



September 2023

Welcome to the September 2023 edition of the NSCP newsletter and my first as a member and chair of the Strategic Leadership Group. A good deal has happened within the partnership since our last newsletter. We saw three long-serving partnership members retire and we wish Joe Foley, Steve Baumber and Bob Ross the very best with their retirement plans. The new partnership team members are introduced in the newsletter.

There have been several significant government publications over the course of 2022 and 2023, these are summarised in the newsletter along with learning from our local case reviews.

You will also find here information about changes in health and information about our multi-agency training programme, of which we remain very proud. I hope you find the newsletter informative, and I look forward to welcoming you to more frequent versions throughout 2023-24.

**Rob Griffin, Assistant Chief Constable
Chair of NSCP Senior Leadership Group.**

The **NSCP Annual Report 2022-2023** will be published on our website shortly, containing details of the partnership's activities and achievements over the last year. Please go to:

[Reports \(nottinghamshire.gov.uk\)](https://www.nottinghamshire.gov.uk/reports).

The Partnership will also shortly be publishing the new **Business Plan for 2023-2027**, which will be a news item on the website.

Also in this issue

- Safer Sleeping for Babies
- The Multi-Agency Safeguarding Hub (MASH)
- National Reports & Guidance
- The Domestic Abuse Act 2021
- Changes in Health – The Integrated Care System (ICS)
- Training, E Learning and Course Evaluations
- The Inter-Agency Safeguarding Children Procedures
- Learning from Local Case Reviews
- Neglect and our new animations
- Managing Allegations Service

Multi-Agency Safeguarding Hub (MASH)

The MASH is the single point of contact for all professionals to report NEW safeguarding concerns.

Opening Times:

- Monday, Tuesday, Thursday: 8:30am to 5pm
- Wednesday: 10:30am to 5pm
- Friday: 8:30am to 4:30pm

Reminder: For referrals that are not urgent, please submit an online form, which will be read on the working day of receipt.

[Report a new concern about a child | Nottinghamshire County Council](#)



0300 500 80 90

MASH Consultation Line

What is it? - However, experienced you are, there may be times when you are not sure what action you should take, or you just need support and guidance. The MASH consultation line is for professionals working with children, young people and families to obtain advice from a Social Worker when you are unsure whether a safeguarding referral is required and discuss signposting or what other support may be provided by wider agencies.

Before contacting the consultation line - You should follow your organisation's safeguarding processes before calling the consultation line for advice. This should include speaking to your named/designated safeguarding lead, referring to the Pathway to Provision, speaking to parents about the concerns that you have where it is safe to do so and giving consideration to Early Help services.

Purpose - The consultation line is to provide advice and guidance about a hypothetical situation without making a referral. You should not use the name of the child or family or discuss any identifying details.

The MASH consultation line will: Provide advice and guidance about the situation you wish to discuss and recommend alternative support and signposting where appropriate.

Consultation Line opening times:

Monday 9.00am – 4.00pm
Tuesday 9.00am – 4.00pm
Wednesday 10.30am – 4.00pm
Thursday 9.00am – 4.00pm
Friday 9.00am – 3.30pm

Phone Number:

Tel: 0115 977 4247

What makes a good MASH Referral E Learning

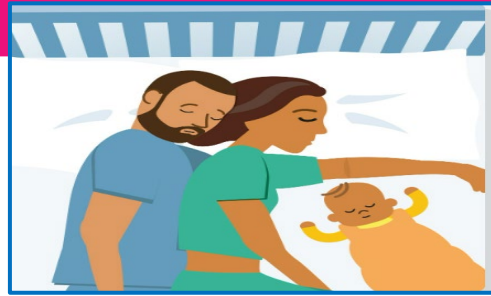
This module is suitable for staff in a variety of roles who work with children, young people and their families and who may need to contact Children's Social Care about a safeguarding concern or to make a request for specialist services.

