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National Child Protection Inspections

Nottinghamshire Police
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Foreword

All children deserve to grow up in a safe environment, cared for and protected from harm. Most children thrive in loving families and grow to adulthood unharmed. Unfortunately, still too many children are abused or neglected by those responsible for their care; they sometimes need to be protected from other adults with whom they come into contact and some occasionally go missing, or are spending time in environments, or with people, harmful to them.

While it is everyone's responsibility to look out for vulnerable children, police forces, working together and with other agencies, have a particular role in protecting children and ensuring that their needs are met.

Protecting children is one of the most important tasks the police undertake. Only the police can investigate suspected crimes and arrest perpetrators, and they have a significant role in monitoring sex offenders. Police officers have the power to take a child who is in danger to a place of safety, or to seek an order to restrict an offender's contact with children. The police service also has a significant role working with other agencies to ensure the child's protection and well-being, longer term.

Police officers are often the eyes and ears of the community as they go about their daily tasks and come across children who may be neglected or abused. They must be alert to, and identify, children who may be at risk.

To protect children well, the police service must undertake all its core duties to a high standard. Police officers must talk with children, listen to them and understand their fears and concerns. The police must also work well with other agencies to ensure that no child slips through the net and that over-intrusion and duplication of effort are avoided.

Her Majesty's Inspectorate of Constabulary (HMIC) is inspecting the child protection work of every police force in England and Wales. The reports are intended to provide information for the police, the police and crime commissioner (PCC) and the public on how well children are protected and their needs are met, and to secure improvements for the future.

Contents

1. Introduction

This report is a summary of the findings of an inspection of child protection services in Nottinghamshire Police which took place in September 2014. The report comprises nine chapters in three main parts. The first part provides information on the background to the inspection and to Nottinghamshire Police. The second part focuses on the inspection findings, and the third part looks to the future and makes recommendations for improvement.

2. Background

Between October 2011 and March 2013, HMIC was involved, on a multi-agency basis, in a number of child protection inspections. Along with evidence of strengths and effective practice, these inspections highlighted areas for improvement, in particular: the quality of joint investigations; the identification of risk; dealing with domestic abuse; and the detention of children in custody.

To address these issues, HMIC decided to conduct a programme of single agency inspections of all police forces in England and Wales. The aims of the inspection programme are to:

- assess how effectively police forces safeguard children at risk;
- make recommendations to police forces for improving child protection practice;
- highlight effective practice in child protection work; and
- drive improvements in forces' child protection practices.

The focus of the inspection is on the outcomes for, and experiences of, children who come into contact with the police when there are concerns about their safety or well-being.

The inspection methodology builds on the earlier multi-agency inspections. It comprises self-assessment and case audits[1] carried out by the force, and case audits and interviews with police officers and staff and representatives from partner agencies, conducted by HMIC.

[1] Details of how we conduct these inspections can be found at Annex A.

3. Context for the force

Nottinghamshire Police has approximately 3,800 staff. The workforce includes:

- 2,105 police officers;
- 1,261 police staff; and
- 337 police community support officers.

Nottingham is the only city in the force area and has a population of approximately 303,900. Significant towns within the force area are Ashfield with a population of 119,500, Newark with a population of 26,330 and Mansfield with a population of 99,600. Nottinghamshire Police has two divisions and these are coterminous with the two local authorities within the force area, Nottingham City Council and Nottinghamshire County Council.

The local authorities are responsible for child protection within their boundaries and each has a separate local safeguarding children board (LSCB)[2] .

The most recent Office for Standards in Education, Children's Services and Skills judgments for each of the local authorities are set out below.

Local authority	**Judgment**	**Date**
Nottingham City	Requires improvement	May 2014
Nottinghamshire County	Adequate	September 2011

Within Nottinghamshire Police**,** public protection services are led by a superintendent, supported by two detective chief inspectors. They have responsibility for public protection provision, which includes a number of units based in the county and city divisions. Across the force these units consist of:

- a sexual exploitation unit;
- child abuse investigation units;
- a rape team;

[2] LSCBs have a statutory duty, under the Children Act 2004, to co-ordinate how agencies work together to safeguard and promote the welfare of children and ensure that safeguarding arrangements are effective.

- a dangerous persons management unit;
- a missing persons co-ordinator;
- an honour based abuse team;
- an adults at risk team; and
- domestic abuse investigation teams.

At the time of the inspection, the force and its partner agencies had established a multi-agency safeguarding hub (MASH)[3] in the Nottinghamshire County Council administrative area. Negotiations were underway with Nottingham City Council for the MASH to be extended to cover the city council administrative area.

[3] This is an entity in which public sector organisations with common or aligned responsibilities in relation to the safety of vulnerable people work. The hubs comprise staff from organisations such as the police and local authority social services, who work alongside one another, sharing information and co-ordinating activities to help protect the most vulnerable children and adults from harm, neglect and abuse.

4. The police role in child protection

Under the Children Act 1989, the police service, working with partner agencies such as local authority children's social care services, health services and education services, is responsible for making enquiries to safeguard and secure the welfare of any child within their area who is suffering (or is likely to suffer) significant harm.[4] The police are duty-bound to refer to the local authority those children in need they find in the course of their work.[5] Government guidance[6] outlines how these duties and responsibilities should be exercised.

The specified police roles set out in the guidance relate to:

- the identification of children who might be at risk from abuse and neglect;
- the investigation of alleged offences against children;
- their work with other agencies, particularly the requirement to share information that is relevant to child protection issues; and
- the exercise of emergency powers to protect children.

Every officer and member of police staff should understand their duty to protect children as part of their day-to-day business. It is essential that officers going into people's homes on any policing matter recognise the needs of children they may encounter. This is particularly important when they are dealing with domestic abuse and other incidents where violence may be a factor. The duty to protect children extends to children detained in police custody.

Many teams throughout police forces perform important roles in protecting children from harm, including those who analyse computers to establish whether they hold indecent images of children, and others who manage registered sex offenders and dangerous people living in communities. They must visit sex offenders regularly,

[4] Section 47 of the Children Act 1989.

[5] Section 17 of the Children Act 1989 places a general duty on the local authority to safeguard and promote the welfare of children in their area who are believed to be 'in need'. Police may find children who are 'in need' when they attend incidents and should refer these cases to the local authority. A child is 'in need' if he or she is disabled, unlikely to achieve or have the opportunity to achieve a reasonable standard of health or development, or if their health and development is likely to be impaired without local authority service provision.

