Local Child Safeguarding Practice

Review Summary

Siblings Child C and Child D

SUZY KITCHING CONSULTANCY

Safeguarding Children Partnership
STOKE-ON-TRENT

Siblings Child C and Child D

1. The Review (LCSPR)

This learning resource has been developed following the findings from a Local Child Safeguarding Practice Review (LCSPR), where two siblings were killed by their mother. This review considered what information was known about the children's and parents' lived experiences and focussed on the short practice episode leading up to the significant incident and the safeguarding response to domestic abuse and coercive control.

Whilst the killing of the children was extremely difficult to predict, there was learning about possible unconscious gender bias and the need to strengthen knowledge around coercive control and multi-agency risk assessment.

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 (ASD). He had an Education, Health, and Care Plan (EHCP)

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.

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. Father was not known to any services. Mother had long-standing mental health difficulties.

Mother has been charged with murder. She has been detained indefinitely for killing her children and attempted murder of her husband.

3. Practice themes to make a difference

The review reflected on key themes that helped the Partnership understand what had happened and what this meant for the children involved. This meant for practice

- **Unconsidered and unseen fathers.** 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.
- **Barriers to engagement with services**. Exploring possible cultural differences in accessing services
- **Maternal mental health**. Understanding the vulnerabilities in the household through whole family practice.
- **Domestic abuse and coercive control.** Understanding the nature of domestic abuse concerning male victims.
- **Multi-agency safety planning.** Children must always be seen as victims following disclosures of domestic abuse.
- **Critical thinking and challenge.** Reflecting on unconscious gender bias.

4. Key Learning

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.

5. Recommendations for the Partnership include

- Evaluating and strengthening managers' and practitioners' knowledge and skills in understanding domestic abuse, including coercive control and unconscious gender bias.
- Seeks assurance that the response to domestic abuse and safety planning is multi-agency and considers all children in the household as victims.
- Promote and explore the role of fathers as caregivers and provide opportunities for engagement.
- Support managers and practitioners in strengthening their practice skills and exploring possible cultural gender and /or neurodiversity barriers to accessing services.
- Strengthen systems and practice at universal and community levels to identify barriers to preventative help and support.
- Ensure services that support /come into contact with parents who have mental health difficulties adopt whole family practice.

6. 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 pro-actively 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.

7. Access to the Report

There is a Learning Briefing. What do you need to know? Associated with this review, READ HERE
READ the full Report HERE