

Welcome to the **January 2026** edition of the NSCP newsletter. Happy New Year to you all.

2025 was a busy year and this year we aim to continue to build on the work and progress that has been made across the Partnership around safeguarding children and young people across Nottinghamshire. The Family First Partnership Programme is progressing at pace and steering a lot of our work across many areas of children's services. This has included work around early help, transitional safeguarding, the referral process from referral into the family support and safeguarding teams, and the establishment of the adolescence work strand.

Work is underway in testing and establishing Multi-Agency Child Protection Teams (MACPT) with Lead Child Protection Practitioners (LCPP) roles within these. The aim is to make Family Group Decision-Making (FGDM) the usual way we do things. This means using restorative and relational practice, where we work with families by giving both strong support and clear challenge.

It is a time of much change and challenges, but I'm sure you will agree we have exciting times ahead where our aim is to keep children and young people at the heart of everything we do.

Thank you again to all your commitment and collaborative working across the Partnership – we couldn't do it without you

Please see list opposite of further content this time – we hope you find it interesting and useful for your roles in safeguarding children.



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Leona Scurr - Temporary Assistant Chief Constable

Neglect

Child neglect has a lifelong impact on a person's wellbeing, and that is why Nottinghamshire Safeguarding Childrens Partnership is committed to doing all we can to prevent it.

Partnership Mandated Approach

All partners were sent communications via e mail recently about the new Partnership mandated approach from the Nottinghamshire Strategic Leadership Group – NSCP. It shared how tackling Neglect across the multi-agency Safeguarding Partnership is a key priority and that the use of the Neglect Toolkit as a default approach across all agencies and services is in place from the 12th of January 2026.

You can access the toolkit and guidance here:

- [Child and Young Person's Neglect Toolkit \[Word\]](#)
- [Guidance for practitioners using the NSCP and NCSCP neglect toolkit \[PDF\]](#)

Supporting information on Neglect:

- [Protecting children from neglect | NSPCC Learning](#)
- [Podcast: recognising and responding to child neglect | NSPCC Learning](#)
- Neglect animation for professionals: [Recognising and Responding to Neglect](#)
- Neglect animation for parents/carers and any members of the public: [Raising awareness about Neglect](#)
- Nottingham and Nottingham procedures [Neglect](#)

Neglect Training and Briefing Events

We offer multi-agency training on Neglect annually for all partners to access, and we are currently in the process of re-designing and updating this training. Whilst we are doing this, we would like to offer some 1-hour briefing events for you to attend over the coming weeks.

Briefings aim to:

- Provide an overview of Neglect as one of the main types of abuse
- Build on your understanding and confidence in using the multi- agency Child and Young Persons Neglect toolkit
- Broaden knowledge of neglect resources available for practitioners across Nottinghamshire

The dates of the first events are (you only need to book onto one):

- Friday 23 January 12-1 pm
- Friday 6 February 12-1 pm
- Tuesday 17 February 12-1 pm
- Wednesday 4 March 12-1 PM

Target Audience:

- Anyone working or volunteering with children, young people and families in Nottinghamshire.

Speakers:

- NSCP Officers

To book on please E MAIL sarah.bale@nottscce.gov.uk or call 0115 9774439 if you have any queries/questions.

A typical day in the life of the Managing Allegations Service (MAS)

The Managing Allegations Service (MAS) in Nottinghamshire undertakes the statutory role of the Local Authority Designated Officer (LADO) and was set up in response to the IICSA inquiry.

The MAS considers allegations and concerns against people working or volunteering with children in Nottinghamshire.

The MAS Day starts with morning Triage, the LADO Allegations Officers and Service Manager consider the online LADO Contact Forms that have come in late the day before and overnight to agree the LADO response and decide who is best placed to respond. It is a good day when the referrals clearly state who has done what while working or volunteering with children and full information is provided and we do not have to decline Contact Forms because the person works/volunteers outside Nottinghamshire, has no role with children or because the allegation/concern is not stated clearly and we do not want to come to an incorrect understanding of what is being referred.

Much of the LADO Allegations Officers' time is taken up with contacting a vast number of different settings and organisations ranging from Education and Early years; Social Care/Residential Care; Fostering; Health, Police, the different Sports, Dance, Youth and Faith organisations - any setting where people work in a position of trust with children. They assess the risk posed by the person of concern and consider next actions from an employer investigation to a strategy discussion with police and social care and a Managing Allegations Meeting process.

