Hartlepool & Stockton-on-Tees
SAFEGUARDING CHILDREN PARTNERSHIP





Learning from Reviews Briefing

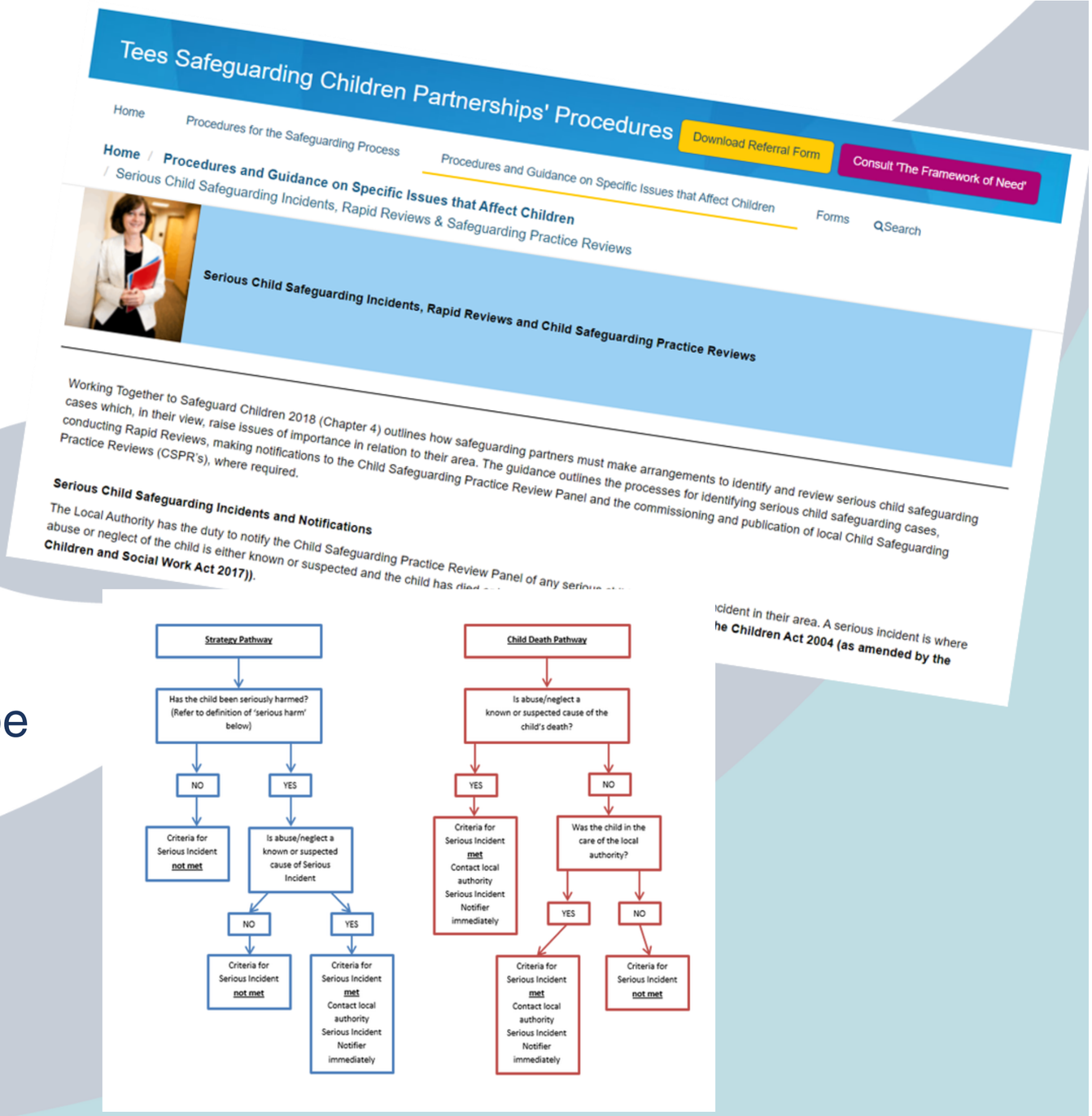
September 2026

Presented by Julie Taylor and Jan Edwards

Role of the Safeguarding Children Partnership

- Duty for partners to identify serious safeguarding incidents

- Duty for the partnership to undertake Rapid Reviews of serious safeguarding incidents and determine whether a LCSPR needs to be undertaken



Serious Safeguarding Incident Notifications and Rapid Reviews

•Since going live in early 2019, HSSCP have received 30 Serious Incident Notifications and has conducted a Rapid Review for each of these notifications made.

