Siblings Child C and Child D

Practitioner Learning Briefing

Strengthening our response to fathers
Developing our understanding of coercive control and female perpetrators.

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SUZY KITCHING CONSULTANCY

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Please be aware that some of the content in this learning briefing relates to the violent killing of two young children.

What do you need to know?

1. The context

This Learning resource has been developed following the findings from a Local Child Safeguarding Practice Review (LCSPR) [1], where two siblings were killed following a self-report by the mother that she had killed her children. The family accessed universal services [2] and was not known to Children's Social Care apart from a brief historical involvement in supporting Child C's behaviour.

This review considered what information was known about the children's and parents' lived experiences and focussed on the short practice episode surrounding the significant incident.

The purpose of a review is to identify learning and consider what went well and what needs to be improved. Significantly, it looks to understand what this means for practice and how multi-agency systems and practice can help children and keep them safe.

The following areas of learning supported analysis of the children and family's experiences and circumstances.

The immediate safeguarding response surrounding the incident is a significant practice episode given specific analysis.

Learning themes

- Multi-agency responses for managing the children's health and educational needs
- Father's role in the family
- Race, ethnicity, and gender
- Appreciating the adult issues
- Underpinned by understanding the children's lived experiences

2. Understanding the children

Child C was a Black-British Caribbean male child aged 11 when he was killed. He was born in the Caribbean and moved with his parents to the United Kingdom when he was about 4. He was identified as having global developmental delay, Autistic Spectrum Disorder [3] (ASD) and suffered from asthma.

He had an Education, Health, and Care Plan (EHCP)[4] and attended a Special School [5] to meet these needs. He was described as a chatty and open boy who talked freely with the school about any worries he had.

Child D was a female Black-British Caribbean female child aged 7 when she was killed. She was born in the United Kingdom and had no additional identified health or learning needs. Issues relating to school attendance were identified, and attendance procedures were initiated. The school described Child C as smiling often and being happy.

At the time of the significant incident, the siblings lived in Stoke-on-Trent with their parents. There was a brief Early Help intervention regarding Child C's behaviour and mother's mental health issues. The children and mother accessed universal services, although health and education appointments were inconsistent. Father was not registered with any service. Mother had long-standing mental health difficulties but did not always attend her appointments.

The parents moved from the Caribbean some eight years ago; it was understood that the family moved to the United Kingdom to get additional support for Child C, who had additional needs. The parents are Black British–Caribbean, legally settled here, and married. Information was shared at the rapid review that the mother has four previous children (now adults) from two relationships. Mother has been charged with murder. She has been detained indefinitely for killing her children and attempted murder of her husband.

1 LCSPR_Child_C_and_D__FINAL_REPORT_JUNE_2024.pdf (stoke.gov.uk)
2 Universal services mean services such as GPs, health visits, School nursing, and education, depending on the child's age and developmental stage.
3 What is autism? - NHS (www.nhs.uk)
4 EHCP is a formal document that describes the child's needs, the support they may need, and desired outcomes.
5 A Special School is a type of school that provides education and support for children who have identified Special Educational Needs and Disabilities (SEND)

3. Key messages

1	The importance of the role of fathers /male caregivers for children and how they can be actively engaged.
2	Recognising and understanding gender bias. Consideration of possible cultural bias as a barrier to accessing services.
3	Increased knowledge and skills in understanding risk characteristics and behaviours in domestic abuse and violence, including female perpetrators.
4	Children must be seen as victims when domestic abuse is known or suspected.
5	Understanding of the impact of parental mental health issues on children and family functioning.
6	Appropriate safety planning to safeguard the victims of domestic abuse must be put in place while risk assessments are undertaken. This should be informed by wider multi-agency information sharing.
7	Regular review of parental mental health medication.
8	Appreciating the significance of children not being brought for health and education appointments and patterns of non-school attendance.

" Much of the parental relationship was unknown and unascertained, father was unseen by services and professionals, but mother was known to have long-term health issues with a general diagnosis of 'mixed anxiety and depressive disorder.' Until the few days leading up to the significant incident, there were no outward indicators of domestic abuse and violence moreover the rapid escalation of the mother's abusive behaviours meant there was little time to understand what was happening, assess and intervene meaning such a set of circumstances were almost impossible to predict."

