not capture individual data like this. The Trust would be able to see the volume of referrals made by the 0-19 service, but not for specific reasons.

- How are staff supported in relation to domestic abuse (e.g. training course options and any available date on the uptake of these)?: Domestic abuse was threaded through all HDFT level 3 safeguarding training in addition to the stand-alone domestic violence training. The Trust also had its safeguarding single point of contact for any staff member to discuss imminent safeguarding concerns. Furthermore, HDFT facilitated 4x4 supervision which took place on a quarterly basis, though staff were also able to access face-to-face supervision with a Specialist Nurse (Child Protection) if they had concerns about a family.

- Working with SBC and its partners with regards domestic abuse – how does this operate; is this effective; is there anything that could strengthen current

arrangements?: Trust staff reported positive experiences of working with partners, and a HDFT Named Nurse sat on the local safeguarding partnership, with the Trust accessing training provided through this function (the benefits of multi-agency training, offering the ability to reflect with other agencies, were noted). In terms of strengthening arrangements, PiTstop being a part of the new 'front door' was highlighted, as was consideration towards receiving *Operation Encompass* notifications (though these would be for information to inform cumulative risk only, so would need to unpick impact of this).

- Any views on key areas of future focus relating to this scrutiny topic (e.g. existing challenges that need to be addressed)?: As above.

Thanking HDFT for its submission, the Committee referenced the response to the request for data on the number of domestic abuse-related referrals made by health visitors in the last three years, and asked how the Trust satisfied itself that it was carrying out its part in identifying, and then making referrals for, those who were experiencing domestic abuse. The HDFT officer reiterated that only overall numbers of referrals were recorded, not the reasons why – however, qualitative (deep dive) work was undertaken around specific cases which could identify issues. Members were reminded that the initial presentation by SBC officers at the Committee meeting in July 2025 stated that health visitors had made 22 domestic-abuse referrals to the CHUB during the 2024-2025 period – a request followed for any further available data on referrals made by health visitors to the Stockton-on-Tees CHUB for the last few years (overall numbers, as well as a breakdown of those which were domestic abuse-related if possible).

The Committee sought clarity on the holistic approach to the health needs assessment conducted by health visitors. With attention drawn to what was a challenging, and often stressful, time after a baby was born, Members were informed that this process assisted in identifying vulnerability and need by looking for physical and emotional signs, adverse childhood experiences, and the individual's own understanding of caregiving (potentially shaped by how they themselves were brought up). To assist with this, health visitors benefitted from good links with maternity professionals.

Acknowledging the demands on the workforce, the Committee questioned whether HDFT experienced any significant absenteeism by health visitors due to the cases they were involved with. It was stated that the Trust recognised the importance of staff wellbeing and that employees were well supported. Whilst the health visitor role was a stressful one, there was not a high absence / sickness rate.

Returning to the theme of referrals, the Committee asked if there were ever instances where concerns were raised by health visitors but then not backed up via subsequent investigation. Assurance was given that HDFT tried to ensure referral information was comprehensive, and that if a reported case gave no further cause for concern, this would be challenged (demonstrating why risk might still be present). In related matters, Members highlighted the issues that could be caused once a family became aware of a referral being made about it / an associated individual, and also cautioned that a child's view on presenting situations may not necessarily give a true reflection of life within the home, particularly if affected by any underlying health condition they may be experiencing. The value and importance of establishing and maintaining positive relationships between health visitors and families was thus emphasised.

NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST (NTHFT)

Maternity provision was another area the Committee wished to explore in relation to this scrutiny topic. The Group (University Hospitals Tees) Associate Director of Safeguarding and the NTHFT Director of Nursing were in attendance and gave a summary of the submitted response to the following lines of enquiry:

- How do maternity staff identify at-risk individuals / families? How confident do they feel about spotting signs of domestic abuse?: All midwives undertook routine enquiry into domestic abuse and asked patients if they were currently experiencing domestic abuse. This was evidence-based to encourage people to disclose in a safe space. There was a Trust Safeguarding Team (including safeguarding midwives) and an Independent Domestic Violence Advocate (IDVA) available to support staff, patients, and their families. The safeguarding midwives provided regular supervision to hospital and community maternity staff.