[6] *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2013.

establish the nature of risk these offenders currently pose and put in place any necessary measures to mitigate that risk.

To ensure that agencies co-operate to keep children safe and look after their welfare, each local authority must establish an LSCB. The two LSCBs in the Nottinghamshire Police area are made up of senior representatives from all agencies (including the police). They promote safeguarding activities, ensure that the protection of children remains a high priority across their area, and hold each other to account.

5. Findings: the experiences, progress and outcomes for children who need help and protection

During the course of the inspection, Nottinghamshire Police audited 33 cases in accordance with criteria provided by HMIC[7]. Although the force was not asked to rate each of the 33 self-assessed cases individually, practice was viewed as good by the force assessors in 29 of the cases, adequate in 3 and inadequate in 1 case. Five of the cases were assessed more than once by the force, and in two cases the judgments differed between the self-assessors. Inspectors reviewed all 33 cases that had been self-assessed. They identified more practice weaknesses than the self-assessors. Inspectors selected and examined a further 35 cases where children were identified as being at risk. Thirteen were assessed as good, nine as adequate, four requiring improvement and nine as inadequate.

Initial contact

Inspectors found that in most cases where the concern from the outset was clearly identified as child protection, such as abuse or neglect of a child, the police responded quickly. They undertook a wide range of initial tasks, such as checking on the immediate safety of the child and gathering relevant information, before taking prompt action to protect the child and ensure his or her needs were met. The head of public protection had delivered bespoke training to frontline staff on vulnerability and safeguarding. Inspectors found that staff were aware of their responsibilities and there were examples of officers showing a clear understanding of a child's vulnerability, using good judgment, identifying risks and taking action to protect the child. For example:

- hotel staff noticed a female guest leaving without her 18-month-old child and found the child crying in a hotel bedroom. Officers quickly attended the hotel, explored the circumstances, contacted children's social care services and undertook thorough background checks on the family. The officers then placed the child in the care of her father: this was in the best interests of the child and minimised distress;

[7] The case types and inspection methodology are set out in Annex A

- a GP surgery reported concerns about the suspected sexual abuse of a six-year-old boy. Officers attended immediately, explored the circumstances, engaged well with the child and his mother and took appropriate steps to make sure the child was not at any further risk; and

- police were called to a house where a woman's ex-partner was outside, demanding to see their eight-month-old child who was asleep inside, making threats and refusing to leave. Officers quickly assessed risk and the suspect was arrested immediately and taken from the area. Officers found the child living in poor conditions and sought help for the child from children's social care services.

There were also good examples of control room staff quickly recognising child safeguarding concerns, obtaining as much information as possible from the caller and making thorough checks across the force IT systems before passing the case on to a response or specialist team for further action. However, officers attending an incident were not always aware that a child protection plan had been put in place for a child (i.e. the child had already been identified as being at risk and a plan developed to protect them).

Inspectors found that officers did not routinely check on the welfare and needs of children when attending a domestic abuse incident. Children were often not seen or spoken to alone when this would have been appropriate (this would be the case if the presence of a parent might inhibit a child expressing their view). In only three out of the eight domestic abuse cases assessed by inspectors was it clear that the children had been seen.

One case which gave cause for concern involved an offender who had assaulted his partner in a public house and again as they arrived home. There were five children at the house, including a new-born baby. The initial response to the domestic abuse incident was good, positive action was taken and the suspect was arrested. However, there was no record to show that the children were seen or spoken to by police that night or subsequently, and inspectors found no evidence to show that the case had been referred to, or discussed with, children's social care services.

The behaviour and demeanour of a child at a domestic abuse incident was rarely recorded. A child's demeanour, especially in those cases where a child is too young to speak to officers, or where to do so with a parent present might present a risk, provides important information about the impact of the incident on the child. It should inform both the initial assessment of the child's needs and whether there should be a referral to children's social care services.

We recommend that Nottinghamshire Police immediately ensures that in domestic abuse incidents, officers see and speak to children (where possible and appropriate) and record their observations of a child's behaviour and demeanour so that better assessments of children's needs are made.

Assessment and help

Nottinghamshire Police has one MASH involving the co-location with police of staff from children's social care services of Nottinghamshire County Council, but not from Nottingham City Council.

Inspectors found that the MASH operated largely as a police referral unit where all police information is sent and exchanged in cases of child protection. Police officers had a good understanding of the referral process and generally sent information about child protection matters promptly to the MASH, where the initial response and police action was timely. However, although they were co-located, police and children's social care services were not well integrated.

Inspectors found the exchange of information and the referral of cases between the agencies in the MASH to be inconsistent, with a lack of inter-agency planning between the police referral team and children's social care services.

We also found a number of cases in the MASH where information had not been shared as part of the initial response, such as a case involving three young children under the age of ten found by police living in a filthy house with little food and signs of drug use. It was not until six days after the initial report that police and children's social care services shared their information on the case in the MASH.

Strategy discussions for child abuse referrals are customarily held in a MASH so that agencies can discuss cases and make quick decisions about how best to protect vulnerable children.[8] However, inspectors saw little evidence in the cases examined and interviews conducted that this was the case in Nottinghamshire. Consequent delays in arranging these meetings reduced opportunities for early intervention to protect children at risk.

[8] "Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm there should be a strategy discussion involving local authority children's social care, the police, health and other bodies such as the referring agency. This might take the form of a multi-agency meeting or phone calls and more than one discussion may be necessary. A strategy discussion can take place following a referral or at any other time, including during the assessment process." *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2013, chapter 1, page 33.

The force recognised that arrangements within the MASH, including agreed processes for referring cases for joint intervention and the timing of strategy discussions, were not working effectively and were leaving children at risk. Discussions were underway to address these issues but progress had been slow.

Inspectors found a backlog of child protection cases in the MASH awaiting police action. For example, at the time of the inspection in September 2014:

- an email dated 16 May 2014 concerning a two-year-old girl with bruising indicated that the team was waiting for medical reports and photographs. There had been no further update since that date;
- an allegation of sexual assault made by a ten-year-old boy in foster care received by the MASH on 5 June 2014 had not yet been investigated (in spite of concerns expressed by a children's social care services manager in July);
- a case of neglect had been awaiting an update from children's social care services since 6 June 2014; and
- no research or activity had been undertaken in a case of a man suspected of having child abuse images and videos on his laptop referred on 28 August 2014.

