Local Child Safeguarding Practice Review
Siblings known as children C and D

Contents

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1: Introduction and summary of learning

1.1 This Local Child Safeguarding Practice Review (LCSPR) was commissioned by Stoke-on-Trent Safeguarding Children Partnership (SOTSCP) following the death of two siblings (Child C and Child D) following a self-report by the mother that she had killed her children. The rapid review[2] recognised there were areas where learning was identified, and this review will consider systems and practice within and between partner agencies to identify learning to strengthen and improve practice across the Partnership

1.2 There was limited information about the children and their family history, however, the learning event was able to share direct reflections of the children through the knowledge of professionals such as the school and show appreciation of their lives. The family accessed universal services[3] and was not known to Children's Social Care apart from a brief historical involvement in relation to support for Child C's behaviour. This review will consider what information was known about the children's and parents' lived experiences and will focus on the short practice episode surrounding the significant incident.

1.3 There are parallel criminal and Independent Office for Police Conduct (IOPC[4]) investigations at the time of undertaking the review, therefore, some information may be limited due to these processes. Mother is currently on remand charged with Murder. There has been good liaison between this review and the police regarding their review this has been helpful and appreciated reflecting their commitment to learning and strengthening practice. Towards the end of the LCSPR process father agreed to meet with the independent reviewer and his views are included and have informed the report.

1.4 Summary learning.

The following learning points are detailed in the report and summarised here

- The importance of the role of fathers /male caregivers for children and how they can be actively engaged
- Consideration of possible cultural bias as a barrier to accessing services
- Increased knowledge and skills in understanding risk characteristics and behaviours in domestic abuse and violence including female perpetrators.
- Children must be seen as victims when domestic abuse is known or suspected
- 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.
- Recognising and understanding gender bias.
- Understanding of the impact of parental mental health issues on children and family functioning.
- Regular review of parental mental health medication

[2] A Rapid Review is undertaken in order to ascertain whether an LCSPR may be appropriate. Chapter 4 Working_together_to_safeguard_children_inter_agency_guidance.pdf (publishing.service.gov.uk)
[3] Universal services
[4] https://www.policeconduct.gov.uk/

- Appreciating the significance of children not being brought for health and education appointments and patterns of non-school attendance.

2: Child and family overview

2.1 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 years old. He was identified as having global developmental delay, Autistic Spectrum Disorder [5](ASD) and suffered from asthma. He had an Education, Health, and Care Plan (EHCP) which meant his Special Educational Needs (SEN) were assessed and supported. He attended a Special School[6] to meet these needs. He was described as a chatty and open boy who talked freely with the school about any worries he had.

2.2 **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. There were identified issues relating to school attendance and attendance procedures were initiated. Child C was described by the school as smiling often and being happy the only worries related to school attendance.

2.3 The parents moved from the Caribbean some eight years ago, the family initially stayed in London but within a few weeks moved to Stoke-on-Trent. There is no known connection with the city, but it was understood the reason the family moved to the United Kingdom was to get additional support for Child C who had additional needs. The parents are Black British–Caribbean legally settled here and are married. Information was shared at the rapid review that mother has four previous children from two relationships, the children are now all adults and remained in the Caribbean. The parents are reported to be Jehovah's Witnesses, but the extent of their practice was not known. The family lived in private rented accommodation.

2.4 Both parents worked, Father in car cleaning services and mother was self-employed for a local charity although it appears at the time of the incident Mother was not working. Father had no services involved with him and was not registered with any services, including GP and had no NHS number. Health information shows Mother had 'mixed anxiety and depression disorder'[7] but did not always attend her appointments.

2.5 At the time of the significant incident, the siblings were living in Stoke-on-Trent with their parents. The family were accessing universal services although health and education appointments were inconsistent.

2.6 The following high-level timeline has been developed to summarise known information and support analysis up to the events leading up to the significant incident. The days before the significant incident are discussed separately as a key episode. (section 4.3)

[5] What is autism? - NHS (www.nhs.uk)

[6] A Special School is a type of school that provides education and support for children who have identified Special Educational Needs and Disabilities (SEND)

[7] It is common to experience anxiety alongside other mental health problems It is described as a relatively new diagnosis characterised by symptoms of both depression and anxiety where neither is predominant

Timeline Siblings C and D

Historical information 2016 -2020	2022 Child C (10 years) Child D (6 years)	First six months 2023 Child C (11 years) Child D (7 years)
Child D was born. Parents lived together and father supports care.	Attendance issues for **Child D**, Education Welfare officer (EWO) involved. Formal proceedings commenced.	Number of attendances at ED and walk-in /centres for children's general ill health. GP notified.
Self-referral support for **Child C's** behaviour. Early help Support provided.	**Child C's** Child C was reported to have hit his mother. Mother said this triggered anxiety /trauma from a previous partner.	Mother requested urgent support regarding **Child C's** physical health from the 0-19 service.
Child C was seen at the Community Paediatric Clinic. Developmental delay. Likely diagnosis of Autism. Sleeping and behavioural difficulties.	Parents did not attend the review of EHCP. Steady progress. Reported in telephone discussion.	Mother spoke to school not feeling her health worries about **Child C** being heard.
Referral to CAMHS discharged as WNB*.	Fixed penalty notices for school attendance given in respect of **Child D.**	Parents did not attend the school attendance clinic.
Mother's mental health deteriorated, struggling to attend appointments for self.	Mother did not attend a number of routine health checks despite reminders.	Closed to 0-19 service. **Child C's** health reported improved.
Family closed to early help outcome referral to Children's Social Care if mother's mental health remains unaddressed.	**Child C:** EHCP reviews not attended by parents. Reviews not attended by parents.	Fixed penalty notices re **Child D's** attendance.
Ongoing problems reported with **Child C's** behaviour and sleep.	Ongoing attendance issues for **Child D.**	**Child C** shared with school he was feeling sad and worried about death particularly his parents. Reported his parents had been arguing..
WNB to Community Paediatric Clinic so discharged.		Discussion with mother by school re above.
Records show in 2020 Mother diagnosed of *'Mixed anxiety and Depression Disorder'* and Prescribed fluoxetine*.		

* Was not brought (WNB)
* Known also as Prozac and is an antidepressant that helps mood, emotion, and sleep

3: The review methodology

3.1 The Case Review Group agreed on the methodology and Terms of Reference for the review and provided oversight and quality assurance. The review process was reflective and proportionate, and involved practitioners and managers in a face-to-face learning event and recall event [8]. It sought to avoid hindsight bias and individual blame. The review process was fully appreciative of the parallel criminal and investigatory processes and the impact on the father and staff dealing with the incident and supporting their well-being. There has been communication with the police regarding the parallel processes.

3.2 Family views are integral to LCSPRs and is best practice. Towards the end of the review process, it was possible to speak to father and the review is grateful for his willingness to speak with the lead reviewer.