•Of the 30 Rapid Reviews undertaken, 13 have progressed to a Local Child Safeguarding Practice Review.

•One HSSCP LCSPR has also been part of a National thematic review on Non-Accidental Injury in under 1's*



Local Child Safeguarding Practice Reviews (LCSPR's)

- LCSPR's replaced Serious Case Reviews

- Safeguarding Children Partnerships have 6 months to complete an LCSPR once a Rapid Review has confirmed that the criteria has been met for one to be undertaken.

- HSSCP have undertaken 13 LCSPR's to date



61%	19/31 were children under 3
52%	In 16/31, the child died.
42%	13/31 involved non-accidental injury or physical abuse
97%	Neglect featured in 30/31 cases
48%	In 15/31 neglect was the cause of the significant incident or death.
65%	20/31 featured hidden significant adults
65%	20/31 featured domestic abuse
61%	19/30 were Stockton children
39%	12/31 were Hartlepool children
71%	23/31 included a lack of understanding of the child's voice and experiences







Learning from Local Child Safeguarding Practice Reviews & Rapid Reviews since April 1st 2026











Learning from HSSCP Reviews since April 1st 2026

Ashley Rapid Review

Context & Background

- Ashley was a 5-month-old, White British baby living with Mother and older sibling (Sibling 1). Ashley had 2 other siblings who did not live with them.
- After being put down for a nap on a mattress on the floor, Ashley was found unresponsive and had sadly passed away.
- The family have a long history of service involvement for concerns including domestic abuse, substance misuse and neglect.
- Ashley was subject to a Child Protection Plan from before birth and throughout their life.
- Following Ashley's death, concerns were raised around physical indicators that the baby may have been shaken, drug paraphernalia in the home, and inconsistencies with information provided by Mother and Sibling 1's friend on the events leading up to Ashley's death.







Learning from HSSCP Reviews since April 1st 2026

Ashley Rapid Review

Findings and Learning

- Disguised compliance
- Domestic abuse
- Over-reliance on parental self-report
- Parental capacity
- Safe sleep
- Young carers with additional vulnerabilities







Learning from HSSCP Audits since April 1st 2026

HSSCP Multi-Agency Audit

Cumulative Vulnerability and Risk

March 2026

Hartlepool & Stockton-on-Tees SAFEGUARDING CHILDREN PARTNERSHIP

Context

The HSSCP Engine Room undertake monitoring and analysis of recurring themes from reviews. One of the recurring themes identified by the Engine Room for further exploration was '**Cumulative Vulnerability and Risk.**' The Engine Room sought assurance via the multi-agency audit process that early indicators of vulnerability and risk were identified, information was shared that children receive the right support at the right time. Cases that had received two or more referrals in the past two years were selected for audit.

6 **Cases were selected for audit - three from Hartlepool and three from Stockton-On-Tees.**

4 boys, 2 girls. 5 were white British, one was an ethnic minority child.

One case was open to Early Help, one CIN, one CP and three were closed to Social Care.

All six cases featured withdrawn consent that had resulted in a start / stop pattern.

All six cases featured Domestic Violence as a significant cumulative risk.

Five cases featured substance misuse as significant cumulative risks.

Three cases featured parental mental ill-health as significant cumulative risks.

Neglect featured in five of the cases.

Audit Findings:

Evidence of Cross-Cutting Good Practice:

⇒ Safety planning
⇒ Tenacity of workforce in engaging families
⇒ Information sharing
⇒ Professional Challenge

When it Works Well, Best Practice is:

⇒ When children have moved schools, strong handovers meant that the new school had all of the information about cumulative harm. This enables school to have a comprehensive overview so that they can refer concerns, within the context of cumulative harm, when additional concerns of a similar nature emerge.

⇒ When workers are consistent

What are the Barriers?

⇒ Disengagement of parents: parents not consenting or withdrawing consent prevents agencies from supporting the child and family.

⇒ Professionals accepting parental reports on face value rather than digging deeper / verifying information and challenging this.

⇒ Professionals focussing on parental issues / risk leading to cumulative risk not being seen / evidenced through what life is like for the child.

Recommendations - HSSCP to consider:

- Flagging / an escalation procedure for cases that have had a number of referrals for similar concerns.
- Develop a tool for cumulative harm (similar to the HOTH screening tool) that can be used as a working document to gather evidence over time.
- What can be put in place to support consent (re-framing consent)
- How to support professionals to challenge parental self report.