The referral system and allocation of tasks took place by email and it was difficult to see when tasks were added or actions taken. Inspectors could not be confident that referrals were being progressed in a timely and effective manner and saw no evidence of monitoring or regular review of cases. Staff attributed the backlog to lack of supervisory resilience over the summer holiday period and other staff abstractions.

By contrast, inspectors saw examples of good partnership working in the MASH on domestic abuse cases, where the approach was better integrated. The agencies worked together, identified risks to children, made plans to reduce those risks and supported victims. Separate to the MASH, police officers and staff also worked effectively in an integrated domestic abuse referral team with Nottingham City Council staff.

When a child is considered to be at risk of significant harm, there may be a need for a child protection plan and an initial case conference[9] will be arranged by children's social care services. Officers were attending only about half of these initial case conferences. Although written reports were always submitted, these are no substitute for the presence of a police officer to discuss children who are in need of help and protection. It also means that the force was not complying fully with its responsibilities under the statutory guidance *Working Together to Safeguard Children*[10].

In the cases reviewed, inspectors could not determine how many initial case conferences had been held; but it was clear that in six cases a case conference had taken place and police had been invited but had not attended. They only became aware that a child protection plan had been put in place for the children when they received the minutes of meetings up to a month later. One case involved a three-year-old girl who had been taken to hospital by her drug-using mother and was found to have amphetamine in her blood. Police were not present at the initial case conference and consequently had no input into decision making.

Nottinghamshire Police refers domestic abuse cases that are assessed as 'high risk' to a multi-agency risk assessment conference (MARAC) for longer term safeguarding plans to be put in place. MARACs across the force area were well attended by a wide range of agencies. In the city council area, inspectors found evidence of a clear focus on children affected by domestic abuse as well as victims. Police information provided to the MARAC was both relevant and comprehensive. Interventions and actions to safeguard and support children were good in all cases examined by inspectors. The focus on the child was less evident in the MARACs for the county council area.

Inspectors found a mixed response to children reported as missing from home. If a child was identified as being at high risk of child sexual exploitation (CSE) and was reported as frequently going missing, a detailed plan was attached to a police record for the neighbourhood police team to work with the child on a longer-term basis. However, the IT system on which these records were stored could not be readily accessed by response teams. Information about the child was also recorded on the missing persons' database, which response teams could access, but it did not

[9] "Following section 47 enquiries [see chapter 4 above], an initial child protection conference brings together family members (and the child where appropriate), with the supporters, advocates and professionals most involved with the child and family, to make decisions about the child's future safety, health and development. If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth." *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, March 2013, chapter 1, page 40.

[10] See footnote 6 above.

include these plans. Therefore, if the child went missing again, response officers, who were often first to attend the incident, did not always have the benefit of the more detailed and updated information in the plans to inform their decisions and actions.

Neighbourhood policing teams had a good working relationship with most of the children's homes in the force area, and with the social worker on the county council Youth Offending Team (YOT) who oversees all cases of children missing from home.

However, inspectors found two of the four missing children cases they assessed to be inadequate. Actions were sometimes delayed and there was limited evidence of systematic information sharing with other agencies. Poor supervision and oversight of investigations was evident in all four cases. In one case, a 15-year-old boy at risk of offending and facing serious long-term problems was reported missing. He was missing for 18 days, during which time no regular supervisory reviews or direction was recorded. A multi-agency meeting was held four days after the boy had gone missing. There were concerns that he was involved in a sexual relationship with a 24-year-old woman prostitute. Despite an abduction notice[11] being served on the woman, and the boy being extremely vulnerable, when he was eventually found no further work was done to identify and reduce potential risks, and no plan was put in place to deal with longer-term safeguarding.

Inspectors found good evidence of culturally sensitive practice, with a dedicated and bespoke safeguarding response and specialist advice for concerns of so-called honour-based violence and female genital mutilation.

We recommend that, within three months, Nottinghamshire Police undertakes a review, together with children's social care services and other relevant agencies, to ensure that the police are fulfilling their statutory responsibilities set out in *Working Together to Safeguard Children*. As a minimum, this should include:

- **attendance at, and contribution to, initial child protection conferences; and**
- **recording decisions reached at meetings on police systems to ensure that staff are aware of these and of all relevant developments.**

[11] A non-statutory notice issued when the police become aware of a child spending time with an adult who they believe could be harmful to them. A notice is used to disrupt the adult's association with the child or young person, as well as warning the adult that the association could result in arrest and prosecution.

We recommend that, within three months, Nottinghamshire Police undertakes a review of the level and quality of supervisory activity in cases involving children missing from home

We recommend that, within three months, Nottinghamshire Police undertakes a review, together with children's social care services, of how it manages child protection referrals to ensure a timely response to initial concerns, that action is subsequently taken, concerns are followed up and cases are regularly reviewed.

Investigation

Inspectors found some very good examples of investigations across the whole force, particularly when children were identified as being at further risk of immediate harm. Officers considered the best approach for interviewing children, gathered evidence from a range of sources, arranged timely medical examinations and made effective plans to pursue and apprehend suspects. For example, police received a call from a mother reporting that a 23-year-old man had raped her 15-year-old daughter. The girl was sensitively interviewed and medically examined on the same day. The suspect was identified, arrested and charged with the rape later that day. He was kept in custody, preventing further potential harm and later received an eight-year term of imprisonment. In another case which involved the alleged sexual abuse of a 15-year-old girl by her father, officers acted quickly, securing important evidence and protecting the girl. They spoke to independent witnesses, promptly arrested the father and took the girl to a place of safety. They continued to work with children's social care services to provide ongoing support for the girl.

In most of the cases examined, the initial investigation and early intervention were good. However, inspectors found that where investigations required further work over a longer period of time, such as finding other witnesses, gathering extra evidential material and interviewing a number of suspects, there was significant drift. Inspectors examined 15 cases where there was a report of physical abuse on a child; of those, 8 were either inadequate or required improvement. The investigations were protracted and lacked direction, and interviews of victims, siblings and suspects, particularly when they involved parents and other carers, were often unplanned and took too long to complete.

Inspectors found limited evidence of supervisory oversight of many child abuse investigations. This was particularly noticeable in the delayed investigations mentioned above, which were not regularly reviewed by supervisors. Consequently, the lines of enquiry and the pace and progress of these investigations were not subject to scrutiny, nor was guidance provided to investigating officers.