Stoke-on-Trent LCSPR Siblings known as Child C and Child D December 2024

4. What did we learn?

How effective was the multi-agency response to managing the children's needs

- There were patterns of inconsistent engagement with services for the children. There was also inconsistency in how information about school attendance and additional needs were responded to by services.
- The family were visible and known to a range of universal and community services. This is evident from Child C's long-term learning and developmental difficulties and the mother's long-term mental health difficulties.
- These did not inform any curiosity or consideration of additional help and support that may be needed
- Service and professional response to these children were singular. It could have benefited from a coordinated multi-agency response that attended to both the adult and children's needs. Stoke-on-Trent has a range of services in place for families and early help processes where children and families can be referred for additional help.

What got in the way

- Father was in plain sight; he was seen daily at school with Child D. His parenting role was not considered or known by any services.
- Possible cultural barriers to accessing services. The family settled here to support Child C's additional needs, but there was no curiosity when he was not brought for follow-up services.
- Appreciation of the impact of mother's mental health difficulties and limited engagement with support services.
- Whilst only known with hindsight, possible neurodiversity is important in how appointments were communicated.

Good practice was shown by Child C's school, who listened to his worries and developed a positive relationship.

5. What does it mean for practice

This matters because an exploration of cultural bias to accessing and engaging with services should have been considered.

- This meant the parents did not always receive the support and guidance needed. Understanding patterns of was not brought (WNB)[6] and poor attendance at school can be an indicator contributing to understanding family needs and/or neglect.
- There were a number of existing systems across education, SEN, child, and adult health services that could have considered the families' circumstances and offered additional support at an early help and preventative level. Particularly when mother asked for help and support.
- Services and practice must consider possible cultural difference and bias as a barrier to accessing support.
- The importance of whole family practice is key national learning and highlights the importance of the 'impact of vulnerabilities in the household' (CSPRP Annual Report 2022/23)

"There were clearly a number of opportunities to offer and provide preventative and coordinated support to the family through Family Hubs [7] that would include GPs, schools, and Children's centres or a referral for targeted early help support"
Stoke-on-Trent LCSPR Siblings known as Child C and D December 2024 [8]

PRACTICE PRINCIPLE : "A child centred approach within a whole family focus is fundamental to safeguarding and promoting the welfare of every child" Working Together 2023

Professional Curiosity
This means showing an interest in families' lives through conversation, observation and information sharing to understand what could be happening for a child and family.
It must include reflection and critical thinking about possible cultural, gender and neurodiversity barriers to engagement and accessing support.

Tools and guidance to support practice
The conceptual model 'Pathways to Harm, Pathways to Protection' [9]
Re-envisaging professional curiosity and challenge: Messages for child protection practice from reviews of serious cases in England - ScienceDirect
Safeguarding children from Black, Asian and minoritised ethnic communities | NSPCC Learning
barriers-inclusion-parents.pdf (jrf.org.uk)

6 Was not Brought (WNB) is the phrase used to record the non-attendance of children for appointments; using the phrase did not attend implies the child is somehow responsible for not attending. Children are dependent on adults to take them to appointments or meetings.
7 Early Help and Prevention Strategy | Stoke-on-Trent
8 Stoke-on-Trent Threshold Framework https://safeguardingchildren.stoke.gov.uk/homepage/52/threshold-framework
9 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

4. What did we learn?

How was father s role understood, and how were the adult issues recognised?

- Assumptions were made that father was integrated into the community. The children talked positively about him at school, and he was seen regularly at school with Child D.
- Despite this, he remained unconsidered. His role in the care of the children was not fully known and was based on information from the mother and the children.
- Mother was registered with a GP and received support for her mental health difficulties identified as a 'mixed anxiety and depression disorder'. [12] She was prescribed medication to manage her symptoms.
- In the eleven months before the significant incident, GP records show that the mother did not attend or respond to follow-up appointments to review and monitor her well-being; nine attempts were made by the Practice to invite her for appointments. It became known later that mother struggled to understand written information.
- She continued to receive her medication, but there was no wider appreciation of her or the family's needs.