Learning from National Reviews since April 1st 2026











‘I wanted them all to notice’ – National Review into Child Sexual Abuse in the Family Environment -

Key Findings

Action plan developed from national CSA report which informed Tees deep dive and workforce confidence survey. The findings from these were as follows:

- **Misunderstanding about forensic medicals** - Purpose is not solely evidence gathering. Key aims of a forensic medical are acknowledge abuse, support the child, assess health, welfare, and unmet needs.
- Very low number of forensic medical referrals (**less than 10 across Tees**) despite **hundreds** of sexual abuse reports → often due to time gap between abuse and disclosure.
- Link not always made between adults accessing indecent images of children and their **roles as parents.**
- **There is a workforce confidence gap –** practitioners lack confidence when speaking directly with children and families and have a fear of asking leading questions.







‘I wanted them all to notice’ – National Review into Child Sexual Abuse in the Family Environment -

Actions

Child Sexual Abuse has been added as priority for both HSSCP and STSCP.

A steering group has been established, who have undertaken the following work:

- The Tees Child Sexual Abuse procedure has been revised. The updated procedure includes Child Sexual Abuse Centre for Expertise practice resources, a video on forensic medicals, a Tees-wide map of support services for children experiencing child sexual abuse, and includes the CSA Centre for Expertise response pathway, which the group are currently in the process of implementing.

- New training added to the programme about how to speak with children and families about child sexual abuse .

- Plans to include a wider child sexual abuse training course that is currently in development







The Southport Inquiry: Phase 1







Following the publication of the *Southport Inquiry: Phase One* report, HSSCP are currently undertaking self-assessment activity to consider the recommendations and issues that were highlighted in the report.

HSSCP will be benchmarking against the following issues:

1. A failure of any organisation or multi-agency arrangement to take ownership of the risk that AR (perpetrator) posed.

2. Poor Information management and sharing.

3. Excusing AR's (perpetrator) behaviour on the basis of his perceived or diagnosed autism spectrum disorder.

4. Failure to oversee and intervene in AR's (perpetrator) online behaviour.

5. The role of AR's (perpetrator) parents.

‘Protecting All Vulnerable Babies Better’ – National Review

Following the publication of the report, HSSCP have set out below the eleven specific recommendations for safeguarding partners and the implications they have for Hartlepool and Stockton-on-Tees.(Some strengths have already been identified and work is currently underway to identify any gaps):

1. **Multi-agency protocol for unborn babies**

   HSSCP has the following procedures:

   Safeguarding The Unborn Baby - Tees Safeguarding Children Partnerships' Procedures

   Concealed Pregnancy Procedure - Tees Safeguarding Children Partnerships' Procedures

2. **Pre-birth Protocols**

3. **‘Think Family’ approach**

   HSSCP have worked with STSCP and TSAB on the Think Family Guidance - Safeguarding Adults Children and Families - Tees Safeguarding Children Partnerships' Procedures







‘Protecting All Vulnerable Babies Better’ – National Review

4. Multi-agency reflection and joint approaches
   - Tees Complex Case Practice Guidance
   - Space to Think: Reflective Supervision Practice Guidance

5. Accessibility of services for families

6. Trauma skills and understanding

7. Involvement of criminal justice services

8. Cooperation and oversight of sex offenders

9. Impact of domestic abuse on babies and children

10. Missing vulnerable women and unborn babies

11. Having key information ready to share
    - 15. Regional Protocol for Protecting Children Who Move Across Local Authority Borders - Tees Safeguarding Children Partnerships' Procedures







‘Why did it take so long to respond?

Child Neglect: A Thematic Analysis







The Child Safeguarding Practice Review Panel have recently published a thematic analysis of national reviews on the theme of child neglect. Relevant findings and recommendations include:

1. See cumulative harm, not isolated incidents
2. Name neglect and act earlier
3. Keep the child’s daily lived experience central
4. Strengthen multi-agency information sharing and chronologies
5. Distinguish poverty from neglect, but address both
6. Avoid over-optimism and premature case closure
7. Use evidence-based neglect assessment tools consistently
8. Think family, but stay child-focused

HSSCP Trauma Priority

HSSCP Trauma-Informed Strategy 2025 - 2028

Hartlepool & Stockton-on-Tees SAFEGUARDING CHILDREN PARTNERSHIP

Vision

Our Vision is to work in partnership with every child to make them feel safe, heard, believed and supported. All members of the workforce will understand the impact of trauma and adversity on children's lives.

