



**Darlington  
Safeguarding  
Partnership**

Protecting Children and Adults

# Darlington Safeguarding Partnership Annual Report

April 2024 to March 2025

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# Foreword by Statutory Safeguarding Partners and Independent Scrutineer and Chair

We are pleased to present the annual report of the Darlington Safeguarding Partnership (DSP) covering the period 1st April 2024 to 31st March 2025. The report provides a transparent assessment of the year's multi-agency safeguarding activity and seeks to outline the work that has taken place across the partnership this year to drive improvements in our practice models and ensure that our local safeguarding system is responsive to our children's needs and our adults with care and support needs.

We hope you enjoy reading our annual report which provides an overview of the progress we have made against our priorities and through learning from case reviews and that it gives you assurance about the strength and impact of multi-agency working to keep children, young people and adults with needs for care and support safe in Darlington.

The past year, DSP has concentrated on delivering the expectations set out in Working Together 2023. We will continue to remain focused on ensuring local multi-agency safeguarding practice remains effective for our children, young people and adults with care and support needs. This includes managing significant organisational changes across our statutory partners which includes cross-cutting measures within the Integrated Care Board's (ICBs) and the national programme of system reform that will change ways of working with children and their families which will require significant capacity and attention from all partners.

We will continue to challenge ourselves to deliver better services, support those who are vulnerable in our communities and further develop the strengths of the multi-agency partnership arrangements.

Darlington Safeguarding Partners are grateful to the Independent Scrutineer/Chair, Ann Baxter, who has worked tirelessly to ensure that the partners have remained focused during the year. The implementation of the new multi-agency partnership arrangements means there has been a change in roles with the introduction of a new Partnership Chair which is different to the current arrangement. Ann made the decision to stand down from her role at the end of this year. We would like to put on record our appreciation for all Ann has achieved over the past 10 years, she has been an excellent Chair and provided a valuable contribution to the Partnership, and we wish Ann all the very best for the future.

We want to thank colleagues across our statutory partners and relevant agencies who continue to work tirelessly to ensure children and adults with care and support needs in Darlington are safeguarded effectively every day. Safeguarding is a collective effort and without them we would not be able to achieve the ambitions of our partnership.

**James Stroyan**

Executive Director of People,  
Darlington Borough Council

**Nicola Lawrence**

Detective Chief Superintendent,  
Durham Constabulary

**Chris Piercy/Jeanette Scott**

Directors of Nursing and Quality, North  
East & North Cumbria Integrated Care  
Board (Tees Valley)

**Ann Baxter**

Independent Scrutineer/Chair

# 1. Outlining requirements set out in statutory guidance

## Introduction and purpose of the partnership and this annual report

Darlington Safeguarding Partnership's (DSP) Annual Report (2024 - 2025) covers the work of this integrated partnership to safeguard both adults and children. This publication meets the requirements of both the Care Act (2014) and Working Together to Safeguard Children Statutory Guidance (2023), which require safeguarding partners to publish a report at least once every 12-month period.

Joint arrangements have been found to strengthen partnership working across adults' and children's services to promote a 'whole family' approach; this is in line with Working Together to Safeguard Children 2023 guidance, which emphasises the importance of a strong multi-agency partnership, working within a whole family approach which requires all agencies to consider the needs of the whole family and take into account how individual problems affect the whole family.

The main focus of the DSP is to ensure that safeguarding arrangements in the Darlington locality work effectively, so that all children and young people are protected from abuse and their welfare promoted and that adults with needs for care and support are able to live their lives free from abuse or neglect.

In Darlington, the statutory partners in this period were Darlington Borough Council, Durham Constabulary and the Integrated Care Board (ICB), North East and North Cumbria (Tees Valley).

The published report reflects the progress of safeguarding activities against strategic priorities and recognises the challenges, achievements and areas identified for improvement across all aspects of the safeguarding partnership.

Key areas for partnership work were identified in the DSP Strategic Plan 2023-2026 and are the focus of this report, the priorities are as follows:

- Communication and involvement - Making safeguarding everybody's business and improving awareness of safeguarding across all communities and partner organisations
- Prevention and Early Intervention - enabling partners to work together to act early to protect those at risk of abuse or neglect
- Joint Working - ensure effective arrangements are in place to protect children, young people and vulnerable adults from abuse and neglect
- Exploitation - ensuring effective multi-agency response and intervention to protect those at risk of exploitation, in all its forms
- Adult Self-Neglect - ensure all partner agencies improve awareness and understanding of adult self-neglect to ensure early identification can be achieved.


In line with Working Together to Safeguard Children (2023), the partnership undertook a review of its partnership arrangements and our approach to delivering these responsibilities is set out in our Multi-Agency Safeguarding Partnership Arrangements, published in December 2024. Further details are outlined in section 3 of this report.

This report reflects on the impact of these changes and the wider activity of the statutory safeguarding partners on children and adults with care and support needs in Darlington.

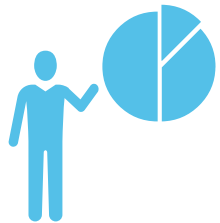
## 2. Local Picture

### Local Area

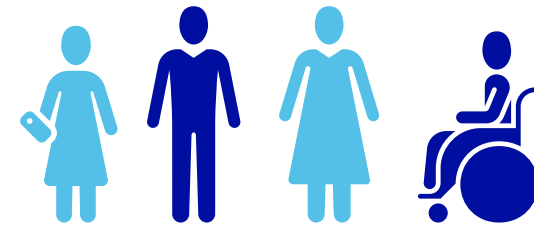
Darlington Borough Council is a Unitary Authority in the Northeast of England which covers 200 square kilometres. Darlington is part of the Tees Valley Combined Authority.



As of 2021 Darlington has a population in excess of **110,562** individuals who live in around **48,475** households.

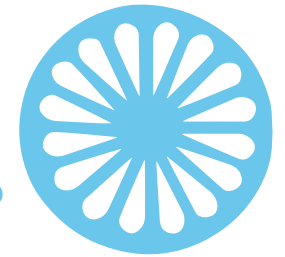


Of this population **64,800** are of working age (16-64 years old).



In terms of ethnicity, the 2021 Census reported 94.4% of Darlington's population as White and **5.6%** from Black and Minority Ethnic (BME) groups.

In County Durham and Darlington the Gypsy, Roma and Traveller (GRT) community form the largest single ethnic minority group, the proportion of Darlington residents who identify themselves as GRT (2021 census) is **0.3%** which is three times higher than the national average.



Overall, comparing local indicators with England averages, life expectancy for both men and women is lower. The health of people in Darlington is varied, about 20% of children live in low-income families/

**DSP Vision is for  
Darlington to be a place where  
children and adults can live  
their lives safely**

# Darlington Safeguarding snapshot

## Children

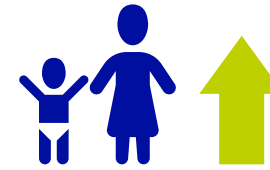


The number of children and young people aged 0-17 living in Darlington is

**22,771**

(20% of the current population)

**28%** of children are living in relative poverty



Number of Contacts into Children's Front door (CIAT)  
**6,822**

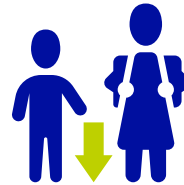


% Contacts referred to Building Stronger Families -

**10.5%**

% Contacts referred to children's social care -

**10.4%**



**265**

Children in Care at end of March



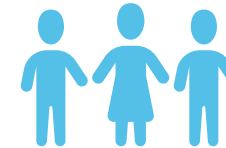
**8.3%**

were unaccompanied asylum-seeking children



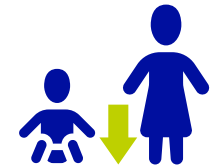
Strategy discussions started **346** for 622 children

% Progressed to section 47 enquiry - **277**



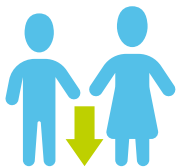
**26**

Children identified as being at risk of Child Exploitation  
**10** Sexual | **16** Criminal



**111**

Children Subject to CPP at end of March



**414**

Children in need



Referrals in relation to allegations against staff working with children and young people - **281** with **58%** progressing to an Initial Evaluation Meeting



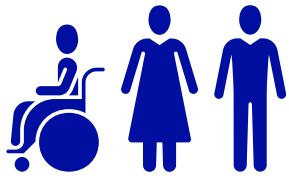
**1,299**

Early Help Assessments completed

**272** ↓

Missing episodes by young people

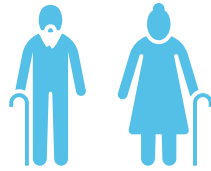
## Adults



There are

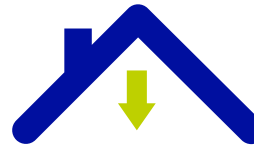
**65,921**

(59%) of people aged 18-64



**23,797**

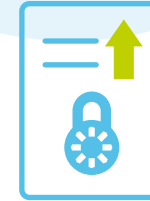
The number of people  
aged over 65 years old in  
Darlington is estimated at  
(21%)



Highest Location of  
abuse: Section 42  
enquiries

Own home - **407**

Residential Care  
Home - **259**



**2,832**

Number of Safeguarding Concerns



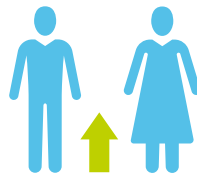
Number of safeguarding contacts into Adult Contact

team **2,832** up (from 1815 2024-25)



