



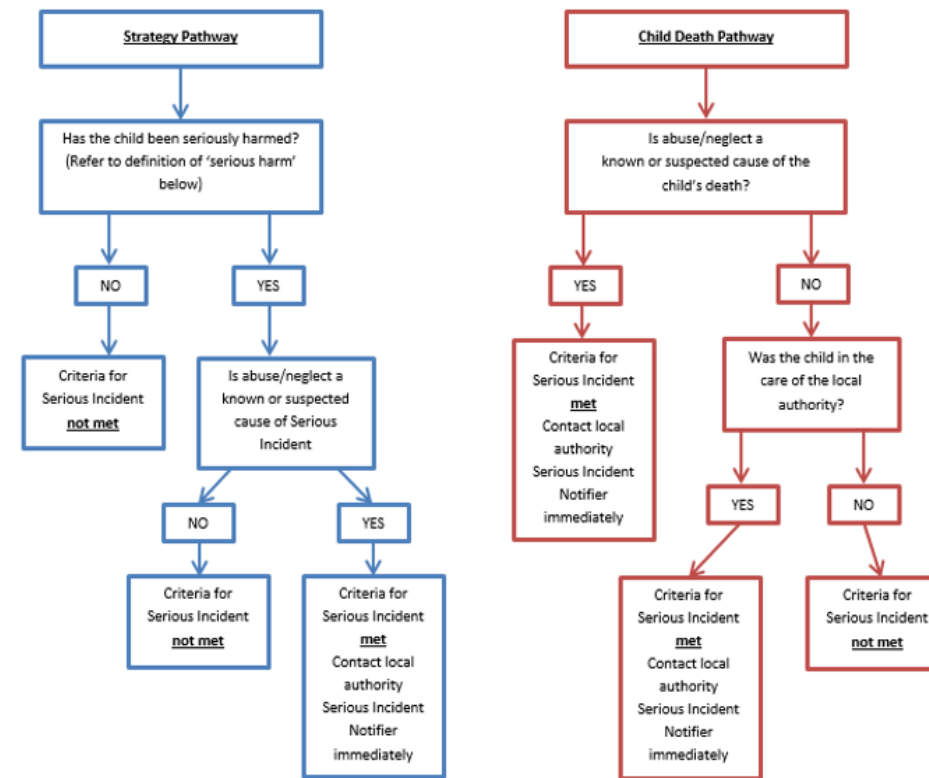
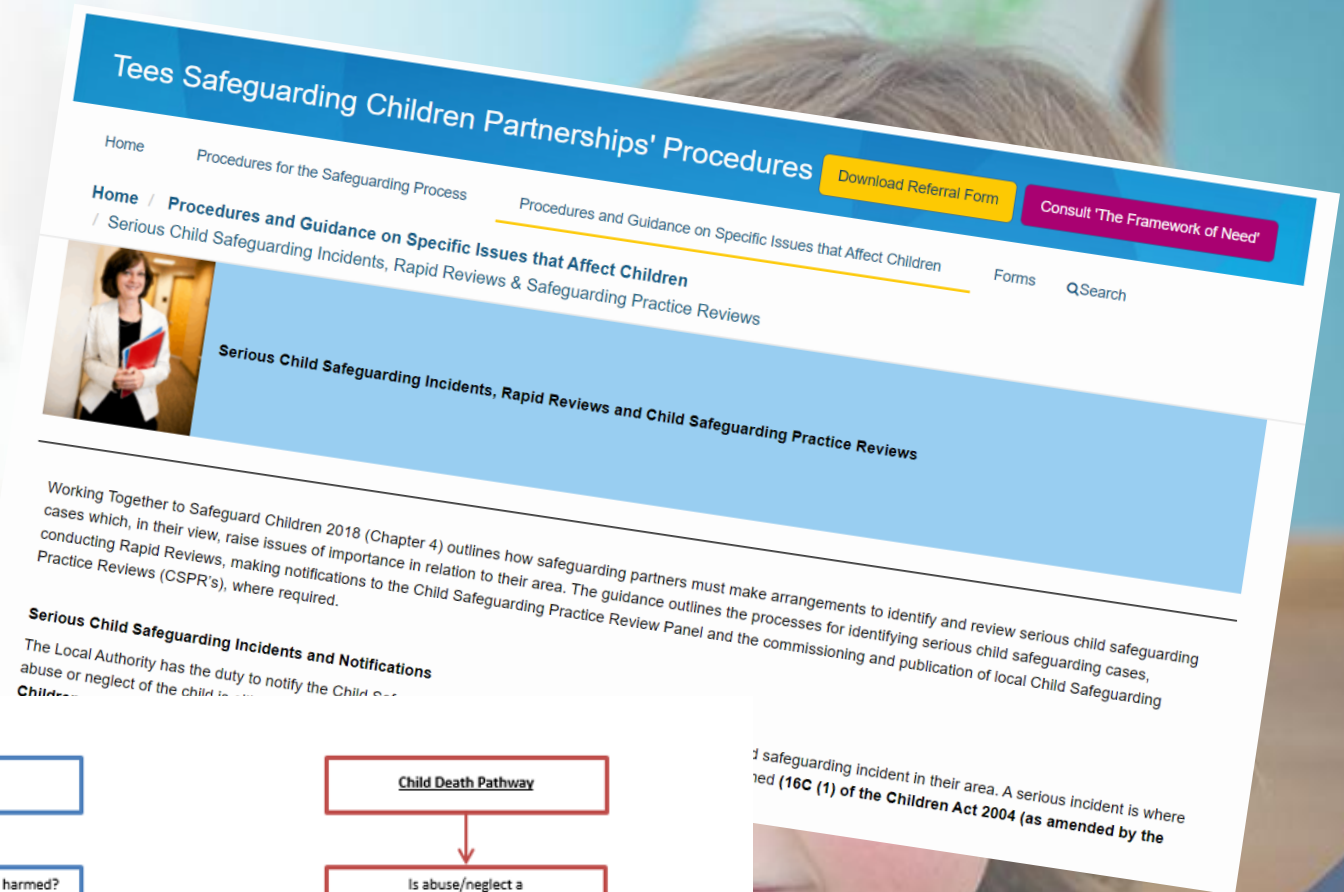
# Hartlepool and Stockton-On-Tees Safeguarding Children Partnership