3.3 Key lines of enquiry were formulated at the rapid review and have been used to appraise multi-agency practices and systems. These developed areas of learning that could be used to analyse the findings and what they meant in these circumstances for these children and helped frame reflective discussions at the learning event. Practitioners and managers attended the learning event, reflected on the key findings in relation to systems and practice and considered; *what was helpful. what got in the way? and specifically sought to highlight the children's voices and experiences.* This was a positive and helpful session which has directly informed this report and supported wider learning and single agency learning and improvements.

3.4 The safeguarding response immediately surrounding the incident is a significant practice episode that is given specific analysis.

Areas of learning
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

[8] The first version of the report is shared with the learning group to sense and fact-check.

4: Appraisal of practice and safeguarding systems

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

4.1. This section explores how information regarding school attendance was understood for both children and what the role of the EHCP plan in supporting Child C was. It considers the effect of when Child C 'was not brought' (WNB) for appointments and how they were managed It also reflected if cultural and neurodiversity (dyslexia) factors affected the service responses to the children and parents.

4.2 Historical information shows parental patterns of accessing help for Child C were inconsistent which meant he did not always receive the specialist support and guidance that he needed. Community Health and Specialist Services (CAMHS) closed their involvement following his diagnosis and completion of the EHCP. Whilst practice and services are likely to have changed over this six-year period and it is not necessarily helpful to current learning, what is relevant here is that information was known to a number of services and held across the multi-agency space particularly given Child C's long-term learning and developmental difficulties and mothers' long term mental health difficulties. These did not inform any curiosity or consideration of additional help and support that may be needed particularly during the last two years leading up to the significant incident. There were clearly a number of opportunities to offer and provide preventative and coordinated support to the family through Family Hubs[9] that would include GPs, schools, and Children's centres or a referral for targeted early help support.[10] What got in the way and potential barriers to parents asking for support are discussed below.

4.3 The review process has reflected on why requests or offers of support and guidance were not consistently followed through and what if anything got in the way. Children not regularly being brought to key appointments can be an indicator of neglect and there was an impact on the children when they did not attend developmental appointments or school regularly. Historically there is a pattern of 'was not brought' for CAMHS (ASD assessment), community paediatric clinic appointments and early help. More recently EHCP[11] appointments for Child C and attendance issues do not appear to have been challenged outside of the school system whereas the non-school attendance for Child D was managed via procedural processes and fines. The differing responses are not clear and there was no enquiry or curiosity to consider why Child D was missing education or reflection on the differing educational attendances. This could have been considered for some additional support to try and understand any barriers for the family. Child C was not brought for his learning disability review and several attempts were made to rearrange this at home or the surgery. These reviews were scheduled via letter and/or text messages. The timeline indicates in this period mother showed some increased anxiety about Child C's health needs and felt her worries were not being listened to it is clear that mother's anxieties were listened to however for whatever reason she continued to seek additional reassurance. This period coincided with reports of a parental argument by Child C, and he was reported to be feeling sad and worried about death. Whilst

[9] Early Help and Prevention Strategy | Stoke-on-Trent

[10] Stoke-on-Trent Threshold Framework https://safeguardingchildren.stoke.gov.uk/homepage/52/threshold-framework

[11] Education Health and Care Plan is a legal document that sets out additional support the local authority must put in place to help children meet their needs beyond what the school can provide

professionals demonstrated a proactive response wider consideration or enquiry about possible emerging needs and discussion about family support may have been helpful here.

4.4 Child C attended a special school[12] to meet his needs, he was described as 'chatty and open' and had good relationships with his teachers able to share his home experiences and any worries. He had an EHCP in place which is a formal document that sets out the support he will need at school concerning his social care and health needs. The learning event shared that his EHCP was fully meeting his needs, there was positive engagement with his mother who was the main point of contact and there was a home school link worker which was good practice. However, his parents did not attend reviews of this plan and whilst this is not unusual for families it presented another opportunity to follow up and explore if there was any additional support needed and linked to his attendance shown at 66% and to consider if home circumstances could be a contributing factor.

4.5 Good practice by the school was listening and following up with mother when Child C reported there were arguments at home, sharing his "*mum and dad have been arguing again and his mum had thrown his father out*"(See also sec 4.3) This was proactively discussed with mother, but this was over the phone and father was not consulted. Mother was his main point of contact for the school and was said to be meeting his needs. This was accepted despite these issues and some uncertainty about the stability of the relationship. This matters here because father's role in caring for Child C was not explored and mother's view was accepted. Fathers have a key role to play in children's development and the importance of a supportive relationship between parents strengthens this.

4.6 Until the learning event, there had been no consideration of possible cultural understanding or barriers that may have prevented the family from fully accessing services. Of relevance here is an understanding of the factors about parents and /or the context in which they are living which makes them less likely to access services[13] Whilst there is limited evidence that relates specifically to access to universal services[14] there is a clear correlation in the research that *"Parents who are most in need of services, including those who lack informal support, are often the least likely to access them" (*Ghate and Hazel 2002 quoted in JFK [13]) The possibility of any cultural barriers were not considered for this family it was known the family had settled in the UK to access support for Child C's additional needs yet there was no curiosity when parents did not attend follow up services, a direct contradiction to the known rationale for moving here. At the rapid review, it became apparent that father had never accessed any health services and was, therefore, not visible on any health systems. Whilst this was not information that was known until the rapid review reflection at the learning event suggests that there were possible cultural barriers to accessing services, for example, there was a reflection on the parents' access to Accident and Emergency in normal GP working hours rather than seeing their GP for the children's ill health that may be due to differing understanding about the use of services. Initial learning highlighted that this could have been an opportunity for the GP to arrange to see the children, discuss the children's health needs and provide guidance about accessing services with the parents. Given Child C's additional needs this would have supported best practice.

4.7 Mother shared, that she was dyslexic and struggled to read in the initial interview with the police. There was reflection at the learning event that letters for example about attendance may not have been understood by the mother and

[12] Special schools provide education for children with special educational needs or disability whose needs cannot be met within a mainstream school.

[13] barriers-inclusion-parents.pdf (jrf.org.uk)

[14] Universal services are services provided by agencies such as GPs, health visiting, school nursing, and education depending on the child's age and developmental stage

similarly the impact of many health appointments sent by text messages. An exploration of services involved with the adults and children in the family could have opened up a conversation to explore attitudes and understanding about services and what, and how the family could be supported to access help. Services and professionals must be open to considering if there are any cultural factors and/or predisposing vulnerabilities that could be contributing to children not being bought for health and care appointments or mainstream education. The limited professional curiosity suggests a level of unconscious bias contributing to the family's experiences and its impact on the children.