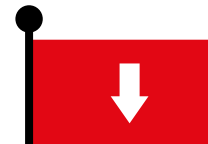
**912**

Number of initial enquiries  
started



% Progressed to a section 42  
safeguarding enquiry

**681**



Highest type of abuse: Section 42 enquiries

- Neglect and Acts of Omission - **371**
- Physical - **268**
- Emotional/Psychological - **152**
- Financial - **133**
- Self neglect - **129**

# Inspections

During this period two Inspections were undertaken:

- In November 2024, there was an Area SEND inspection of Darlington Local Area Partnership. Inspectors evaluated how services in the area support children and young people with special educational needs and/or disabilities. The outcome highlighted the local area partnership's arrangements lead to inconsistent experiences and outcomes for children and young people with special educational needs and/or disabilities (SEND). The local area partnership must work jointly to make improvements.
- In January 2025, Care Quality Commission (CQC) inspectors visited Darlington Borough Council as part of their new national approach to assessing local authorities. The final report recognised the strength, dedication and professionalism of the teams across adult social care and they were rated 'Good'.
- The assessment highlighted several key strengths:
  - A strong, strength-based approach to assessment and care planning.
  - Positive experiences from people and carers, with many feeling supported, heard and in control of their care.
  - No delays in hospital discharges and impressive outcomes from reablement services.
  - Robust safeguarding arrangements and a clear commitment to continuous improvement.
  - Effective partnerships with health services and the voluntary sector.
  - There were systems, processes and practices in place to make sure people were protected from abuse and neglect.
  - The local authority worked well with the safeguarding partnership and other partners to deliver a coordinated approach to safeguarding adults.





## Governance and Structure

The DSP has reviewed its governance structure to ensure there are robust arrangements in place to have appropriate oversight of partnership activity. The Lead Safeguarding Partners (LSPs) have overarching responsibility and accountability with the Management Group, made up of Delegated Safeguarding Partners, having day to day accountability for ensuring DSP upholds its statutory responsibilities and duties and holds agencies to account for their work. The chairs of the LSP and Management Group will be determined annually on a rotating basis.

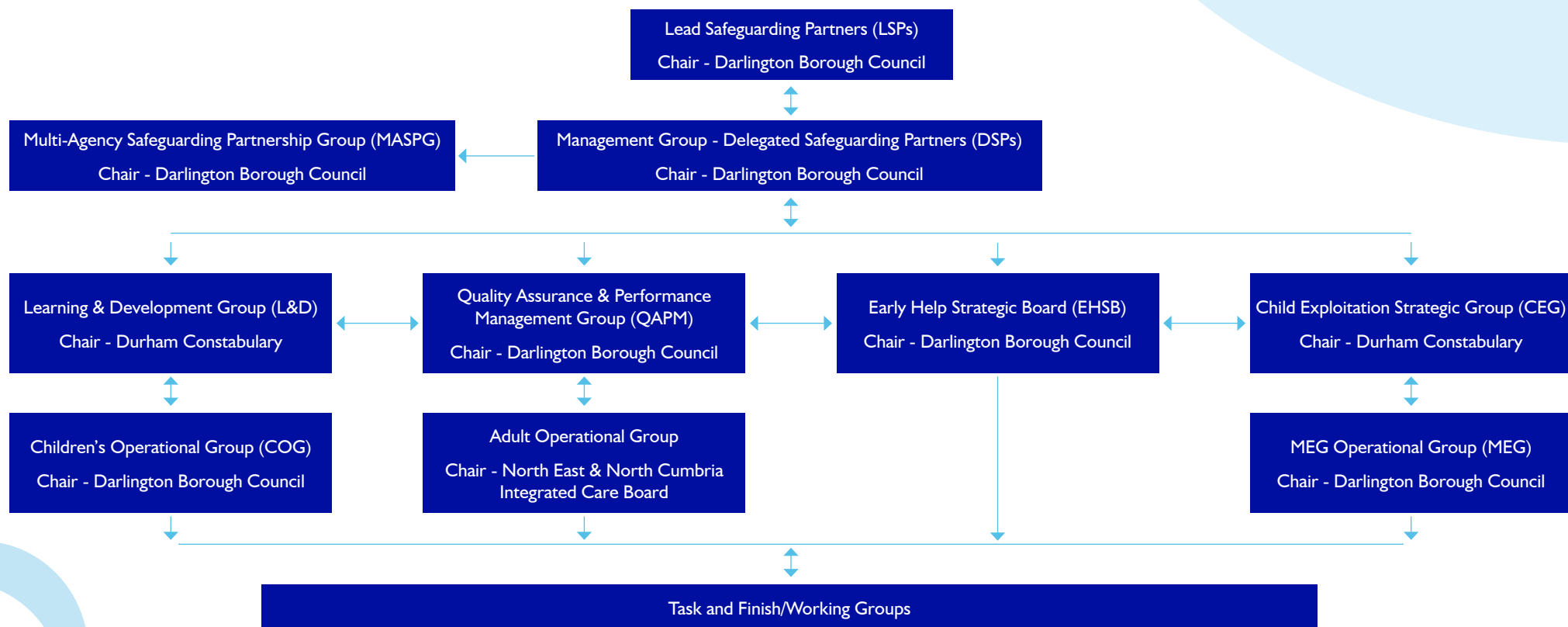
Below the Management Group is a series of sub-groups chaired by relevant senior leaders from across statutory partner agencies. These key leads are responsible

for chairing, engaging, contributing, and carrying out actions within their relevant group. Each group will have its own terms of reference and objectives and will be developed and agreed in the next reporting period. Chairs of sub-groups will report into the Management Group, this structure enables clear escalation routes and lines of scrutiny. If needed, the partnership can set-up specific time-bound T&F groups to supplement the core sub-groups.

A wide range of organisations are represented in the Partnership groups, and which include senior safeguarding leads. Details are outlined in Appendix 2 of this report. Details of the activities undertaken by each of the sub-groups in this reporting period are outlined in section 4 of this report.

The graphic outlines the structure of the DSP and its core sub-groups.

## Partnership Governance Structure



## Funding the Partnership

Partners agree funding contributions each year and funding is used directly to support the work of the partnership including the business unit, Independent Scrutineer/Chair, conducting learning reviews and the training programme. Partners also provide resources 'in kind' to support the functioning of the partnership including chairing and participating in sub-groups, task and finish groups, conducting reviews, audits, analysing and submitting data.

Contributor	Value of Contribution
Statutory Safeguarding Partner - Darlington Borough Council	£148,378
Statutory Safeguarding Partner - North East and North Cumbria Integrated Care Board (Tees Valley)	£41,310
Statutory Safeguarding Partner - Durham Constabulary	£34,404
<b>Education</b>	
Schools Forum	£10,000
Darlington College	£1,600
County Durham and Darlington NHS Foundation Trust	£16,973
Probation Service North East	£1,875
<b>Total Contribution/Income</b>	<b>£254,540</b>

Funding contributions have remained unchanged for a number of years as the partnership has seen a significant carry over due to a vacant post however, annual expenditure will exceed annual income in the next reporting period and Partners have agreed to review funding arrangements.



# Impact of DSP funding

## Staffing

Darlington Safeguarding Partnership is supported by a Business Unit which undertake the management and support function of the partnership and is responsible for the coordination and organisation of all strategic and operational groups and the work they undertake.

During this reporting period:

Role	FTE
Safeguarding Partnership Business Manager	1.0
Safeguarding Partnership Policy & Development Officer	1.0
Safeguarding Partnership Training & Development Officer	1.0
Information Officer	0.6
Business Unit Analyst (solely funded by Durham constabulary)	0.4
Business Support Officer Level 2 (vacancy)	1.0

- The majority of the funding has covered the salaries of the staff within the business unit.
- A Partnership Independent Scrutineer/ Chair has supported the partnership at a cost of £500 per day.

- Funding has subsidised the ME learning platform to support the delivery of a programme of direct safeguarding training courses and e-learning modules which are available to any practitioner working with children or adults in the Darlington locality to help build safeguarding knowledge and skills across the multi-agency workforce and lead to improvements in individual practice.
- The funding includes a contingency for undertaking Safeguarding Adult Reviews or Child Safeguarding Practice Reviews and the cost of commissioning any Independent Authors. During this reporting year, the Partnership funded two reviews.



# 3. Progress against statutory guidance

## How we have worked this year

Whilst this report covers the period April 2024-25, it includes some reference to work already started in the previous year which continued into this reporting period, along with new work which has commenced, and will continue beyond April 2025.

In this report, you will find an overview of the key changes made to partnership arrangements, the activities achieved against the agreed priorities and the impact of these activities. The report includes updates on Serious Incident Notifications, Local Child Safeguarding Practice Reviews and Safeguarding Adult Reviews, the learning opportunities highlighted and our future plans.

A key change in this reporting year was the significant changes to our leadership and governance arrangements in line with revised Working Together statutory guidance and which were implemented on 1 April 2025, this was a focus for the year. Partners appointed a Project Manager to conduct a review of the current partnership arrangements; a number of recommendations were shared for partner approval along with preparing the final document for publication.