The term 'MASH referral' is used throughout as this phrase is commonly used to describe a referral to Children's Social Care in Nottinghamshire.

To access the course, go to the NSCP Training log on page: [Notts CC LMS: Log in to the site \(learningpool.com\)](#)

Safer Sleeping for Babies

Co-Sleeping



The advice you give to parents and carers on co-sleeping hasn't changed but the wording on the Lullaby Trust website has changed slightly to reflect that not all families will have a cot or Moses basket and particularly, highlights avoiding co-sleeping when there are risk factors that make this dangerous and always planning for a safer sleep environment.

They advise:

To reduce the risk of sudden infant death syndrome (SIDS) the safest place for a baby to sleep is in their own clear, flat, separate sleep space, such as a cot or Moses basket.

However, we know that many parents find themselves co-sleeping whether they mean to or not. Wherever you're planning for your baby to sleep we recommend making your bed a safer place for baby.

To watch a short video: How to co-sleep more safely go to: [How to co-sleep more safely - YouTube](#)

For more information go to: [Co-sleeping with your baby: advice from The Lullaby Trust - The Lullaby Trust](#)

Safer Sleeping for babies in the autumn/winter months

As we approach autumn and winter the colder months can be difficult for families, with worries about heating bills and the cost of living, such as buying food. It can be tempting for parents/carers to wrap their baby up to keep them warm. However, overheating a baby increases the chances of sudden infant death syndrome (SIDS), commonly known as cot death. Research shows babies are better cooler rather than overheated, so as practitioners supporting families, please bear this in mind and offer them general advice around safer sleeping.

To access the Safer Sleep Risk Assessment tool go to:

[For professionals and volunteers \(nottinghamshire.gov.uk\)](http://nottinghamshire.gov.uk)

For more information go to:

[Safer sleep in winter - The Lullaby Trust factsheet-temperature.pdf \(lullabytrust.org.uk\)](#)

[Safer Sleep For Babies - YouTube](#)

To access E Learning on **Safer Sleeping for Babies** or a virtual training event on 3rd October called **Sudden unexpected death in infancy and safer sleep for babies** go to your NSCP training log on page:

[Notts CC LMS: Log in to the site \(learningpool.com\)](http://learningpool.com)



National Reports and Guidance

Over the last 12 months there has been many publications of which you may find useful and particularly relevant to your role and organisation:

- **Independent Review of Children's Social Care (May 2022)** Josh MacAlister. [Independent review of children's social care: final report - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/102444/independent-review-of-childrens-social-care-final-report.pdf)

This review is the most wide-ranging rethink of children's social care in more than a generation. The review launched in March 2021. It prioritised hearing the voices of children, young people and adults that have received the help or support of a social worker, or who have been looked after.

- **Child Protection in England. National review into the murders of Arthur Labinjo-Hughes and Star Hobson (May 2022)** Child Safeguarding Practice Review Panel. [National review into the murders of Arthur Labinjo-Hughes and Star Hobson - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/102444/national-review-into-the-murders-of-arthur-labinjo-hughes-and-star-hobson.pdf)

This review sets out recommendations and findings for national government and local safeguarding partners to protect children at risk of serious harm. It examines the circumstances leading up to the deaths of Arthur Labinjo-Hughes and Star Hobson and considers whether their murders reflect wider national issues in child protection.

- **The government published its response to the above 2 reports :** [Children's social care stable homes built on love consultation \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/102444/childrens-social-care-stable-homes-built-on-love-consultation.pdf) which included a wide ranging consultation 'open to all those who receive or provide children's social care services in England, and those who have an interest in it'. This was open until May 2023. The recommendations from this and the findings from the review/consultation of Working Together to Safeguard Children will inform practice moving forward.
- **The Independent Inquiry into Child Sexual Abuse (IICSA) 2022.** [The Independent Inquiry into Child Sexual Abuse | IICSA Independent Inquiry into Child Sexual Abuse](https://www.iicsa.gov.uk/)

The Independent Inquiry into Child Sexual Abuse (IICSA) has published its final report into child sexual abuse and exploitation in institutions in **England** and **Wales**. The report draws on evidence from public hearings, the Inquiry's research programme and submissions to the 'Truth Project' from people who were sexually abused as children.