Professionals in adult services don't always know, or didn't demonstrate professional curiosity, about children in the family or household of the adults they were working with. This meant that potential safeguarding concerns weren't identified or passed onto children s services.
NSPCC Multi-agency working and information sharing: learning from case reviews

5. What does it mean for practice

Understanding adult themes

- Learning here explored the father's role in the family and how gender bias can influence professional practice. No enquiry or exploration about the father's role as a caregiver showed a gendered response.

PRACTICE PRINCIPLE : Fathers' role in providing safe care for their children must be fully explored, and fathers must be given the support they need to do so.

- Learning also considered how well adult issues and their impact on the children were understood.
- Assessing the impact of adult mental health on parenting and family functioning is complex. [10] Studies show it is the family disruption that the mental ill health causes that present the most significant risk Duncan and Reader [11] talk about availability and predictability when considering the impact on children.

"Mother sought support from her GP regarding her depression and stresses in managing Child C's behaviour and this support continued. It is positive she continued to access support for her mental health, but this was a missed opportunity to consider a referral for preventative early help and support and to consider what else may be happening in the family."
Stoke-on-Trent LCSPR Siblings known as Child C and Child D December 2024

Tools and guidance to support practice

Unseen men: learning from case reviews | NSPCC Learning
HOME | Fatherhood Institute
GPs and primary healthcare teams: learning from case reviews | NSPCC Learning
DFE-00108-2011-Childrens_Needs_Parenting_Capacity.pdf (publishing.service.gov.uk)
Parents with a mental health problem: learning from case reviews | NSPCC Learning
Assessing parenting capacity An NSPCC factsheet February 2014

10 Murphy M Rogers, M 2019) Working with Adult -orientated issues
11 Duncan, Reder (2003)How do Mental health problems affect parenting
12 It is common to experience anxiety alongside other mental health problems characterised by symptoms of both depression and anxiety where neither is predominant

6. Key Practice episode

Summary

Learning here considers the safeguarding response to domestic abuse and how risks were understood in response to each parent over the six days leading up to the death of the children.

The review sought to understand the circumstances that led to the serious incident from a multidisciplinary safeguarding perspective, to support learning and understanding, and to help practitioners identify possible high-risk cases.

The Police commissioned Professor Jane Monckton Smith, a criminologist who researches interpersonal violence, especially homicide and stalking, to inform their Review. Both review processes were completed independently and drew similar findings that the killing of these children was extremely difficult to predict.

> "There were opportunities identified in both reviews where possible gender bias, knowledge around coercive control and risk assessment are important learning factors."
> **Stoke-on-Trent LCSPR Siblings known as Child C and Child D December 2024**

Research and knowledge about maternal filicide [13] in the UK is limited due to the complexity and rarity of such tragic incidents.

Of relevance here relating to children killed by their mothers, the study highlighted that the majority of children (80%) were previously unknown to services as being at risk of harm: -

> "To professionals, they presented as healthy, thriving children with no indicators of concern…. The relationship between the mother and the child was typically perceived—by professionals and other family members—as loving and warm, with the mother responding well to the physical and emotional needs of the child."

It is estimated that one-third of domestic abuse victims are men. [14] Where they have parental responsibilities, their situations are more complex. Men face a particular set of challenges and stereotypes in being recognised as victims of domestic abuse.