We found a number of examples of poor investigations:

- in a case of suspected physical abuse of a two-year-old girl by her mother, a bite mark seen on the girl by foster carers was not photographed until three days later when the mark had faded. As a result important evidence was lost;
- in a physical abuse case where a nine-year-old boy was pinned down and held around his throat by his father who had returned home drunk, there was a delay in arranging a medical examination and interviewing the three other children in the family. This was a missed opportunity to obtain vital evidence; and
- in a case involving an allegation by a ten-year-old boy in foster care that he had been sexually assaulted by another ten-year-old boy, there was no record to show that either of the boys had been spoken to by police, leaving them both at risk of further harm.

Staff attributed both the delays and limited case supervision to lack of capacity and the high volume of work, an increase in the number of historic abuse cases that required safeguarding action and investigation, and officers being deployed to deal with domestic abuse and adult rape investigations. Inspectors were told that there were also unfilled vacancies within the child abuse investigation teams. Staff expressed frustration that they could not always deal with cases expeditiously and were concerned about the effect on children.

Inspectors found that cases referred to the high-tech crime unit were risk assessed, prioritised and analysed in good time. However, the analysis was frequently limited to crimes under immediate investigation. The force recognised that this carried some risk that evidence of other crimes could be missed but considered that this approach made the best use of available resources.

There were delays of three months or more in some cases sent to the Crown Prosecution Service (CPS) for review and decisions on charging. For example, in a case involving a six-year-old boy alleging rape by his foster parent's son, the police investigation and safeguarding action were timely and thorough and the case was sent to the CPS for a decision to charge in October 2013. However, police were not informed of the outcome until 1 May 2014. Inspectors acknowledge that there have been efforts made by senior officers to address these delays with the CPS, but more needs to be done to resolve the problems.

The standard and progress of child sexual exploitation (CSE) investigations were mixed. Inspectors examined ten cases and found five to be inadequate or requiring improvement.

There was some evidence of good practice. For example, a worried parent called police about sexualised conversations seen on her six and eleven-year-old daughters' Facebook accounts, including plans to meet with two men the mother did not know. Police quickly seized the computer and found and arrested two suspects. A joint visit with children's social care services took place promptly, and protective measures were put in place to safeguard the two vulnerable girls.

Most of the cases assessed as inadequate involved a failure by police to take appropriate action when a concern was raised. Examples included:

- a 16-year-old girl returning home after being reported missing on the sixth occasion. She told her parents that she had been raped by two men after drinking alcohol. The rape investigation was progressed but there was no record of work done to safeguard the girl from further risk of CSE or consideration that the men would continue to pose a risk to other vulnerable girls; and

- a case involving a 14-year-old girl groomed on the internet by a man who invited her to meet him for sex. It took three months for the police to interview the victim and a further eight months before a warrant was executed and the suspect arrested.

In these cases, officers did not recognise the risks the offenders could pose to the victim and other young girls and failed to take prompt action to mitigate them.

Overall, inspectors were concerned about the force's capacity to deal effectively with CSE investigations, particularly officers' failures to consider the wider risks to the victims or other children.

We recommend that Nottinghamshire Police immediately develops an action plan to improve CSE investigations, paying particular attention to:

- **improving staff awareness, knowledge and skills in this area of work;**

- **ensuring a prompt response to any concern raised;**

- **undertaking risk assessments that consider the totality of a child's circumstances and risks to other children; and**

- **improving the oversight and management of cases (to include auditing of child abuse and exploitation investigations to ensure that standards are being met).**

We recommend that, within three months, Nottinghamshire Police initiates discussions at a senior level with the CPS to improve the timeliness of actions and decisions by both the police and the CPS.

Decision making

There were good examples of effective decision making by frontline staff to protect children in circumstances which involved removing a child from his or her family. It is a very serious step to take a child into police protection[12]. Inspectors found that the initial police response was good in all of the five cases they assessed in which such a decision had been made. Efforts were made quickly to safeguard the children; for example, an eight-year-old girl was taken by police to a place of safety after neighbours reported she had been left at the house on her own following a domestic argument. In another case, an eight-year-old boy, who been reported missing by his mother, told frontline officers when they located him that he had been physically assaulted by his mother. The boy was taken into police protection and the officers contacted children's social care services for support.

However, inspectors also found cases where police did not make good decisions. In one case, police executed a warrant to search a house where drug use was suspected. Three children, aged ten, eight and six years old were present. Officers noted the squalid living conditions in the home and took photographs. They arrested the father and left the children at home in the care of their mother. The children had previously been subject to a child protection plan, were clearly very vulnerable and their protection required immediate consideration. There was no record that this had taken place.

Inspectors found a good level of understanding among frontline staff of the need to record and report information that had come to their attention when attending an incident involving concern for a child. As well as taking any necessary action to protect the child, officers recorded their initial actions and sent the information about the child to the MASH. This is important because it is through these records that patterns of abuse are identified. Most officers spoken to were knowledgeable and confident with this process.

Nottinghamshire Police has two recording systems for child abuse investigations but these were not integrated. This is inefficient and results in duplication and confusion for officers about where the most recent details of an investigation might be found. In many of the cases assessed by inspectors, minutes of strategy meetings and case conferences were not attached to the case files in either IT system.

[12] Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, (a) to remove the child to suitable accommodation and keep him/her there or (b) to take such steps as are reasonable to ensure that the child's removal from any hospital, or other place, in which he/she is then being accommodated is prevented.

As a result, it was not always clear what decisions had been made to protect a child or what the priorities were within the criminal investigation. Accurate, timely and consistent recording of information on a single system would better support decision making.

We recommend that Nottinghamshire Police immediately takes steps to ensure that all relevant information is properly and uniformly recorded, and is readily accessible in all cases where there are concerns about the welfare of children.

Trusted adult

Inspectors found examples where good engagement with partner agencies, family members and other individuals better protected a child and resulted in stronger relationships with the police. In one case, an eight-year-old boy had been left at home for many hours on his own. Officers immediately identified the risks posed to the boy and through sensitive enquiries located his grandmother. They involved them both in planning where the boy should stay that night and listened to their views about what should be done in the longer-term to protect him.

In another case, a 15-year-old boy disclosed at school that his father was assaulting him and his siblings. Police and children's social care services worked together, and discovered that the father was struggling to cope with the five children after the death of their mother and the children were being beaten regularly. Enquires were undertaken sensitively and police took positive action to protect the children, arresting and bailing the father with strict conditions around his contact with the children. Both police and children's social care services maintained regular contact and provided support for the family.