- **Keeping Children Safe in Education (KCSIE) DFE,2023.** [Keeping children safe in education - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/102444/keeping-children-safe-in-education-2023.pdf)

This is the updated statutory guidance for schools and colleges on safeguarding children and safer recruitment, which comes into force on 1st September. Some changes include: clarification around the roles and responsibilities of education staff in relation to filtering and monitoring, clarification that being absent, as well as missing, from education can be a warning sign of a range of safeguarding concerns, including sexual abuse, sexual exploitation or child criminal exploitation, additional information on online pre-recruitment checks for shortlisted candidates, and information on responding to allegations related to organisations or individuals using school premises.

- **Working Together to Safeguard Children and Information Sharing Consultations.** [Working Together to Safeguard Children: changes to statutory guidance - Department for Education - Citizen Space](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/102444/working-together-to-safeguard-children-changes-to-statutory-guidance.pdf)
[Information sharing advice for safeguarding practitioners - Department for Education - Citizen Space](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/102444/information-sharing-advice-for-safeguarding-practitioners.pdf)

Consultations opened **21 Jun 2023** and close **6 Sep 2023**

Updating Working Together now is central to delivering on the first phase of the Governments ambitious plans to transform Children's Social Care, set out in [Stable Homes, Built on Love](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/102444/stable-homes-built-on-love.pdf). The last substantive update of the Information Sharing Advice was in July 2018 to reflect the revised Data Protection Act 2018 and introduction of the UK General Data Protection Regulation (UK GDPR).

The Domestic Abuse Act 2021

On April 29th, 2021, the Domestic Abuse Bill passed becoming the Domestic Abuse Act. For the first time the **DAA recognises children themselves as victims of domestic abuse when they see, hear or experience domestic abuse**. Recognising and acknowledging the experience of a child helps to validate that experience.

New statutory guidance came out July 2022 [Domestic Abuse Act 2021 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/consultations/domestic-abuse-act-2021)

The first part deals with the relationship between the abuser and the abused. The second part defines what constitutes abusive behaviour. The definition emphasises that domestic abuse is not just physical or sexual violence, but can also be emotional, coercive or controlling, and economic abuse. It is a framework document designed to support organisations to identify and respond to domestic abuse and promote best practice.

Domestic Abuse Training

Equation offer FREE training to all practitioners who work in Nottingham City and Nottinghamshire County. For example:

- Understanding & Responding to Domestic Abuse
- How Perpetrators of Domestic Abuse use Technology
- Domestic Abuse in Same Sex Relationships
- Non-Domestic Abuse Stalking Awareness training and many more

[Upcoming Events – Equation](#)

Changes in Health – The Integrated Care System (ICS)

There are 42 Integrated Care Systems (ICSs) across the country. They are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

They exist to achieve four aims:

1. Improve outcomes in population health and healthcare.
2. Tackle inequalities in outcomes, experience and access.
3. Enhance productivity and value for money
4. Help the NHS support broader social and economic development.

The biggest change this new way of working will bring is that the NHS and local councils – which deliver many care services – will be working together as part of a new organisation.

When the NHS was set up in the 1940s its aim was to treat symptoms. But it has come a long way since then, supporting people to live healthier lives. This change is continuing along that journey and aims to make social care and health even more aligned.

Our health is affected by many things – housing, unemployment, financial stress, domestic abuse, poverty, and lifestyle choices.

This is something that we need to look at through a partnership between the NHS, local government and the voluntary sector.