## Key decisions

### Multi-Agency Safeguarding Partnership Arrangements:

Introducing new roles and establishing Lead Safeguarding Partners (LSPs) and Delegated Safeguarding Partners (DSPs):

- Lead Safeguarding Partners are:
  - Executive Director of People, Darlington Borough Council
  - Detective Chief Superintendent, Durham Constabulary
  - Chief Nurse, North East and North Cumbria Integrated Care Board, Tees Valley.
- Recognising the importance of including Education representatives, who can influence strategic safeguarding discussions in relation to their sector, whether it be primary, secondary, further and SEND and they will be involved in partnership decision making as Delegated Safeguarding Partners.
- Delegated Safeguarding Partners are:
  - Darlington Borough Council - Assistant Director Children's Services and Assistant Director Adult Social Care
  - North East and North Cumbria integrated Care Board, Tees Valley - Director of Nursing
  - Durham Constabulary - Detective Superintendent
  - Education representatives covering primary, secondary, tertiary and SEND provision





- Introduction of partnership chair to replace the Independent Chair role, which will rotate annually, the Executive Director of People within the local authority is assuming the role for the first year.
- The introduction of an Independent Scrutineer to drive continuous improvement across Adult and Children's safeguarding arrangements to strengthen, scrutinise and develop the work of the partnership and provide independent, rigorous, and effective support and challenge at both a strategic and operational level. The recruitment process will take place in the next reporting period.
- Reviewing our governance and accountability structure to ensure that escalation routes and lines of scrutiny are clear and reviewing terms of reference to ensure each group is explicit about its role and responsibilities and partnership membership is reflected accordingly. This will be taken forward in the next reporting period.

### Other key decisions made:

- Approved a Local Child Safeguarding Practice Review and Discretionary SAR review and agreed the recommendations to take forward
- Introduction of the Early Help Strategic Board
- Considered three Serious Incident Notifications and agreed one met the criteria for notification
- Agreement to continue to fund the ME learning platform for another three years
- Agreement to remove the Child Death Overview Panel and its administration from the governance of the Partnership.

## Overview of Partnership activity

The Statutory Safeguarding Partners continued to have collective oversight of safeguarding arrangements and first met as Lead Safeguarding Partners in March 2025. During this period they considered three Serious Incident Notifications and approved two review reports and the learning and agreed the recommendations which are outlined in section 4 of this report.

Discussions took place with Durham Safeguarding Children's Partnership regards the Child Death Overview Panel (CDOP) which sits across both local authority areas and there was agreement to remove governance and administration from Safeguarding Partnerships to Local Authority and Health, in line with Statutory Child Death Review Guidance. The process of the transition will continue into the next reporting period. The Partnership will continue to have oversight of the CDOP, through established reporting processes.

The Management Group which is made up of the Delegated Safeguarding Partners (DSPs) and Chairs of sub groups met for the first time in March 2025. The focus of the agenda was the new safeguarding partnership arrangements and familiarising education partners with the new arrangements. This will be the decision-making group of the partnership and the DSPs will monitor and seek assurance on the effectiveness of multi-agency practice across child and adult services. Its first task will be to review and agree the terms of reference for all the partnership groups and provide more clarity on the focus of each of the groups and how they function.

The Partnership introduced an Early Help Strategic Board which has become part of the structure of safeguarding. Its purpose was to look at how we work in partnership with early help as all the work we do in safeguarding is linked with early intervention and take forward the Early Help Strategic Plan, developed to support the partnership to work collaboratively at the earliest opportunity and establish effective, targeted and co-ordinated preventative and early help support for children, young people and families across Darlington. However, in response to the Children's Wellbeing and Schools Bill and the shift to the Family First Reforms and how this will shape children's service provision in Darlington in 2027, the focus for this group next year will change. The legislation is still progressing through

parliament, Darlington is in a good position, and it is anticipated that the changes will build upon existing good practice.

Partners considered the Department for Levelling Up, Housing and Communities letter to Directors of Adult Social Services, Housing and Safeguarding Adult Board (SAB) Chairs and the recommendations for SABs regards Individual Rough Sleeping. Partners agreed there are some measures already in place to address the specific recommendations and there is good representation on partnership groups from Strategic Leads in Housing and data is fed into the sub-groups. The partnership will consider Safeguarding Adult Review (SAR) referrals for cases of deaths involving rough sleepers as it would any other SAR. It will continue to develop measures needed to address the specific recommendations in the next reporting period.

The Multi-Agency Safeguarding Partnership group met twice in this period; it is not a decision-making body but rather provides a useful forum for wider partnership discussion, information sharing and consultation. Meetings are themed around agreed local and national safeguarding priorities and areas identified through partnership work, data, performance and reviews. Themes considered this reporting period included:

- The 'Eyes on the Baby' Sudden Unexpected Death in Infancy (SUDI) prevention programme led by Durham University Infancy and Sleep Centre Programme. The partnership supported the role out of multi-agency training using the ME learning platform, there were three strands of training to seek to engage a wide workforce on safe sleeping.
- Preventing Homelessness and Individual Rough Sleeping- as outlined earlier in the report the partnership considered the recommendations made in the ministerial letter for SABs.
- Darlington Borough Council practice changes implemented within Adult Social Care following a safeguarding transformation programme and the impact of these changes on strengthening multi-agency partnership working.
- Right Care, Right Person (RCRP) also featured following the implementation of phase one (concern for welfare) in June 2023, with all further phases implemented during this reporting period. Working in partnership is key and

Safeguarding partners have a responsibility to monitor its impact and ensure partner agencies carry out their roles and responsibilities. It was reported that RCRP is working well with lots of engagement from partner agencies.

## Sub Group Activity and Key achievements

### Learning and Development sub-group:

Is responsible for learning and improvement, multi-agency training and learning opportunities and policy and procedure and governance responsibility for all learning reviews undertaken.

- **Learning Reviews:** Throughout the year the sub group continued to be busy due to the submission of a number of Serious Incident Notifications (SIN), Safeguarding Adult Review (SAR) referrals or Learning Requests (when there is learning to explore but does not meet criteria for SAR or SIN) and the subsequent reviews which took place. For children, there were three SIN referrals, one of which resulted in notification to the National Panel and a Rapid Review undertaken; two were deemed no further action by the LSPs as there was no learning to explore and two Learning Requests progressed to learning reviews. There were two adult Learning Request referrals, one of which progressed to a learning review. Work also continued on a Local Child Safeguarding Practice Review and an Adult Discretionary Review which were notified in the previous reporting year 2023/24. Details of the reviews undertaken in 2024/25 are outlined in Section 4 of the report.
- The group has continual oversight of national and regional review findings to identify any learning that may be relevant for Darlington. Partner agencies which sit across a bigger footprint have a role to play in sharing themes and learning identified through their organisation's involvement.
- **Policy and Procedure:** The sub-group continues to monitor policy, procedure and practice guidance.

- The launch of a range of resources, tools and guidance on self-neglect and hoarding following the learning from a number of adult reviews.
- The Multi-Agency Safeguarding Adult Procedures have been revised and published in this reporting period.
- The Safeguarding Adult Review protocol and the Serious Incident Notification and Child Safeguarding Practice Review procedure were revised to incorporate notification to the coroner.
- A Partnership Pledge regarding professional challenge (both child and adult safeguarding) has been agreed and is being promoted across the partnership.
- Launch of regional protocol on protecting children who move across local authority borders
- One minute guide to Children's Front door to raise awareness of service along with some myth busting and fact examples.
- **Website:** Oversight and monitoring of the content on the Darlington Safeguarding Partnership website continued. During this year, it has been further upgraded and the multi-agency safeguarding procedures and practice guidance are now in a web-based format and more easily accessible to practitioners.
- **Training and Development:** The sub group continues to monitor and evaluate multi-agency learning and development opportunities and identify training needs. The Partnership provides a comprehensive training offer to build safeguarding knowledge and skills across the multi-agency workforce and the Training and Development Officer continues to develop and deliver high quality multi-agency safeguarding training to help lead to improvements in individual practice. The training offer is fluid and as a result the partnership is also able to offer a series of e-learning modules which are aligned to safeguarding priorities and details about each of the courses and enrolments is outlined in section 4 of this report.

## Quality Assurance and Performance Management (QAPM) sub-group

Is responsible for monitoring and evaluating the effectiveness of safeguarding work across partner agencies, seeking assurance on those areas of practice improvement.

- Robust data and operational oversight of Children's multi agency performance is well embedded; however, work is ongoing in respect of the Adult Safeguarding performance frameworks in conjunction with the review of Adult Services which was undertaken by Darlington Borough Council in the previous reporting year. The Partnership Analyst and Information Officer are working with the QAPM to collectively bring together a wealth of quantitative as well as qualitative data, intelligence and information to help understand the strengths and areas for improvement at both operational and strategic level. Work will continue into the next reporting period to develop the Partnerships Quality Assurance Framework and the approaches to drive continuous improvement and when appointed the Independent Scrutineer will work alongside the group to further develop its quality assurance processes.
- The group is responsible for undertaking multi-agency audits to check individual agency practices and following the learning and recommendations identified in the Family H LCSPR, an audit focused on cases which were closed to Children's Services with a safety plan still in place. The audit highlighted that safety planning should part of any Child Protection Plan, Child in Need Plan or Early Help Plan and closure should be captured and shared in a multi-agency assessment. The group will be revisiting in the next reporting period to establish if measures have been addressed and the number of cases closing on a safety plan have reduced.
- A second live audit was carried out following a complex/multiple abuse investigation, Operation Esdras, which identified a number of cases of child sexual exploitation involving several young people to review and reflect on the specific circumstances of the young people and consider any areas of good practice and learning. Learning points were identified including the importance of information sharing and the identification of vulnerability at the earliest opportunity. The audit identified the need for change in the Missing

and Exploited Operational Group and changes to the exploitation matrix. Areas for development include training practitioners in the use of non-blaming language and it was highlighted that the death of a parent can increase a child's vulnerability to exploitation. Areas of good practice identified included intervention work undertaken by the Youth Justice Service, good information sharing by children's homes and work implemented by Harrogate District NHS Foundation Trust to develop tools to understand the child's lived experience.