However, it was also noted by inspectors that significant delays in progressing some child abuse investigations (as outlined above) left children and families feeling unsupported, sometimes causing them to lose confidence in the police. Child abuse investigators were committed to listening to children but their heavy workloads meant they had limited time to maintain the contact necessary to build a trusting relationship.

In most of the cases assessed, inspectors found very little information about the views of the child, the effect of an offender's behaviour on the child and the outcomes of a case. In Mansfield, the neighbourhood teams that manage anti-social behaviour[13] provided a good model.

[13] Behaviour by a person which causes or is likely to cause harassment, alarm or distress to one or more other persons not of the same household as the person (section 101 of the Police Reform and Social Responsibility Act 2011).

They considered the needs of the child, including the child's family and home environment, to identify the reason for the anti-social behaviour before determining action, and then worked with children's social care services to provide the support needed.

A multi-agency team in the city division worked well to develop effective relationships with young people by engaging with schools and black and minority ethnic groups and gangs, particularly targeting ten and eleven-year-old children. The team undertook effective safeguarding work, building relationships with hard-to-reach families. Inspectors were told about a recent spate of attacks in which children had been stabbed in the buttocks. The victims would not speak to police, but spoke with the social worker within the team who then worked with police to tackle these crimes and prevent further harm to other children.

We recommend that, within six months, Nottinghamshire Police ensures that all staff:

- **record the views and concerns of children; and**
- **record any available outcomes at the end of police involvement in a case.**

We recommend that, within six months, Nottinghamshire Police ensures that information about children's needs and views are regularly made available for consideration by the police and crime commissioner and to service managers to inform future practice.

Managing those posing a risk to children

Nottinghamshire Police has a dedicated unit to manage known registered sex offenders: the dangerous persons management unit. Inspectors found that the information and intelligence about sex offenders was recorded and managed in a timely manner, with accurate monitoring of all the registered sex offenders. This allowed officers quickly to put in place measures to reduce risk. The unit had the staff resources in the numbers and ratio recommended by national guidance[14], which allowed officers to dedicate time to managing offenders who posed the highest risk.

[14] Registered sex offenders are managed under multi-agency public protection arrangements (MAPPA). National guidance on these arrangements was issued in 2012: MAPPA Guidance 2012, Ministry of Justice, available from www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf

Staff working in the unit were clear about their responsibilities, assessed risk and took action to reduce it, although inspectors did identify that, on occasions, a more rigorous approach to safeguarding was required. For example, when a mother with a baby said she had left a sex offender, no further checks were conducted at that time. However, officers later confirmed that she had continued her relationship with him.

Inspectors also found some good examples of single and multi-agency work. In one case, a mother raised concerns with police about her ex-husband's new partner. The police, with children's social care services, developed a protection plan for the children and longer-term support was provided to the family. In another case, specialist officers became aware that a registered sex offender was fitting blinds in a school. They worked carefully (and confidentially) with the school to ensure he had no contact with pupils.

Local neighbourhood officers were generally aware of sex offenders living in their area and knew how to respond. For example, a police community support officer noticed a child's bicycle outside the house of a sex offender and immediately alerted specialist officers.

The force has a specialist team to deal with offenders who sexually exploit children. This is a reactive team, primarily investigating suspects of internet-related sexual exploitation or offending. The force also uses a computer system to identify potential offenders. At the time of the inspection, inspectors were told that 800 potential offenders had been identified and then assessed as low risk. As a result, the team executed search warrants to seize computers from two of these suspects per month.

Senior officers had good links with other organisations across the force area. A strategic group had been established to address CSE. The group had introduced multi-agency training to raise awareness in secondary schools and care homes to help staff identify risk factors associated with CSE and to understand the importance of protecting early forensic evidence where appropriate. Although this group was in the early stages of development, it provides a good basis for the force to develop its plans for identifying, disrupting and prosecuting perpetrators in CSE.

Police detention

Inspectors looked at 12 cases of children in police detention. The youngest was 13 years old, and the oldest 17. One of the detainees was a girl aged 16; all the others were boys. The offences included rape, robbery, burglary and breach of bail conditions. The force self-assessed three of these cases, all boys. In three of the cases the children had been detained under section 136 of the Mental Health Act (MHA) 1983.

Inspectors judged that only 6 of the 12 cases examined had been handled adequately.

In all of the cases examined by inspectors, the children had been charged and refused bail by the custody sergeant. The local authority is responsible for providing appropriate accommodation if a child is to be detained overnight[15]. It should only be in exceptional circumstances (such as extreme weather) that transfer of the child to alternative accommodation would not be in the child's best interests. In rare cases, secure accommodation might be needed if the child presents a high risk of serious harm to others.

Custody officers expressed frustration that, although a call was always made to the local authority, they did not expect that alternative accommodation would be found by children's social care services, and in the cases we examined no alternative accommodation was in fact provided. This was a longstanding problem which had been escalated by the head of custody to senior officers in early 2013, but inspectors saw limited evidence of progress since then. The director of children's services for the city council told inspectors that although they had no secure accommodation available, they were exploring other alternatives with the Youth Offending Teams.

Inspectors were very concerned with some practices in the care of children detained for their own protection. Section 136 of the Mental Health Act 1983 allows a police officer to remove an apparently mentally disordered person from a public place to a place of safety. Although a place of safety can include a police custody suite, these should only be used in exceptional circumstances and it is preferable for the person to be taken directly to health facilities such as a hospital[16]. This was recognised by relevant agencies in Nottinghamshire in a joint protocol of October 2013 on the use of section 136. Nonetheless, during the 12 months from June 2013 to May 2014 the force had detained 11 children in police custody as a place of safety under section 136. Inspectors examined records in three of these cases and found two to be inadequate. In each of these cases, the children had limited access to a family member, their only contact being by telephone. Custody staff appeared to rely on children's social care services and mental health professionals[17] to act as appropriate adults[18], but the physical presence of an adult was limited.

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[15] Under section 38(6) of the Police and Criminal Evidence Act 1984 a custody officer must secure the move of a child to local authority accommodation unless he certifies it is impracticable to do so or, for those aged 12 or over, no secure accommodation is available and local authority accommodation would not be adequate to protect the public from serious harm from him.