## Learning from HSSCP Child Safeguarding Practice Reviews

March 2026

# 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



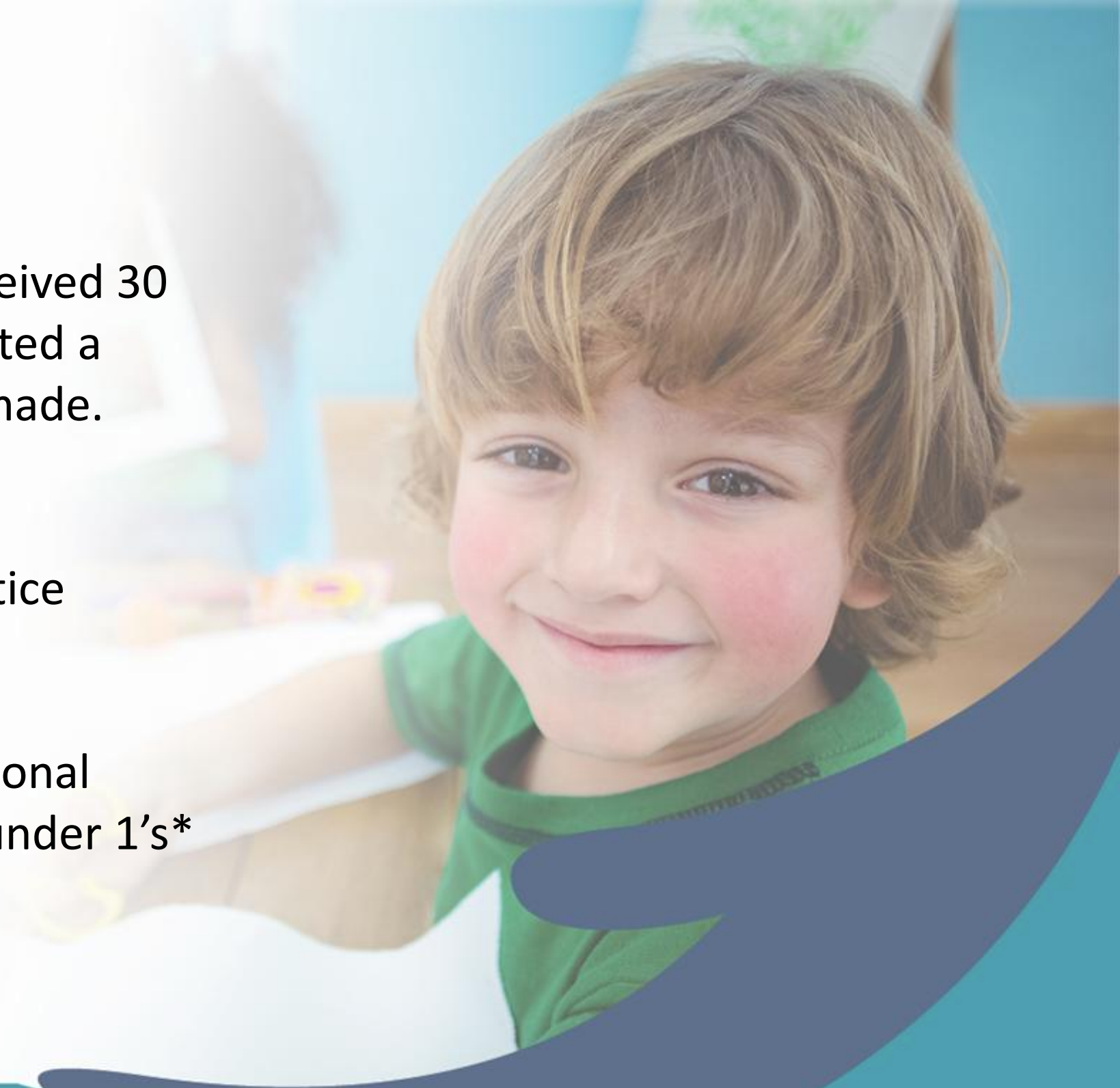
# Self Care

Working with trauma related content can activate emotional, physical or cognitive stress responses.

- Be aware of Triggers
- Step away if you need to
- Stay and speak at the end if you need to
- Take a little break before you move onto your next task

# 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



- 64%** 18/30 were children under 3
- 50%** In 15/30, the child died.
- 36%** 12/30 involved non-accidental injury or physical abuse
- 96%** Neglect featured in 29/30 cases
- 44%** In 14/30 neglect was the cause of the significant incident or death.
- 67%** 20/30 featured hidden significant adults
- 67%** 20/30 featured domestic abuse
- 64%** 19/30 were Stockton children
- 36%** 11/30 were Hartlepool children
- 73%** 22/30 included a lack of understanding of the child's voice and experiences



# Learning from Local Child Safeguarding Practice Reviews/Rapid Reviews since April 1<sup>st</sup> 2025



## KDJ Rapid Review

### Context & Background

- KDJ was 15 when he was involved in a serious accident whilst riding an e-scooter.
- KDJ had been a child in our care for approx. 1 year before the serious incident and lived at an out-of-area placement, which he had requested due to feeling at risk in the community in Teesside.
- KDJ previously lived with Nana and his 2 siblings due to Mothers issues with mental illness and substance misuse.
- He was known to HOTH until his out-of-area move due to concerns around CCE.



## Findings and Learning

- **Over-reliance on families or children to report their struggles**
- **Understanding of the child's life and experiences**
- **Domestic abuse**
- **Recognising trauma at an early point**
- **Road traffic collisions (e-scooters)**
- **Cross-boundary information sharing**
- **Harm outside the home**



# JSW Rapid Review

## Context & Background

- JSW is a 15-year-old female who resides with her mother, stepfather and two brothers.
- She was sexually assaulted by her stepbrother when she was 6/7 years old. Stepbrother does not live in the family home but does visit.
- Police were notified that JSW had uploaded indecent images of herself to the internet and attended the home, where she disclosed further incidents of sexual abuse by adult males.
- JSW disclosed a year-long sexual 'relationship' with a 30 year old male who was a serving police officer.
- JSW also disclosed a number of online encounters with adult males around the country where indecent images were exchanged, with one male travelling to Hartlepool and forcing JSW to perform oral sex on him.
- There are significant concerns around JSW's mental health and wellbeing. She has previously attempted suicide and has suffered many incidents of self-harm.