## Early Help Strategic Board (EHSB)

Is responsible for the strategic and operational delivery of effective, targeted and co-ordinated preventative and early help support for children, young people and families.

The group was established in February 2024, following agreement by Statutory Partners that it will sit within its governance. It was acknowledged it will take some time to embed, and its first meetings focussed on scene setting and defining and clarifying some of the misconceptions about early help. Terms of Reference were developed and agreed, along with partners to sit within the group. There was agreement to establish an Early Help Operational Group and progress and develop the Early Help Strategy. Its aim is to deliver on the ambitions outlined in the Strategic Plan and those key priorities identified.

## Strategic Child Exploitation Group (CEG)

The Child Exploitation Group (CEG) is a group that has a joint governance with Durham Safeguarding Partnership. The purpose of the CEG is to monitor, improve and evaluate the strategic response of partner agencies in tackling children missing from home, care and education and the reduction of child exploitation across Durham and Darlington.

- Partners are committed to the identification, risk assessment and risk management of children at risk of being missing and/or exploited and targeting places and spaces and people of concern who may pose a risk and continue to

establish ways of educating children and young people to recognise the risks of exploitation and support parents, carers and practitioners to understand the signs of harm outside the home.

- The CEG has an agreed plan broken down into three priority areas:
  1. Child/Children or Young Person(s) focus: partners are committed to the identification, risk assessment and risk management of those children identified as being at risk of missing and child exploitation. Children are at the centre of what we do.
  2. Context focus: partners are committed to targeting spaces and places and people of concern who pose a risk to exploiting children and young people
  3. Early Identification focused: Partners are committed and equipped to educate children to recognise the risks of Harm outside the Home. Partners will support parents, carers, and practitioners to understand the signs of harm outside the home.
- Darlington continues to provide an overview of the activity within the operational missing and exploited group.
- Police and Children's Services investigated allegations of child sexual exploitation as part of Operation Esdras, a cross border complex abuse case involving sexual exploitation of young people travelling into Darlington. The operation was overseen by a multi-agency Strategic Management Group. Police linked the activity to the Operation Make Safe scheme to strengthen the response of hotel chains with remote check-ins in preventing exploitation. It was identified that the uptake of multi-agency Child Exploitation training is low, and the partnership is in the process of seeking assurance about the availability and uptake of training.
- Darlington Borough Council Licensing team provided assurance that taxi drivers are required to complete the Child Sexual Exploitation on-line course before they are licensed. It is part of the DfT Statutory Standards and in our policy.
- Work was carried out to raise the profile of the Philomena Protocol which is a police initiative to improve the response when a child is reported missing.



- The group was advised that Darlington Borough Council has commissioned Barnardos to carry out a review of exploitation processes and systems across Darlington, the report is to be finalised through internal governance processes with agreement for the wider findings from the review to be reported to the group in the next reporting period.

## Child Death Overview Panel (CDOP)

The Child Death Overview Panel (CDOP) oversees all deaths of children under the age of 18. There have been 13 deaths in Darlington during this reporting period, and all of these were subject to a Child Death Review. The CDOP works closely with the Partnership to highlight any emerging themes and issues and learning from child death reviews that require further consideration. CDOP completes an annual report which provides a summary of activity, the report will be published in the next reporting year.

## Operational Groups

Two operational groups (Child and Adult), which report into the Learning & Development and Quality Assurance & Performance Management groups provide an overview of any emerging trends and patterns to ensure that any themes or emerging risks can be identified at an early stage and reported accurately to the Statutory Safeguarding Partners and the group continues to have oversight of national and regional review findings which may identify learning relevant to Darlington.

### Children's Operational Group

Has oversight on Front Door practice in Children's Social Care and considers performance data and emerging patterns and multi-agency practice issues to determine how they can be addressed collectively. The group also spends time focussing on key learning points from local, regional and national

reviews to understand whether Darlington is compliant with the learning and recommendations.

The below key areas were addressed in this reporting period

- A focused session to look at learning from Family H LCSPR (2023/24) and how the recommendations of the review should be implemented. A mapping exercise was undertaken looking at single agency practice on reflective discussion standards, recording information in respect of unconsidered/hidden adults in households and the child's lived experience. Discussions are ongoing relating to the implementation of multi-agency reflective supervision discussions and will be developed in the next reporting period. The Partnership developed a multi-agency reflective discussion standard as supporting tool.
- The number of children who are electively home educated (EHE) has increased nationally, and this pattern is reflected in Darlington. A task and finish group looked at the issue in Darlington to help understand whether there is appropriate line of sight on this cohort of children and consider what is needed from a multi-agency perspective. There were a number of good practice models already in place when compared to other areas; a robust EHE register, meetings with regional teams and schools engage well with the system. Multi-agency practice guidance is to be developed to help practitioners navigate the pathways and understand processes in Darlington. It was acknowledged that the Family first Reforms will likely bring changes to Elective Home Education and the responsibilities of the Local Authority.
- Following a concern raised by Darlington Superintendent Registrar of Births, Deaths and Marriages, discussions commenced on the issue of Birth Registration and the safeguarding implications of a parent failing to register a birth and to establish a pathway for the reporting of instances when a birth is not registered. This work is ongoing, and the outcome will be reported in 2025/26.
- The group agreed to sign up to the Regional Protocol for Protecting Children who move across Local Authority Areas and the Harm Outside the Home and Harmful Sexual Behaviour procedures were updated.

## Adult Operational Group

Has oversight of performance data to obtain an understanding of the changing landscape and key themes coming through contacts and referrals into Darlington Borough Council Adult Social Care. Work continues within the local authority to improve data recording and the collation of data on safeguarding casework system to improve the identification of emerging themes and trends.

The key theme continues to be self-neglect and hoarding, and which is reflected regionally and nationally. The complexity of these cases has been highlighted as a factor with many of those affected having substance misuse and mental health issues.

The group were made aware of the improvements the local authority is making to technology to enhance the customer experience and improve the call handling system and the plans to implement a portal for reporting concerns, removing the need to complete a form, meaning that information will be captured directly onto the system.

The group also spends time focussing on key learning points from local, regional and national reviews to understand whether Darlington is compliant with the learning and recommendations.

Settings in the Executive Strategy Process (where there are serious safeguarding concerns or suspected organised or institutional abuse) are monitored and discussed, four providers were subject to the Executive Strategy process during the 2024/25 period. Settings continue to remain in this process until it is satisfied that the necessary changes/improvements have been made and all regulatory action had been completed with assurance that improvements are sustainable.

The reported concerns include increased safeguarding referrals, medication omissions, infection control and clinical oversight concerns. The partnership was reassured that relevant actions have been put in place to support ongoing improvements and the Local Authority continues to work closely with the CQC, contracting and commissioning partners and the Integrated Care Board, as well as the providers, to support ongoing improvements.

The Executive Strategy Process and practice guidance has been amended to ensure that learning from the Executive Strategy Process is shared with providers and throughout the partnership.

## Scrutiny Arrangements

The Independent Scrutineer/Chair continues to ensure there is a clear focus on the effectiveness of the multi-agency safeguarding arrangements from a strategic perspective and ensures safeguarding partners and relevant agencies are challenged and supported in their roles to work collaboratively to meet the safeguarding priorities identified by the Partnership. The Independent Scrutineer/Chair continued to chair the meetings of the Statutory Safeguarding Partners and the Multi-Agency Safeguarding Partnerships Group.

The Independent Scrutineer/Chair has presented the Partnerships Annual Reports, outlining the Partnership achievements and effectiveness of multi-agency safeguarding arrangements to the Local Authority's Children and Young People and Adult Scrutiny Committees, the Community Safety Partnership and the Health and Wellbeing Board. She also chaired two Risk Enablement Forums, which were introduced during the year for agencies to come together to discuss complex or high-risk cases in respect of adult safeguarding when there is a real risk of harm to the individual or others.

Under the new multi-agency partnership arrangements, Partners agreed to introduce an Independent Scrutineer to drive continuous improvement across Adult and Children's safeguarding arrangements to strengthen, scrutinise and develop the work of the partnership and provide independent, rigorous, and effective support and challenge at both a strategic and operational level. The recruitment process will take place in the next reporting period.

# 4. Additional Information

## Achievements: Partnership Priorities

### Priority One

**Communication and involvement - Making safeguarding everybody's business and improving awareness of safeguarding across all communities and partner organisations.**

DSP continues to engage with partners and professionals and share key messages across the multi-agency workforce.

#### → Independent Scrutineer/Chair Engagement

The Independent Scrutineer/Chair continues to meet with relevant agencies of the Partnership and attend meetings such as primary and secondary education forums, Child and Adult Scrutiny Committees, the Health and Wellbeing Board and Community Safety Partnership to raise awareness of safeguarding and talk about current issues and themes and what is working well and what needs to change relating to current safeguarding arrangements.

