Hartlepool & Stockton-on-Tees
SAFEGUARDING CHILDREN PARTNERSHIP

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Context

This Local Child Safeguarding Practice Review was commissioned following the tragic death of Antony, an eight year old boy with significant additional needs, including autism and communication differences.

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Background

Antony lived with his mother and 2 older siblings. His mother had long standing challenges relating to substance misuse and poor mental health. Despite these chronic issues, assessments across agencies repeatedly focused on isolated concerns rather

Antony had a diagnosis of autism and one of his older siblings has a learning disability. Mother was open to adult services. The children had been historically open to social care but not since Antony's birth.

Risks increased significantly in 2025 when his mother's mental health deteriorated following an alleged rape and escalating paranoia. In the weeks leading up to Antony's death, she had contact with multiple agencies - GP, police, 111, ED, school, and drug services - yet no professional had sufficient information to form a clear picture of escalating risk.

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Key messages

(What can I do now)

- Consider everyone in the home and network
- Proactively seek and share information
- Think beyond the reason for involvement
- Triangulate and test information
- Keep children and safe-guarding at the centre

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Vulnerability Factors

- Child vulnerabilities: autism, communication differences, reliance on routine, and agency misunderstandings about his abilities, leading to limited direct work.
- Parental and environmental risks: long-term substance misuse, chronic and worsening mental health, trauma, paranoia, social isolation, and fragmented health records that obscured key history. Reduced service engagement, limited home visits, and unshared domestic abuse incidents further heightened concern.
- Systemic issues: poor information sharing across schools, health, drug services, and social care, over-reliance on parental self-report, and inconsistent whole-family assessments or involvement of supportive relatives.

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Recommendations

- improving safe, confident information-sharing;
- strengthening practitioner skills, assessment quality and supervisory oversight;
- embedding genuinely holistic, whole family approaches;
- formalising and integrating family networks; and
- enhancing safeguarding practice within the drugs and alcohol service

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Themes

- Fragmented systems including poor transfer of information
- Professional over□optimism and assumptions
- Lack of holistic "Think Family" practice
- Insufficient professional curiosity
- Missed opportunities for early help and intervention

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Learning

- Poor understanding of children's needs and parental capacity
- Weak information transfer
- Over-reliance on parental self-reporting
- Failure to identify the primary issue
- Tokenistic involvement of the family network
- Single-agency learning: Drugs and Alcohol Services