4.8 Predisposing vulnerabilities and risks considered later in the report are relevant here, mother's mental health difficulties were known and together with her stated difficulties with managing Child C's behaviour would have placed additional stresses upon the family unit and parenting capacity. The interplay of these coexisting factors will have shaped the experiences of these children and the capacity of these parents to access support and help.

Why does it matter?

4.9 Reflecting on the findings here shows that the service and professional response to these children was singular and could have benefited from a coordinated multi-agency response that attended to both the adult and children's needs. Stoke- on-Trent have a number of services in place for the family and multi-agency and early help processes where children and families could be referred for additional help. The family were visible and known to a range of universal and community services where adult and child issues were identified such as adult mental health, patterns of poor and late school attendance, a child with additional needs (captured in an EHCP), requests for help with behaviour management and patterns of WNB to health appointments. Multi-agency working is the cornerstone[15] of effective safeguarding practice (Working Together 2023) and is evidenced by case reviews. What matters here is the opportunity to bring professionals together, with the family to understand needs, consider any barriers and provide additional support.

Professional curiosity means that professionals ask questions that will help them understand the family situation better and it can help develop relationships. The use of **respectful enquiry** can support reflection on the families' opportunities and ability to access support services and would have been best practice here, particularly regarding the father who was known to have an active role in the care of the children but was not visible or engaged with services. there was information shared by mother and known by professionals about the families' circumstances, mothers view was the prevailing narrative despite father being known to have an active caring role for Child C and taking Child D to school every day. There was an opportunity for guidance and review of the children's health needs when they were brought to the hospital during normal working hours for health needs that could be best met via the GP practice.

Was not Brought (WNB) Understanding patterns of WNB and patterns of 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'

[15] The Lord Laming

circumstances and offered additional support at an early help and preventative level particularly when mother asked for help and support.

Cultural barriers and gender bias Consideration of any possible cultural barriers to accessing and responding to services for the family and professionals involved was not considered and suggests some unconscious bias which meant in this situation that the family narrative was not fully appreciated and therefore understood meaning the children were less likely to receive any additional support.[16]

What needs to happen- Learning points	
1	The significance of children not being brought for health and educational appointments (particularly where there are additional needs and EHCPs (Education, Health, and Care Plan) (Education, Health, and Care Plan) in place) and patterns of poor school attendance can be an indicator of needs and/ or neglect within the family Therefore, opportunities to offer preventative early help support must be explored across the multi-agency space. This can be initiated and supported via education services and /or health (disability) review systems already in place and consider early help assessment and support.
2	Asking questions and keeping an open mind rather than accepting something at face value is an important skill for practitioners when engaging with parents/carers and demonstrates an essential practice skill of being *professionally curious*. These skills need to be strengthened and include an attitude of respectful enquiry. Reflection about possible cultural, gender and neurodiversity barriers to accessing services need to underpin professional practice and service delivery.
3	It is acknowledged that everyone has biases some of which may be conscious of and others we are not. Gender bias is one of the most common types of bias and professionals need opportunities to reflect on these and consider how they may affect thinking, behaviour, and practice. This can be supported and challenged through reflective supervision and personal and organisational learning and development. (see also learning point 4)

4.2 How was the father's role understood? How were the adult issues recognised?

4.2.1 This section explores the father's role in the family and how gender bias can influence professional practice. It also considers how well adult issues such as mental health and domestic abuse and their impact on the children were appreciated. Events leading up to the death of the children are considered in the next section however adult factors and needs can contribute to trying to understand the circumstances around the significant event. It is important to note for this review that any analysis is limited due to the incomplete knowledge about the family including parental histories and circumstances before the family came to the UK. What is reasonable to assume based on the information previously discussed is that there was limited professional curiosity about the family's circumstances given the family's move to a new country and consideration of any possible cultural barriers, identified maternal mental health needs, children's learning, and educational needs.

[16] Safeguarding children from Black, Asian and minoritised ethnic communities | NSPCC Learning

4.2.2 The learning event discussed that there was a belief that father was integrated into the community, was working and was well-liked. Whilst there was limited evidence to support this it was reasonably based on the openness of the children talking about their home, and their presentation and that he was seen regularly at school when he brought Child D to school most days. It was felt there was an opportunity for father to speak to staff if needed. Information shared at the learning event challenged this view and practitioners reflected on their assumptions and understanding of fathers' access to services, (given he was not registered for any services) and how they worked, for example, the process around sanctions for non-school attendance and attending reviews about his son's EHCP and attending to his own health needs through registering with a GP. Although father was seen regularly by the school he remained '*unseen*,' meaning his role in the care of the children was not fully known and was based on limited information from mother and the children. Case reviews[17] have identified how fathers are often overlooked in providing safe care for their children and their roles were not fully explored or fathers given the support they needed to do so. It is not possible to say what this could have looked like because father was not known to any services other than the school until the days leading up to the significant event, this meant his role as a father was not fully understood and any needs, he may have had were undetermined.

4.2.3 Mother was registered with the GP and had received support for her mental health difficulties for several years identified as 'mixed anxiety and depression disorder' (8) and had been taking prescribed medication[18] to support her management of this. In the eleven months before the significant incident GP records show that 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 at a later date that mother struggled to understand written information and whilst this was not known at the time difficulties in engagement should have promoted some questions. Reflection during the review process has highlighted the importance of ensuring all patients are asked routinely how they would like to receive their information and appointments.

4.2.4 Mother continued to receive her medication and some professional curiosity and questions about mother's well-being should have been raised over such an extended period given her known long-term mental ill health. Further reflection in the review process highlighted that whilst it is left to the individual GPs to review medication best practice would be to undertake a medication review on at least an annual basis. This would involve seeing the patient and exploring how the medication was taken, considering any side effects, and assessing if it was making a difference. In the period leading up to the significant event, it seemed that mothers' pressing perimenopausal symptoms were the main focus of the discussion at the most recent GP appointment (see page 13). This meant that the mother's mismanagement of her medication, whilst discussed, appeared to account for her presenting symptoms, therefore the given rationale for the doubling up of her medication and any subtle cues to her behaviour would not have been flagged as unusual.

[17] Unseen men: learning from case reviews | NSPCC Learning

[18] Fluoxetine (Prozac) is used to treat mental health conditions including depression

4.2.5 Furthermore, it was known that there were children and there should have been some curiosity about the likely impact of adult mental health on parenting and family functioning. Professional curiosity is a key barrier to effective information sharing and is of relevance here.[19]

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."

Assessing the impact of adult mental health on parenting and family functioning is complex[20] and studies show it is the *family disruption* that the mental ill health causes that presents the greatest risk. Duncan and Reader[21] talk about availability and predictability when considering the impact of mental ill health on children. What is significant here is the long-standing mental health difficulties of the mother and whilst there is nothing to indicate a causal link to the significant incident her mental wellbeing is likely to have impacted her parenting over the years. Historically the Early help assessment (see timeline) identified maternal mental health as problematic following the birth of Child D and a self-referral for support with managing Child C's behaviour. 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.