Social Workers in the MAS Social Work team are contacting people of concern and preparing the reports for the Managing Allegations meetings. The Social Workers keep the subjects up to date on how the process is progressing, check they have support in place and provide them an opportunity to give their views. Contacting the professionals who will attend the meeting to ensure everyone is prepared is a key role and helps ensure a productive meeting.

The MAS Team Manager is preparing to chair a Section 47 Strategy Discussion for other local authority children living in Notts who have made allegations against their foster carer from an independent fostering agency. This meeting gathers the professionals involved to consider the allegations made, the harm posed to the children, agree actions for CSC, Police, the employer and the LADO response.

The independent Chair is preparing for a Managing Allegations Meeting, reading the Social Work report and the updates from the Police, Employer and Children's Social Care. These meetings work well when all parties are attending and have full information and are prepared to contribute - the employer has the person of concern's full employment history to hand, the Police have clear updates from their investigation and children's social care bring the child's voice and assure the child is safe and their needs are being met.

Need to know:

- *Nottinghamshire LADO only takes referrals relating to individuals (including 16 and 17 yr olds) who are **working or volunteering with children in Nottinghamshire** - please read the Advice and Guidance section of the LADO Contact Form.
- *LADO does not take referrals from parents - please don't share details of LADO referrals with parents or advise them to contact LADO.
- * The LADO does not undertake investigations – the police and the employer investigate.
- *Please provide a clear and detailed statement of the allegation/concern you are referring to LADO i.e. what is the person working/volunteering with children alleged to have done? To which child/ren? What have you done so far? – clear details are key.

Useful links:

- For all new referrals to LADO : [Submit a LADO Contact Form](#)
- Employer leaflet: [ladoleafletforemployers.pdf](#)
- Hazel McKibbin, on behalf of the Managing Allegations Service

Rapid Reviews



There is a statutory requirement on safeguarding partners to conduct a 'Rapid Review' when serious child safeguarding cases are identified. The reviews should be completed within 15 working days and a report provided to the National Child Safeguarding Practice Review Panel (NCSPPR). The NSCP remains committed to gathering as much learning as possible during the rapid review process and to only progressing to a Local Child Safeguarding Practice Review (LCSPR) where necessary. LCSPR Reports are published on our website, however we do not publish Rapid Reviews Reports, as there is no statutory requirement to do this.

We have one Rapid Review to share with you this time. Please be aware you may find some of the content, particularly around the family circumstances distressing:

25-6

A two-year-old child was admitted to hospital with serious injuries consistent with sexual and physical abuse. Medical findings were consistent with non-accidental injuries including signs of historic injuries. He was placed under police protection and following emergency surgery is now a looked after child. There is a documented history of neglect, poor engagement with services, exposure to unsafe individuals and adults. It is of note that a Local Child Safeguarding Practice Review will be completed following this Rapid Review.

Partnership Learning:

- Consideration of how multi-agency decision making can influence evidence based defensible decision making in relation to the need for strategy discussions in complex situations.
- Promotion of cultural competency consideration and training to support an increased understanding of systems and support available.
- Utilisation of third sector working and support available.
- Consideration should be given to the current format of PPNs (Public Protection Notice – an information sharing document used by Police to record safeguarding concerns about an adult or child).

To find out more information about our published Local Child Safeguarding Practice Reviews and to see Learning Briefings on our rapid reviews go to our website: [Learning from practice](#). New Learning Briefings are now available on Rapid Reviews: 25/4, 25/5 and the above review 25/6.

Special Guardianship Orders

A previous rapid Review **25-1** – which concerned a 9-year-old boy who was found deceased at home on 16 December 2024, with a ligature around his neck highlighted the need to raise awareness across the partnership on Special Guardianship Orders (SGO's) as at the time he was living under an SGO.

So, what is a Special Guardianship Order?

A Special Guardianship Order (SGO) is a legal order made by the Family Court that gives a child a permanent home with someone other than their birth parents, usually a relative or close family friend. It provides the carer with parental responsibility, allowing them to make day-to-day decisions for the child, while still maintaining the child's legal link to their birth parents.

Safeguarding considerations:

- Once an SGO is granted, the child is no longer subject to regular social work visits or statutory reviews unless a new concern is raised.
- Without social care involvement, emerging risks or deteriorating circumstances (e.g. neglect, emotional harm, parental separation) may go unnoticed.
- Initial support plans can be limited or short-term, with no guarantee of long-term practical or financial support for guardians.
- Schools, health services, or extended family may be unaware of the SGO, meaning safeguarding signs may not be linked to the child's legal status.
- Guardians are often family members, which may lead to challenges in identifying and addressing harm within the family network.