## Findings and Learning

- **Child's voice and understanding of past experiences**
- **Recognising trauma at an early point**
- **Disproportionate response to child sexual abuse**
- **Over-reliance on children/families to report concerns**
- **Over-optimism from professionals**



# IW Rapid Review

## Context & Background

- IW was 2 years old when she died following a physical assault perpetrated by her mother and mother's new partner and sexual assault by mother's partner .
- Mother previously fled significant domestic abuse from IW's father; there were no concerns around mother's parenting, and they appeared to have a strong bond.
- New partner was a serial domestic abuse perpetrator with an 18-month outstanding warrant, but no agency knew Mother was in a new relationship.
- There were two CHUB contacts in the month leading up to IW's death, all of which resulted in NFA, which was deemed appropriate with hindsight at the review.
- 12 days before her death, IW presented to A&E with a leg fracture and bruising. The delayed presentation raised concern, but there were differences of opinion between medical staff and EDT. The injury was judged accidental at the time but later confirmed non-accidental at post-mortem.



## Findings and Learning

- **Hidden significant adults**
- **Out of hours response**
- **Cross-boundary information sharing**
- **Delayed presentation as an indicator of physical abuse**
- **Cumulative vulnerability and risk**
- **Professional curiosity**



## RAC Rapid Review

### Background

- RAC was 8 years old at the time of his death. He lived with mother and his older brother and sister. Parents had separated the previous year and there was limited involvement with father.
- RAC had additional needs including autism diagnosis, global developmental delay, and sensory difficulties. Parents engaged well with services historically.
- Mother had history of substance misuse, mental health diagnosis and trauma.
- Mother displayed signs of deteriorating mental health in 2025: paranoia, fear for children's safety, inconsistent accounts, erratic behaviour noted by her sister.
- There had been historic social care involvement for RAC's siblings, but limited involvement for RAC in his own right.

### Context

- 10 days before RAC's death, school had reported concerns to the CHUB regarding a disclosure that mother had made and the belief that she was being targeted but a paedophile ring.
- Social worker completed first home visit—children seen alone, home conditions good, grandmother present, interim safety plan agreed. No immediate concerns identified.
- On the next working day the social worker undertook the first assessment visit and RAC was found deceased in bed. Mother was unconscious, suspected to have poisoned him. Suicide notes were also discovered.
- RAC's sister reported mother giving her a drink but refused to drink it as it 'tasted funny'.



## Findings and Learning

- **Child's voice and understanding their life and past experiences**
- **Hidden significant adults**
- **Cumulative vulnerability and risk**
- **Information sharing between services**
- **Professional curiosity**
- **Over-reliance on parental self-report**



# CF Rapid Review

## Background

- CF was 9 weeks old when he died after Mother awoke to find him unresponsive whilst co-sleeping.
- CF lives solely with his Mother. Father had no involvement. Mother's partner – who she described as a 'friend' - had a history of domestic abuse, supervised-only contact with his own child, Class A drug offences, and was linked to Mother's home and vehicle. Mother denied ongoing involvement.
- Mother has a long history of anxiety, depression, childhood adversity, past overdose, and past cocaine/Pregabalin misuse. She has limited family support and is estranged from her own mother. Mother stopped antidepressants early in pregnancy - her mental health was considered "stable" by professionals but she minimised impact on functioning.

## Context

- The month before CF's death, an anonymous referral raised significant concerns: Mother was allegedly taking Pregabalin "daily," using substances through pregnancy, associating with her friend/partner who has a criminal history, and videos showing Mother apparently under the influence with drugs visible in the home. CHUB triaged as high risk and a social worker completed a same-day visit. Mother denied drug-use, agreed to a safety plan, and no concerns were raised regarding the care the CF was receiving.
- CF was seen at home with Mother by health visitor 1 week prior to his death and no concerns were reported regarding CF's care of the home. It is thought that the conditions of the home deteriorated rapidly in the following week.
- Following CF's death, neighbours reported parties, long periods of the baby crying, and concerns someone might harm CF— none of which had previously been reported to agencies.