Each Integrated Care Partnership has two statutory elements:

1. Integrated Care Partnership (ICP) - a statutory committee formed between the NHS Integrated Care Board and upper-tier local authorities. The ICP will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population.
2. Integrated Care Board (ICB) – a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services. The ICB works to deliver the ICS outcomes with partners from across our system.

For more information watch this short video:

[How does the NHS in England work and how is it changing? - YouTube](#)

Managing Allegations Service - LADO online form is now live!

Nottinghamshire's Managing Allegations Service was launched in November 2020 and has allowed the local authority to better manage the concerns and allegations against professionals and volunteers working with children. Over time there has been an increase in contact with the LADO Allegations Officers and that is why a new LADO Online Referral Form has been introduced. This became effective from Monday 3 April 2023 to help manage this more effectively. From now onwards referrers phoning in will be directed to the Online Form and no referrals will be taken over the phone.

The aim of the form is that it will allow you to consider the criteria for making a referral to LADO and gather the required information needed to submit a full referral, as much as it will allow the LADO Allegations Officers to process your contacts efficiently.

Online referral form for all new referrals : [Make a LADO referral online form](#)

If you have questions about the form, please visit our [contact page](#) or use the details below.

- email: LADO@nottsc.gov.uk
- Safeguarding Independent Review telephone: 0115 8041272

New E learning Course went live November 2022!

Since our new course **Managing allegations and concerns in relation to adults working with children** went live in November 2022, 299 practitioners have completed this e learning module which is great news. Feedback includes:

- I thought the eLearning was good, informative, and delivered in an engaging way.
- Very informative and I thought the materials were easy to understand and follow.

All allegations of abuse of children by those who work with children must be taken seriously. Allegations may be against any person who works with children, whether in a paid or unpaid capacity.

This module is suitable for staff in a variety of roles who work directly with children and young people and particularly for managers/staff who may deal with any allegations or concerns made against adults working with children. It will explain the role of the Managing Allegations Service in Nottinghamshire and explain the Local Authority Designated Officers (LADO) role and process. The course will take approx. 1 hour to complete.

To access the course please go to the NSCP training log in page:

[Notts CC LMS: Log in to the site \(learningpool.com\)](#)

Charges may apply – please see our charges page: [Training charges \(nottinghamshire.gov.uk\)](#)

For more information and to access the Inter-Agency Safeguarding Procedures go to: [Allegations Against Staff or Volunteers](#)

Safeguarding Children at Risk of Neglect

Child Neglect Strategy

Child neglect has a lifelong impact on a person's wellbeing, and it is vitally important that as a Partnership we do all we can to prevent it.

Both the Nottinghamshire and Nottingham City Safeguarding Children Partnerships recognise that tackling neglect must be a priority if we want to improve our children's life chances and prevent poor outcomes later in life and as such, we developed our joint Neglect Strategy in 2021.

To read or download a copy of the strategy go to: [Plans and strategies \(nottinghamshire.gov.uk\)](https://nottinghamshire.gov.uk/plans-and-strategies)

Child and Young Person's Neglect Toolkit

The child and young person's Neglect Toolkit is not a clinical tool to diagnose neglect but is designed to assist you in identifying and assessing children and young people who are at risk of and experiencing neglect. It is to be used when you are concerned that the quality of care of a child/young person you are working with suggests that their needs are being neglected. This tool does not replace assessments such as the Early Help Assessment or Children's Social Care assessments. This toolkit focuses on six key areas of need and considers the extent of the parent's commitment to care and the extent to which children and young people's needs are being put first or come secondary to the needs of their parents/carers. Although poverty does not cause neglect it is acknowledged that it can exacerbate it.

To access the toolkit, go to: [Additional Resources \(proceduresonline.com\)](https://proceduresonline.com)

New Neglect Animations

Two new animations have been developed jointly by the Nottinghamshire and Nottingham City Safeguarding Children Partnerships and Small Steps Big Changes (SSBC) as part of the Child Neglect Strategy 2021-2023.