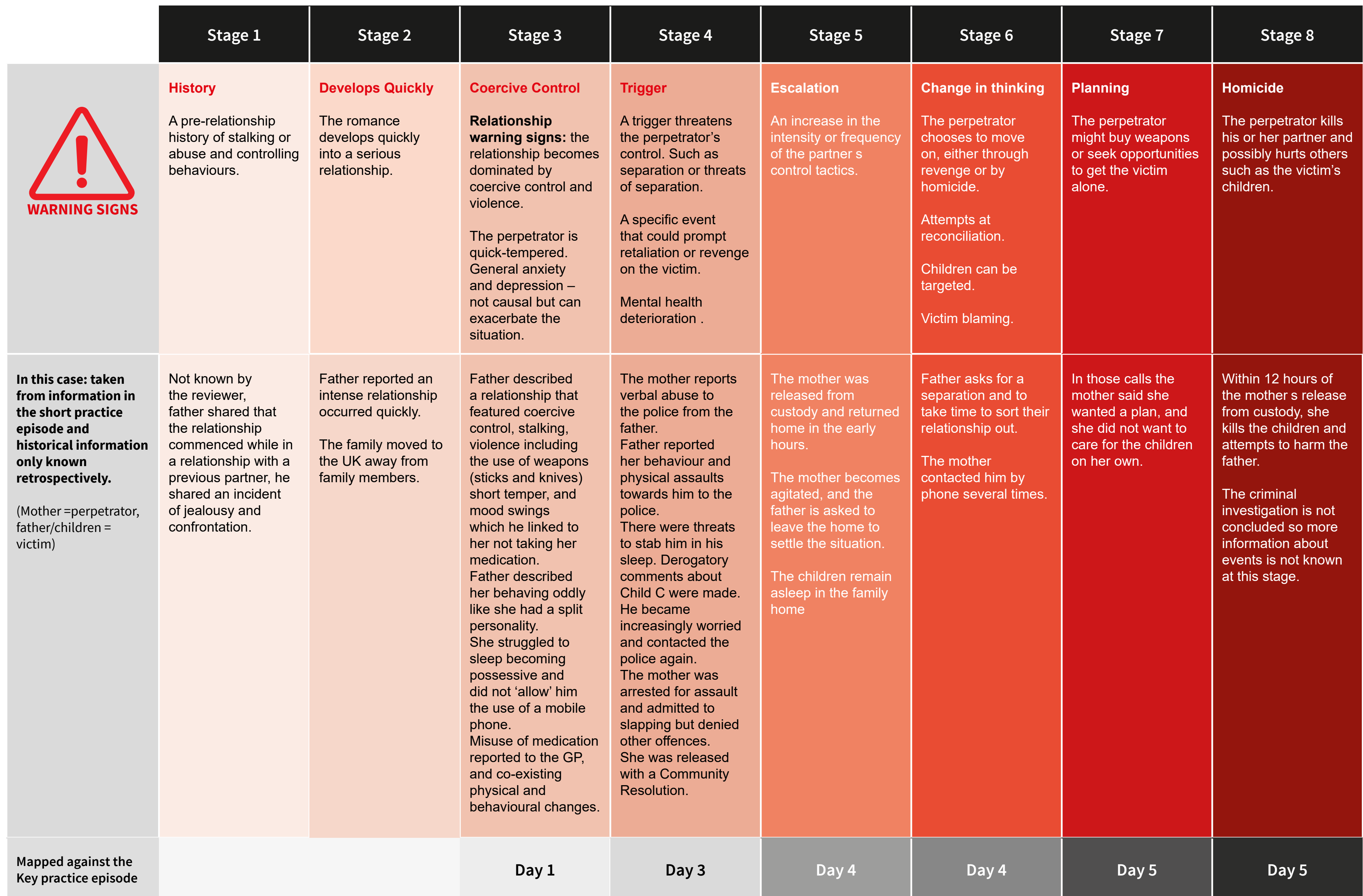
The following diagram has been developed to illustrate the history (as known, retrospectively) of events known in the key practice episode mapped against the **Homicide 8-step timeline**.

All the factors were present here. This evidences the rapid escalation of the behaviours within a few days and supports learning here for this family.

13 Filicide is the murder of a child by their parents, maternal filicide is the murder of a child by the mother
14 Why are men often overlooked as victims of domestic abuse? (centreforsocialjustice.org.uk)