Why does it matter?

4.2.5 Reflecting on the findings indicates some understanding of the perceived role of father from professionals and services and how possible gender bias may have inhibited opportunities for him to be considered as a supportive and/or protective factor regarding Mother's long-standing mental health problems, or indeed consider if he had any needs in his own right. Previous analysis considered how cultural issues can get in the way of accessing services and this is also relevant here. The response to mothers' long-term mental health difficulties would have benefitted from a whole family perspective. Appreciation of additional support needs and could have considered the impact of this on the children and the vulnerabilities it can create, particularly where there are children with additional needs and the stresses this can add. This was known information within health systems when mother accessed support for her mental health. Mother also experienced some periods of physical ill health, and this would have contributed to the family's vulnerability but was not recognised as such.

Gender bias, father's role in parenting and caregiving General information about the father was known in the services involved with mother and the children both historically and more currently, however, there was no consideration of his role as a father. The Fatherhood Institute[22] supports the wide body of research that evidences the unique and positive outcomes for children's well-being directly through the involvement of men as involved fathers and caregivers. Two important considerations here contributed to Father being hidden in plain sight. There was no enquiry or exploration about Father's role as a caregiver, and the role and support he could provide was not explored by professionals involved

[19] Multi-agency working and information sharing: learning from case reviews | NSPCC Learning
[20] Murphy M Rogers, M 2019) Working with Adult -orientated issues
[21] Duncan, Reder (2003)How do Mental health problems affect parenting
[22] HOME | Fatherhood Institute

with the children and mother. It seemed despite evidence that Father had an active role in settling Child C and bringing Child D to school that conversations and communication were mostly with mother. This meant that father was not considered as an equal parent who could provide supportive care to his children while mother was experiencing difficulties. This shows a gendered response and was a missed opportunity to offer support.

Maternal mental health Analysis of SCR between 2017 – 2019 [23] highlighted the prevalence of mental health problems (over half of the reviews) particularly for mothers when considering parental characteristics, it also highlighted that *"mental health problems occur more commonly in the SCR population than the general population."* It is known that poor parental mental health can have a detrimental effect on the health and development of children and whilst many parents can manage these well and lessen the impact on the children it requires wider support networks and can be compounded by pre-existing vulnerabilities and family circumstances, particularly the co-existence of domestic abuse. This can affect the capacity of parents to provide safe and loving care. Adult and children's practitioners need to reflect on the impact of maternal mental health, the vulnerabilities, and the risks this can have on children in the family. Practitioners across adult and child services can then identify protective factors and consider the need for additional support.

Of relevance here is a study[24] of 21 cases of maternal filicides[25] in the UK which found an over-representation of mental ill health in line with other studies. The most common diagnoses identified were mood disorders and personality disorders not as perhaps thought some type of psychotic disorder such as schizophrenia and suggested "that the perpetrators were either not experiencing serious mental health problems at the time or, that they had not sought help. [26] Mother had an initial psychiatric assessment following the significant incident where the outcome, at that time, showed no evidence of enduring or acute mental illness.

What needs to happen - Learning points	
4	Practitioners should routinely consider the role of fathers and male caregivers in their interactions with families and consider opportunities where they can be actively engaged. Gender bias should be routinely discussed in supervision and professional development opportunities and learning.
5	Professionals involved with parents who experience mental health problems should be mindful of the impact of adult mental health issues on parenting and their children particularly where this is long-standing. There should be robust consideration of protective factors and who and how the children can be supported to mitigate any vulnerability and actively consider the need for additional support for the whole family (see also learning point 2)
6	Best practice for general practitioners concerning adult mental health medication should consider undertaking a medication review on an annual basis (or in the case of commencing a new medication within four weeks) with the patient to discuss how it is taken, are there any side effects and consider the difference it is making.

[23] Learning for the future - final analysis of serious case reviews 2017 to 2019.pdf (publishing.service.gov.uk)

[24] McKee, A., & Egan, V. A case series of twenty-one maternal filicides in the UK. Child Abuse & Neglect (2013), http://dx.doi.org/10.1016/j.chiabu.2013.02.008

[25] Filicide is the murder of a child by their parents, maternal filicide is the murder of a child by the mother

[26] Manchester University 5th April 2013

	There should be clear discussions with patients to understand how they would like to receive invites for appointments considering their communication needs.

4. 3 Exploration of the Key Practice Episode

4.3.1. This section will consider the safeguarding response to domestic abuse and how risks were considered in response to each parent over six days (see key practice episode diagram below). Whilst there is important learning here, a wider understanding of the circumstances that led to the tragic event is constrained due to ongoing criminal and investigative processes. This review has been completed with the full knowledge and cooperation of the police.

4.3.2 Research and knowledge about maternal filicide[27] in the UK is limited due to the complexity and rarity of such tragic incidents. The role of this review is not to investigate the crime or to apportion blame but to try and understand the circumstances that led to the serious incident from a multi-disciplinary safeguarding perspective, to support learning and understanding and to help practitioners identify possible high-risk cases.

[27] Filicide is the murder of a child by their parents, maternal filicide is the murder of a child by the mother

Key practice episode

This covers a six-day sequence of events leading up to the death of the two children.

Day 1

- Mother attended a GP appointment. She appeared to have increased her fluoxetine (doubled) and shared concerns about weight, fluctuating mood, and hot flushes. Plan agreed.

Day 3

- **08.17** Morning 999 call from Mother reporting verbal domestic abuse, a similar incident was reported about a month previously, but police were not called. Police attended, and the children were upstairs and spoken to by officers. Father had left the home address.
- **22.03** Evening father reported domestic assault by the mother, who reported hitting him 4 times, earlier that morning witnessed by the children. she had made threats to him. The outcome was viewed as a continuation of the same incident and referred back to the attending officer to be picked up the next day.

Day 4

- Early hours of the morning further call from the father waiting to speak to an officer, reiterated it was a serious domestic incident.
- Hour later Father called again to speak to an officer and was worried Mother would come to his workplace.
- Early evening PNN completed, father shared he was scared of further assaults, and she has threatened to stab him and will use the children against him. Shared controlling behaviours. Father did not want to make a complaint. Medium risk assessment.
- **23.59** Mother arrested for assault of husband. Admitted slapping and denied other offences. Mother shared suffered from depression and was prescribed medication. Stated was dyslexic. Outcome Agreed to Community Resolution.

Day 5

- **02.55** Mother was released with community Resolution Police returned her to the family home where father and the children were. Suggested father leave after mother became agitated; mother left at home with the children.
- Early afternoon mother called the police to say she had killed the children.

