Child Antony
Safeguarding Practice Review

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Executive Summary

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. The review was initiated after a Rapid Review in October 2025 identified opportunities for system learning relating to agency practice, information-sharing, and the understanding of risk within the family.

Antony lived with his mother and two older siblings. His mother had long-standing challenges relating to **substance misuse** and **poor mental health**. Although agencies were involved with her over many years, no single organisation held a complete picture of her needs or the children's lived experience. Each service worked within its own remit, and assessments were often based solely on **parental self-report**, with limited triangulation or direct work with Antony. As a result, key risks were misunderstood or missed entirely.

The review found that Antony's vulnerabilities - including autism, communication differences, and his dependence on consistent, informed caregiving - were not fully recognised across agencies. Similarly, his mother's mental health deteriorated significantly in the months before his death, yet this deterioration did not trigger coordinated multi-agency intervention. Critical information was fragmented across multiple systems, and assumptions were made about her progress, parenting capacity, and the support available from the wider family network.

Across agencies, there were recurring patterns:

- **Information was not routinely shared**, including crucial historical concerns about drug use, mental health, domestic abuse, and the children's needs.
- **Assessments relied heavily on self-report**, with minimal direct contact or home visits.
- **Professionals lacked a holistic view**, leading to an over-focus on one presenting issue (usually substance misuse) and insufficient exploration of root causes such as mental health.
- **Family members who had vital insight** into the mother's wellbeing and the children's safety were not meaningfully involved or listened to.
- **System design issues**, including non-interoperable recording systems, contributed to significant gaps in understanding.

Using the SCIE *Learning Together* methodology, the review identified **seven interlinked systemic findings**, including weaknesses in recognising children's needs, failures in information transfer, reliance on parental narrative, insufficient identification of the primary issue, and missed opportunities to integrate family networks into assessment and planning. The cumulative effect of these issues impeded the safeguarding system's ability to understand Antony's daily lived experience and act protectively.

The review concludes with a set of **recommendations** focused on:

- 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.

Collectively, these recommendations aim to ensure that agencies develop a clearer shared understanding of children's lived experiences, intervene earlier and more effectively, and work together to prevent the recurrence of such tragic outcomes.

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1. Introduction

1.1 Why was this case chosen to be the focus of the review?

1.1.1 Working Together 2018 requires the Local Safeguarding Children Partnership (LSCP) to make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases where they consider it appropriate for a review to be undertaken.

1.1.2 Serious child safeguarding cases are those in which: abuse or neglect of a child is known or suspected, and the child has died or been seriously harmed. When a serious incident becomes known to the safeguarding partner, they must consider whether the case meets the criteria for a local review and determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements in practice. There is a requirement to undertake a rapid review of the case to consider the potential of the case for identifying improvements to safeguard and promote the welfare of children.

1.1.3 A Rapid Review Meeting led by the Safeguarding Children Partnership was convened in October 2025 following a serious incident which led to the death of Antony. The Rapid Review Meeting recommended a Local Child Safeguarding Practice Review be initiated, to identify learning from work with Antony and his family. The LCSP Chair and the National Child Safeguarding Practice Review Panel supported this recommendation.

1.2 Succinct summary of the case

1.2.1 Antony was an eight-year-old boy who, at the time of the incident, lived with his mother and his two older siblings. While Antony's Father did not live in the family home at the time of the incident they had lived together at times throughout Antony's life. Issues within the adult relationships led to Father not to have had contact with Antony for approximately a year prior to his death. Antony had significant additional needs and was diagnosed with autism early in his school career. Antony's oldest sibling has a diagnosed learning disability. Save for school, it was said across Antony's and mother's records that he was non-verbal. The reviewers could see opportunities where Antony's voice could have been ascertained, however, they were overlooked due to the belief that Antony was unable to take part in direct work due to his significant communication needs. Antony had an Education, Health and Care Plan. Antony had attended mainstream primary school in his community until he was 7 years old when he transferred to a specialist provision. On transfer to his new school the history of concerns regarding parenting, mother's drug use and poor mental health got left behind on his older sibling's records who had transferred to other schools much earlier.

1.2.2 Family identified Antony made progress at his new school, however, the review noted that as the specialist provision that Antony attended required him to be transported by bus, this hindered any parental interaction between school staff and parent. This also included any 'informal' interactions and community building for mother e.g. talking to other parents at school.

1.2.3 Mother had been engaged with drug and alcohol services since 2010 and had remained on a methadone programme throughout this period. Reviews and prescriptions were provided over the years, with the majority of appointments conducted by telephone, some undertaken in an office setting, and very few completed within the home - only nine during Antony's lifetime. Assessments relied primarily on parental self-reporting,

with limited face-to-face contact. No triangulation with other involved agencies, including the children's schools or health services, was undertaken to inform the drug service's assessment.

1.2.4 The local drug and alcohol service offers an assessment process designed to develop a 'Service User Plan', monitored through a 'Full Risk Review' to identify and address strengths and vulnerabilities related to substance use, including safeguarding considerations and wider family networks. In Mother's case, she was offered prescription reviews and appointments delivered via telephone, in-office, or within the home.

1.2.5 Mother's challenges with poor mental health were long standing including a diagnosis in 2015 of Emotionally Unstable Personality Disorder. Despite the challenges with mental health co-existing with her drug use causing her to be acutely unwell at times the review found that no one agency held all this information about Mum's circumstances. In particular, the review found that Mum was represented on at least four standalone health recording systems serving as a barrier to putting together a whole picture approach.

1.2.6 Antony was not open to social care for this period of involvement until September 2025. He had previously been known to social care for 2 assessments, one Pre-birth and one when he was one year old.