One is for **professionals** who work directly with children and young people and the other is for **parents, carers and any members of the public**.

Both were created to help raise awareness about neglect.

To access them please go to our Child Neglect Strategy topic on the [Plans and strategies page](#)



Paediatric Asthma Safeguarding Bulletin

In the UK, one in eleven children live with asthma. Whilst asthma can usually be managed with medication, poorly controlled asthma can be serious and sometimes fatal for a child.

The UK has one of the highest death rates in Europe. Child maltreatment, including **medical neglect**, is a known contributor to the development of asthma and a barrier to its proper management.

This briefing aims to support professionals to consider what life is like for a child suffering from asthma and what their role is in supporting the child and family.

[Paediatric Asthma Safeguarding Bulletin \[PDF\]](#)



Virtual Training Events are here to stay!

2022-23 was another busy year with us continuing to offer all our face-to-face courses virtually via Microsoft Teams, with 3009 practitioners attending these events. eLearning has also continued to be a very popular method of training, with 8,620 course completions.

Feedback and course evaluations have clearly indicated that overall delegates do prefer virtual training to face to face events. Positive feedback has included: that courses are much easier to access, and therefore being released from work is more manageable, there is no travelling across the County, so more time efficient, and delegates have reported that their learning and development hasn't been impeded by them being virtual and increased interaction opportunities such as quizzes and the introduction of break out rooms has been welcomed. The key feature missed from not attending events face to face is the opportunity to actually network and talk to colleagues in person.

Moving forward with the Training Programme 2023-24, you may have noticed we are now offering more of a blended approach with the courses we offer. The majority are still virtual, but we have offered some face-to-face events also. We will continue to do this where we think it will be more beneficial and this will include some subject matter courses, workshops and conferences.

Course Evaluations and Feedback

After attending any of our events we offer you the opportunity, via a short evaluation form to give us your feedback (immediately afterwards and then an impact evaluation after 3 months). We do read these evaluations regularly and if required we use the feedback to amend or improve the content or organisation of the events. Your feedback is very important to us!

We are pleased to share that course evaluations have continued to be very positive:

- *The training was really good, and it was nice to hear from other professionals who work in different settings, it helped me to gain a bigger understanding and perspective on the whole picture when dealing with a safeguarding issue.” (Working Together to Safeguard Children)*
- *“The course provided me with the knowledge of the topic and an understanding of how this can present. I will implement these skills in my daily practice with families.” (Perplexing Presentations including Fabricated or Induced Illness.)*
- *“This course was fantastic and really believe more training like this morning will massively help us looking after our vulnerable mothers we work with.” Volatile Substance Use.*
- *“Absolutely brilliant course and course leaders by the way, really learnt so much and will be following through in practise with more confidence and a better understanding now too, so thank you to you all.” Emotional Abuse.*
- *“Thank you it was really enjoyable; I like working through case studies and working in collaboration with a range of professionals.” Safeguarding Children and Neglect.*

We would like to say a **big thank you** to all practitioners who have attended our events over the last year for your active participation during our events, including sharing your knowledge, experience, and resources. This has helped make the sessions much more interesting, fun and promoted great multi-agency working.

To see what new courses are coming up and to book onto any of our events please go to: [Training events \(nottinghamshire.gov.uk\)](https://www.nottinghamshire.gov.uk/training-events).

If you are unable to attend, please cancel your place via the course log in page. This will allow someone else to attend and you may otherwise incur a non-attendance fee.

The Inter-Agency Safeguarding Children Procedures

The Nottinghamshire and Nottingham City Interagency Safeguarding Children Procedures and Guidance are available online and can be accessed via desktop, mobile or tablet.

The Safeguarding Children procedures include:

- Core safeguarding procedures - which provide guidance on the recognition, investigation, and assessment of child abuse.
- Safeguarding guidance – access to more detailed information about how to respond to different types of abuse.
- Additional resources – links to local guidance documents, templates and tools.