#### → Darlington Safeguarding Partnership (DSP) website

The DSP continues to use a variety of communication methods to share information with a wide range of different audiences. The Partnership website continues to be a key forum to provide key safeguarding messages to practitioners and to the wider public as well as useful information and resources to support those working with children and adults.

Feedback indicated that the existing website was hard to navigate, meaning the reach of our resources was limited. The site was redeveloped, and work continues to ensure information is directly uploaded to the site as opposed to linking to PDF or Word documents, hopefully creating a better user journey.

→ 16,648 visitors to the DSP website

→ 38, 698 pages views on the DSP website

Partnership website

[www.darlington-safeguarding-partnership.co.uk](http://www.darlington-safeguarding-partnership.co.uk)

#### → Darlington Safeguarding Partnership newsletter

The Partnership's monthly newsletter continues to communicate and raise awareness of safeguarding matters and helps to keep in touch with all our agencies to provide information, signposting and guidance to those working across child and adult services. The 'In the spotlight' section of the newsletter focuses on a different safeguarding topic each month to help raise awareness of specific safeguarding themes.



#### → Communication and Engagement with children, young people and adults with care and support needs

The voice of children, young people and adults with needs for care and support and their families is at the heart of all partnership activity, however it is a challenge to evidence their lived experiences through a multi-agency lens to help understand how that may inform multi-agency working and influence service provision. This is an area that needs further exploration and will be a key area of focus in the coming year.

#### → Social Media

Whilst the Partnership does not have its own social media platforms, it regularly requests partner agencies promote key safeguarding campaigns throughout the year on their own social media platforms.

## → Staff Carousel

DSP business unit staff joined a staff carousel in December 2024, hosted by Darlington Borough Council aimed at local authority staff working with children and adults. Partner agencies were also invited to attend as participants. Staff were asked to set up stalls to raise awareness of their work and service areas to help others understand each of our roles and provide a simple overview of the team, what we do and what we have achieved over the year. This was a great opportunity to raise awareness of the Safeguarding Partnership with staff within the local authority area and how the work they undertake contributes to the work of the Partnership. A number of resources were developed and shared on the day for staff to take away.

## → Raising awareness of key safeguarding campaigns, which include:

- National Safeguarding Adults Week
- Stalking Awareness Week
- National Hate Crime Awareness Week
- 16 Days of Action against Domestic Violence
- Anti-Slavery Week
- White Ribbon Day
- Safe sleeping awareness

## → Self-Neglect Conference

DSP hosted a practitioner conference in July 2024, which was open to all multi-agency practitioners working across Darlington. The purpose of the conference was to raise awareness of the issue of self-neglect and hoarding and to focus on the issues and challenges practitioners faced working with individuals who are resistant to support and who may have additional complex needs.

## Priority Two

**Prevention and Early Intervention - enabling partners to work together to act early to protect those at risk of abuse or neglect**

## → Training and Development

DSP provides free multi-agency training, designed to supplement single agency training provision and support prevention and early intervention. The Partnership introduced the ME Learning Platform in January 2024, to support with the delivery of safeguarding training and managing bookings. The platform allows the partnership to offer its core training modules as well as tapping into a range of additional e-learning modules created by specialists on a range of safeguarding topics relevant to the Partnership's Priorities. There are often crossovers between children and adult safeguarding work, and it is recognised that people who work with children and/or adults greatly benefit from having access to a wide range of safeguarding courses. Providing a comprehensive training offer can help build safeguarding knowledge and skills across the multi-agency workforce and provides a greater opportunity for professionals and volunteers to access a wide range of training modules that would not ordinarily be able to access.

As of 31 March 2025, DSP currently offers 20 different courses and there are over 1650 active registered learners.

There were 1770 total completions for Digital courses and 422 Microsoft teams delivered sessions.

The Partnership has introduced a Risk Enablement Forum which provides a framework to manage those complex or high-risk cases when all previous multi-agency work has been unsuccessful in managing the risk to the individual or a case would benefit from being escalated and discussed at a strategic level, to explore what further steps can be considered. This may include cases where agencies are working with people who have care and support needs who have the mental capacity to make unwise choices, and who are at risk of serious harm or death through self-neglect as a result of those choices, they may have difficulty in engaging with services or pose a high risk to themselves or wider



the community. Referrals will only be accepted when other multi-agency processes have not been successful in reducing the risk of harm or a strategic approach to case oversight is required. The Risk Enablement representatives will consider operational issues, share information/knowledge and experience to remove barriers to safeguarding in order to promote the safety and wellbeing of those individuals. It will be responsible for making balanced and informed decisions to support the individual and consider the necessary actions required to help reduce or remove the risk of harm resulting in a better outcome for the individual. Three cases were referred in this reporting period resulting in several meetings being held with positive discussions and key action points identified.

During this reporting period, we added to our digital library by bringing in new courses, particularly in the area of child exploitation and have added courses on criminal exploitation, County Lines, sexual exploitation and online abuse in order to provide a full offer on this subject matter. We also have continued to deliver sessions on child exploitation in collaboration with Barnardo's. The partnership hosted the 'Eyes on the Baby' multi-agency sudden unexpected death in infancy prevention in Darlington to support a programme led by Durham University Infancy and Sleep Centre Programme. The training is designed to raise awareness of all aspects of safer sleeping to prepare staff across a number of disciplines to know what to see, what to say and what to do to help prevent future SUDIs. We will continue to offer these courses and to promote this subject matter when the campaign has ended.

### → **Development of Policy and Procedure, guidance and resources**

Enabling continual improvement and learning for partners and practitioners is important to the Partnership. The ongoing review of policies, procedures and practice guidance documents is essential to support front line practitioners with both prevention, early intervention and awareness raising.

During 2023/24 the following procedure and guidance documents were developed, reviewed and revised by the Partnership:

- The launch of a range of resources, tools and guidance on self-neglect and hoarding following the learning from a number of adult reviews.
- The Multi-Agency Safeguarding Adult Procedures have been revised and published in this reporting period.
- The Safeguarding Adult Review protocol and the Serious Incident Notification and Child Safeguarding Practice Review procedure were revised to incorporate notification to the coroner.
- A Partnership Pledge regarding professional challenge (both child and adult safeguarding) has been agreed and is being promoted across the partnership.
- Launch of regional protocol on protecting children who move across local authority borders

An Early Help Strategic Board (EHSB) was established in February 2024, with agreement to sit within the structure of safeguarding and within the partnership governance arrangements. It will have responsibility for the strategic and operational delivery of effective, targeted and co-ordinated preventative and early help support for children, young people and families across Darlington by bringing together all strategic partners responsible for delivering on the vision. The EHSB will support the partnership to develop innovative ways to join up and provide a seamless offer to support children, young people and their families to improve outcomes and empower families to continue their success and deliver on the Board's vision to ensure children live healthy, active, happy and fulfilled lives and feel a sense of belonging in their community.

To note, in response to the Children's Wellbeing and Schools Bill and the shift to the Family First Reforms and how this will shape children's service provision in Darlington in 2027, the focus for this group next year will change to respond to the requirements of the new legislation. The legislation is still progressing through parliament, Darlington is in a good position and it is anticipated that the changes will build upon existing good practice.

The implementation by Adult Services of a Weekly Review Meeting, a process which is already embedded within Children's Services, allows senior managers to review the decision making and the outcomes of safeguarding referrals

which has improved the collation of intelligence and the identification of themes for the Partnership to address. This process has already identified a number of themes which cut across both child and adult safeguarding and will be addressed through quality assurance processes.

The Partnership continues to focus on a Think Family approach to ensure practitioners continue to identify wider family needs which extend beyond the individual they are supporting, the needs of all members of the family are explored as individuals and how their needs impact on one another. A number of local and national reviews have recently highlighted the importance of a holistic family approach as a learning point.

The introduction of the Risk Enablement Forum provides a pathway to manage those complex or high-risk cases on a multi-agency basis. This may include cases where an individual has difficulty engaging with services and there is a high risk to the individual or wider community. Three cases were referred in this reporting period resulting in several meetings.

## Priority Three

### **Joint Working - ensure effective arrangements are in place to protect children, young people and vulnerable adults from abuse and neglect.**

Darlington Safeguarding Partnership is committed to working together to protect children, young people and adults with needs for care and support from the risk of serious harm and abuse.

There is strong evidence of effective strategic leadership and collaborative working, with a shared commitment and responsibility for the partnership. Integrated partnership arrangements in Darlington have been a real strength. The wider safeguarding partners (including relevant agencies) are appropriately informed of and engage with the safeguarding partnership arrangements, actively contributing to the DSP priorities and key areas of work.

It was acknowledged that Education is already very well engaged in safeguarding arrangements in Darlington through participation in the sub groups but have not had an input at a strategic level. This will be strengthened under the new

partnership arrangements with education representatives, now as delegated safeguarding partners (DSPs). The appointed representatives have been endorsed by their colleagues and are members of primary, secondary and tertiary education forums, enabling them to act as channels for safeguarding information, in and out of the partnership.

Darlington has been in a very unique position and the arrangements have worked as well as others and we do not want to lose sight of that.