Day 6

- **Multi-agency** strategy Meeting held

4.3.3 Dr Jane Monckton Smith senior criminology lecturer developed the 'domestic homicide timeline' based on research into intimate partner homicide where she found patterns of behaviour that occurred in many cases to identify a series or sequence of events that could be broken down into eight distinct stages. This model supports an understanding of the motivation behind the actions patterns and behaviours that can precede domestic homicide. This is helpful because it can inform risk assessment and consider possible interventions by identifying some of the common stages. The circumstances as they are known in this instance have been mapped against the key practice episode and show the rapid escalation of the behaviours and events that led to the killing of the children. (**see page 20**) The police because of this tragedy have been working with Dr Monckton Smith to consider how risk assessment and intervention in similar situations can be used to inform and support practitioners and managers in similar situations. This report has provided the police with additional independent analysis to support their learning about the circumstances leading up to the significant incident concerning coercive control, risk escalation and considered gender and coercive control. The learning here supports the findings in this LCSPR particularly how men's and women's behaviours as perpetrators are perceived, possible systemic barriers this can present and how men are less likely to seek help for intimate partner violence.

4.3.4 The key episode (page 13) commenced (**Day 1**) when mother accessed a GP appointment. It was discovered that she was doubling up on her medication apparently to manage her increased mood swings and other symptoms causing distress. This mismanagement of her medication was discussed, and a plan was agreed upon with the GP. Agency reflection regarding this appointment was that it showed limited curiosity about home and work and no risk assessments were taken regarding for example alcohol, drugs, or risk of harm. Further reflection considered the period of missed review appointments suggested the management of her mental health difficulties through medication compliance was not as effective as it could have been i.e., her moods may well have been up and down. There was however nothing to suggest in the interaction that mother was demonstrating acute anxiety or distress that could indicate the events that followed. There was information in the system and shared at the rapid review that showed mother had some 10 years ago attempted to take her own life by ligature indicating a much longer history of mental ill health. The appointment response although appropriately adult-focused to support mother's needs was limited because it did not consider the impact of mother's mood swings and increased medication on the children over time and how she was managing at home. While it is unlikely to have directly influenced the rapidly unfolding events that followed this was a key opportunity to think about and discuss the needs of the children and how the family was functioning and a referral for family support should have been considered here.

4.3.5 It is noteworthy that mother shared with the school in 2022 that she had previously experienced domestic violence from a former partner. The disclosure of these memories was triggered by a verbal and physical incident from Child C towards his mother. In the month before the significant incident, Child C shared he was feeling sad and was worried about the death of one or both of his parents it transpired he had seen this online, and the school appropriately offered advice to Child C and his mother. It is not unusual for children to worry about death, particularly of a parent however within two weeks Child C shared his worries with the school about an instance of his parents arguing where his mother had apparently thrown his father out and he was worried that he (Child C) would have to move ***"It makes me feel very sad, very, very sad please will you ring and speak to my mum'.*** The impact of domestic abuse within the home can impact adversely on children and place them at risk of physical and emotional abuse and children should be recognised as victims in their own right[28]. Children often take responsibility for adult issues and the impact on their emotional and

[28] Children classed as domestic abuse victims under new guidance | The Crown Prosecution Service (cps.gov.uk)

physical wellbeing is far-reaching. Whilst the school responded well to these worries there was no further exploration of this and no reflection and curiosity about the family's circumstances and the incidents were managed in isolation. Only mother was spoken to there was no consideration of an early help assessment which would have enabled the joining up of information from both schools and exploration of the children's needs and vulnerabilities, the adult needs and family functioning.

4.3.6 The events over the next few days during the key practice episode were focussed on allegations and counter-allegations of domestic abuse. On **Day 3** mother made an emergency call to the police and reported verbal domestic abuse from her husband, she reported a similar occurrence a few weeks before, but this was not reported to the police. The police spoke to the children who were in the home and had heard the argument, this was good practice, and the children were reported to say that their parents *'always argue.'* There is no further information to support the context of this. Father was not present, and advice and guidance were offered to mother should her husband return. No additional concerns were raised, and a Public Protection Notification (PPN)[29] was recorded. Operation Encompass[30] is working across the partnership where CHAD reviews and progresses these notifications with appropriate schools and/or professionals. In this instance the information from the police (PPN) was made on the Friday following the incident however events escalated rapidly over the weekend before the PPN could be read at the start of the next working week. The timing and response to the PPNs and immediate operational changes in CHAD are discussed below.

4.3.7 Later that evening father reported a domestic assault by his wife to the police and that threats had been made towards him. This was seen by the police as a continuation of the same incident earlier that day and the matter was deferred to be picked up by the initial responding officer who was on duty the next day. This meant there was a lack of appropriate response and a delay in the investigations. However, the allegations were very different and involved different types of incidents, perceived levels of risk and asserted perpetrators. The nature of the risks here will be discussed below and consideration of the children in the household. Whilst a further PPN was completed after meeting with father the matter continued to be managed as a single agency response. Complicating factors meant that it was by now out of hours and moving into the weekend and the PPNs were not reviewed or processed by the police Harm Reduction Hub (HRH)[31] or the multi-agency Children's Advice and Duty Service (CHAD). Whilst CHAD does not work out of hours any Safeguarding concerns are managed by the Emergency Duty Team who respond out of working hours (EDT). There have been some immediate changes to some of the police and CHAD processes following this incident where now all Domestic abuse PPNs are reviewed by the HRH which considers the safeguarding of victims including children. The CHAD reviews any PPNs including domestic abuse with children the next working day. The learning event confirmed that any identified high-risk domestic abuse incidents where children were involved would be referred to EDT. There was a good discussion about this at the learning event and whilst it was not feasible for all PPNs to be reviewed by the EDT team there needed to be a much greater consideration of any children in the household. If the case had been assessed as a high risk this would have been discussed with EDT ensuring a multi-agency safeguarding response.

4.3.8 **Day 4** Father made two further calls to the police wanting to speak to an officer about what was happening about his disclosures and sharing his anxiety about his wife, he was worried she would come to his place of work, and he stressed it was a *'serious domestic incident'* Later that day father was interviewed at work and advised not to go home.

[29] Public Protection Notification PPN is the information sharing document from the police regarding safeguarding concerns about the police
[30] Operation Encompass is part of a wider national initiative to offer immediate support to children and young people experiencing domestic abuse. What we do : Operation Encompass It is an information-sharing partnership between Staffordshire Police and educational settings in Staffordshire and Stoke on Trent.
[31] In February 2022 the police moved to a new local policing model to be more responsive to local issues

The new PPN was completed, and father shared a history of previous physical assaults on him by his wife including threats to stab him with a knife, he reported he was afraid about further assaults and scared she would use the children against him. He went on to describe controlling and stalking behaviours by his wife such as not being allowed a mobile phone, constantly calling him, and following him.