1.2.7 Other agencies involved in Antony's life conducted assessments of the family's circumstances. These individual assessments were completed in isolation and focused solely on each agency's specific reason for involvement, such as special educational needs or concerns regarding drug use. Professionals appeared to rely primarily on the mother's self-reports, which seemed to provide them with reassurance that support was being delivered at an appropriate level. The level of concern was dictated by Mother's active drug use, there being confidence that she was doing well and Antony was safe as at times she was using the methadone programme effectively. Equally, the lack of attention given to family history and functioning, root causes, cumulative and hidden harm and the input of the family network, meant that Antony's daily lived experience and safety wasn't well understood.

1.2.8 Around a year prior to Antony's death, children's social care received a Police notification setting out concerns regarding a domestic abuse incident that had taken place at the family home. Social work screening showed no information held regarding mother's substance misuse or mental health which led to the decision making of no further action.

1.2.9 Overall, the review found that no one agency held all of the information regarding Antony, his mother and their family to be able to holistically assess Antony's situation and associated risks to be able to offer the correct help and intervention at the right time.

1.2.10 Following a planned solo trip in June 2025, Mother returned home and reported to her family, the police, and health professionals that she had been subject to a traumatic event. In the period that followed, Mother stated that she had received communication from the people she stated were involved, as well as threats toward herself and her children. Family members observed a significant deterioration in her presentation and mental health and supported her to seek medical assistance

1.2.11 Mother attended her GP in August 2025 and was advised to make a self-referral to support services. She subsequently contacted the drug and alcohol service to request a home visit. Around the same time, family members contacted mental health services by telephone; however, as Mother stated during the call that she did not wish to receive mental health support, the outcome was a referral to the emergency department (ED) for a minor, unrelated medical issue. Mother attended the ED accompanied by a family member, who informed staff that she believed Mother to be experiencing significant mental health difficulties. Mother stated that she did not require input from mental health services and subsequently left the department.

1.2.12 In September 2025, Mother has disclosed the same concerns to Antony's school. Following this disclosure the children were allocated for a social care assessment. An initial visit took place. On the date of the second social worker assessment visit, the social worker arrived and was informed that Antony had passed away.

1.3 Methodology

1.3.1 The purpose of a Local Child Safeguarding Practice Review is:

- To promote effective learning and improvement to services and how they work together;
- To learn lessons about how the local safeguarding system works that will help to reduce the likelihood of future harm;
- To understand what happened and why;
- Identify improvements that can be made to safeguard and promote the welfare of children;
- Understanding whether there are systemic issues, and whether and how policy and practice need to change;
- Seek to prevent or reduce the risk of recurrence of similar incidents.

1.3.2 The LSCP have chosen to adopt the Social Care Institute for Excellence (SCIE) Learning Together Review Methodology[1]. This is a well-established and evidence-based approach to facilitating learning and improvement in safeguarding children through the review of professional practice in an individual case. The aim is to support the staff, managers, and strategic leaders involved in the case to apply systems thinking to develop a comprehensive understanding of the social and organisational factors influencing practice, both within the specific case and in the wider context. The process also seeks to foster a culture of shared learning among all participating partners.

1.3.3 Learning Together provides the analytic tools to support both rigour and transparency to the analysis of practice in the case and identification of wider systems learning. This creates a two-stage process:

- The timeline is first divided into Key Practice Episodes. Each episode is then analysed to evaluate the quality of practice and to identify the contributory factors influencing it.
- From the case analysis, the reviewers identify the underlying systemic issues that either facilitate or impede effective practice on a broader scale. The Learning Together finding's structure requires reviewers to provide evidence demonstrating the generalisability of the issues identified within the case.

1.3.4 The approach has involved two groups of professional participants (APPENDIX 1)

[1] Social Care Institute for Excellence (SCIE) Learning Together Methodology Learning Together to safeguard adults and children: a multi-agency systems approach - SCIE

Case Group - Practitioners with direct case involvement and their line managers. Along with equivalent representatives from another Local Authority area.
Review Team - Senior managers who were not directly involved in the case, but who hold responsibility for supporting system learning and therefore, play a critical role. They contribute broader organisational insight, enabling the differentiation between issues that are specific to the individual case and those that reflect wider local trends.

1.3.5 The reviewers also sought to engage with family members to discuss the analysis, address any questions they may have had, and gather their perspectives, in accordance with the methodology and statutory guidance.

1.4 Time Period

1.4.1 It was agreed that the rapid review would consider individual agency chronologies for the period of 2 years prior to Antony's death.

1.4.2 During the review, the timeframe was extended to ensure greater clarity regarding professional involvement and the sharing of information.

1.5 Research Questions

1.5.1 This two-part review builds upon the work initiated through the Rapid Review. Participating agencies were asked to examine their own records and provide a response to the following question:

- What was known about Mother's circumstances / lifestyle, such as her substance misuse and poor mental health, and how has this impacted on her ability to parent?
- What tools / assessments were used to identify strengths and vulnerabilities and how did these enable you to understand what life was like for the child?

1.5.2 The reviewers analysed the submissions provided by each agency and convened agency representatives in a focus group to discuss their responses. The purpose of this session was to identify any further lines of enquiry or additional documentation requiring examination to inform Phase 2 of the review.

Phase Two of the review applied the *Learning Together* systems methodology. Research questions, developed from the learning themes identified during the Rapid Review, were explored to provide a deeper insight into the functioning of the system. These research questions and the subsequent findings can be found in Section 3

1.6 Involvement of the child and family

1.6.1 Antony's mother and Father were offered the opportunity of contributing to the review. Mother and Father were not able to contribute to the review - due to their own circumstances.

1.6.2 Antony's wider family, who played a significant part in their life, were also provided with the opportunity to continue to the review. The reviewers met with Maternal Aunt, Maternal Grandmother and Paternal Grandmother on one occasion. The family's contributions have informed the appraisal of practice and findings, along with their perspective of the effectiveness of the support provided to Antony, his mother and his siblings.

1.7 Methodological Comment and Limitations

1.7.1 Managing Analytic & Ethical Difficulties

1.7.1.1 As with the vast majority of serious incident reviews, an important analytic challenge has been the need to minimise hindsight and outcome bias. The reviewers know about the incident that triggered the Local Child Safeguarding Practice Review.