Links to Local/National/Themed Guidance:
[Special guardianship guidance - GOV.UK](#)

[The Special Guardianship Regulations 2005](#)

[Kinship carers in Nottinghamshire | free support and](#)

Safeguarding Black, Asian and Minoritised Ethnic Children from Sexual Abuse

We are aware that adultification is an issue in Nottinghamshire through lessons learnt from a previous rapid review, so we wanted to share some more details about what it is and to raise more awareness across the Partnership.

What is Adultification?

Adultification refers to the process where children are expected to take on adult roles and responsibilities, often leading to premature exposure to adult knowledge and experiences.

Understanding Bias in Practice:

- Unconscious bias can distort how professionals interpret behaviour, sometimes excusing harmful practices as “Cultural” (IICSA 2020).
- Adultification bias leads to Black children being perceived as older, less innocent and more “streetwise”, reducing protective responses.
- Racism and stereotyping may cause reluctance to intervene where harm is suspected Within faith or community contexts.

Barriers to Disclosure and Help-Seeking:

- Fear of dishonour and community shame deters victims from speaking out (Community Care 2020).
- Boys may struggle to disclose due to expectations of male strength or fear of being labelled gay.
- In some cultures, limited sex education and language gaps prevent children from naming abuse (CSA Centre 2024).
- Children may mistrust statutory services due to past experiences of racism.
- Reverence for religious or community leaders may silence victims.

Embedding Anti-Racist and Culturally Informed Practice:

- Start from the assumption that children and families from Black, Asian and Mixed Heritage backgrounds have experienced racism.
- Actively challenge adultification and racial bias in all assessment and strategy meetings.
- Ensure the child's lived experience and voice are central – avoid cultural assumptions overriding their narrative.
- Recognise and address community-specific barriers honour, shame, sexuality taboos, faith hierarchies).
- Build relationships with trusted community advocates and faith leaders who support safeguarding principles.
- Embed anti-racist learning within supervision, audits and multi-agency training.

Specialist Support Services

- AFRUCA Safeguarding Children – <https://afruca.org/>
- CSA Centre Support Directory – <https://www.csacentre.org.uk/find-a-support-service/>
- Breaking the Silence – [Break the Silence – Professional support for survivors of childhood sexual abuse.](#)

National Case Reviews

The NSPCC ensures that learning from all case reviews can be accessed and shared at a local, regional and national level.

Go to their website: [Case reviews | NSPCC Learning](#)

Where can you:

- Sign up to monthly e mail updates
- Read recently published case reviews
- Read learning from case review briefings – a series of thematic briefings highlighting the learning from case reviews for example: Child Sexual Abuse, Domestic Abuse, Harmful Sexual behaviour
- Read learning from case review briefings - learning from specific sectors – such as Early Years sector, Education, Healthcare, Housing, Police and Voluntary agencies.
- Access national collection of Case Reviews

The most recent learning from case review briefing is for Healthcare Professionals: Summary of key issues and learning for improved practice for the health sector. Publication date October 2025.

[Healthcare: learning from case reviews | NSPCC Learning](#)

Public Consultation on Child Protection

The Department for Education (DfE) has launched a consultation on the creation of a new national body to improve child protection in England. The Child Protection Authority (CPA) aims to provide national leadership and oversight, use data and intelligence to spot risks early, and advise on policy at local and national level.

The consultation is seeking views on the CPA's proposed functions, governance and interaction with existing bodies. Responses are invited from children and families with lived experience of the child protection system, **frontline practitioners**, local authorities, inspectorates, professional bodies, and voluntary, community and statutory organisations involved in safeguarding.

The consultation closes on 5 March 2026 : [Child Protection Authority - Department for Education - Citizen Space](#)

Read the DFE statement: [Child protection](#)

Find out more: [Establishing the Child Protection Authority in England](#)

Education and Health Information Sharing

In September 2025 we launched a new Nottingham City and Nottinghamshire-wide information sharing process between the education and health sectors. This initiative aims to strengthen communication channels between both agencies, following several serious case reviews and high-profile learning incidents where earlier, more direct communication could have helped prevent or reduce harm to children.

Education colleagues in both City and County have worked alongside the GP Leads to develop a process designed to remove barriers that DSLs and GPs may face when needing to share safeguarding information.