4.3.9 Whilst the father shared these behaviours, including threats to stab him in his sleep, with the reviewer he did not identify this as abuse towards him, he simply said he could cope with this, he did not share this with anyone he just '*got on with things*' believing '*she would settle and be ok'.* This mirrors research into the experiences of men who like female survivors find it difficult to identify coercion and control as abuse and for men additional barriers of embarrassment and confidence feature around the concept of masculinity. He did feel that something was *'different'* this time in the days leading up to the incident and he tried to explain this to report that how she was behaving was not the same. It is noteworthy this was the first time he had talked about '*stuff*,' and he presented as uncomfortable when explaining this. What he was able to clearly articulate was that he only talked about this now was because of her remarks about Child C. He shared he was used to her saying stuff about him and he was able to brush this off but when she said '*you have given me a retarded son'* this was on a different level that he could not accept verbal abuse directed towards his son and this shocked him.

4.3.10 There was some confusion over physical evidence of an assault on the father, it was subsequently confirmed he had an injury to his head but did not inform the assessment of risk. Father did not want to make a complaint; he was not referred for support from an IDVA[32] because the case did not meet the threshold for MARAC, but he would have been given details about local domestic abuse services and received follow-up from the Victims Gateway[33] as this was classed as a crime. The risk was reviewed by the police and assessed as Medium. There was no indication that consideration of risks to the children formed part of this risk assessment or there were any multi-agency safeguarding considerations. The police have undertaken significant work to strengthen their risk assessment response to domestic abuse. This will also need to explore if there are any additional ethnic and cultural barriers.

4.3.11 The learning event discussed the nature of male disclosures and there were two matters of significance here, firstly the historical threats of harm from stabbing, the current physical assault and the stalking and controlling behaviours[34] indicating an increased level of risk to the victims here. Whilst the issues of domestic abuse and gender are complex it is important to acknowledge that domestic violence and abuse are not gender-specific (recognising that domestic abuse proportionately affects more females than males[35] and that there is a wider influence of gender in

Controlling or coercive behaviour should be dealt with as part of safeguarding and public protection procedures and professionals should be aware of the impact of this behaviour on victims, including children and young people Home Office Guidance 2022 (32)

[32] An IDVA is an independent Domestic Abuse Advisor A trained specialist who provides a service to victims at high risk of harm from intimate partners, ex-partners, or family members, with the aim of securing their, and their children's, safety. They are also known as independent domestic violence advocates and serve as a victim's primary point of contact. Independent domestic violence adviser (IDVA) - His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (justiceinspectorates.gov.uk)

[33] staffsvictimsgateway.org.uk

[34] The legal definition of domestic abuse is: any incident of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of their gender or sexuality.

[35] Home Office 2022 Controlling and Coercive Behaviour Statutory Guidance Framework

everyday experiences) studies show that men are less likely to report domestic abuse and violence and therefore seek help than women[36] In this instance, it meant that the risk should have been given greater rigour and secondly safeguarding considerations for the children and a male victim were not fully considered in the context of the assessed risks. The police have commenced work regarding the Homicide 8-step timeline following a review from Dr Jane Monckton Smith[37] .

4.3.12 **Day 4** Later that evening police attended the home and arrested mother. Present in the home were the children (who were awake) and father. The children were seen by the police and Child D was said to upset and was reassured by a police officer which was positive practice. The children were left in the care of their father in the family home. There were no questions raised about the initial referral where the father was advised to stay away from the family house, no concerns were raised about father's care of the children. It is not clear if any safety planning was considered or put in place. This should have occurred and would be best practice.

4.3.13 **On Day 5 Mother** was interviewed and within a few hours, the decision was made to release mother with a Community Resolution[38] Concerns about the appropriateness of this outcome and the decision-making around this must be raised and are subject to independent police review. Whilst a DVPO was considered this was not felt appropriate. This could have afforded some immediate and short-term protection[39] for the children and father as victims until further safeguarding assessments could be undertaken and appropriate domestic abuse support put in place.

A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator. Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support, they require in such a situation.

4.3.14 It is a substantial concern that mother was returned by the police to the family home where father and the children were, furthermore, it was around three in the morning and father was woken up. Mother then was reported to have become quite *'irate and agitated about being arrested'* The outcome was that father was asked to leave to calm the situation leaving mother at home with the children. Whilst there were no reported worries about violence towards the children the decision-making and subsequent actions show a poor understanding of the nature of domestic violence and intimate family relationships, in particular, a poor appreciation of the psychology of abuse and control. Matters had escalated at home which had led to father reporting his concerns about his wife's behaviours. Studies show disclosures by male victims are uncommon and the consequence of this was highly likely to inflame perpetrator behaviours and the situational risks for the victims.

[36] Statistics on Male Victims of Domestic Abuse - Mankind
[37] The Homicide Timeline - University of Gloucestershire (glos.ac.uk)
[38] Community Resolution is an out-of-court settlement used for low-level/first-time offences or antisocial behaviour with agreement of the parties
[39] Understanding risk and vulnerability in the context of domestic abuse | College of Policing
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/506148/2016-03-08_DVPO_report_for_publication.pdf

4.3.15 The learning event discussed the gender bias in this response and that if mother was the victim here would we have expected her to move out of the family home? The decision-making around this is difficult to understand and although there was no indication that the children would have been harmed by the mother there was no appreciation that the children should have been treated as victims in their own right[40] and therefore safeguarding considerations should have been made before mother was returned to the family home where all the victims were. It became clear that mother was angry regarding the arrest and to calm this situation father was asked to leave, this was a flawed decision based on what was known and an understanding of the nature of intimate domestic abuse and coercive control. The reported controlling behaviours meant all the victims here were more vulnerable to abuse. It is not clear what was known about mothers' mental health by the police at this time, but mental health is a known risk factor and increases situational risks significantly. The arrest occurred late in the evening/early morning so there was no direct access to the Health and Justice team. This team works out of hours including the weekend but not late, so she was not seen directly. There is an automatic referral for all female detainees. The coexistence of parental mental health with domestic abuse intensifies risk and emotional harm to the safety and well-being of children.

Day 5 Later that day mother reported to the police that she had killed the children.

4.3.16 The Child Safeguarding Practice Review Annual Report 2021 reported six deaths by a parent in the year by overt Filicide. A study of Serious Case Reviews (SCR) over a three-year period was undertaken by Peter Sidebotham and Ameeta Retzer in 2018 and identified 86 deaths attributable to filicide, of these mothers were suspected of 20 deaths. It considered that deaths associated with "impulsive violence or severe, persistent cruelty are almost exclusively perpetrated by males, while those with an apparent intent to kill the child are slightly more likely to be perpetrated by mothers." The study identified four key themes that have some relevance here that may support understanding of the circumstances and behaviours within the family:

- **domestic violence, maternal mental illness, separation, maternal isolation, and the invisibility of the child**. It is noteworthy that these factors were all present here.