The Homicide 8- step timeline

Mapped and adapted Dr Jane Monkton Smith



	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6	Stage 7	Stage 8
WARNING SIGNS	**History** A pre-relationship history of stalking or abuse and controlling behaviours.	**Develops Quickly** The romance develops quickly into a serious relationship.	**Coercive Control** **Relationship warning signs:** the relationship becomes dominated by coercive control and violence. The perpetrator is quick-tempered. General anxiety and depression – not causal but can exacerbate the situation.	**Trigger** A trigger threatens the perpetrator's control. Such as separation or threats of separation. A specific event that could prompt retaliation or revenge on the victim. Mental health deterioration .	**Escalation** An increase in the intensity or frequency of the partner s control tactics.	**Change in thinking** The perpetrator chooses to move on, either through revenge or by homicide. Attempts at reconciliation. Children can be targeted. Victim blaming.	**Planning** The perpetrator might buy weapons or seek opportunities to get the victim alone.	**Homicide** The perpetrator kills his or her partner and possibly hurts others such as the victim's children.
In this case: taken from information in the short practice episode and historical information only known retrospectively. (Mother =perpetrator, father/children = victim)	Not known by the reviewer, father shared that the relationship commenced while in a relationship with a previous partner, he shared an incident of jealousy and confrontation.	Father reported an intense relationship occurred quickly. The family moved to the UK away from family members.	Father described a relationship that featured coercive control, stalking, violence including the use of weapons (sticks and knives) short temper, and mood swings which he linked to her not taking her medication. Father described her behaving oddly like she had a split personality. She struggled to sleep becoming possessive and did not 'allow' him the use of a mobile phone. Misuse of medication reported to the GP, and co-existing physical and behavioural changes.	The mother reports verbal abuse to the police from the father. Father reported her behaviour and physical assaults towards him to the police. There were threats to stab him in his sleep. Derogatory comments about Child C were made. He became increasingly worried and contacted the police again. The mother was arrested for assault and admitted to slapping but denied other offences. She was released with a Community Resolution.	The mother was released from custody and returned home in the early hours. The mother becomes agitated, and the father is asked to leave the home to settle the situation. The children remain asleep in the family home	Father asks for a separation and to take time to sort their relationship out. The mother contacted him by phone several times.	In those calls the mother said she wanted a plan, and she did not want to care for the children on her own.	Within 12 hours of the mother s release from custody, she kills the children and attempts to harm the father. The criminal investigation is not concluded so more information about events is not known at this stage.
Mapped against the Key practice episode			Day 1	Day 3	Day 4	Day 4	Day 5	Day 5

7. What does this mean for practice?

Understanding the domestic homicide timeline (Dr Jane Monckton Smith) This is a valuable tool looking at patterns to help professionals understand and potentially prevent serious harm to victims of domestic abuse. The rapid escalation with no known history illustrates the challenges of predictability.

Knowledge and skills in understanding risk characteristics and behaviours in domestic abuse. There must be an increased understanding of the psychology of intimate domestic abuse and coercive controlling behaviours. The controlling behaviours meant that all the victims here were more vulnerable to abuse.

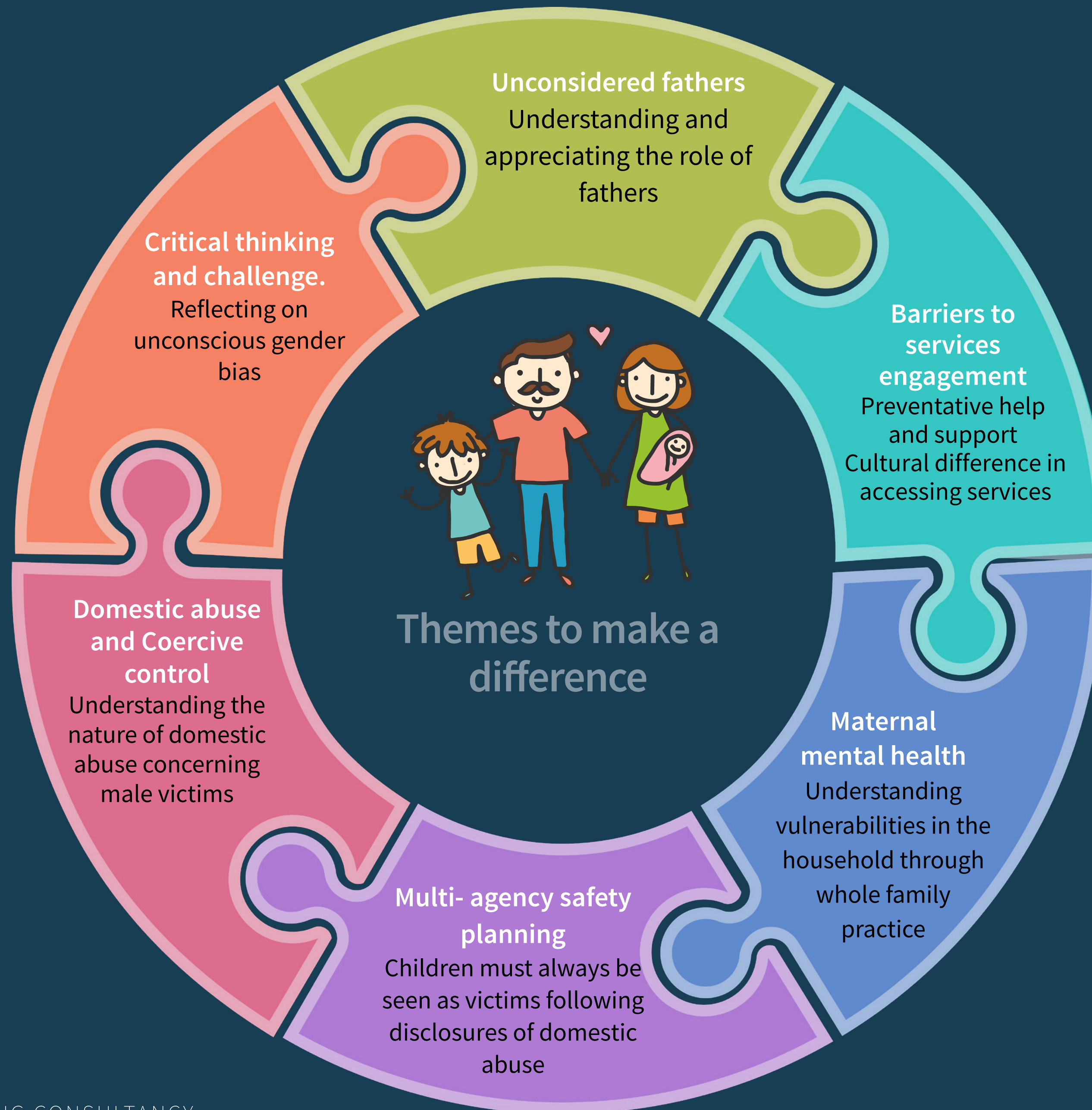
Understanding of the nature of domestic abuse concerning male victims. Unconscious gender bias is a barrier to understanding and, therefore, protecting male victims of domestic abuse. Father disclosed abusive and controlling behaviours by his wife. There was insufficient appreciation of the risks and a lack of any protective strategies being put in place. Studies show that disclosures by male victims are uncommon. The consequence of disclosure is likely to inflame perpetrator behaviours and the situational risks for the victims.