- Are maternity staff aware of how to report domestic abuse? How does the Trust promote reporting routes?: The Trust Safeguarding Team was well recognised across the organisation and staff were made aware of how to contact from the point of induction, through every training level, and through the Trust intranet and bulletins. As well as this, there were posters on how to contact both the team and the IDVA within wards and departments.

- Who / what is the responsible person / role within your organisation regarding written safeguarding policies / training / submitting referrals?: Whilst the executive leadership sat with the Group Chief Nursing Officer, the Group Associate Director of Safeguarding had overall responsibility for safeguarding policy and practice, and for ensuring standards and availability of training delivery. The Trust promoted a 'safeguarding is everyone's business' principle, and it was expected that each staff member was responsible for ensuring their own mandatory training completion (monitored through appraisal). Collective compliance data was provided to each senior manager within clinical areas.

- Data on the number of domestic abuse-related referrals made by maternity services: A comparison between referral data before and after the IDVA post was installed demonstrated the increase in victims receiving support.

- How are staff supported in relation to domestic abuse (e.g. training course options and any available date on the uptake of these)?: Staff were trained in accordance with the Intercollegiate Documents (which included how to make an adult / child referral), as well as on how to complete a DASH assessment. Guidance on MARAC (Multi-Agency Risk Assessment Conference – a meeting where information was shared on domestic abuse cases deemed to be high-risk) was available within policy for both sites (the IDVA was available to support with these), and external training offered by partners was also offered and shared via Trust bulletins and internal systems.

- Views on the Hospital Independent Domestic Violence Advocate (IDVA) (e.g. visibility, working with Trust staff, effectiveness): Through client outcomes and data collected, Harbour had gathered evidence that the IDVA service was creating opportunities for survivors to safely disclose abuse and access tailored support. Case studies highlighted both the direct engagement between clients and the Hospital IDVAs, and the proactive steps taken to ensure survivors received timely

and effective interventions. Without this role, many clients may not have accessed specialist domestic abuse support.

There had been a marked increase in referrals from the hospital to the IDVA / Harbour service. Having the IDVA based on site had enhanced communication, encouraged patient engagement, and allowed for immediate safeguarding, signposting, and referrals. This also showed that hospital staff were becoming more confident and consistent in recognising victims of domestic abuse and referring them to the right support at the point of crisis. If a patient did not wish to access ongoing support, each person referred still had the opportunity to engage with the IDVA on site for support and safety planning.

The Hospital IDVA role was vital in supporting clients who attended hospital and may be vulnerable or unaware that they were experiencing domestic abuse. The role not only raised awareness of domestic abuse but also enabled engagement with specialist support services. By working closely with ward staff, the IDVA promoted knowledge and understanding of domestic abuse, and strengthened responses to disclosures.

As the role was trauma-informed, the Hospital IDVA was able to respond quickly and effectively in an environment where staff were often extremely busy and may not have the capacity to provide in-depth support themselves. The IDVA delivered immediate safety advice and guidance to clients at the point of disclosure, ensuring timely intervention that may not otherwise be available. The presence of an IDVA within the hospital also increased access to support for clients who were harder to reach, thereby reducing risk and encouraging engagement with services (e.g. elderly clients, who were often less likely to access external support, were more effectively engaged through the IDVAs consistent presence on wards and their ability to build trust through repeated contact).

- Working with SBC and its partners with regards domestic abuse – how does this operate; is this effective; is there anything that could strengthen current arrangements?: There was strength in working across both safeguarding partnerships together with community safety in order to tackle some of the challenges related to domestic abuse as it straddled all three and affected all ages. As a provider, it was a challenge working across multiple Local Authorities, especially for children as the Teeswide Safeguarding Adults Board (TSAB) worked well to encompass all.

- Any views on key areas of future focus relating to this scrutiny topic (e.g. existing challenges that need to be addressed)?: Funding for domestic abuse within health settings, as well as across partnerships, was both limited and inconsistent. Also, the allocation from central government did not reflect the needs of the area.