[16] Code of Practice: Mental Health Act 1983, Department of Health, 2008, paragraph 10.21. http://webarchive.nationalarchives.gov.uk/20130123193537/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597

[17] A mental health professional is a health care practitioner or community services provider who offers services for the purpose of improving an individual's mental health or to treat mental illness

[18] An appropriate adult is a parent, guardian or social worker; or if no person matching this description is available, any responsible person over 18. In England and Wales, an appropriate adult

The most serious case seen by inspectors involved a 16-year-old girl who was detained for 52 hours in the central police custody suite before being transferred to a healthcare setting. It was only after the girl had been in custody for 44 hours that custody staff realised that she had gone without food or water. She was subsequently treated by a paramedic before being taken to hospital. The force was fully aware of the circumstances of this case, which was subject to an independent health service review at the time of the inspection, but it was not clear to inspectors that steps had been taken to learn the lessons.

Inspectors were also concerned that the central custody suite was not an appropriate place to take children detained under section 136. It is a large prisoner holding facility that is imposing and an unsuitable environment in which to safeguard a vulnerable child who has been removed to a place of safety.

However, inspectors were encouraged by the recent introduction in Mansfield custody suite of a dedicated mental health nurse to support children and young people with mental health problems. At the time of the inspection, Nottinghamshire Police had secured significant funding from NHS England to provide mental health nurses for all custody suites in the force area.

Some custody staff lacked awareness of, and knowledge about, child vulnerability. They told inspectors that they had not received any training, or that training had taken place some time ago. Custody staff told us that they felt that an emphasis on acquisitive crime influenced their approach to children suspected of these crimes and meant that other concerns raised by these children might not be addressed promptly. For example, a 14-year-old boy was arrested for burglary and in the early stages of being held in custody disclosed to a nurse that he had been raped that morning prior to arrest. However, his complaint of rape and anxiety about self-harming were not addressed until well into the second day.

We recommend that, within three months, Nottinghamshire Police undertakes a review (jointly with children's social care services and other relevant agencies) of how it manages the detention of children. This review should include, as a minimum, how best to:

- **improve custody staff awareness of child vulnerability and child protection;**
- **improve risk assessments to reflect the needs of children and the support they require at the time of detention and on release;**

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must be called by police whenever they detain or interview a child or vulnerable adult. They must be present for a range of police processes, including intimate searches, and identification procedures, to safeguard the interests of children detained or questioned by police officers.

- **ensure that all staff act within the law so that all children are only detained when absolutely necessary and for the absolute minimum amount of time;**
- **assess at an early stage the likely need for secure or other accommodation, and work with children's social care services to achieve the best option for the child;**
- **ensure that children detained under section 136 of the Mental Health Act are only detained in police custody as a last resort, for a minimum amount of time, are regularly checked and receive the services of the mental health nurse; and**
- **ensure specific additional consideration is given to using family members as appropriate adults for children detained under section 136 of the Mental Health Act, and parental support and personal attendance at the custody suite are encouraged.**

6. Findings: leadership, management and governance

There is a focus on vulnerability in the Nottinghamshire police and crime plan[19] and senior leaders expressed commitment to child protection.

Inspectors noted some encouraging developments. For example, the force centralised the management of public protection in September 2013. This model has provided dedicated leadership for public protection with the potential to drive a more consistent approach across the force area. It retains local flexibility and provides greater resilience. A daily public protection management meeting, to focus on high-risk incidents involving vulnerability and safeguarding, was noted as good practice. At these meetings, high risk incidents were identified and resources allocated to deal with them. The development of a strategic inter-agency group[20] to address child sexual exploitation is another positive development.

It was evident during the inspection that the force had already identified some of the issues of concern highlighted in this report and taken steps to address them. However, the weaknesses in practice found in this inspection are indicative of a lack of wider management oversight of the force's work to protect children. In particular, issues of capacity, poor supervision, unacceptable delays in investigations and confusion over roles and responsibilities in the MASH suggest that management oversight needs to improve.

With the exception of those working in custody, inspectors found that frontline staff generally had a good understanding of child vulnerability and child protection matters. Officers used good judgment when dealing with incidents. Throughout the inspection, it was apparent that most of the staff responsible for managing child abuse investigations were knowledgeable, committed and dedicated to providing good outcomes for children identified as being at risk of harm. There were some excellent individual examples of police child protection work, with officers displaying a mix of investigative and protective approaches. However, there was limited evidence of good practice being shared among specialist units and a tendency for units to work in isolation.

[19] The Nottinghamshire police and crime plan for 2013-18 can be accessed at: www.nottinghamshire.pcc.police.uk/Document-Library/Public-Information/Police-and-Crime-Plan/Police-and-Crime-Plan---Web-Version-Final.pdf

[20] Membership includes senior representation from Nottingham City Council, Nottinghamshire County Council and the head of public protection in Nottinghamshire Police.

Although inspectors found cases where the initial response to an incident was poor, particularly with the referral delays in the MASH, most of the practice weaknesses identified in this report relate to shortcomings in, or lack of, follow-up action. Inspectors also identified limitations in the force's approach to tackling child sexual exploitation, which was mainly confined to reactive investigations and analysis of computers in relation to suspects of internet-related sexual exploitation or offending. There was very little proactive work being done.

Staff knew to whom they were accountable and most were supported by their immediate line managers, heads of unit and the head of public protection, who were all aware of current workloads. Inspectors found that in the units where there was management focus on workloads, such as the dangerous people management unit, the quality of practice was of a much higher standard. This contrasted with the child abuse investigation unit, where staff reported that they were unable to manage their investigations effectively because of heavy workloads. Staff in this unit were concerned about the impact on the quality and timeliness of work. Oversight and supervision of ongoing investigations were inconsistent, but poorer supervision was seen in cases that were subject to delays. The force had recognised the need for more staff for public protection and was undertaking a force re-structure review which was due for completion shortly after our inspection.

Police performance data was limited and there was scant information about children's views and needs. This constrained the force's ability to improve services and work with partner organisations and LSCBs to meet needs and improve services and outcomes for children. The force did not routinely audit cases or carry out service reviews to identify effective practice and areas for improvement. Inspectors also found that just under half of the cases assessed by the force for this inspection lacked critical analysis and detail. Inspectors were not confident that senior managers had a good understanding of the quality of the work (and could not, therefore, take the appropriate steps to improve it).