Partners acknowledged Darlington as a joint child and adult partnership which should continue so as not to lose the benefits. Darlington is a very small local authority area and whatever changes are made need to reflect what is needed for Darlington. The Independent Scrutineer/Chair role has provided a valuable contribution to the Partnership since its inception in 2019 and has been a real strength which has helped the Partnership to develop and embed its multi-agency safeguarding arrangements. However partners recognise the need to be open and reflect on what is needed from a partnership perspective to further strengthen the way we work and ensure all organisations are committed and engaged.

Engagement with voluntary and community sector organisations remains a development area. Services are provided by a wide variety of organisations and whilst DSP shares information, newsletters and updates across all the whole partnership, it can be difficult to ensure that representatives of smaller organisations are aware of multi-agency partnership arrangements.

DSP is open to respectful challenge, an indicator of a strong and mature partnership as well as having a shared commitment to developing and strengthening the arrangements further.

A new Named GP for adult safeguarding joined the partnership in July 2024 and this role has proved useful in liaising with GP practices for the purpose of SARs and learning reviews.

The CQC inspection of Darlington in January 2025, as part of the new national approach to assessing local authorities, recognised the strength, dedication and professionalism of teams across adult social care and acknowledged that the local authority worked well with the safeguarding partnership and other partners to

deliver a coordinated approach to safeguarding adults, with processes and practices in place to make sure people were protected from abuse and neglect.

Governance arrangements have been strengthened with the implementation of the Management Group made up of the Delegated Safeguarding Partners which will further underpin safeguarding practice.

Despite national and local workplaces challenges alongside high levels of need, both the child and adult workforce across the partnership are highly motivated and deeply committed to safeguarding children and adults with needs for care and support.

The governance, leadership and the shared responsibility for identifying and investigating learning from local and national case reviews is robust.

DSP coordinate and deliver a comprehensive and effective Safeguarding Training Programme. Learning activities are delivered across various media, including live training events, E-Learning and Practitioner Briefings.

The co-ordination, administration and delivery of Partnership safeguarding activity are managed extremely well by the DSP Business Unit.

### Quality Assurance Framework

Partners recognise the need to build upon the progress that has been made this year with further work needed to develop and embed a quality assurance and performance framework in Darlington to help evidence and demonstrate impact and is awaiting the appointment of an Independent Scrutineer who will oversee Child and Adult safeguarding scrutiny work, acting as an external critical friend to evaluate the work of safeguarding partners and identify areas for potential improvement.

Participation in wider forums

Darlington participates in a number of wider forums to help improve connectivity and understanding of the wider safeguarding issues and areas of common interest which include:

- Modern Slavery and Human Trafficking Network

- North East Regional SAR Champions Network
- UK Hoarding Partnership
- Domestic Abuse and Sexual Violence Executive Group

## Priority Four

### Exploitation - ensuring effective multi-agency response and intervention to protect those at risk of exploitation, in all its forms

When the strategic priorities were identified the partnership initially focused on child exploitation, both sexual and criminal, however it is recognised there are many other risks children face outside the family environment. DSP recognises the need to ensure young people, parents/carers, public and practitioners have increased awareness and are supported and educated to recognise risks of exploitation and Harm Outside the Home. Children and young people who are at risk of Harm Outside the Home (HOTH) can be children who are not always visible to practitioners, therefore the DSP want to look at how can we strengthen and challenge the partnership to look at increasing awareness, offer a greater understanding of places and spaces, focus on missing children and disruption. It recognises the need to revise and develop resources and tools to support the identification of children at risk of HOTH and make places and spaces within the Darlington locality safer for young people.

The Strategic Child Exploitation Group continued to raise awareness across the partnership, particularly in relation to the language that is used when discussing young people who are at risk of exploitation. During this reporting period it reviewed and agreed the Partnership Information Sharing form to help improve sharing of intelligence with Durham Constabulary in relation to suspected offenders; suspected vehicles; or locations of interest.

To enable partners to be able to identify young people at risk of sexual exploitation or experiencing sexual exploitation at the earliest opportunity, the group revised and agreed the child exploitation matrix. The Risk Assessment Information form was revised, and training was offered to key practitioners on how to use it and promote the knowledge to partners of the shared responsibility to identify young people at the earlier opportunity and how to share this information.

Review of the child exploitation vulnerability tracker (CEVT): The tracker provides the framework by which practitioners identify and monitor risk. The improvements have made the assessments more accurate and timelier. They also monitor risk over time so the effectiveness of interventions can be measured. It also allows us to see escalation in risk more clearly.

The work of the CEG continues to be underpinned by partnership data from both local authority areas which puts the group in a better position to identify and contend with exploitation and reporting provided by the Partnership Analyst.

Promoted and driven the use of the Philomena protocol for missing children in care.

Darlington Borough Council commissioned Barnardo's to carry out a review of its exploitation processes and systems across Darlington and the impact and involvement of multi-agency partner agencies. The review has highlighted a number of key strengths and areas for improvement which will be taken forward and include partners in the next reporting year.

### Key strengths:

- Agencies are engaged and harm outside the family
- Key issues have been identified
- Practitioners seek advice and support
- Young people at risk are well supported which includes outreach support
- Good service from social care, youth justice and family group conference

### Areas for improvement:

- Improve the Operational Missing and Exploited Group process (better structure, clearer actions and more focus)
- Revise and review current guidance and consider implementation of Tier 2 Information Sharing Protocol for HOTH.
- Quality assurance of the Child Exploitation matrix.
- Young people can be adultified by professionals (need to look at them as children)

- Early look at exploitation and how those children are identified when at lower risk of exploitation to prevent risks escalating
- Staff training
- Implement a targeted approach to places and spaces

### Complex and Multiple Abuse investigation

Darlington undertook an investigation (Operation Esdras), under its Complex and Organised Abuse Procedure in June 2024, with the focus being on national hotel chains in Darlington and the exploitation of a number of girls. A Strategic Management Group was established, and individual strategy meetings were held and all girls were discussed within the Operational MEG, with the local authority continuing to have oversight of those considered as lower risk. The concerns highlighted a loophole within the check in facilities provided in hotels which has been exploited by the perpetrators.

There is an ongoing criminal investigation into those who were alleged to have caused the abuse and Durham Constabulary continued to work with the national Operation Make Safe scheme, working with hotels and looking to strengthen their response and close the loophole which assisted the perpetrators. As a result of the investigation an audit was undertaken with findings highlighted in section 3 of this report along with the actions to be taken forward by the partnership and which link with the findings from the Barnardo review and will be overseen by the Strategic CEG.

### Priority Five

**Adult Self-Neglect - ensure all partner agencies improve awareness and understanding of adult self-neglect to ensure early identification can be achieved.**

Self-Neglect continues to be a challenge with numbers of reported concerns highlighting a steady increase year on year and highlighted as a recurring theme in local, regional and national SARs. Following learning from a number of learning lesson reviews, including the published Philip & Loraine Discretionary SAR, a task and finish group considered whether practitioners recognise self-neglect and



understand what action can be taken. As a result, the partnership agreed to:

- Revising self-neglect practice guidance to include key characteristics of self-neglect, examples of positive, flexible approaches of engaging people who are self-neglecting
- Promotion of the clutter scale tool
- Develop self-neglect pathway
- Develop self-neglect multi-agency risk assessment tool to support practitioners assessing and identifying risk
- Developing a Risk Enablement Forum to manage high risk and complex cases
- Consider the development of Mental Capacity Act Guidance to support practitioners on the importance of Mental Capacity Act Assessments and Legislation when working with individuals who are reluctant to engage with services

As outlined in section 3 of this report, the Partnership has introduced a Risk Enablement Forum which provides an opportunity to manage those complex or high-risk cases on a multi-agency basis. This may include cases where an individual has difficulty engaging with services and there is high risk to the individual or wider community. Three cases have been heard to date.

In July 2024 the partnership hosted a Self-Neglect Conference which was well attended and well received by front line practitioners from all agencies. The purpose of the conference was to raise awareness of the issue of self-neglect and hoarding and to focus on the issues and challenges faced by practitioners. Presentations were delivered by keynote speakers, the learning from local and national Safeguarding Adult Reviews was shared and the new policy and procedural practice guidance was launched. Briefing documents have been published to share the learning from Safeguarding Adult Reviews where self-neglect is a factor. Feedback included:

*'Particularly enjoyed hearing about building relationships with people and the importance of listening to their story'*

*'The conference enabled me to learn something new'*

*'It was extremely interesting with all the guest speakers being very knowledgeable'*

*'Very impactful conference'*

*'A valuable insight into an area that is rarely talked about, all professionals delivered interesting information from differing perspectives and really good personal experiences shared'*

*'Conference was very informative and has influenced my practice'*

The task and finish group continues to monitor the Philip & Loraine action plan and develop further learning and opportunities to continue to improve awareness and understanding of self-neglect and hoarding.

## Learning from Rapid Reviews, Local Child Safeguarding Practice Reviews, Safeguarding Adult Reviews and Learning Lesson Reviews

A core function of all Safeguarding Children Partnerships is to assess serious safeguarding incidents to identify key learning for the safeguarding system and ensure this, and any key recommendations, are effectively implemented by partners.

The Statutory Safeguarding Partners determine whether a Serious Incident Notification (SIN) referral meets the criteria for notification, or a Safeguarding Adult Review referral meets the criteria for statutory review. Partners discussed the requirements as outlined in Working Together guidance regarding the appropriateness of serious incident notifications and concluded that these were not always required, where no new issues were identified and agreed they will continue to have oversight and determine on a case-by-case basis whether or not notification is required.