These findings highlight the important role of domestic violence and its interaction with maternal mental health. Professionals working with mothers with mental health problems need to adopt a supportive but professionally curious stance, to be alert to signs of escalating stress or worsening mental ill-health, and to provide supportive and accessible structures for at-risk families.

4.3.17 Whilst there is limited evidence and understanding of filicide in the UK[41] and international studies do identify common themes and patterns as indicated by the study of SCRs where individual and situational risk factors co-exist and may increase the risk, these include in this case mental illness, the invisibility of the children and domestic violence. Of relevance here relating to children killed by their mothers the study highlighted that the majority of children (80%)

[40] hhttps://www.cps.gov.uk/cps/news/children-classed-domestic-abuse-victims-under-new-guidance

[41] McKee, A., & Egan, V. A case series of twenty-one maternal filicides in the UK. Child Abuse & Neglect (2013), http://dx.doi.org/10.1016/j.chiabu.2013.02.008

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."*

4.3.18 Whilst there is important learning here around professional curiosity from services in touch with the family because factors were viewed in isolation and there was no consideration of additional support it meant that the family's needs were not fully considered. There were opportunities and indicators of need for both the children and adults that could have supported the family and significantly connected some of the information known across the multi-agency systems. Significant learning here is the nature of the reported domestic abuse and the understanding and identification of the level of risk to the victims and the poor safeguarding response. The findings from this review mirror learning involving similar significant events meaning it is highly likely that because maternal filicide is so uncommon, the perpetrator is not well known to services and the circumstances are so unique it was almost impossible to predict.

4.3.19 The author has had sight of the review report undertaken by Professor Jane Monckton Smith commissioned by the police to consider the police response. It is important to note that independently and concurrently both authors have reached similar findings and learning concerning the police response including the view that the killing of the 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.

4.3.20 The following diagram has been developed to illustrate the history (as known, retrospectively) of events known in the key episode mapped against the Homicide 8-step timeline.[42] This evidences the rapid escalation of the behaviours within a few days to support learning.

[42] The Homicide Timeline - University of Gloucestershire (glos.ac.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

Why does it matter?

4.3 15 This matters because professionals need to have a comprehensive understanding about the nature of domestic abuse and understanding risk. It must include an appreciation and recognition of the experiences of male victims of domestic abuse and what support and services, they may need to ensure their wellbeing and safety. Where there are children involved this should include them. The Office for National Statistics estimates that one-third of domestic abuse victims are men and where they have parental responsibilities their situations are more complex.[43] Men face a particular set of challenges and stereotypes in being recognised as victims of domestic abuse. It matters here particularly because the response to risk about father was limited, there was no safety planning and removing the victim from the house was a poor decision and did not recognise his parenting and potential protective role. It is hard to consider a situation where a female victim would be asked to leave her children in the middle of the night without any safety planning or safeguarding considerations.

Understanding the domestic homicide timeline (Dr Jane Monckton Smith)

This tool is an important tool that helps professionals understand and potentially prevent serious harm to victims of domestic abuse. This was developed after a study of over 300 domestic killings which identified an eight-stage pattern of behaviours /circumstances that perpetrators typically follow before committing a homicide. This can be mapped against the circumstances of this case and shows that all were prevalent here. We must learn from these patterns to help risk assessment and possible intervention where these features are emerging (see page 20) The rapid escalation with no known history illustrates the challenges of predictability.

Understanding of the nature of domestic abuse concerning male victims. Gender bias is a barrier to understanding and therefore protecting male victims of domestic abuse. There was insufficient appreciation of the risks to the father (and the children) and a lack of any protective strategies being put in place Risk assessments must reflect appropriate vulnerabilities, consider gender bias, and involve safeguarding oversight. The return of mother to the family is indicative of gender bias. Understanding family relationships and ensuring both parents /carers are visible, and fathers are seen and engaged with (see also section 4.2 How was father role understood) The role of men /fathers needs to be enquired about, explored, and challenged across all professionals and services. Fathers' needs and safety were not fully attended to.

Children must be always 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 and disclosures from the children to the police and the school sharing worries that their parents *'always argued'* There was a lack of any safeguarding considerations or follow-up.

Safeguarding response There should be clear safety planning in place to support the safety of victims and mechanisms such as a DVPO (36) which could have enabled space for an appropriate multi-agency safeguarding risk assessment regardless of the outcome of any criminal investigation. Information sharing would have flagged co-existing risk factors.

The multi-agency learning is covered below, much of the learning here relates to the police response but its relevance is much wider. Learning here will be supported by identified learning from the parallel independent police review not fully concluded at the time of writing this LCSPR.

[43] Why are men often overlooked as victims of domestic abuse? (centreforsocialjustice.org.uk)

What needs to happen -Learning points	
7	There needs to be increased knowledge and skills in understanding risk characteristics and behaviours in domestic abuse including how coercive control is understood. This should include: • An appreciation of the patterning of information included in the Eight-step Domestic Homicide Timeline. • An appreciation of male victims of domestic abuse. • Consideration and reflection concerning gender bias. • Reflection of the impact on children where coercive and controlling behaviours occur within parental relationships.
8	Professional curiosity (see learning point 2) needs to be used when children share worries about what is happening at home to enable support to be put in place at the earliest opportunity. When children share their lived experiences of domestic abuse the likely impact on their physical, emotional, social, and psychological development can be far-reaching and they require protection and support.
9	Children must be always seen as victims when domestic abuse is known or suspected in line with statutory guidance.
10	Multi-agency Safety Planning must be put in place to safeguard children and adult victims of domestic abuse while multi-agency risk assessments are undertaken. They must be informed of the potential for increased risk following disclosure of domestic abuse and effective safeguarding put in place for all potential victims.

5: Father

5.1 Father presented as a calm and reflective man and talked with love and emotion about his children. Child C loved the tablet that he had bought for him and enjoyed watching cartoons. He shared a 'hands-on' role as dad, he would help with Child C's bedtime and regularly took Child D to school on his way to work. Child C had school transport and would sometimes get dropped off at his place of work.

Father shared a little about his earlier relationship with his wife, they met in the Caribbean where they both lived at the time, and he was aware she had elder children. Child C and D were his only children. Comments about their early relationship described an intense relationship where jealousy featured regarding his previous partner concerning threats to her, but he was unaware of this at the time. He commented that he did not realise she was possessive until they were fully together. He did not see himself as a victim concerning her controlling and abusive behaviours. He hoped she would take up support i.e. take her medication and things would settle seeing her behaviour as part of her mental well-being. He was aware she had a diagnosis of depression and felt that when on her medication she was calmer he also shared

she experienced headaches and struggled to sleep. He hoped she would sort herself out and take the help, and he could not comprehend that she could or would do what she did. It is significant but not unusual that he did not see himself as a victim of domestic abuse at the time.