Aim and Priorities

Our aim is:

- For all members of the workforce to understand the impact of trauma and how it can affect different people.
- To enable all members of the workforce to respond with empathy, consistency, and a shared commitment to building resilience.

Definition

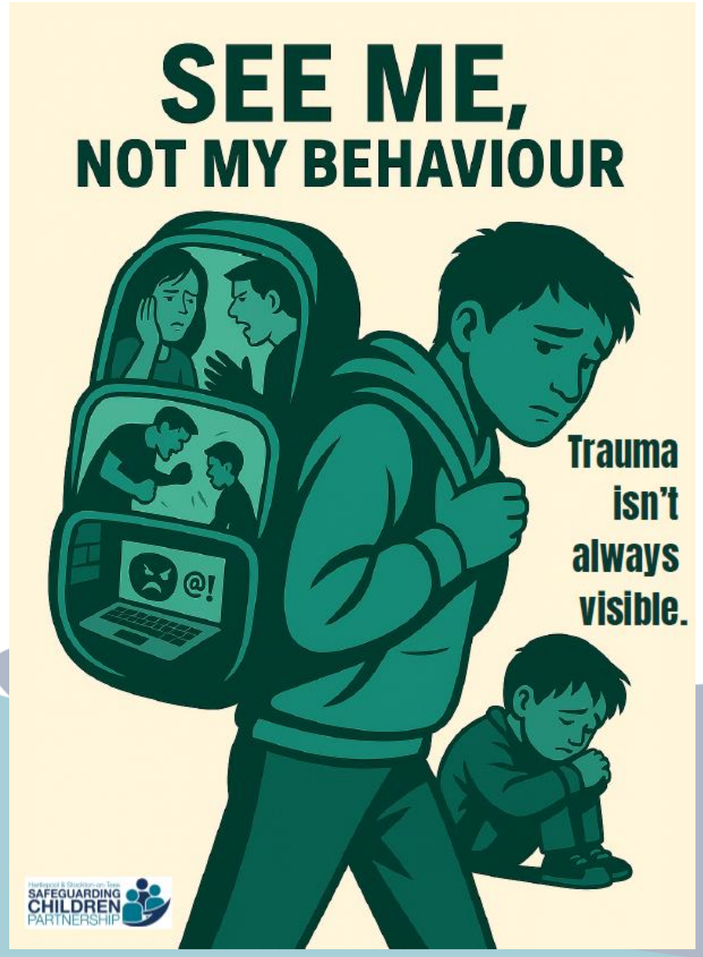
Being trauma-informed allows people to connect and build relationships with others, recognising that some have had difficult experiences and responding with care, compassion, understanding and creating safety.



Core Principles

- Safety
- Trust
- Choice
- Collaboration
- Empowerment
- Cultural Consideration

HSSCP Trauma Priority



Workshop	Where and When
Relational Practice – The Role of the Key Adult in School Stacey Bell - Stockton Virtual School	Thursday 1st October 1pm - 3pm Microsoft Teams
The Impact of Trauma on the Brain Sarah Wilcox - Hartlepool Inclusion & SEND	Friday 2nd October 10am - 11am Microsoft Teams
VR Headsets: Understanding Experiences of Trauma and the Impact (for Primary Schools only) Stacy Stoker - Stockton Virtual School	Wednesday 7th October 9:30am - 11:30am Hartlepool
Trauma Basic Awareness Jennifer Higgins - Hartlepool Workforce Development	Wednesday 7th October 10am - 12am Microsoft Teams
The Human Cost of Caring: Trauma Exposure in the Workforce Dr Megan Middlemiss - TEWV	Friday 9th October 10am - 11:30am Microsoft Teams
Trauma Informed Partnership Active Learning Julie Taylor & Lauren Stevenson	Tuesday 13th October 9:30 - 16:00 Stockton
VR Headsets: Understanding Experiences of Trauma and the Impact (for Secondary Schools only) Stacy Stoker - Stockton Virtual School	Wednesday 14th October 12:30 - 14:30 Stockton

Resources

HSSCP Training Programme & E-Learning

HSSCP Booking Form

HSSCP Reviews

Tees Procedures

Working with Neglect: Self-Assessment

Child Safeguarding National Review Panel (practical safeguarding learning and resources)

‘I wanted them all to notice’ – National Review into Child Sexual Abuse in the Family Environment

Southport Inquiry: Phase 1

Child Neglect: A Thematic Review