It requires deliberate effort to minimise the extent to which this distorts the reviewer's perception of a professional's work when reflecting on and evaluating their actions and decision-making. The analytical tools employed through the SCIE's Learning Together model have supported the reviewers in avoiding disproportionately harsh judgments of the professionals' practice due to the known negative outcome. These tools have also helped ensure that the reviewers do not oversimplify the complex circumstances and challenges that practitioners faced at the time.

1.7.2 What is in and out of Focus in the Report

1.7.2.1 This report concentrates on:

- **The professional practice** directly relevant to the circumstances under review.
- **Decision-making processes**, including the rationale behind key actions taken by practitioners at the time.
- **The organisational context**, such as policies, procedures and systemic influences that shaped practice.
- **The sequence of events** that contributed to the outcome, as understood through the Learning Together model.
- **Areas of learning and improvement**, with a focus on systemic strengths, vulnerabilities, and opportunities for development.

1.7.2.2 This report does **not** focus on:

- **Apportioning blame** or evaluating individual performance.
- **Judging professional actions with hindsight**, including conclusions based solely on knowledge of the eventual outcome.
- **Examining issues unrelated to the scope of the incident**, including historical practice not directly connected to the case.
- **Providing detailed assessments of individuals or families**, except where relevant to understanding professional decision-making.

2. The Methodology and Process of the Review

2.1 The review process

2.1.1 The key components of the review process were as follows:

a) **Establishing the Systems Questions** to form the basis of the Terms of Reference.

b) **Developing a merged chronology** and undertaking an early analysis of practice within the case, using Key Practice Episodes to highlight significant incidents.

c) **Engaging with family members** to understand their perspectives, experiences, and concerns.

d) **Facilitating a Practitioners' Workshop**, bringing together frontline staff and managers who were directly involved in the case (or working within the relevant services at the time). The purpose of the workshop was to develop a shared understanding of what occurred, why professionals responded as they did, and the factors influencing their practice and decision-making.

e) **Working with the Reference Group** - comprising senior local managers - to validate the systems findings and gather the necessary local evidence to support these conclusions.

f) **Developing the findings and recommendations** for consideration by the partnership.

g) **Submitting the review** to the partnership for the standard quality assurance process.

3. The Review - Systems Findings

3.1 The process of identifying the findings

3.1.1 The learning has been derived initially from a detailed examination of practice within the case - specifically, what occurred and the insights provided by practitioners regarding the factors that influenced their actions and decisions at the time.

3.1.2 Practitioners, managers, and strategic colleagues within the Reference Team contributed their knowledge of practice and the operation of local services. Utilising the research questions from the Rapid Review to guide thinking.

1. What does this case review tell us about what helps or makes it harder to understand what life is like, and risk, for children who live with parents who have poor mental health or substance abuse issues? In particular, children who have additional needs.

2. a) What helps and hinders professional information sharing outside of statutory intervention?

   b) How enabled are practitioners to consider a child and/or family's whole circumstances in their individual roles?

3. How are agencies currently involving family networks in risk assessments, and what can we learn from their approaches to strengthen this practice?

4. What does good practice look like when professionals triangulate self-reported information with other sources, and what can we learn from this to improve assessments, intervention and safety planning?

3.1.3 This collaboration supported the identification of systems findings, which are designed to highlight organisational factors within the local safeguarding system that either support or hinder effective outcomes for service users in cases of this nature.

3.1.4 The systems findings aim to develop a clear understanding of each identified issue or challenge, explaining how it manifested in this particular case, presenting evidence to indicate whether it is also a wider issue affecting other children/families in similar circumstances, and outlining the implications for the broader safeguarding system.

3.2 Findings Headline Chart

3.2.1 The reviewers note that there are significant areas of overlap across the findings. These issues did not arise in isolation; while each finding independently created challenges for the child and their family, it was the cumulative impact of all six findings that contributed to the outcome of the death of Antony.

1.	**A need to strengthen understanding of children's needs and parenting** including the impact of parental drug use and mental health needs on parenting
2.	**Ineffective transfer of information** between agencies limited the practitioner's ability to develop a thorough understanding of the family's lived experience. Key information was not shared due to a lack of interoperability between agency systems, and in some instances, important details were not recorded on the child's file. These gaps resulted in significant deficits in multi-agency understanding.
3.	Assessments depending exclusively on **parental self-report** leads to the information gathered representing only one viewpoint. This reduces the validity of the assessment and restricts practitioners from forming a balanced and accurate picture of the family's situation.
4.	**The need for increased curiosity about underlying issues** and root causes that prevent practitioners from developing peripheral thinking regarding a family's whole situation and beyond their role and the initial reason for involvement.
5.	**Individuals in the Family Network** may be identified within assessments; however, their involvement is tokenistic; they are considered as being able to increase safety for the family but are not meaningfully integrated into the planning and review processes or provided with structured opportunities to share updates or insight. Despite being credited to a role to keep a child safe their attempts to share their increasing concerns weren't given the same weight.
6	**Single Agency Learning - Drugs and Alcohol Services** The agency demonstrated an over-reliance on the mother's self-reports and focused narrowly on her as an individual rather than in her parenting role. Key family members with valuable insight were overlooked, and information was not shared effectively between agencies. Practitioners did not sufficiently connect concerns about substance misuse or mental health with the impact on the children's care and safety. Issues around consent compounded information sharing and seeking. A siloed approach meant cumulative risks were not recognised, resulting in missed opportunities for timely intervention and appropriate escalation to children's social care.

3.3 Finding 1 – A Need to Strengthen Understanding of Children's Needs and Parenting Ability.

3.3.1 How did the finding manifest in the case?

3.3.1.1 The review highlighted inconsistent understanding of Antony's needs, from his communication style to what his daily life looked like. During the time that mother was open to drug and alcohol services, there is little evidence of exploration of Antony 's (or siblings) needs, and their experience of being parented by mother given the vulnerabilities in this case. Furthermore, without interrogation of system records and re-visiting certain 'knowns' with the family and other important people, incorrect information can become seen as factual.