The head of public protection represents the force at senior level on the two LSCBs. Chairs of the LSCBs and the directors of children's services with whom inspectors spoke welcomed the commitment and support for child protection shown by the force. They were particularly appreciative of the close working relationship with the head of the public protection unit, which enabled problems to be discussed early and addressed quickly by agencies working collaboratively. Involvement in LSCBs by local command teams would give them a better understanding of child protection arrangements, enable them to make better decisions about resources and influence practice in child protection, both within the force and through the LSCB.

Chairs of the LSCBs commented on the inconsistent attendance at initial case conferences, and inspectors' examination of cases revealed six instances where police had not attended. Although officers were present at multi-agency public protection (MAPPA) meetings, the force was not always represented by an officer of the rank recommended in national guidance[21].

While relationships between agencies were positive, the force needs to bring greater pace and purpose to its work with partners and LSCBs to improve practice and deliver better outcomes for children overall, but in particular in respect of:

- the detention of children in police cells, especially those detained under section 136 of the Mental Health Act 1983 and those for whom alternative accommodation is required;
- the response to child sexual exploitation; and
- a more integrated MASH to ensure timely strategy discussions take place and information is shared to identify and reduce risks to children at an early stage.

Nottinghamshire Police has a number of recording systems for different areas of police activity: crime management, a specific system for child abuse investigations, command and control, intelligence, missing persons and sex offenders. These are not well integrated and often require entries of information to be duplicated. This makes it difficult to ensure that staff have all the information they need before taking decisions about how best to protect children.

Throughout the force we saw a good understanding among police officers and staff that protection of children is important. However, we observed that acquisitive crimes (such as burglary, car crime and robbery) and related performance measures were much more likely to be the focus at operational briefings and in daily task setting than safeguarding children.

[21] See footnote 14.

7. Findings: the overall effectiveness of the force and its response to children who need help and protection

Although Nottinghamshire Police expressed commitment to child protection and inspectors found some encouraging developments, much more needs to be done. The force must bring greater focus, pace and rigour to improving services and its work with partners if it is to achieve the step change necessary to better safeguard and protect children.

Inspectors found knowledgeable and committed staff and some good practice, particularly at the first point of contact and in emergency situations. Staff knew what to do and there were good examples of early effective interventions to protect children. The force has clearly made efforts to improve the ability of frontline staff to recognise that children may be at risk of abuse or neglect, but knowledge and understanding of CSE varied and more is needed to ensure that all staff are alert to the signs of CSE and risks to children.

Inspectors also found areas of practice that were uniformly good, for example, the management of sex offenders, and there was some evidence that the force was managing some pressing demands well (for example in the high tech unit). However, significant weaknesses in practice were identified.

Lack of supervisory oversight was a recurring theme. Poor supervision featured in over 30 percent of cases examined by inspectors, and there was little evidence that managers were actively addressing the quality of practice. More oversight is needed of day-to-day work, especially investigations, and the force would benefit from undertaking regular reviews and audits to improve performance.

Practice in relation to children involved in long-term and high-risk domestic abuse incidents was inconsistent. Arrangements need a greater focus on the impact on the child as well as the adult victim.

Staff working in the child abuse investigation units were highly committed and knowledgeable, but their heavy workloads were having a direct impact on the quality of service to children. There was a tendency for specialist units to work in isolation from each other and good practice was not shared sufficiently across the force.

Performance information for child protection was under-developed. The force needs to do more to understand and record outcomes for children to improve and further develop services. Although police data was provided to the LSCBs, it was described by the LSCB chairs as quantitative, for example it was limited to numbers of cases referred and length of investigations.

The concerns outlined in the earlier section on children detained in police detention indicate the need for a more thorough review of all agencies' understanding of their responsibilities towards children in this context, coupled with further inter-agency efforts to resolve the problems.

The force has good relationships with partner agencies and LSCBs. These relationships may be tested as the force strives to secure and sustain essential improvements in child protection.

8. Recommendations

Immediately

We recommend that Nottinghamshire Police ensures that in domestic abuse incidents, officers see and speak to children (where possible and appropriate) and record their observations of a child's behaviour and demeanour so that better assessments of children's needs are made.

We recommend that Nottinghamshire Police develops an action plan to improve CSE investigations**,** paying particular attention to:

- improving staff awareness, knowledge and skills in this area of work;
- ensuring a prompt response to any concern raised;
- undertaking risk assessments that consider the totality of a child's circumstances and risks to other children; and
- improving the oversight and management of cases (to include auditing of child abuse and exploitation investigations to ensure that standards are being met).

We recommend that Nottinghamshire Police takes steps to ensure that all relevant information is properly and uniformly recorded, and is readily accessible in all cases where there are concerns about the welfare of children.

Within three months

We recommend that Nottinghamshire Police undertakes a review, together with children's social care services and other relevant agencies, to ensure that the police are fulfilling their statutory responsibilities set out in *Working Together to Safeguard Children*. As a minimum this should include:

- attendance at, and contribution to, initial child protection conferences; and
- recording decisions reached at meetings on police systems to ensure that staff are aware of these and of all relevant developments.

We recommend that Nottinghamshire Police undertakes a review of the level and quality of supervisory activity in cases involving children missing from home;

We recommend that Nottinghamshire Police undertakes a review, together with children's social care services, of how it manages child protection referrals to ensure a timely response to initial concerns, that action is subsequently taken, concerns are followed up and cases are regularly reviewed.

We recommend that Nottinghamshire Police initiates discussions at a senior level with the CPS to improve the timeliness of actions and decisions by both the police and the CPS.

We recommend that Nottinghamshire Police undertakes a review (jointly with children's social care services and other relevant agencies) of how it manages the detention of children. This review should include, as a minimum, how best to:

- improve custody staff awareness of child vulnerability and child protection;
- improve risk assessments to reflect the needs of children and the support they require at the time of detention and on release;
- ensure that all staff act within the law so that all children are only detained when absolutely necessary and for the absolute minimum amount of time;
- assess at an early stage the likely need for secure or other accommodation, and work with children's social care services to achieve the best option for the child;
- ensure that children detained under section 136 of the Mental Health Act are only detained in police custody as a last resort, for a minimum amount of time, are regularly checked and receive the services of the mental health nurse; and
- ensure specific additional consideration is given to using family members as appropriate adults for children detained under section 136 of the Mental Health Act, and parental support and personal attendance at the custody suite are encouraged.