### Children

Three serious incident notification referrals were submitted to the partnership in this reporting year. The SSPs agreed in July to notify a referral following the death of child and a Rapid Review was undertaken, it was recommended not to proceed with a Local child Safeguarding Practice Review (LCSPR) as whilst it was recognised it was an unusual and violent incident, there was nothing to indicate any immediate learning for the partnership. The Child Safeguarding Practice Review Panel also agreed with the decision not to initiate an LCSPR. It was determined by SSP's not to notify two of the SIN referrals as they did not meet the criteria for notification.

Two Learning Requests were referred to in the Partnership's Learning & Development Group (cases where there is learning to explore but do not meet criteria for SIN), both cases were taken forward as Local learning Reviews, with key

learning points identified as outlined below:

The first one was submitted in September 2024 by Children's Services involving a child under the age of three who suffered a head injury perpetrated by a family member during a domestic assault.

The second was submitted in February 2025 by Children's Services and Mental Health Trust involving a child who experienced familial sexual abuse with concerns being raised about how effectively agencies worked together to protect the child.

Both learning reviews continued into the next reporting period and the findings and learning will be reported in next year's annual report.

Child J LCSPR - the Partnership undertook a Local Child Safeguarding Practice Review which had been notified in the previous reporting year, following the death of a child as a result of a non-accidental injury perpetrated by a family member. An independent reviewer was commissioned and the review commenced in April 2024. The review concluded in November 2024; however the report was not published until February 2025 due to an ongoing criminal investigation.

The review focused on five key themes that helped the partnership understand what had happened and what this meant for the children in the family. The review identified learning for the multi-agency partnership to consider and reflect upon regarding current systems and practice and there were eleven recommendations made.

The partnership published two practitioner briefing papers outlining the learning from the review and the implications for front line practice, one to be shared with practitioners and discussed in team meetings, supervision and training and a shorter seven Minute briefing to be shared more widely across organizations.

## What did we learn?

### The children's lived experience - what it was like to be an infant and child in this family

Practitioners did not always identify why children's needs were not always met; being curious and exploring parental history and their lived experiences will help understand what parents may need to help their children thrive and keep them safe alongside other factors which may be affecting family life, such as new relationships, parental mental health difficulties, domestic abuse and financial issues.

Services did understand this family needed help and some practical support was provided, however there was often too much focus on the adult problems, which were not seen as an indicator of neglect.

Practitioners need to observe interactions between children and their parents/carers through direct work to help them understand that children often communicate through their behaviour and physical presentation.

### Parental mental health - the impact this has on parenting and family functioning

There were some good strength-based approaches that supported mother's mental health difficulties; however, the focus was all too often on her needs with limited understanding of the child's experiences. Practitioners did not have full knowledge of her long-standing mental health history or what her mental health difficulties meant in relation to family functioning, with limited reflection and curiosity. Whilst there was a range of adult service responses and assessments to her mental health needs, they were not widely shared or used to inform family assessments.

The children's anxieties and behaviour were linked to what was happening at home, mothers fluctuating moods and who was providing care, however this was not picked up by the agencies involved. Mother's mental health crises were often dealt with episodically with no reflective and holistic multidisciplinary assessment of her mental health needs and the impact on the children.

There was some evidence of neglectful home conditions and whilst practical support was provided the underlying reasons were not fully appreciated or assessed, meaning improvements were short-term.

### Neglect and its impact on child development and wellbeing

There had been previous statutory involvement with all mother's children relating to significant neglect and neglectful home conditions and her ability to meet their needs, along with issues relating to her mental health. There appeared to be a level of professional optimism with professionals being incident-led, that got in the way of recognising cumulative neglect.

It is unclear why neglect was not explicitly considered and understood by services. Critical thinking was missing, there appeared to be a lack of clarity about what neglect looked like, recurrent and historical themes tended to focus on the adult's needs and mothers' frequent requests for help seemed ambiguous. Effectively assessing child neglect requires a holistic approach.

Financial difficulties were a consistent feature, practical support and guidance were provided several times; however it was not seen as an indicator of neglect.

It was evident, the elder sibling was a young carer, considering her needs were a gap in identifying her specific needs.

## Unseen or unconsidered adults/caregivers within the household - what was known about them and their role with regard the children

The men and caregivers involved with the family and what was known about them and their role with the children, were not unseen but unconsidered. There were males involved with the children's lives and they were referenced as supporting and caring for the children, but there was limited professional curiosity about them or their role in the care of the children. Often an over reliance on mothers' narrative and missed opportunities for exploring information and support from wider family members/care givers.

Child J's father had limited contact with him, it was reported his weekly contact was difficult to manage as was always led by mother, he remained anxious that she would stop contact, as she had done before. He was not always aware of professional involvement during his son's life as there was reliance on mother's narrative of who was involved.

There was limited knowledge of mother's current partner and whilst police checks were made, there was no indication that he presented any risks to the children, however further exploration of his role in the family was missing. Mother's report that he did not stay overnight was not challenged and accepted at face value. There should have been greater curiosity about him and some exploration of his role in the household.

Knowing who is involved in a household is important when providing help and support to families and considering risks, vulnerabilities, and support they could provide.

## Multi-agency working and how it provided the children with help, support and protection

It was evident professionals worked hard to engage with the family and provided a wide range of support and help and positive relationships were developed. The range of services was extensive across child and adult services, including specific voluntary services chosen by mother for support and which provided a high level of practical and emotional support, however there was no sense they formed part of a multi agency community support network.

There appeared to be overconfidence that the range of services meant the family's situation was fully supported, however the support was intermittent and there was a lack of clarity about who was doing what, when and with whom.

Many services did not know the full background and often relied on mother's narrative. Mother often sought support and then failed to engage, she failed to take child J to some health appointments, which were not viewed in the context of 'Was Not Brought' (WNB) policy and wider neglect factors for both children. Disguised compliance was not considered as a factor.

Some evidence of multi-agency meetings and service involvement, however this was limited or only involved one or two agencies, meaning information was often seen in isolation. Opportunities to reflect on and analyse the family's history, circumstances, needs, worries and protective factors were missed; a coordinated multi-agency interdisciplinary response that attended to both the adult and children's needs may have benefited the family

It was evident, the elder sibling was a young carer, considering her needs were a gap in identifying her specific needs.



## So, what next?

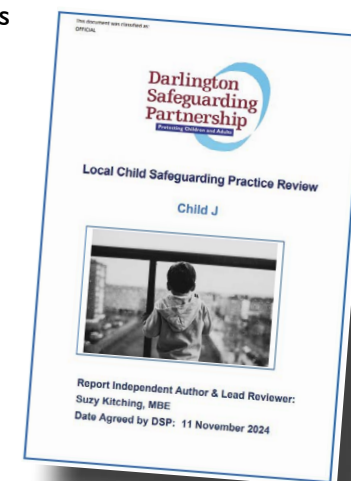
The review sought to understand the circumstances that led to the sad and tragic death of Child J, a number of multi-agency recommendations were identified to reflect the areas deemed as priority areas for improvement which will be taken forward in the next reporting period:

- Strengthen and evaluate the impact of learning from a previous LCSPR (Family H), which mirrors similar key learning from this review.
- Improve Practitioner knowledge, skills and confidence in:
  - Understanding children's lived experiences and appreciating what life is like for them.
  - The use of critical thinking to fully consider a family's circumstances and using 'professional curiosity.'
  - Ensuring all men associated with the family /adult caregivers are fully considered.
  - Effective information sharing and seeking about all adults and children in the family during multi-agency safeguarding discussions/meetings.
- Strengthen knowledge and understanding of the impact of adverse childhood experiences and parental mental health difficulties can have on family functioning and parenting.
- Review and revise multi-agency practice guidance on neglect to support practitioners in the identification of neglect and pathways of support and intervention, consider identified practice tools which will help improve outcomes for children.
- Ensure there are clear systems in place to support collaboration across adult and children's services when there are parental mental health difficulties to support information sharing and assessment.

- Revise the Neglect Strategy and reflect on the research and understanding about adverse childhood experiences and building resilience for families through multi-component programmes, family-based interventions, trauma-informed approaches, and prevention strategies to support wider system change and build resilience and repair for children.
- Provide leadership and guidance on developing a child-centred approach within a whole family focus, in line with the multi-agency expectations in Working Together 2023 that supports the needs of all family members and considers how they interact.
- Ensure there are processes in place that consider all adults associated with the family and their roles are identified by all services.

## What we still want to achieve:

- Continue to discuss and develop multi-agency actions to respond to the recommendations to help embed the learning across partner organisations.
- Develop and implement multi-agency reflective supervision to help improve agency collaboration and address some of those complex cases to support practitioners to reflect on their practice and improve decision making to help lead to better outcomes for children and families.
- Consider the learning from this and other reviews and co-ordinate the actions necessary to address some of those persistent and common areas highlighted and consider how this can be shared with practitioners.
- Continue to evaluate how the learning has been embedded within partner organisations through deep dive, audits and other quality assurance processes.