Safeguarding response Risk assessment must be informed by the potential for increased risk following disclosure of domestic abuse, and effective safeguarding must be put in place for all potential victims. Multi-agency Safety Planning must be put in place to protect children and adult victims of domestic abuse, regardless of the outcome of any criminal investigation and while risk assessment is ongoing. Information sharing would have flagged co-existing risk factors such as maternal mental health difficulties.

Children must always be seen as victims. The children were not identified as victims of possible abuse despite specific disclosures of domestic abuse by their father, including physical harm and controlling behaviours.

Mother's mental health. Mental health is a known risk factor and increases situational risks significantly. The coexistence of parental mental health with domestic abuse intensifies risk and emotional harm to the safety and well-being of children.

8. Practice themes to make a difference



9. What can you do?

1	Reflect on the significance of children not being brought for health and educational appointments. Consider that this may be an indicator of need and/or neglect.
2	Be alert to the need for early help for children and families who have additional needs.
3	Strengthen curiosity about possible cultural barriers and/or neurodiversity to engagement and accessing services.
4	Use critical thinking and respectful challenge in supervision and through multi-agency discussions to challenge assumptions, unconscious bias, and attitudes regarding gender.
5	Ensure you routinely consider fathers' role as caregivers and facilitate opportunities for them to be actively engaged. Ensure information about them is not based on assumptions.
6	Appreciate the impact of long-term mental health issues on parenting and family functioning and work proactively with adult and child-facing colleagues to consider needs, strengths, safety, and support.
7	Understand your responsibilities in seeking and sharing information and its critical importance in understanding what is happening within a family.
8	Strengthen your knowledge and skills in understanding risk characteristics and behaviours in domestic abuse, particularly concerning male victims, and how coercive control is understood. Children must always be seen as victims following a disclosure of domestic abuse.
9	**Ensure there is a multi-agency risk assessment and safety plan to protect children and adult victims of domestic abuse following a disclosure/s of domestic abuse.**
10	To support practice, read and reflect on knowledge and evidence from Learning Reviews locally and nationally, including Domestic Abuse-Related Deaths.