



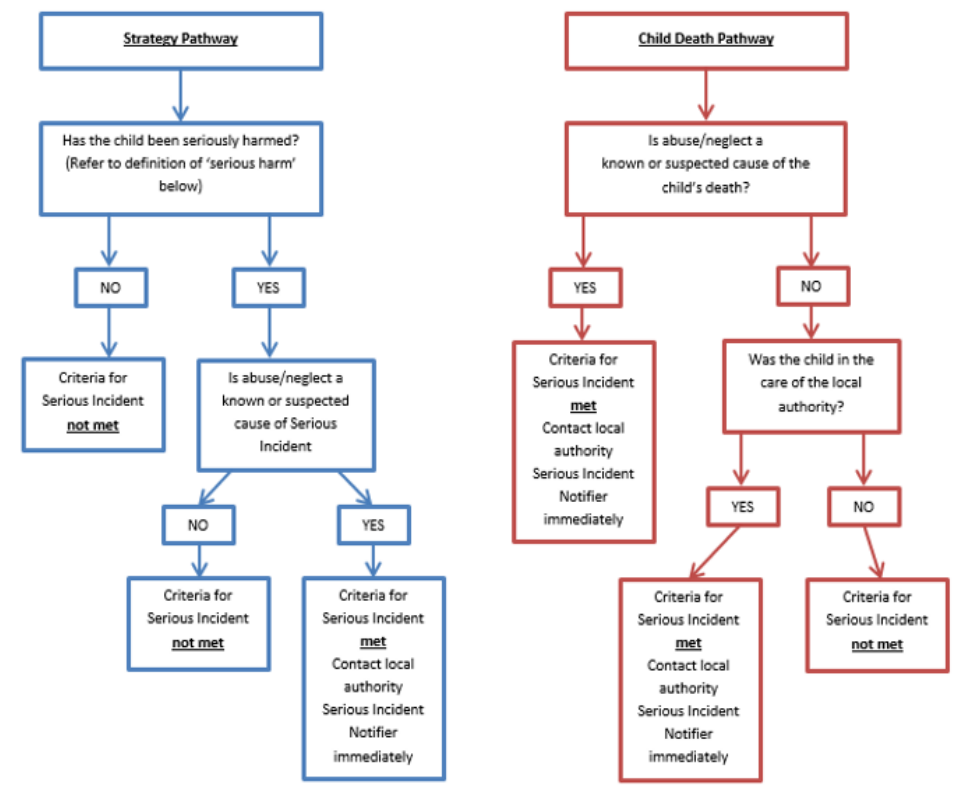
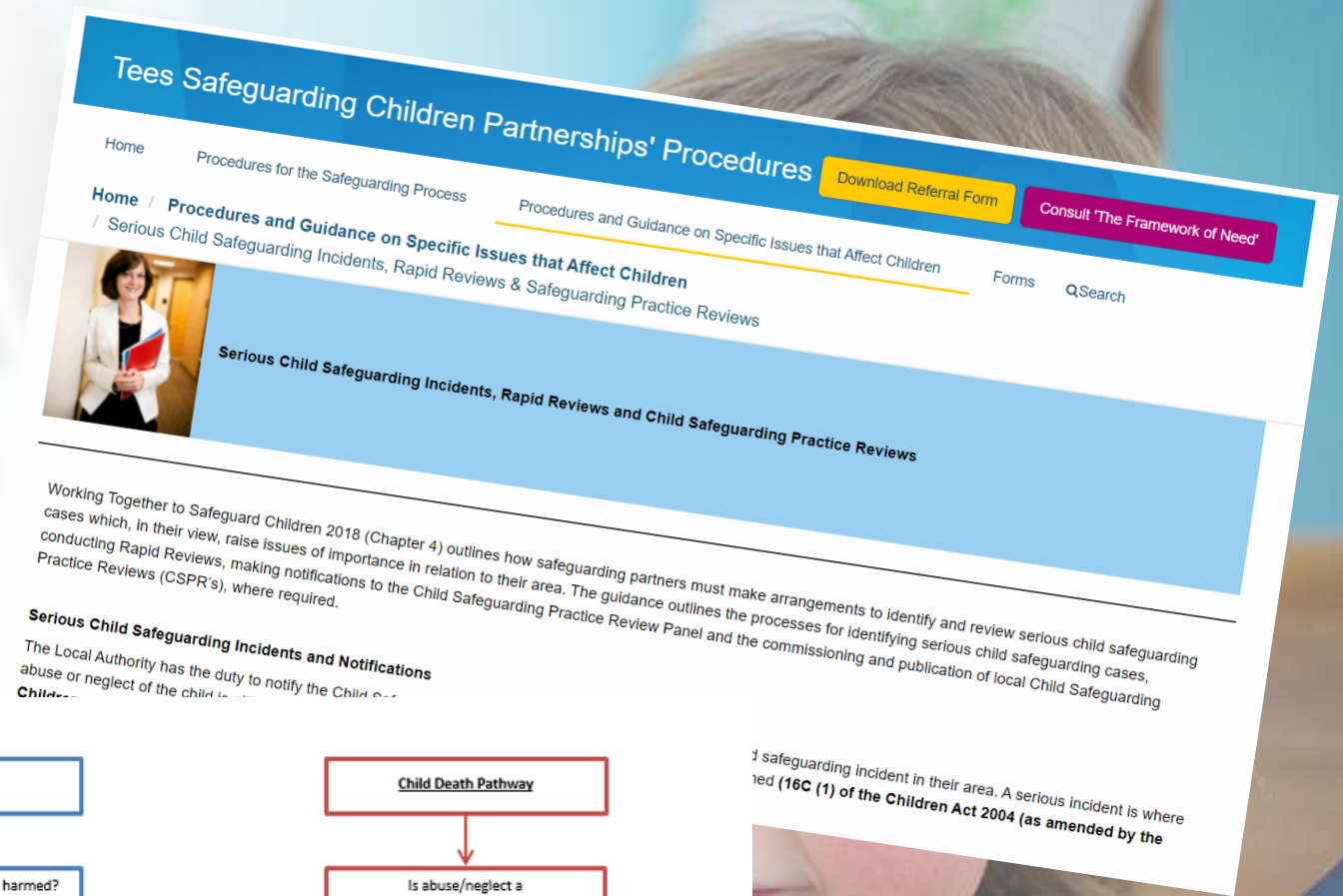
Hartlepool and Stockton-On-Tees Safeguarding Children Partnership