There is a new **Information Sharing Form (ISF)** – a tool for DSLs to facilitate communication with General Practices in the following circumstances:

- To share information for awareness, ensuring the GP practice is alert to a child's needs.
- To request that the GP practice contact the school to discuss relevant concerns.
- To inform the practice that a parent/carer, or where appropriate, a young person, has been advised to make a GP appointment.

The ISF is not to be used for:

- Cases of acute illness, even where safeguarding concerns exist.
- Referrals for neurodevelopmental or neurodiversity assessments – please follow local referral pathways.
- Requests for information or letters from the GP practice.

Early feedback is positive, and there are reviews planned for this term. Thank you to everyone in our Education Settings and our GP Practices for your continued commitment to safeguarding children and for supporting the successful rollout of this process.

Dr Lucy Genillard (Named GP for Children's Safeguarding, Nottinghamshire).
Moira Loadman (Nottinghamshire MASH Education Adviser).

Introducing Magic Notes



Nottinghamshire County Council, Children's Services are excited to share with you what is being done to support practitioners to focus more on the children, families and agencies input within meetings, in person and online with the use of the Magic Notes tool.

In a time of limited resources NCC are continuously striving to find creative and innovative ways of supporting practitioners within their role to focus more upon the people we serve and reduce the administrative pressures upon practitioners. Magic Notes is an AI solution lots of councils are using to help with this endeavour. It is an AI technology that will record during a conversation/meeting, provides the worker with detailed notes to assist in their day-to-day role, provides the children, families and partner agencies with records of the assessments, meeting and discussions in a timely manner.

The introduction of Magic Notes within Nottinghamshire, albeit in its infancy, is proving to 'do what it says on the tin', which is both exciting and progressive for practitioners. There has been a real buzz in the services so far as the rollout is being offered. It is enabling Independent Reviewing Officers to spend their time on working with families, instead of writing meeting summaries.

Partner agencies and families will be seeing Magic Notes now being used in all Looked After Children reviews. We'd like to provide reassurance that Magic Notes is compliant with NCC requirements on data protection and information governance. All records obtained through the use of Magic Notes are checked for accuracy before circulation and approved by the leading practitioner.

Interagency Safeguarding Children Procedures; NSCP & NCSCP

Safeguarding Unborn Babies Guidance – updated September 2025

Focus on the additional needs of babies born prematurely

Young infants are particularly vulnerable to suffering serious harm as a result of child maltreatment. Premature babies are at even greater risk, and there are many reasons why this might be the case.

Why are premature babies even more vulnerable?

To start with babies are more likely to be born early if there are psychosocial risk factors including maternal stress, poverty, lack of social support or domestic violence. In addition, when a baby is born early, pre-birth safeguarding assessments and plans are often incomplete. Once born premature babies are vulnerable because their organs and systems, like their lungs, brain, immune system, and digestive tract, are not fully developed, making them more susceptible to complications like infections, breathing difficulties, brain bleeds, and feeding issues. Premature babies will often require many months of care on a neonatal unit, which at times may be some distance from their home. Parents of infants admitted to the neonatal unit are known to experience heightened distress, including increased anxiety, depression, and trauma symptoms, compared with parents of healthy infants. It also places a financial burden and causes difficulties balancing other caring responsibilities all of which place additional stress on any family. Many babies who are born extremely prematurely will have short-, medium- or long-term additional health and developmental needs.

What can help?

When there are known safeguarding concerns an early multi agency meeting in the days after birth can help professionals to have a shared understanding of how they can ensure that parents / carers and siblings are supported even during the time that their baby is 'safe' on the neonatal unit.

Planning for discharge needs to start at admission and will need to understand the neonatal journey. There should be a shared understanding between the neonatal team / parents / carers / community health colleagues, and if involved children's social care / early help / housing, about what is known about the likely current or longer-term health needs of the baby and their family. Early planning means that discharge is less likely to be delayed due to housing or social issues. A joint visit of the planned discharge location can be a great way for multi-agency professionals together with parents / carers to consider if the environment is optimal for discharge, including the impact of environmental factors such as the risk of second hand smoke / vape, housing issues including mould or damp on lungs which may have been damaged by being born early.

Assessment of the parental capacity should include consideration of how the parents have responded to meet the needs of their baby whilst in hospital but must recognise the challenges of this assessment in what is a stressful and highly artificial parenting environment. It should not be focused just on how often the parents / carers have visited but also consider evidence that they are able to notice and respond appropriately to their baby. It should also consider the wider strengths, supports and stressors of the family. This is particularly important where there is expectation of parents providing addition care to their baby e.g. feeds through a tube inserted through the nose into the stomach, or if the baby needs home oxygen. In this situation careful analysis of information known about the family both on the neonatal unit and historically needs to be considered to ensure all professionals agree that the parents / carers are likely to be able to provide this safely.