Father was overwhelmed and devastated about what had happened, he described his wife as having a 'split personality' and that she could be loving with the children. He gave an example of this and described the incident where Child C had hit his mum which he was surprised about where Child C said his mum had been mean to him. Father believed his wife had handled this well acknowledging that Child C's behaviour was not easy for the family. When asked about what help they had received with this, what they needed and what could have supported them he shared that he thought they had had some help in the past and this was about checking up on how Child C was doing. He was positive about the help they had from the school for Child C but did not understand the role of services and how he could be involved and presented as isolated, functioning within a very limited sphere of home and work. He appeared unconcerned about any help for himself and could not give any particular reason for not being registered himself for any health needs. He did not present as resistant, and it is difficult to understand now knowing the history if this was his own choice or possible cultural barriers or if he was not included or enabled to through controlling behaviours.

He was appreciative of all the support he was currently receiving and stated if you didn't say anything nobody would know, and he felt it was important not to ignore things as they can get worse. How father could or would have accessed help earlier is difficult to identify and despite being visible to services involved with his children and working within the community he was unseen therefore his narrative was unknown, and any needs remained hidden and unmet. Responsibility for this cannot rest with the father and learning through reviews such as this, understanding the nature of domestic abuse and utilising evidence-based models such as the Homicide timeline can help key professionals identify risks and possible interventions. The complexity of the characteristics and behaviours involved cannot be underestimated in the context of what we now know about the family how the father's life was controlled, and the rapid escalation of events. The statutory definition of domestic violence and abuse helps understanding here [44]:

> *Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence, or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality.*

[44] Domestic Abuse Act 2021 (legislation.gov.uk)

6: Summary and Recommendations

6.1 The purpose of undertaking this practice review has been to identify any learning following the tragic deaths of two children, known in the review as Child C and Child D siblings aged 7 and 11. Due to the circumstances of the deaths, there have been parallel criminal and professional review processes that have meant additional care over some information whilst criminal investigations have run alongside the review.

6.2 The loss of these children due to parental violence presents huge emotional challenges and can impact the capacity to process the trauma of surviving relatives and also professionals involved with the family. The partnership is sensitive to how professionals can be supported, and this review has taken a proportionate and empathetic approach. Appropriate specialist professionals are supporting father with the trauma of losing both his children due to maternal violence, and his involvement in the review process has been valued.

6.3 The review has sought to honour the children by trying to understand what life was like for them, they were happy and engaged in school life and for most of their lives were well cared for, they appeared to have loving relationships with both parents. Both parents took an active role in their children's care and overall, their needs were met. The family was involved in universal services, there were no identified worries about their care and Child C's additional needs were identified and supported via his EHCP. Both schools had positive relationships with the children who were happy in their care where they were thriving. Whilst there were some issues over attendance at health and educational reviews and with school attendance overall the professionals involved with the children were satisfied their needs were being met and they were developing appropriately.

6.4 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.

6.5 The process of this review has identified some key areas for the partnership to consider and reflect upon regarding systems and practice that include the role of fathers/male caregivers and how they can be engaged in services, increased knowledge and skills in understanding risk characteristics and behaviours in domestic abuse and coercive control including female perpetrators, gender and cultural bias and increased curiosity of practitioners where adult mental health can impact on family functioning. Whilst some key learning relates to single agencies the importance here is a multi-agency understanding of some of the particular characteristics surrounding the experiences of these children.

Recommendations for the Safeguarding Partnership

Practice

1. The Safeguarding Partnership needs to be confident that universal and community-based practitioners are alert to the need for early help for children and families who have additional needs such as disability,

special educational needs, periods of non-school attendance[45] and parents who have additional mental health needs. (Learning points 1,5,8)

2. The Safeguarding Partnership **is** to be provided with assurance that managers and practitioners are supported through professional development, supervision and learning to strengthen their practice skills in being 'professionally curious.' This must include an exploration of any possible cultural, gender and /or neurodiversity barriers to accessing services and supporting service delivery. (Learning point 2,3)

3. The Safeguarding Partnership to seek assurances that practitioners and managers are provided with regular opportunities to reflect on the role of fathers and male caregivers in their interactions with families and consider opportunities for fathers to be actively engaged. (Learning points 3, 4)

4. The Safeguarding Partnership to strengthen practitioners' and managers' knowledge and skills in understanding risk characteristics and behaviours in domestic abuse through training and development. This work will be enhanced by collaboration with the Community Safeguarding Partnerships to ensure a whole family focus. (Learning points 7, 9) and must include an understanding of the following characteristics :
    a. How coercive control is understood.
    b. A consideration of male victims and reflection on possible gender bias and unconscious bias
    c. An appreciation of the patterning of information included in the eight-step Domestic Homicide timeline.
    d. Consideration of the impact on children of coercive control within parental relationships.

5. The Safeguarding Partnership to seek assurance from the Police that risk assessment in situations of domestic abuse considers all children in the household as victims (Learning Point 8)

6. The Safeguarding Partnership to seek assurance from the Integrated Care Board (ICB) that in line with best practice GPs should review in-person adult mental health medication at least annually. (Learning point 6)

[45] Working Together 2023 Chapter 3 Identifying children and families who would benefit from help

7. The learning from this LCSPR is disseminated across the Partnership and partner agencies to provide evidence to the partnership of how the learning is making a difference in practice, to children and families they work with, particularly at a universal and early help level. (all learning points)

Systems

1. The Safeguarding Partnership to have clear systems that identify emerging problems and unmet needs for children and families and consider existing systems, such as Stoke-on-Trent's developing 'Family Hubs' and established review systems (EHCP/Attendance reviews) These can support the identification and delivery of early help assessment and support. The Early Help System Guide[46] provides a toolkit for self-assessment and guidance for local strategic partnerships responsible for early help systems that can support partnership delivery and conversations that are happening across the City.

2. The Safeguarding Partnership is assured when families access support services organisations and agencies have systems in place that identify and meet individual communication needs as needed. (Learning points 2,6)

3. The Safeguarding Partnership establishes clear culture, guidance, and principles about how it works with the whole family and identifies any needs and support for adults with child-caring responsibilities, whilst maintaining a clear child-centred approach. This must be considered across all threshold levels. (Learning Points 1,2,8, 4, 5)

4. The Police to provide assurance that there is a clear risk management process concerning domestic abuse that includes Safety Planning for victims and protective processes are in place while multi-agency risk assessment is undertaken. (learning point 9)

[46] Early_Help_System_Guide.pdf (publishing.service.gov.uk)