Learning from HSSCP Child Safeguarding Practice Reviews

March 2025

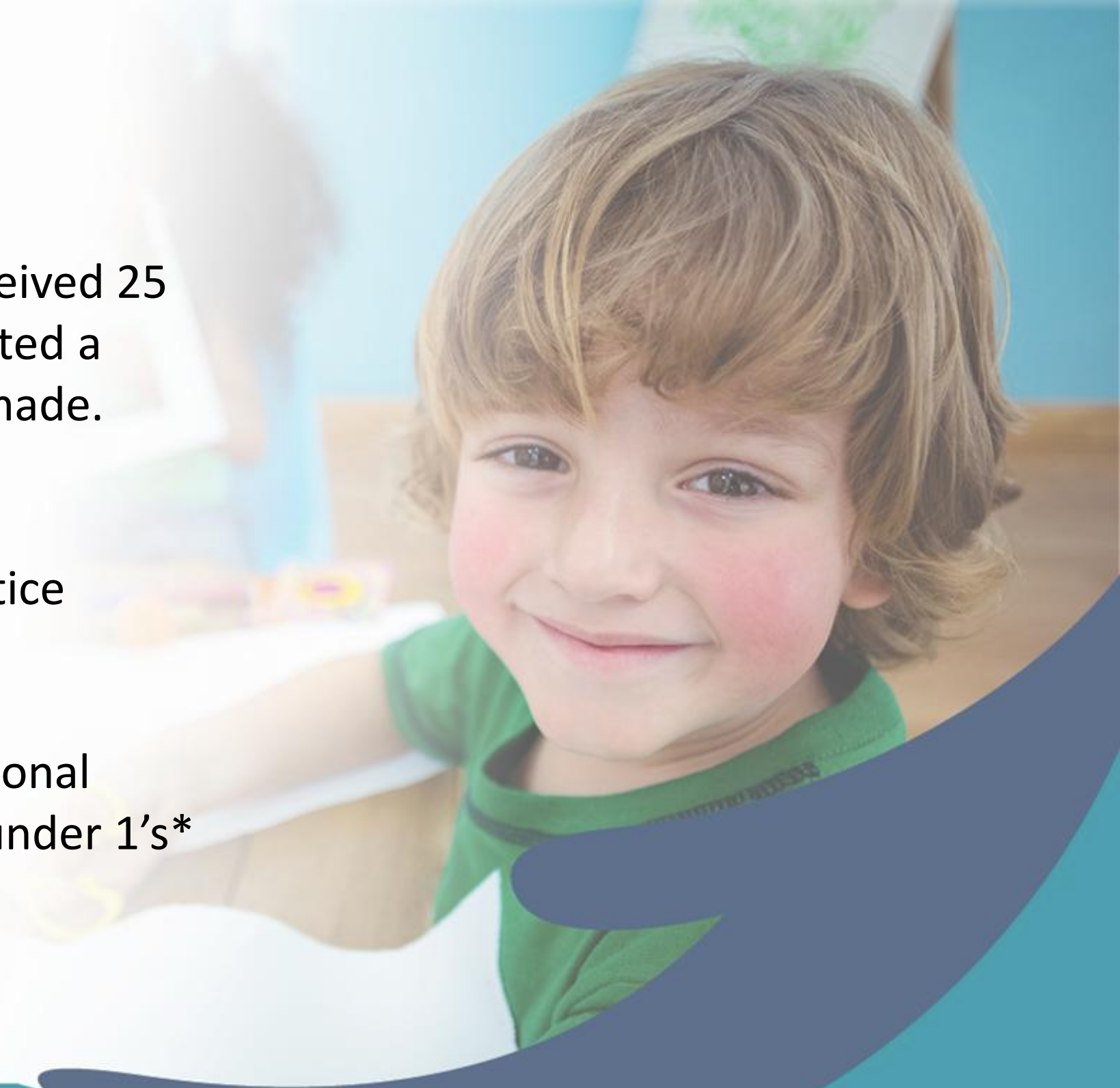
Role of the Safeguarding Children Partnership

- 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 25 Serious Incident Notifications and has conducted a Rapid Review for each of these notifications made.
- Of the 25 Rapid Reviews undertaken, 10 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 ten LCSPR's to date



64% • 16/25 were children under 3

48% • In 12/25, the child died.