Historical concerns particularly about medical neglect including not following medical or safe sleep advice, not bringing children to health appointments or for vaccinations, or poor home conditions should be recognised as potentially lethal in the context of a vulnerable preterm infant.

More information about how you can support preterm babies can be found in our Interagency Safeguarding Children procedures at: [Safeguarding Unborn Babies](#)

Prior to discharge is there a shared understanding between neonatal team / parents / carers / community health colleagues and if involved children's social care / early help / housing about:

- Premature babies are particularly vulnerable to suffering serious harm as a result of child maltreatment
- Likely impact of any medical concerns and investigations including
 - Growth and / or feeding concerns,
 - Respiratory
 - Brain scans, neurology or development
 - Crying and ability to settle once home
- Parental attunement with baby / visiting / ability and willingness to provide all care for their baby prior to discharge
- Where there is expectation of parents to provide addition care e.g. NG feeding or home oxygen parents are able to provide this safely, including being attuned to their baby to be able to recognise deterioration early and will seek routine and urgent health care as needed
- Understanding of safe sleep guidance and potential challenges



- Wider strengths, supports and stressors of the family
- Additional needs of vulnerable preterm babies including the impact of environmental factors such as the risk of second hand smoke / vape, mould or damp on preexisting medical conditions such as chronic lung disease. **Should there be a joint home visit with neonatal / HFT / CSC?**

DBS Checks and Carers Employed for Children using Disability Living Allowance (DLA) or Personal Independence Payment (PIP)

Did you Know?

- Families in receipt of Disability Living Allowance (DLA) or Personal Independence Payment (PIP) for their children may use these funds to employ individuals directly to provide care and support.
- Under current arrangements, there is no legal requirement for those individuals to undergo a Disclosure and Barring Service (DBS) check.
- By definition, children in receipt of PIP will have additional needs or vulnerabilities.

Safeguarding Concern

- No statutory DBS requirement: Carers employed directly through DLA or PIP arrangements may not be vetted.
- False assumptions: Parents and professionals may assume that vetting has taken place when it has not.
- Vulnerability of cohort: Children with additional needs are more reliant on carers and may be less able to report concerns.
- Limited parental awareness: Although parents can request a DBS check, awareness of this option is low, and there is no systematic mechanism in place.

Risk Implications

- Increased potential for unsuitable individuals to gain unsupervised access to vulnerable children.
- Inconsistent safeguarding practice across families and local areas.
- Risk of erosion of trust in safeguarding systems if an incident were to occur.

Advice you can give to parents/carers. Current safeguards:

- Parents can request that individuals provide a DBS check. Some local services advise families to do so, but this is not mandated or routinely supported.
- They can ask for references – Speak to people who have employed or worked with the person before.
- Trust their instincts – If something doesn't feel right, don't ignore it.
- Be clear about their expectations – Write down what they expect from the role, agree clear boundaries about routines, behavior management, and how their child's needs will be supported.
- Keep communication open – Regularly check in with their child about how they feel with their carer (where possible). If their child cannot communicate directly, look for changes in their behavior or mood.
- Talk to professionals involved with their child, in childcare, school or health settings if needed.

If they are worried:

If they ever have a concern about someone working with their child, they can contact:

- Their local safeguarding team (MASH - 0300 500 80 80)
- The NSPCC helpline (0808 800 5000)
- In an emergency, call 999



Up and Coming Courses!

Please visit our website regularly as we add new courses throughout the year: [Training events](#)

Here are some of the courses available for you to book onto:

- MAPPA- Multi-Agency Public Protection Arrangements
- Reducing Parental Conflict awareness and resource training
- Safeguarding Children Today
- Working Together to Safeguard Children
- Tackling Child Exploitation
- Gas and Solvent Use

Coming up after April:

- Child Poverty
- Effective Strategy Discussions
- Safer Sleep for Babies

Booking onto events:

You can now book onto all of our events and access our e-learning via our course login page : [Identity](#)
We have had our new LMS - booking on system for 10 months, however if you haven't booked onto a course

since then and need any support or guidance please contact the NSCP Training Administrator Sarah Bale

who would be happy to help: email: sarah.bale@nottscc.gov.uk or phone: 0115 9774439

Course Charges

- Some Partners have to pay for attendance on NSCP courses – to check if this applies to you and your organisation go to: [Training charges](#)
- From April we will be increasing our course charges as we haven't increased them since 2019.
- We will also be increasing our Non-Attendance charges which is applicable to ALL partners.
- Please see our website in April for more details.