## Adults

Two Adult Learning Requests were referred into the Partnership's Learning & Development Group (cases where there is learning to explore but do not meet criteria for SIN), both cases were taken forward as Local learning Reviews, with key learning points identified as outlined below:

The first one was submitted in July 2024 by Police following the death of an adult with reported concerns around self-neglect and exploitation. This learning review continued into the next reporting period and learning will be reported in next year's annual report

The second, submitted in November 2024 by Adult Services, upon review it was agreed no further action to be taken. Concerns were being addressed through safeguarding processes, learning had already been identified and embedded, with no further lessons to explore, the case is more than 12 months old and therefore a learning review is not appropriate.

**Adult Review Philip and Loraine:** The Partnership continued work on an Adult Discretionary Review which was referred in the previous reporting year. In August 2023, County Durham and Darlington Fire and Rescue Service submitted a SAR referral in respect of two adults who died in a house fire. The occupants had needs for care and support and there were concerns about self-neglect and hoarding in the home environment. An independent review author was commissioned, and the Adult Discretionary Review concluded and was published in September 2024.

## What did we learn?

### Understanding of Self-Neglect and Hoarding

Self-neglect was a feature for Philip and Loraine as there was substantial evidence of hoarding type behaviour, concerns around unhygienic conditions and out of date food in the kitchen and concerns over the amount of unused medication in the family home.

### Understanding Hoarding Disorder

Hoarding Disorder is a recognised medical condition, although Philip and Loraine were never formally diagnosed with hoarding disorder, they demonstrated hoarding behaviour. Efforts were made by agencies to address the symptoms of hoarding with attempts to reduce the clutter, however this often led to them becoming distressed and agitated. Practitioners should be more curious to understand what is important to the adult and how this may be used to influence positive changes in lifestyle.

### Smoking and Fire Risk Smoking and fire risks were never fully explored.

Philip was a chain smoker and smoked throughout the property, he and Loraine had mobility issues and used a stair lift. In 2019, due to the risks associated with Philip's smoking, the Fire and Rescue Service conducted a home visit and provided a flame -retardant bed pack, however information about this was not passed onto other agencies which were unaware the equipment was in the property. It remained unopened until a Care Agency raised the matter in 2022. This was followed up twice, but Philip refused the first visit, on the second visit advice was provided on various fire risks including keeping escape routes clear in event of a fire and additional fire-retardant equipment was provided. The home was recorded as very high risk but again information was not communicated to other agencies.

## Multi-Agency Practice issues

Multi-agency safeguarding processes, including documentation designed to provide structure, were not fully completed with sections incomplete, amounting to a missed opportunity to document considerations and decisions. Key agencies were not invited to further strategy discussions, leading to missed opportunities to raise concerns. All individuals in a household should be considered in an enquiry, not just the person which is the subject of the concern.

### So what next?

The review sought to understand what was known about Philip and Loraine leading up to their deaths and how agencies worked together to understand and identify lessons to be learnt. A number of multi-agency recommendations were identified to reflect the areas deemed as priority areas for improvement which will be taken forward by the Partnership:

- Provision of multi-agency training to provide a better understanding about the medical condition of Hoarding Disorder, its various root causes and potential treatment.
- Promote strength-based and asset-based approaches used by ASC with other partners to ensure there is a consistent approach used across the DSP.
- Seek agency assurance on single agency MCA awareness training on the MCA - if none in place agencies to ensure appropriate staff have ability to access the DSP e-learning module on MCA awareness and ensure all frontline delivery staff and line managers complete the e-learning module. Training should be included in any induction processes.
- Incorporate the latest published version of the MCA Code of Practice and the paper published by 39 Essex Chambers on conducting MCA assessments to support practitioners within guidance documents.

## Mental Capacity Act assessments

Agencies were of the opinion both Philip and Loraine had the capacity to make decisions, and no formal capacity assessment was undertaken in relation to their understanding of the risks associated with their excessive hoarding or to have items removed to reduce the clutter. Loraine had no diagnosis of cognitive impairment, Philip did have memory issues and there were concerns around capacity, therefore there were no grounds under the MCA to warrant an assessment.

- Undertake quality assurance activity to seek assurance that agencies are conducting and recording mental capacity assessments appropriately.
- Establish a suitable solution to enable key information to be shared for those high risk or complex cases, particularly when any fire safety equipment is left following a Home Fire Safety Visit by the Fire Service.

### What have we done?

- The findings were addressed by a self-neglect task and finish group and the partnership published a Practitioner Briefing Paper outlining the recommendations, key learning and key practice themes.
- Hosted a practitioner conference in July 2024, to raise awareness of the issue of self-neglect and hoarding and the issues and challenges practitioners faced working with individuals who are resistant to support and who may have additional complex needs which was open to all multi-agency practitioners working across Darlington, with over 100 delegates attending.
- The Task and Finish Group has continued to review the recommendations and identify appropriate actions and monitor the progress.

### What we still want to achieve:

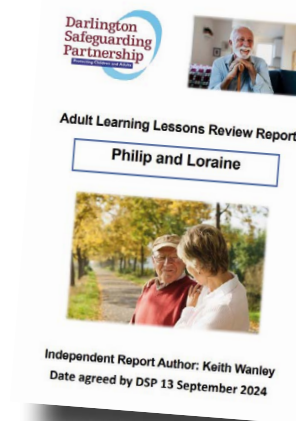
- Continue discussions with CDDFRS to finalise and implement a process to enable key information to be shared for those high risk or complex cases, particularly when any fire safety equipment is left following a Home Fire Safety Visit by the Fire Service.
- Continue to evaluate how the learning has been embedded within partner organisations through deep dive audits and other quality assurance processes

### Embedding Learning from local and national reviews.

The learning from the local child and adult reviews highlights professional curiosity, information sharing, unconsidered adults or caregivers in households, the impact of parental mental health, self-neglect and mental capacity assessment as ongoing themes which cut across a number of reviews, both locally and nationally over

recent years. The partnership is seeking assurance that the learning is embedded in front line practice and a task and finish group has been established to review the recommendations from the learning reviews and will determine specific actions for the group to progress. The outcome will be reported in next year's annual report.

In November 2024 the National Child Safeguarding Practice Review Panel published a report on protecting children and responding to child sexual abuse within the family environment. The LCSPR Family H published by the partnership in November 2023 is referenced in the report the partnership will seek assurance that the learning from the National Panel report is also embedded in practice.



## 5: Future Planning

### Looking forward to 2025/26 we will:

- Continue to plan for the Family First Reform for children and families and the impact that it will have on safeguarding partnership arrangements
- Recruit and Appoint an Independent Scrutineer to drive continuous improvement
- Continue to raise awareness of abuse and neglect among the public and professionals in Darlington
- Continue to apply the learning from Local and National Child and Adult Reviews
- Review Strategic Plan and determine key priorities to take forward
- Develop how children, young people and adults and their families are involved, with plans to seek their voice and influence in partnership arrangements

- Ensure appropriate quality assurance procedures are in place for multi-agency data collection, audit and information sharing
- Embed multi-agency reflective supervision and Re-Think formulation models

For more information about Darlington Safeguarding Partnership, please visit - [www.darlington-safeguarding-partnership.co.uk](http://www.darlington-safeguarding-partnership.co.uk)

Or email us at: [DSP@darlington.gov.uk](mailto:DSP@darlington.gov.uk)



# Appendix 1

## Relevant Agencies

Relevant agencies are those organisations and agencies whose involvement the safeguarding partners consider is required to safeguard and promote the welfare of children, young people and adults with care and support needs. The relevant agencies can support and work in a collaborative way to provide targeted support to children, adults and their families.

Agency	How were they involved?
<b>Health</b>	
County Durham and Darlington NHS Foundation Trust (CDDFT)	Subgroups
Harrogate and District NHS Foundation Trust (HDFT)	Subgroups
Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)	Subgroups
North East and North Cumbria Integrated Care Board (NENC ICB)	Subgroups
North East Ambulance Service NHS Foundation Trust (NEAS)	Subgroups
NHS England	Subgroups
Darlington Primary Care General Practices	Subgroups
Healthwatch	Subgroups
<b>Local Authority - Darlington Borough Council</b>	
Adult Social Care	Subgroups
Children's Social Care	Subgroups
Youth Justice Service	Subgroups
Education Safeguarding Officer	Subgroups
Public Health	Subgroups
Housing	Subgroups

Agency	How were they involved?
<b>Police Service</b>	
Durham Constabulary	Subgroups
Durham Police and Crime Commissioner	Subgroups
British Transport Police (BTP)	Subgroups
<b>Education</b>	
Primary, Secondary and Further Education and SEND	Subgroups
Early Years settings	Training and Learning Events
<b>Other Organisations</b>	
County Durham and Darlington Fire and Rescue Service (CDDFRS)	Subgroups
Probation Service North East	Subgroups
Care Quality Commission (CQC)	Subgroups
Children and Families Advisory and Support Services (CAFCASS)	Learning Events
H.M. Coroner	Learning Events
Independent Providers including private hospitals, children's homes and care homes and domiciliary providers	Training and Learning Events
Chairs of key local boards (Community Safety Partnership, DASVEG)	Training and Learning Events
Family Justice Board	Training and Learning Events
Department of Work and Pensions (DWP)	Subgroups
<b>Voluntary and Third Sector Organisations</b>	
Harbour (Domestic Abuse Service)	Subgroups
We are With You (Substance Misuse Service)	Subgroups
Voluntary and Community Organisations	Training and Learning Events
Youth Groups (sports clubs, Guides, Scouts)	Training and Learning Events
Faith Settings	Training and Learning Events
Minority Communities	Training and Learning Events



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