36% • 9/25 involved non-accidental injury or physical abuse

96% • Neglect featured in 24/25 cases

44% • In 11/25 neglect was the cause of the significant incident or death.

72% • 18/25 featured Domestic Abuse

52% • 13/25 had recently closed to children's social care

64% • 16/25 were Stockton children

36% • 9/20 were Hartlepool children

64% • 16/25 featured hidden partner/carer



LOCAL CHILD SAFEGUARDING PRACTICE REVIEWS/ RAPID REVIEWS

LB Rapid Review

Context & Background

- LB was 3 months old when she died at home whilst sleeping.
- Parents reported smoking cannabis at 3:30am as they had been unable to sleep. LB remained in her cot at this time.
- She was fed at 8am then placed in bed with parents.
- When parents woke at 11am, LB was unresponsive.



Findings and Learning

- Safeguarding the unborn baby
- Visiting
- Safe sleep
- Engagement of Father
- ACE's
- No evidence of Neglect



LA Rapid Review

Context & Background

- LA was 16 years old, was in the care of the local authority and placed out of area when he died from suicide.
- The night before LA was found deceased by placement staff, LA had been heard on the phone arguing with his girlfriend, as well as making other calls to friends and family where it became clear that his relationship had ended. He was described as 'angry and agitated' by placement staff who had witnessed the calls. Staff had attempted to speak with LA to discuss the issues, but LA refused any support.
- LA was last heard playing music in his room at 19:15 and no further noise was heard. This was not unusual for LA, who had abnormal sleeping patterns and oftens slept through the day and was awake at night.
- Staff grew concerned after some time and checked on LA at 04:00, where he was found unresponsive. Staff immediately called 999 and followed advise, but LA was pronounced deceased a short while later.



Findings and Learning

- Trauma
- Missed appointments
- Missing from education
- Criminal exploitation



LH Rapid Review

Context & Background

- LH was 2 years old when Police were called to the home of her mother's partner as LH was not breathing.
- LH was sleeping on the sofa with her 3-year-old brother when she was found unresponsive with vomit in her mouth and was unable to be resuscitated.
- Police officers found drugs at the scene that were within reach of the children.
- LH's sibling underwent a child protection medical where cocaine was found in his system.



Findings and Learning

- Missed health appointments
- Missed opportunity to engage father
- Assessment of significant other
- Consent



AW Rapid Review

Context & Background

- 17-year-old AW was arrested on suspicion of Murder following the stabbing of an adult male.
- Prior to the serious incident, several referrals were made to Social Care following arrests, most recently for a positive stop search of a car where a baton and drugs were found. AW was in the car with adult male occupants who are known for their criminal connections. A Child Exploitation screening tool was completed, and AW was assessed as medium risk with support needs.
- AW has been on remand in Youth Detention since being arrested.



Findings and Learning

- Domestic abuse
- Trauma
- Self-reporting
- Changes in attendance
- Victim-blaming
- Information sharing



AL & JL Rapid Review

Context & Background

- At 8 weeks old, AL was taken to hospital due to worries about her arm. AL underwent scans that identified several healing fractures on her ribs, arm, legs and feet, which were treated as non-accidental injuries.
- AL had also presented with various abrasions on her body. An explanation for these was initially accepted by medical staff.
- While investigations were ongoing, supervision was put in place for AL's 3 other young siblings, including her twin JL, who was brought to the hospital to be with Mother and AL.
- A full child protection medical was undertaken on JL, which revealed multiple healing rib and leg fractures.
- Mother, Father, and AL & JL's 18-year-old brother were arrested for GBH with intent, causing/allowing significant harm to a child, and child neglect.



Findings and Learning

- Significant other
- Information sharing in relation to dads
- Domestic abuse
- Bruising in Non-Mobile Babies pathway
- Out of hours communication



Cross-cutting themes:

- **Father inclusive practice**, including involving fathers in care during pregnancy and after birth, and ensuring father's medical records are linked with their children.
- **Over-reliance** on families or children to report their concerns/struggles.
- **Support for young parents**, especially those with additional vulnerabilities.
- **Understanding the life and experiences of the child** and how their past traumas continue to affect their development.
- **Domestic abuse** and the lasting impact that experiencing this can have on young people.
- **Recognising trauma** at an early point and intervening to try and minimise the lasting effects that this can have on physical and emotional development.
- **Transient families** and seeking past information for families who move into area.
- **Hidden significant adults** who may have caring responsibilities for children and understanding the risks they may pose.
- **Bruising in Non-Mobile Babies** procedure not being followed correctly.