3.3.1.2 There were several instances where it became evident that inaccurate information had been recorded about the family across various professional systems. This included Antony's ability to communicate. The review found that there were substantial inconsistency and poor understanding about Antony's communication. Antony was recorded by all agencies, except for school, as being 'non-verbal'. It said in visiting records and assessments work that this was an insurmountable barrier to him taking part or even being spoken to. It was only as part of the family and case group discussions, that all practitioners and reviewers were able to establish that Antony could communicate and could have taken part in direct work.

3.3.1.3 Mother's diagnosis of Emotionally Unstable Personality Disorder, episodes of acutely poor mental health and interaction with mental health services, were not recorded and/or accessible by all health practitioners/services. Different health recording systems e.g. GP, hospital, NHS 111 and mental health services meant that mother's experiences of poor mental health, certainly from June 2025 onwards, were not readily known when she accessed different health settings. Furthermore, information held by school about mother's drug use and mental health needs was fractured when the three children left to go to other schools.

3.3.1.4 Inaccuracies relating to the mother's mental health, the children's additional needs, and the overall family dynamics resulted in professionals lacking a clear understanding of the family's needs, which in turn affected their ability to determine the appropriate support and/or interventions required.

3.3.4 Significance of the finding?

3.3.4.1 The review identified that inaccurate recording practices can lead to incorrect information becoming embedded within the system and subsequently treated as factual. When unverified or inaccurate details are documented and then relied upon by professionals, they can shape assessments, influence decision-making, and contribute to a distorted understanding of the child's circumstances.

3.3.4.2 This creates a systemic vulnerability in which the quality of recording directly affects the accuracy and reliability of multi-agency practice. As a result, professionals may form incorrect assumptions about the child or family, potentially leading to inappropriate levels of support, overlooked needs, or missed safeguarding opportunities. Inaccurate records can also obscure the actual concerns, reducing the clarity needed for effective risk assessment and coordinated intervention.

3.4 Finding 2 - Ineffective transfer/ sharing of information

3.4.1 How did the finding manifest in the cases?

3.4.1.1 The review identified several instances where information was not shared between the professionals and agencies involved with the family. Most notably, important historical information regarding the family's needs, mother's drug use and mental health was not transferred between schools as the children moved settings. Much of this detail had been recorded on the files of older siblings, meaning that when Antony and their siblings transitioned to different schools, key information was not carried forward. As a result, essential insights relating to the family dynamics, previous support provided, and earlier professional concerns were lost.

3.4.1.2 This was also the case in drugs and alcohol services commissioned to support mother who held information regarding the family's circumstances but did not share this with any other agency involved with the family. The agency did not consider that it was necessary to share the information with wider agencies.

3.4.1.3 The commissioned drugs and alcohol service supporting mother did not share information as they believed they did not have the appropriate consent. It was reported that they felt unable to inform others about their involvement or emerging concerns because they did not consider these to meet the threshold for significant safeguarding worries and that sharing this information would breach GDPR. However, other professionals reflected that, had they been aware of this information, it would have offered a different perspective on the issues they were observing. The historical context and professional insights that could have been shared would have contributed to a more accurate and holistic understanding of the family's circumstances.

3.4.1.4 There were also instances where key systems were unable to interface effectively with one another. This was particularly evident within Health, where the information held on GP records was not accessible to staff in the Emergency Department or to clinicians within the ambulance service. The absence of interoperability between these systems limited professionals' ability to access relevant medical history in real time, reducing opportunities for fully informed clinical decision-making and coordinated multi-agency responses.

3.4.4 Significance of the finding?

3.4.4.1 This finding highlights the importance of robust information-sharing processes across agencies and settings, ensuring that relevant historical and contextual information remains accessible and informs ongoing assessment, support, and safeguarding practice.

3.4.4.2 This represents a wider systemic issue in which structural and recording-system limitations create barriers to effective information flow. When agencies operate with disconnected systems and variable recording practices, critical information can remain siloed, leading to gaps in multi-agency understanding and reducing the system's capacity to make timely and well-informed decisions about children and families.

3.4.4.3 This learning highlights the importance of improving system interoperability, strengthening recording standards, and ensuring that crucial information is consistently captured and shared across all agencies involved in a child's care.

3.4.4.4 The review found that one agency had opted not to share the information they held about the family, based on a belief that this information was not relevant or necessary for other agencies, such as schools, to be aware. This emphasised the need for all agencies to recognise the significance of the information they hold, and to understand how this connects with information held by other professionals involved with the family. Only through effective information sharing and collaboration can a comprehensive and holistic understanding be formed of the child's lived experience.

3.4.4.5 The review found that some practitioners were hesitant to share information with other agencies due to concerns that doing so might breach GDPR requirements. This uncertainty contributed to a reluctance to share broader contextual information that would have enabled agencies to develop a fuller understanding of the family's day-to-day lived experience.

3.4.4.6 This reflects a wider misunderstanding across agencies regarding the circumstances in which information can be shared to safeguard and promote the welfare of a child. Practitioners appeared to believe that information sharing was only permissible when significant safeguarding concerns were present.

However, statutory guidance makes clear that information can be shared when it is necessary to protect a child's welfare, and that data protection legislation should not be seen as a barrier to proportionate and appropriate information sharing. This misconception resulted in missed opportunities for agencies to develop a shared, accurate, and holistic view of the family's needs and the emerging risks.

3.4.4.7 The Department for Education guidance[2] emphasises that sharing of information is vital to safeguarding children. This does not mean only when there is evidence of a safeguarding concern, but in regard to welfare and to '*join up pieces of the jigsaw'*, so a true picture of what is happening can be understood. While this guidance supports practitioners to share information confidently, it does not replace having transparent conversations with adults/parents – and even young people – about consent and what information sharing means for them.