External Training Opportunities

New webinar series: Strengthening multi-agency leadership in responding to intra-familial child sexual abuse

The centre of expertise on child sexual abuse is offering six FREE online sessions between January and July 2026 to support safeguarding partners to reflect, plan and lead the implantation of the recommendations for safeguarding partners in England, set out in the 2024 [National review into child sexual abuse within the family environment - GOV.UK](#)

In November 2024, the review's final report uncovered significant and long-standing systemic issues in the identification of and response to child sexual abuse in family settings.

The final report made six recommendations for local safeguarding partnerships which they can **implement immediately** without waiting for changes at a national level.

Each workshop will take a closer look at the recommendations, covering topics from improving professional knowledge, skills and practice, to how to talk to children about sexual abuse.

Book onto an individual session:

Wednesday 14th January

[Workshop 1: Strategic planning with Dr Natasha Sabin and Jenny Coles](#)

Tuesday 3rd February

[Workshop 2: Professional knowledge, skills and confidence with Anna Glinski and Lorraine Myles](#)

Thursday 12th March

[Workshop 3: Enquiries and investigations with Paul Burnside and Nick Connaughton](#)

Thursday 21st May

[Workshop 4: Assessment of people presenting risk of sexual harm with Anna Glinski, Paul Burnside, TJ Abrahams, and Becky Canning](#)

Wednesday 17th June

[Workshop 5: Talking to children with Lorraine Myles and Dr Natasha Sabin](#)

Monday 13th July

[Workshop 6: Health with Dr Natasha Sabin and Dr Alison Steele](#)



Education partners- Whole School Training Update

In January, we will launch a new suite of Whole School Safeguarding Training products. Available as workshops or flexible e-learning modules, each option is quality-assured to help schools meet safeguarding legislation, standards, and Ofsted requirements.

More information on each option is available here:

- [Safeguarding in schools training | Nottinghamshire County Council.](#)

Workshops

Workshops offer deeper discussion and direct access to a safeguarding expert, while e-learning provides a convenient, self-paced training pathway. The new workshops will be delivered by UK Learning Network, who already provide our Designated Safeguarding Lead training, and will be available later in January.

E Learning

E-learning modules will be available from the 5th January.

Contact us

If you have any questions about this change, please email:

- safeguarding.training@nottscc.gov.uk

Meet the NSCP Team



Haley Thompson is the Interim Service Manager for the safeguarding partnership. She facilitates the NSCP's strategic meetings, manages the NSCP procedures and audit framework and supports the partners in their drive towards delivering the business plan priorities



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.



Emma North 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. Emma also has a role in facilitating the Child Death Overview Panel.



Miranda Speed is the Business Support Officer for the Safeguarding Partnership. She line manages the Business Support Administrators within the Partnership and has oversight of the administrative tasks.



Levin Nahmad is a Business Support Administrator for the Safeguarding Children Information Management Team (SCIMT). He is currently reviewing the administrative processes of SCIMT. Levin also provides cover for Sarah Beet.



Jenny Ford is a Business Support Administrator for the Safeguarding Children Information Management Team (SCIMT). She provides administrative support by responding to enquiries from partner agencies of whether a person is or has been known to children's social care.



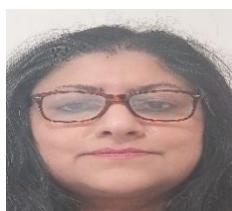
Anita Catton is a Business Support Administrator for the Safeguarding Children Information Management Team (SCIMT). She provides administrative support by responding to enquiries from partner agencies of whether a person is or has been known to children's social care.



Karen Ford is a Business Support Administrator for the Safeguarding Children Information Management Team (SCIMT). She provides administrative support by responding to enquiries from partner agencies of whether a person is or has been known to children's social care.



Julie Worsnop is a Business Support Administrator for the Safeguarding Children Information Management Team (SCIMT). She provides administrative support by responding to enquiries from partner agencies of whether a person is or has been known to children's social care.



Nita Odedra is the Business Support Administrator for the NSCP. She supports Haley Thompson by arranging and minute taking for the partnership's operational and strategic meetings and provides administrative support for the Creative Solutions

E mail: info.nsdp@nottscce.gov.uk
Telephone: 0115 9773935