  The Trust IDVA post was at risk because Office of the Police and Crime Commissioner (OPCC) for Cleveland funding ended in March 2026. IRIS (a general practice-based domestic violence and abuse training, support, and referral programme) supported primary care with identification and seeking help for victims, however, this was not consistently funded. MARAC was not statutory, therefore it was harder for agencies to gain resource to support the process when other statutory duties took precedence. Integration and unification of clinical records systems was required in order to facilitate better recognition and support for victims and better risk information-sharing.

Welcoming this important contribution, the Committee began its response by questioning if NTHFT had links with other Trusts (other than neighbours South Tees Hospitals NHS Foundation Trust) regarding those individuals coming into the area and using its services. Members heard that whilst relationships did exist between Trusts, information-sharing was limited due to the use of different systems for patient records.

The Committee sought confirmation, and was subsequently assured, that NTHFT processes allowed for a child to be referred for support should a parent present with / disclose domestic abuse-related issues (figures for this could be provided if required). Members were also informed that posters within Trust departments directed patients to help where needed, and that an initiative existed whereby individuals could discreetly seek support by using a codeword. The Committee asked that the stated number of referrals for Hartlepool and Stockton (277) following the introduction of the Hospital IDVA post be separated out so Stockton-only data could be established.

From a wider perspective, Trust representatives were asked if they felt the overarching local 'system' was operating effectively in terms of identifying and responding to domestic abuse. In response, challenges in relation to the IDVA funding and MARAC not being statutory were reiterated, with financial shortfalls meaning organisations needed to prioritise their statutory duties. Whilst NTHFT shared information and took actions, many health organisations were unable to physically attend meetings due to the length and frequency. Regarding the IDVA situation, it was also noted that recently published joint targeted area inspection (JTAI) reports on the multi-agency response to children and families needing help in Redcar and North Yorkshire had highlighted the importance of health IDVAs.

TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST (TEWV)

Recognising the mental health impact on children who had experienced domestic abuse, a contribution had also been sought from TEWV. Representing the Trust, the TEWV Community Team Manager (Stockton Child and Adolescent Mental Health Services (CAMHS)) gave a presentation which covered the following:

- <u>What is the mental health impact on children experiencing domestic abuse?</u>: Children who experienced domestic abuse, whether directly or by witnessing it, faced significant and often long-lasting mental health challenges – this included emotional and psychological effects (e.g. anxiety, depression, post-traumatic stress disorder (PTSD)), developmental delay, relationship and behavioural difficulties, and long-term mental health difficulties associated with adverse childhood experiences (ACEs).

- <u>How do CAMHS staff identify at-risk individuals / families?</u>: Referrals were received from a variety of sources, and may include concerns about emotional distress, behavioural issues, exposure to trauma or abuse, or family dysfunction / parental mental health. During initial screening, the CAMHS Single Point of Contact (SPOC) Team conducted triage assessments to determine urgency and appropriateness – these looked for risk indicators such as self-harm or suicidal ideation, signs of neglect or abuse, substance misuse, domestic violence, and school refusal or exclusion. Physical presentation and any changes to the 'norm' were also assessed.

  Beyond this initial phase, holistic assessments established any mental health symptoms (e.g. anxiety, depression, PTSD), family dynamics and parenting

capacity, social determinants (housing, poverty, isolation), and ACEs. Multi-agency collaboration (including liaison with Local Authorities to share concerns / obtain further information) was undertaken where identified, and further formulation and risk assessment was conducted using the 'five Ps' framework (presenting problems, and perpetuating, precipitating, predisposing and protective factors).

- How confident do staff feel about spotting signs of domestic abuse?: This was dependent on the experience of the clinician working with the child / young person / family. However, TEWV supported its workforce in this regard via monthly supervisions for clinical staff, daily huddles (where concerns could be raised and advice sought), and the provision of training around domestic abuse (included in all mandated safeguarding training at levels 1-3, the Durham Tees Valley Care Group compliance rate was 95%). In addition, all teams had good relationships with the Child Safeguarding Team / Leads, and had access to domestic abuse basic awareness training delivered by a MARAC specialist advisor.

  The TEWV Safeguarding Children Policy outlined domestic abuse as a safeguarding concern and encouraged staff to view children as victims. It highlighted the support staff should access to understand the steps to be taken when concerns were raised (including referral to the Local Authority where appropriate).