3.5 Finding 3 - Parental Self-Reporting

3.5.1 How did the finding manifest in the cases?

3.5.1.1 It is evident that some agencies in this case placed substantial reliance on parental self-reporting when completing assessments, developing plans and interventions, and conducting reviews of risk. Certainly, there were times that Mother reported progress in treatment, no illicit drug use and stable mental health, and these assertions were relied upon. The skill in making that determination in these circumstances required an understanding of what 'safe' and 'unsafe' looks like for Antony and their family. Relying solely on parental self-reporting caused over optimism about Mother's progress in drug treatment and offer of safe care, restricted curiosity, and the hindered the opportunity to offer the right support at the right time.

3.5.1.2 Over the years that Mother was in drug treatment, she was asked if she was following her methadone prescription, using illicitly, or experiencing challenges with her emotional well-being or mental health. Mother largely reported no illicit drug use, and where she did test positive for illicit heroin she had already reported using or agreed she had after testing, so concerns were mitigated. Equally, Mother is recorded as describing stable mental health at most calls/appointments with the drug service. During calls that Mother did highlight feelings of anxiety and panic attacks, she was directed to her GP, and it was confirmed she had contact details in case of a crisis.

3.5.1.3 In early September 2025, Mother's sister contacted NHS 111 services to seek support for Mother, who she described as increasingly paranoid, not sleeping, and referred to Mother reporting the traumatic event. Aunt provided significant detail to support her views, saying that Mother and the children had stayed with her (despite living close by) to ensure she could offer the most support. Aunt also explained that Mother was suffering with an untreated health complaint which could be making her presentation more erratic. Mother was heard in the background to the call saying she was, 'fine'. Aunt and Mother presented at A&E and were seen for a triage appointment. While Mother continued to say that she was 'fine', Aunt frantically conveyed her concern about Mother's mental health deterioration. Mother accepted treatment for a physical health concern but declined to meet with a mental health practitioner. Mother was in the hospital for 24 minutes.

[2] Department for Education (2024): *Information Sharing: Advice for practitioners providing safeguarding services for children, young people, parents and carers*. London: Department for Education. Available at Information sharing advice for safeguarding practitioners - GOV.UK

3.5.1.4 The reliance on parental self-reporting was compounded by the fact that most interactions between drug treatment services and Mother occurred solely via telephone. The review found that after Antony was born nine visits were made to the home to see Mother and the children. After three home visits in 2016 and 2017, there were no visits to Mother and the family until 2024. Mother was visited on six occasions in 2024 and 2025, two at her request. The adult's drug and alcohol service do not offer unplanned visits as they have '*no authority to intervene in this way without consent'*.

3.5.1.5 The combination of these factors contributed to a skewed or limited perspective on the family's circumstances, resulting in a potentially biased assessment of the needs and/or risks relating to mother and her children. The absence of direct observation and limited triangulation of information reduced opportunities to support parental accounts, identify difficulties, or build a fuller understanding of the lived experience of the children.

3.5.4 Significance of the finding?

3.5.4.1 The review found that reliance solely on parental self-report can have multi-faceted consequences: unidentified problems and risks, poor assessment of the child/adult needs and vulnerabilities, inadequate risk analysis and ineffective safety planning, and interventions. Without triangulation from wider sources, practitioners are limited in their ability to develop an accurate and holistic understanding of the family's circumstances. Working with children, adults and families relies on building relationships and trust to work together, address problems and increase safety. This review does not seek to suggest mistrust is a caveat to making genuine relationships, but that to work transparently means preparing parents for how theirs and other information will be substantiated.

3.5.4.2 Reliance on a single perspective represents a systemic vulnerability. When assessment processes do not routinely incorporate multi-agency information, direct observations, and wider/family network input, important aspects of the family's lived experience may be missed. Over time, this can contribute to repeated cycles of assessment that do not fully capture risks, strengths, or underlying needs, thereby reducing the effectiveness of interventions.

3.5.4.3 The review identified that concerns regarding consent influenced perceptions of the mother, and this issue was a recurring theme evident across multiple findings within the review. Practitioners from the drug and alcohol service were unable to conduct unplanned visits to Mother's home as they did not have consent to do so. The Case Review group considered that allocation to a social worker and 'statutory' involvement overrides parental consent to unplanned visits to the family home, it doesn't. All practitioners can and should talk to adults/parents about visiting types within the consent to service and development of plans.

3.5.4.4 This finding highlights the importance of robust information-gathering practices, including the validation of self-reported information and the use of face-to-face engagement where feasible, to ensure accuracy and rigour in assessing need and risk. It also emphasises the importance of ensuring that assessment frameworks are consistently grounded in multi-source evidence and supported by reflective supervision that encourages practitioners to explore and test multiple hypotheses.

3.6 Finding 4 - The need for increased curiosity about underlying issues

3.6.1 How did the finding manifest in the cases?

3.6.1.1 Within this case, mother's mental health needs were not identified or treated as the primary issue. Instead, her substance use was consistently viewed by agencies as the central concern for the family. As a result, assessments did not sufficiently explore the underlying factors contributing to her drug use, despite opportunities to do so. Although mental health was referenced within calls, appointments and assessments, this did not translate into further exploration of her emotional and psychological wellbeing or onward referral for specialist support.

Changes in the mother's presentation - such as reporting that she was unable to leave the house, expressing significant anxiety about being in the community, or failing to collect her prescription due to these anxieties - were not recognised as indicators of a potential deterioration in her mental health. Consequently, these signs did not prompt reassessment or escalation.