Examples included within the **Additional Resource section**: Child Criminal Exploitation Multi-Agency Assessment Tool, Child Sexual Exploitation Multi-Agency Assessment Tool, Child & Young Peoples Neglect Toolkit, Guidance for practitioners in using Chronologies and Genograms, Bruising in Babies Pathway, Agency report template for Initial/Review Child Protection Conferences.

The procedures are updated twice a year.

[Welcome to the Interagency Safeguarding Children Procedures \(proceduresonline.com\)](http://proceduresonline.com)

Learning from Local Case Reviews

Serious child safeguarding cases are those in which:

- Abuse or neglect of a child is known or suspected; and
- The child has died or been seriously harmed.

All members of the partnership are responsible for identifying serious child safeguarding cases which raise issues of importance to the area. A serious incident notification must then be submitted by the Local Authority. A **rapid review** of such cases is then undertaken to determine if any immediate action is needed to ensure a child's safety. The rapid review will also consider if there is any learning or potential for improving practice and if necessary a more in depth review, known as a local child safeguarding practice review (LCSPR) will be commissioned. Local child safeguarding practice reviews will take six months to complete and will usually be published on the NSCP website, alongside a Learning Bulletin which is a shorter summary version of the final report.

The learning from case reviews continues to be presented at our regular NSCP "Safeguarding Children Today" seminar events, as well as influencing the subject matters for inclusion in our Annual Training Programme.

Some of the key themes from the reviews included:

- Injuries to babies under 1 year old
- Harmful sexual behaviour
- Looked after children in foster care or in a residential home

Local Child Safeguarding Practice Reviews (LCSPR)

We have published two LCSPR's recently. **Please be aware you may find the below content disturbing:**

LCSPR VN21 "Alison"

This review concerns a four-year-old girl and her unexplained serious injuries while in foster care with her two older siblings. The children had complex needs as they had experienced many traumatic events in the care of their birth parents. The foster carers were new and inexperienced, they had no children of their own and this was their first placement. There was no single 'trigger' incident for the serious incident notification and rapid review. It followed an analysis of a number of incidents involving injuries to the girl whilst in the care of her foster carers from April 2020 to February 2021. Two of the episodes of injuries required significant medical treatment – serious damage to her pancreas which led to surgery to remove 70% of her pancreas and a fracture to her arm.

The level of experience of the involved carers and social workers impacted in this case. Strategy discussions were not undertaken at key points. Professional curiosity and challenge around assumptions should have been more thorough.

Key learning:

- The importance of recognising when to follow safeguarding processes on open cases when there is uncertainty about the cause of an injury or other harm that a child has suffered.
- The importance of the availability of services that address adverse childhood experiences and which can help mitigate the impact on children of those experiences.
- The importance of ensuring that formal meetings such as strategy meetings or Looked After Child reviews are effective in their primary purpose and do not become exercises to be completed.
- That staff or carer inexperience may affect service delivery and that additional support and systems may be necessary to maintain service standards and quality.

Concerns about the presentation of a situation for a Looked after Child should be referred to the involved social work team as a safeguarding concern.

LSCPR UN21 "David and Daniel"

This review addressed how professionals responded to harmful sexual behaviour between two siblings, eleven-year-old David and fourteen-year-old Daniel. The two boys were in a long-term foster care placement with three other siblings. Two of the siblings were assessed as having learning difficulties and the disclosures involved the older sibling harming his younger brother.

The identified areas of learning were: -

- How professionals responded to disclosures of sexual behaviour between the siblings and the need for the use of expertise, toolkits, and best practice guidance.
- The need for precise language in the recording of sexual behaviours.
- The need for assessments to take previous traumatic events and other significant factors into account.
- Risk assessments for sibling groups should take into account the needs of all the children. It may be that children are not best placed together in all circumstances.
- Complicated organisational pathways can impede effective cross agency working.
- The need for clarity regarding the role of foster carers and their degree of influence in the communication with other professionals.
- Emphasising role of the Independent Reviewing Officer and the need for professional curiosity from the wider professional group.