- Safeguarding Data from TEWV electronic records: Tees Valley-wide data showed a recent increase in the rate of recorded safeguarding concerns involving domestic abuse – 131 from April 2024 to March 2025 (12 months), compared to 71 from April 2025 to August 2025 (5 months). Only one case had been reported to the police for each of these periods, though all cases since April 2025 had multi-agency liaison (compared to 83% in 2024-2025).

- SBC as a Partner Agency: In general (not specific to domestic abuse), staff reported positive working relationships with SBC, noting reliability, effective communication, being a voice around the table, and responsiveness.

- Any views on key areas of future focus relating to this scrutiny topic (e.g. existing challenges that need to be addressed)?: Understanding / recognising partner roles, responsibilities and expertise, and understanding service limitations (organisations had specialisms and could not cover everything).

Thanking the TEWV representative for their presentation, the Committee enquired about any age-related limitations on gathering information. The CAMHS offer was designed for 0-18 year-olds, though most service-users were over the age of 10 (rather than in the early years phase). Members queried the current CAMHS waiting list for Stockton-on-Tees and were informed that a routine appointment could now be obtained within a week (if urgent, this would be available earlier).

After being assured that the service was able to meet existing demand, the Committee asked if there was a set time between receiving a referral and triage taking place. It was stated that CAMHS managers met every week, cases were triaged within a week of receipt, and the referred individual was seen within two weeks (though usually well within this timeframe). Responding to a Member query around the average length of intervention, it was noted that this would depend on the complexity of an individual's situation / previous experiences, but that CAMHS tended to focus on moderate-to-

severe cases, so contact was usually longer (reflecting the time required to build the therapeutic relationship which was vital in ensuring effective intervention).

The Committee sought clarity on whether a scenario where a child was living in poor conditions was considered 'abuse', and heard that an understanding of the bigger picture would be required to ascertain this (though such a situation could suggest neglect and / or financial abuse). Home visits were conducted, and professionals were active in the community, though it was stressed that any inklings around potential abuse needed to be reported to allow investigations to be initiated.

A number of requests were made to the Trust for further information – this related to 1) any data on the numbers of children accessing CAMHS who were victim-survivors of domestic abuse over the last three years, 2) any data on which organisations were referring into CAMHS, and 3) the percentage of children referred to CAMHS who a) the service went on to engage with, and b) were referred to another agency. The Committee was informed that domestic abuse-specific data may be difficult to provide as this would often not be the principal reason for a referral (though may be one of several factors).

SCOPE AND PROJECT PLAN

The next evidence-gathering session (due to take place at the October 2025 meeting) was scheduled to feature contributions from the remaining health-related entities identified during the original scoping exercise for this review – namely the NHS North East and North Cumbria Integrated Care Board (NENC ICB) and local Primary Care Networks (PCNs).

AGREED that the information provided by Harrogate and District NHS Foundation Trust, North Tees and Hartlepool NHS Foundation Trust, and Tees, Esk and Wear Valleys NHS Foundation Trust be noted, and further information be provided as requested.

CSS/24/25 Chair's Update and Select Committee Work Programme 2025-2026

CHAIR'S UPDATE

The Chair had no further updates.

WORK PROGRAMME 2025-2026

Consideration was given to the Committee's current work programme. The next meeting was due to take place on 30 October 2025 and would feature the fourth evidence-gathering session for the ongoing Scrutiny Review of Children affected by Domestic Abuse involving contributions from the NHS North East and North Cumbria Integrated Care Board (NENC ICB) and the views of local Primary Care Networks (PCNs). It was also anticipated that the next progress update on outstanding actions in relation to the recommendations of the previously completed Outdoor Play Provision review would be presented.

The Committee was reminded of the 'Other Information Sources / Updates' section of the work programme, with new material highlighted for specific attention (this included developments in relation to expected new guidance for Community Safety Partnerships). The Committee Chair also referenced the proposed new statutory duty

for individuals undertaking key roles with responsibility for children and young people in England to report sexual abuse when they were made aware of it (as part of the Crime and Policing Bill).

AGREED that the Chair's Update and Community Safety Select Committee Work Programme 2025-2026 be noted.

Chair: …….

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