3.6.1.2 At the times Mother was asked about drug use she was also asked about her experiences of poor mental health. It is recorded that in October 2023, 13 years into treatment, Mother advised drug services during a telephone appointment that she has a diagnosis of Emotionally Unstable Personality Disorder. Mother says that while she is not in treatment or accessing medication, she considers her mental health stable and she can meet the children's needs, such as getting them to school. A month after that call in November 2023, Mother cancels a planned appointment due to anxiety and panic attacks. Mother reported the same reason for non-attendance to two appointments in December 2023, saying that she had anxiety and did not want to leave the house, referencing childhood trauma. When Mother is seen in January 2024 for a review of her methadone prescription, she reports illicit heroin use and '*worsening anxiety, but no other mental health concerns reported'.*

3.6.1.3 In 2020, Antony was found alone outside the house whilst inside mother could not be roused. Police attended this incident, but a notification was not sent to Children's Services. In November 2024, Children's Services received a Police notification following a domestic abuse incident at the family home that had occurred in October 2024. During which mother reported Antony's Father for causing a disturbance at the house. When Police attended, she also referred to an incident 3-4 months earlier during which he had assaulted her. The review found that the Police notification was not submitted in a timely way following the incident, likely attributable to Antony not being home when the incident happened. Furthermore, when Police submitted the notification to social care, they did not refer to the long-standing worries about mother's drug use and mental health difficulties. As part of the review, Police confirmed mother was '*well recorded'* on their system, referring to concerns about poor mental health and drug use, men acting suspiciously visiting the home and calling her mobile phone. Had this information been received by social care in the 2020 and November 2024 via Police notification, it is reasonable to say their enquiries would have extended to school, health and drug services and the information consolidated.

3.6.1.4 In August 2025, Mother attended her GP where she discussed allegations made to police and threats to her and her children. Despite a history of mental health problems, a diagnosis, and long-standing drug use/treatment, Mother was encouraged to take part in the investigation and await police advice.

3.6.1.5 As stated, the review highlights the transfer of information being a barrier to sharing concerns and in Antony's case, being alert to the vulnerabilities and any changes in them or the adults at home. When Antony left mainstream primary school in 2023, that detail was left behind so the review found that Antony's special school had no information about Mother's challenges with drug use or poor mental health. An example of the impact of this was towards the end of 2023, when Mother was finding it difficult to attend appointments and describing poor mental health. While drug services were unable to meet with Mother, Antony's school sent a letter to her about their poor attendance.

3.6.1.6 A further example was evident in August/September 2025 when Mother had interactions with the police, GP, 111, drug services and school in one week. Mother first reported allegations to police, then attended her GP to repeat those and here her mental health challenges are highlighted. Mother next contacted drug services and requested a home visit, which was completed, and she gave detail about the allegations again. Mother's sister then raises her concerns with 111 mental health services and she and Mother attend A&E but leave soon after when Mother declines assessment. Lastly, School contact Mum to enquire about Antony's absence, to which she says they are unwell.

3.6.1.7 The review found that not all agencies had all the information they needed to be able to consider Antony's or Mother's situation holistically or identify root causes, or in some instances make a SAFER referral. On each occasion that Mother was seen/spoken to in 2025, she was directed to seek support from another service by all but school. School contacted mother the next day and when they visited her at home, they submitted a SAFER referral for Antony and his sister.

3.6.1.8 The review found that issues of perceived barriers to consent prevented legitimate information sharing. The review also found no evidence of Mother being asked by those agencies that had known her a long time if they could contact the children's schools or meet with people in her family network.

3.6.1.9 Reviewers had the opportunity to meet with Antony's close family. Family were acknowledged in agency recordings and assessments as being supportive to Antony and Mother. The network was aware that Mother was in drug treatment but had never been asked to take part in an assessment/plan or attend a meeting to support Antony and their family by any agency. Family members reported that they did not regard mother's substance use as the primary issue. Instead, they described a marked decline in her emotional stability and overall presentation during periods of abstinence, suggesting that her mental health difficulties were masked by drug use.

3.6.1.10 The case review group stage identified that lack of practitioner confidence, knowledge and skill had prevented exploration of the issues beyond the reason for individual involvement, such as mental health. Equally, having a role to conduct an assessment does not always mean practitioners possess the communication and investigative skills needed to complete these well. These aspects contributed to Mother's situation being less understood, and the impact of this on Antony's daily care and safety unmitigated in safety planning and intervention.

3.6.1.11 If opportunities for early and effective support are missed, the family may experience repeated cycles of involvement and 'start again' without meaningful change. This finding highlights the importance of robust multi-agency contribution and analysis, reflective supervision, and mechanisms that support practitioners to challenge assumptions and maintain a clear focus on the true drivers of risk and need. Practitioners need to develop skills in asking questions and having conversations.

While the process of assessment is 'forms' led, it distracts from the importance of and provides less opportunity to grow relationships. Agencies should not underestimate the need to offer continuous development, training and support to professionals on this topic.

3.6.4 Significance of the finding?

3.6.4.1 This finding highlights the importance of holistic assessment that considers the interplay between mental health and substance use, avoids over-simplifying presenting issues or viewing them in silo, and ensures that emerging indicators of deterioration are identified and responded to at the right time. The review found that even when questions about other vulnerabilities or safety were posed, they were superficial and had little impact on risk management or interventions. Including family networks in assessment, intervention and planning is fundamental to increasing safety for children. While the network was acknowledged as supportive, they were excluded from any tangible work with Antony and Mother.

3.6.4.2 The review identified a consistent lack of clear identification of the primary (index) issue within the family. Practitioners at multiple points in the system appeared to focus on the long-standing concern or reason for their involvement. While updated assessment and plans were recorded as completed by drug services, these were based on parental reporting and a measure of success being compliance with treatment.

3.6.4.3 The narrative about Mother's drug use and treatment had been long established, but the underlying worries about poor mental health were not assessed or considered as coexisting with heroin use, or the impact on parenting and safety. If support and intervention is only directed at one of the problems or symptoms, it will unlikely be successful and overall progress and safety will not improve.