Within six months

We recommend that Nottinghamshire Police ensures that all staff:

- record the views and concerns of children; and
- record any available outcomes at the end of police involvement in a case.

We recommend that Nottinghamshire Police ensures that information about children's needs and views are regularly made available for consideration by the police and crime commissioner and to service managers to inform future practice.

9. Next steps

Within six weeks of the publication of this report, HMIC will require an update of the action being taken to respond to the recommendation that should be acted upon immediately.

Nottinghamshire Police should also provide an action plan within six weeks to specify how it intends to respond to the other recommendations made in this report.

Subject to the responses received, HMIC will revisit Nottinghamshire Police no later than six months after the publication of this report to assess how it is managing the implementation of all of the recommendations.

Annex A
Child protection inspection methodology

Objectives

The objectives of the inspection are:

- to assess how effectively police forces safeguard children at risk;
- to make recommendations to police forces for improving child protection practice;
- to highlight effective practice in child protection work; and
- to drive improvements in forces' child protection practices.

The expectations of agencies are set out in the statutory guidance *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of Children*[22], published in March 2013. The specific police roles set out in the guidance are:

- the identification of children who might be at risk from abuse and neglect;
- investigation of alleged offences against children;
- inter-agency working and information-sharing to protect children; and
- the exercise of emergency powers to protect children.

These areas of practice are the focus of the inspection.

Inspection approach

Inspections focused on the experience of, and outcomes for, the child following its journey through child protection and criminal investigation processes. They assessed how well the service has helped and protected children and investigated alleged criminal acts, taking account of, but not measuring compliance with, policies and guidance.

[22] *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children,* HM Government, March 2013. Available from www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf

The inspections considered how the arrangements for protecting children, and the leadership and management of the police service, contributed to and supported effective practice on the ground. The team considered how well management responsibilities for child protection, as set out in the statutory guidance, were met.

Methods

- Self-assessment – practice, and management and leadership.
- Case inspections.
- Discussions with staff from within the police and from other agencies.
- Examination of reports on significant case reviews or other serious cases.
- Examination of service statistics, reports, policies and other relevant written materials.

The purpose of the self-assessment is to:

- raise awareness within the service about the strengths and weaknesses of current practice (this formed the basis for discussions with HMIC); and
- serve as a driver and benchmark for future service improvements.

Self-assessment and case inspection

In consultation with police services the following areas of practice have been identified for scrutiny:

- domestic abuse;
- incidents where police officers and staff identify children in need of help and protection, e.g. children being neglected;
- information-sharing and discussions regarding children potentially at risk of harm;
- the exercising of powers of police protection under section 46 of the Children Act 1989 (taking children into a ‘place of safety’);
- the completion of Section 47 Children Act 1989 enquiries, including both those of a criminal nature and those of a non-criminal nature (Section 47 enquiries are those relating to a child ‘in need’ rather than a ‘child at risk’);
- sex offender management;

- the management of missing children;
- child sexual exploitation; and
- the detention of children in police custody.

Below is a breakdown of the type of self-assessed cases we examined in Nottinghamshire Police.

Type of case	Number of cases
Child protection enquiry (s. 47)	5
Domestic abuse	5
General concerns with a child where a referral to children's social care services was made	5
Sex offender enquiry	3
Missing children	3
Police protection	3
At risk of sexual exploitation	3
On-line sexual abuse	3
Child in custody	3

Annex B
Glossary

child	person under the age of 18
Crown Prosecution Service (CPS)	established in 1986 as an independent body and the principal prosecuting authority in England and Wales; responsible for advising the police on cases for possible prosecution; reviewing cases submitted by the police; determining any charges in more serious or complex cases and preparing and presenting cases for both magistrates and the high courts, including Crown Court and the Court of Appeal
child protection plan	a written record for parents, carers and professionals which identifies specific concerns about a child and assesses the likelihood of a child suffering harm; sets out what work needs to be done to protect a child from harm, by when and who is responsible for that work; a child is no longer subject to a protection plan when it is judged that he or she is not believed to be suffering or at risk of suffering harm
multi-agency public protection arrangements (MAPPA)	arrangements set out in the Criminal Justice Act 2003 for assessing and managing the risk posed by certain sexual and violent offenders; require local criminal justice agencies and other bodies dealing with offenders to work together in partnership to reduce the risk of further serious violent or sexual offending by these offenders

multi-agency risk assessment conference (MARAC)	locally-held meeting where statutory and voluntary agency representatives come together and share information about high-risk victims of domestic abuse; any agency can refer an adult or child whom they believe to be at high risk of harm; the aim of the meeting is to produce a co-ordinated action plan to increase an adult or child's safety, health and well-being; the agencies that attend will vary but are likely to include, for example: the police, probation, children's, health and housing services; there are over 250 currently in operation across England and Wales
multi-agency safeguarding hub (MASH)	entity in which public sector organisations with common or aligned responsibilities in relation to the safety of vulnerable people work; the hubs comprise staff from organisations such as the police and local authority social services, who work alongside one another, sharing information and co-ordinating activities to help protect the most vulnerable children and adults from harm, neglect and abuse
neighbourhood policing team	team of police officers and police community support officers who predominantly patrol and are assigned to police a particular local community; teams often comprise of specialist officers and staff with expertise in crime prevention, community safety, licensing, restorative justice and schools liaison

Office for Standards in Education, Children's Services and Skills (Ofsted)	a non-ministerial department, independent of government, that regulates and inspects schools, colleges, work-based learning and skills training, adult and community learning, education and training in prisons and other secure establishments, and the Children and Family Court Advisory Support Service; assesses children's services in local areas, and inspects services for looked-after children, safeguarding and child protection; reports directly to Parliament
police and crime commissioner (PCC)	elected entity for a police area, established under section 1, Police Reform and Social Responsibility Act 2011, responsible for securing the maintenance of the police force for that area and securing that the police force is efficient and effective; holds the relevant chief constable to account for the policing of the area; establishes the budget and police and crime plan for the police force; appoints and may, after due process, remove the chief constable from office

registered sex offender	a person required to provide his details to the police because he has been convicted or cautioned for a sexual offence as set out in Schedule 3 to the Sexual Offences Act 2003, or because he has otherwise triggered the notification requirements (for example, by being made subject to a sexual offences prevention order); as well as personal details, a registered individual must provide the police with details about his movements, for example he must tell the police if he is going abroad and, if homeless, where he can be found; registered details may be accessed by the police, probation and prison service