## Findings and Learning

- **Hidden significant adults**
- **Cumulative vulnerability and risk**
- **Safe sleep**
- **Over-optimism**
- **Multi-agency safety planning**
- **Information systems & processes**
- **Disguised compliance**
- **Parental Capacity i.e. ACE's, impact of mental health/substance misuse**



# National Reviews with Local Significance



# National Reviews – Sara Sherif CSPR

## Context & Background

- Sara was born in 2013 to a family with longstanding domestic abuse, coercive control and instability. Her 2 older siblings were subject to child protection plans when she was born with concerns around neglect, physical abuse and domestic abuse.
- Father had a significant history of violence against women. Stepmother (who Sara lived with at the time of her death) has significant unaddressed vulnerabilities, including poor mental health, social isolation and past trauma.
- When Sara was 6, her father and stepmother were granted residency in a private law decision. Abuse began shortly after she began living with Father and Stepmother and escalated over several years, hidden behind apparent compliance and parental manipulation.
- The house was severely overcrowded (up to nine people living in a two-bedroomed flat) and Sara became a young carer for younger children, which masked her own vulnerability. Father and Stepmother also systematically reduced Sara's contact with her mother and half-sibling, who may have been protective factors in her life.
- In 2022, Sara was withdrawn from school to be Electively Home Educated. Errors, delays and lack of multi-agency oversight meant that Sara disappeared from professional view.
- In the final months of her life, Sara was severely abused, malnourished, and confined inside the home, with escalating violence revealed through later evidence.



# National Reviews – Sara Sherif CSPR

## Key Learning

- Over-reliance on parental explanations
- Information Sharing – consent is not a barrier
- Elective Home Education (EHE) Can Mask Significant Risk
- Domestic Abuse: Under-recognition of Serial Perpetrator Behaviour
- Weaknesses in Private Law Processes and Section 7 Reporting
- Supervision Orders Provided Insufficient Protection
- Race, Culture, Religion and Identity Were Not Considered
- Whole-Family, Whole-History Approach Was Missing
- Weaknesses in Professional Challenge, Supervision and Multidisciplinary Confidence



# National Reviews - 'I wanted them all to notice' – National Review in Child Sexual Abuse in the Family Environment

## Key Findings & Actions

• **Action plan developed** from national CSA report → informed Tees **deep dive** and **workforce confidence survey**.

- **Task & Finish Group revising CSA procedure** in line with CSA Centre referral pathway. Updated procedure will include:
  - CSA Centre **practice resources**
  - **Video** on forensic medicals
  - **Tees-wide map of support services** for children experiencing CSA
- **Misunderstanding about forensic medicals:**
  - Purpose is **not solely evidence gathering**
  - Key aims: **acknowledge abuse**, support the child, assess **health, welfare, and unmet needs**
- **Deep dive finding:** 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.
- **Working with uncertainty:**
  - Link not always made between adults accessing indecent images of children and their **roles as parents**
- **Workforce confidence gap:**
  - Practitioners lack confidence speaking directly with children
  - Fear of asking leading questions
  - **CSA Centre briefings** being delivered to strengthen skills



# Cross-cutting themes from HSSCP Reviews (incl. national learning):

- **Child's voice & lived experience** not consistently understood/recorded
- **Early trauma recognition** & trauma-informed responses inconsistent
- **Over-reliance on self/parental report**; disguised compliance not tested
- **Hidden significant adults**; father-inclusive practice gaps
- **Domestic abuse** (incl. serial perpetrators/coercive control) minimised
- **Cumulative risk missed** due to siloed information & variable thresholds
- **Professional curiosity/challenge** & supervision/escalation need strengthening
- Cross-boundary & out-of-hours **information-sharing**/coordination gaps
- **Harm outside the home** (CCE/CSE/online) under-addressed
- **Infant risks**: safe sleep & NAI/bruising/delayed-presentation protocols not followed
- **Multi-agency safety planning** & forensic medical pathways unclear; low referrals
- **EHE** can remove children from view and mask risk