3.7 Finding 5 - Support Networks

3.7.1 How did the finding manifest in the cases?

3.7.1.1 The review found that the wider family, particularly Antony's maternal Aunt, provided consistent safety, support, and stability for mother and her children. Aunt and other family members were highly attuned to mother's presentation and were often able to identify at an early stage when additional support was required. Despite this, they were not aware they were formally recognised within professional assessments/plans as part of the family's support network, nor were they informed of the expectations or role attributed to them regarding safety. Family were never asked to attend a meeting for Antony or mother, and they never met a professional at her home prior to the first social care visit in September 2025.

3.7.1.2 This finding also connects to the issue of reliance on parental self-reporting, triangulation, and identifying root causes in assessment. Mother named family support she had around her; however, this information was not routinely verified with anyone in the network. As a result, assumptions were made about the adequacy and reliability of the support available, without triangulation to confirm whether those identified were willing, able, and appropriately positioned to fulfil the role described.

3.7.1.3 When the mother's support network did raise significant concerns about her presentation, they reported that their views were not listened to, and that the mother's right to decline intervention appeared to carry greater weight than the risks they were highlighting. In early September 2025, when Aunt contacted NHS 111 to access mental health support, the caller could do little to progress support as mother declined.

Later that day when Aunt accompanied mother to A&E, she made every attempt to raise the alarm about mother's mental health and presentation. Aunt described trying to alert the triage nurse to mother's behaviour being attributable to psychosis. This was not misplaced of Aunt, who explained to reviewers at some length her experience of mother's mental health and periods of psychosis since her middle teens. Despite significant time passing, Aunt could recall detail from their childhoods that indicated mother had been managing overwhelming emotions of some kind since childhood. The information about mother's history of mental health difficulties was separated across health systems, meaning neither the NHS 111call handler or A&E could easily check out Aunt's concerns. This contributed to missed opportunities for professionals to act on emerging concerns and to use the family's insights to inform assessment, decision-making, and safeguarding activity.

3.7.4 Significance of the finding?

3.7.4.1 Family networks and decision making is threaded throughout the findings of this review. Identifying family members is only the beginning of genuine family networking. It is not sufficient to record who a person is related to and consider them 'support, 'safety' or a 'network'. These family and friends must be brought into assessment, intervention and planning work and their role agreed. Not to be underestimated, often individuals in the network are instrumental in offering support to parents and children, maintaining safety, and raising the alarm when worry increases. Safe networks can assist to triangulate parental self-reporting, sometimes nurturing the relationship between parents and professionals when it is more difficult to find common ground. Like Antony's Aunt, networks can offer valuable insight into a parents' family history and functioning. This helps to identify significant life events (positive and negative), vulnerabilities and root causes, and experiences of trauma. Notwithstanding the need to check out and validate network information – indeed any information, but certainly in this case Antony's Aunt was the only person to hold all key information about mother.

3.7.4.2 When family and network voices are missed, assessments become less accurate and interventions less responsive to the family's lived reality. Over time, this contributes to a systemic pattern in which practitioner-led narratives dominate casework, reducing the diversity of information used to inform decision-making. This increases the likelihood of misidentifying need, overlooking emerging risks, and perpetuating cycles where plans are ineffective because they do not reflect the whole-system understanding of the child's context.

3.7.4.2 The case highlights the importance of:

- formally identifying, documenting, and involving the wider family network;
- ensuring they understand their role;
- listening actively when they raise concerns;
- and treating family insights as a crucial component of safeguarding intelligence.

3.8 Finding 6 - Single Agency Learning- Drugs and Alcohol Services

3.8.1 How did the finding manifest in the case?

3.8.1.1 The agency did not fully recognise or respond to key safeguarding risks due to an over-reliance on parental self-reporting and a narrow focus on the adult as a service user rather than a parent. Despite Mother being involved with the service for a considerable period key family members were not included in assessment, review or safety planning. Maternal Aunt had an important role in the care of the children and was experienced in spotting the signs of mother's decline.

Maternal Aunt informed the reviewers that she was aware that Mother was involved with drugs services however had never met them and had never been asked to attend visits or meetings. Information was not shared effectively with partner agencies, and assessments were not completed collaboratively, which limited the agency's understanding of the wider context and cumulative risks to the children.

3.8.1.2 Practitioners relied heavily on the parent's own account of her circumstances without seeking external verification or triangulation. As a result, important concerns—including substance misuse, mental health difficulties, and their combined impact on parenting capacity—were not sufficiently explored. The co-existence of drug use and mental health needs was not recognised, and the parent's vulnerabilities were not considered in the context of her caring responsibilities.

3.8.1.3 Although practitioners asked occasional questions about the children, these were tokenistic and based largely on the mother's descriptions. There is little evidence that the practitioner viewed mother holistically as a parent or considered the implications of her presentation on the safety and wellbeing of the children.

3.8.1.4 Consent requirements appeared to be seen as a barrier to information sharing, with no recorded evidence that consent was revisited when concerns escalated or when the parent experienced significant deterioration in her mental health. When the mother reached a point of crisis, she was signposted back to other services rather than receiving proactive, coordinated support. The practitioner's response during the time mother's mental health was declining showed limited insight into the impact of that recent events on her ability to parent Antony and keep him safe.

3.8.1.5 The lack of multi-agency communication and joint risk assessment meant the agency did not appreciate the cumulative risk factors present within the family. As a result, opportunities were missed to recognise safeguarding concerns and to intervene earlier.

3.8.4 Significance of the finding?

3.8.4.1 This finding highlights that agencies working in silo do not develop a wider understanding of a person's whole needs and circumstances, particularly when they are both vulnerable and a parent. Thus, it more likely that other agencies working with the family, including statutory agencies such as school, do not understand the needs and vulnerabilities of the family unit.

3.8.4.2 Without an understanding of individual family challenges agencies are prevented from offering timely and effective support as they deal with the presenting problem rather than the underlying issues. Equally if there is not a multi-agency view of cumulative worries and harm opportunities to escalate to social care are missed.