To see all information and reports relating to learning from local case reviews go to our website:

[Learning from practice \(nottinghamshire.gov.uk\)](https://www.nottinghamshire.gov.uk/learning-from-practice)

Independent report - Review of safeguarding practice into the events at Harlow Academy 2023

Harlow Academy (now renamed Fountaindale) is a special school for some of the most vulnerable and disabled children, including children receiving end of life care and with severe physical disabilities. An Ofsted judgement that the school was inadequate in February 2020 led the DfE to make an academy order and find an academy sponsor, the Evolve Trust.

In Autumn 2021 incidents of concern were reported included inappropriate use of restraint, failure to provide equipment required to support children's mobility, poor management of behaviour and inappropriate exclusions. Despite agencies including Nottinghamshire County Council, Nottinghamshire Healthcare Foundation Trust, Ofsted and the Regional Schools Commissioner being made aware, no plan effectively addressed the multiple safeguarding concerns.

Harlow Academy was temporarily closed following an Ofsted inspection in January 2022 due to the conclusion that pupils were not being kept safe with some at risk of immediate or imminent harm.

- Nottinghamshire Safeguarding Children Partnership (NSCP) to consider the circumstances where concerns about children's care requires a **structured multi-agency response led by senior staff** in the partnership and which can give direction and authority to the work of the services working with individual children.
- The NSCP agencies should look at how intelligence could be routinely gathered and analysed across agencies from enquiries, complaints and referrals that might give **early warning of concerns** about organisations failing to effectively safeguard children.
- All NSCP staff working with children should be aware of **how to raise concerns** about the quality of children's care including how they can use their own or other agencies **whistle blowing process**.

Meet the SCIMT - Safeguarding Children Information Management Team

The SCIMT responds to enquiries from partner agencies in terms of whether a person is or has been known to children's social care. You can contact SCIMT in one of the following ways:

- submitting a known person enquiry form by secure email to the SCIMT on safeguardcimt@nottscc.gov.uk
- telephone: 0115 804 1274



Rachel Watson, Aimee Bird, Anita Catton

Karen Ford, Julie Worsnop

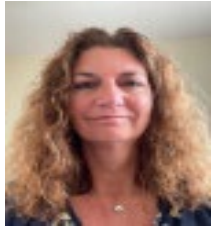
Meet the NSCP team:



Sam Harris is the Service Manager for the NSCP. She facilitates the partnership's operational and strategic meetings and is currently supporting the development of the new business plan and the cross-partnership audit framework.



Haley Thompson is the Development Manager for the safeguarding partnership. Her main responsibilities are around statutory review, including writing the rapid reviews following serious safeguarding incidents and supporting independent Local Child Safeguarding Practice reviews. Haley also has a role in facilitating the Child Death Overview Panel.



Trish Jordan is the NSCP Training Coordinator. Her main role is to organise and facilitate the Annual Multi-Agency Training Programme on behalf of the Partnership. The learning from local case reviews, national reviews and guidance and feedback from partner organisations informs this.



Sarah Bale is the Training Administrator for the NSCP. She supports Trish with the setting up and promotion of all new training events and supports partners to access both the face-to-face events and the e learning, including giving any other advice required. She also minutes the Learning and Workforce Development Group.



Sarah Beet is a Business Support Administrator. She administers the multiagency Child Death Review process for Nottinghamshire and Nottingham City and provides administrative support to the NSCP in the area of case reviews and other developmental work.



Lucy Argyle is the Business Support Administrator for the NSCP. She supports Sam Harris by arranging and minute taking for the partnership's operational and strategic meetings and provides administrative support for the Creative Solutions Panel.