4. Recommendations for the partnership

4.1 The following findings are interconnected and should be considered collectively. As outlined in section 3.2, there is significant overlap across all findings; therefore, the recommendations cannot be developed or applied in isolation.

4.2 All recommendations are multi-agency in nature, with the exception of Recommendation 4, which is directed solely to the Drugs and Alcohol Service as a single-agency recommendation.

	Recommendations
1	In line with Department for Education guidance on information sharing, practitioners must be confident in sharing information with or without consent when it is necessary to safeguard and promote the welfare of children. Practice should remain open and transparent, with professionals engaging families in honest conversations about consent—what it means, how information may be used to keep children safe, and how sharing supports timely access to the right help. Consent should not be treated as a one-off discussion; instead, these conversations must be revisited regularly. Embedding this approach will help ensure positive, timely, and proportionate information sharing to safeguard both children and adults. Agencies should: **1. Strengthen Practice Guidance and Procedures** • Ensure policies clearly reflect DfE guidance on information sharing, emphasising that safeguarding overrides the need for consent. • Accurate case recording on the issues of consent **2. Introduce Routine, Ongoing Consent Conversations** • Build consent into assessment, review and supervision. **3. Improve Practitioner Confidence Through Training** • Provide mandatory, multi-agency training on the issues of consent **4. Introduce Tools That Support Transparent Practice** • Ensure children, adults and professionals understand and have guidance around consent **5. Promote a Culture of Transparency and Safeguarding** • Reinforce organisational messages that: ○ information sharing is *an essential safeguarding action*, to prevention and early intervention not a breach of confidentiality
2	Equip all practitioners working with children and adults possess the necessary knowledge, skills and professional confidence to deliver effective interventions with families. This includes the ability to safeguard every family member, engage in difficult or sensitive conversations, and clearly identify and escalate concerns when children may be unsafe. Practitioners should work collaboratively with other professionals and demonstrate strong assessment skills, including the ability to explore needs, ask purposeful questions, understand the experiences and needs of adults, identify underlying causes of concern, and analyse the impact of these factors on the children within the home. Agencies should; **Provide High-Quality, Role-Specific Induction, Ongoing Training and Strengthened Supervision** Including; • child development and risk indicators • adult vulnerabilities • motivational interviewing • trauma-informed practice • having difficult conversations • disguised compliance • analysing root causes

	• whole-family working • reflective, analytical supervision • escalation of professional worries
3	Practitioners working with children and/or adults must offer a whole family approach to assessment, planning and review. Children and adults must be seen separately and as part of their home and network. This means irrelevant of role, professionals should seek to explore a child's individual needs and how well those are being met by the parent, considering any vulnerabilities they may have. Assessment processes must be revised to ensure that practitioners explore the circumstances of the whole family, including multi-agency input and the wider support network. Assessment tools should promote the use of open, reflective questioning that encourages meaningful discussion rather than reliance on 'tick-box' approaches. All professionals involved in assessment and intervention should receive training to strengthen their ability to recognise and evaluate how adults' needs, vulnerabilities, or behaviours may impact their parenting capacity and the overall safety and wellbeing of children.
4	The **single agency** should undertake a comprehensive review of its policies, processes and procedures relating to the assessment of need within families. This should be supported by targeted staff training on safeguarding, consent, effective multi-agency communication and best practice. In addition, the agency should strengthen its application of a 'Think Family' approach to ensure that practitioners consistently consider the needs, relationships and vulnerabilities of all family members when planning and delivering support.

Appendix 1 - The agencies involved in the review

Job Title	Agency
Lead Reviewer 1	Hartlepool Borough Council
Lead Reviewer 2	Redcar & Cleveland Borough Council
Social Worker	Hartlepool Borough Council
Social Worker	Hartlepool Borough Council
Drugs and Alcohol Worker	START
SEN Team Manager	Hartlepool Borough Council
Clinical Practice Lead	Hartlepool Borough Council
Clinical Practice Lead	Hartlepool Borough Council
Social Worker	Stockton Borough Council
Social Care Officer	Stockton Borough Council
Social Work Lead	Change Grow Live (CGL)
Social Work Lead	Change Grow Live (CGL)
Business Manager	Hartlepool & Stockton Safeguarding Children Partnership
Lifestyle Practitioner	Hartlepool District Foundation Trust
Psychological Wellbeing Practitioner	Hartlepool District Foundation Trust
Senior Safeguarding Professional	Tees, Esk and Wear Valley NHS Foundation Trust
Emergency Department Matron- Responsive Care	North Tees & Hartlepool Foundation Trust
Staff Nurse	North Tees & Hartlepool Foundation Trust
Designated Safeguarding Lead	Primary Specialist Academy
Designated Safeguarding Lead	Post 16 Provider
Workforce & Development manager	Hartlepool Borough Council
Safeguarding & Assessment Head of Service	Hartlepool Borough Council
Safeguarding Specialist Nurse	Hartlepool Borough Council
Head of Service for Quality & Review	Stockton Borough Council
Head of Service- Education	Stockton Borough Council
Service Lead- Children & Response Team	Stockton Borough Council
Service Lead- Alternative Provision	Stockton Borough Council
National Safeguarding Manager	Change Grow Live (CGL)
Detective Chief Inspector	Cleveland Police
GP	Integrated Care Board
Specialist Safeguarding Practitioner	Integrated Care Board
Named Nurse- Safeguarding	Tees, Esk and Wear Valley NHS Foundation Trust
Associate Director- Safeguarding	North Tees & Hartlepool Foundation Trust
Head Teacher	Primary Specialist Academy
Head Teacher	Secondary Academy
Assistant Head Teacher	Secondary Academy
Virtual School Head Teacher	Hartlepool Borough Council
Head of Service	Stockton Borough Council
Designated Nurse	Integrated Care Board
Specialist Safeguarding Practitioner	Integrated Care Board
Named Nurse	HDFT 0-19 service