ALICE AND BETH

SERIOUS CASE REVIEW REPORT

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1. Introduction

1.1 The subjects of this review are sisters, Alice and Beth. At the time of her death Alice was 3 years and 3months old, her sister Beth was 1 year and 5 months old when she died. Both girls died within two weeks of each other.

1.2 The mother to both children is Clare, the father of both children is David, although at the time the children died the parents were estranged. Clare also had a relationship with Ethan. After the death of Beth, Clare was arrested and subsequently charged with the murder of both children. Clare was convicted of the murder of both Alice and Beth and is currently serving a term of imprisonment.

1.3 At the time of the deaths Clare and the children lived in the Warwickshire area but had previously lived in Walsall. The Warwickshire Safeguarding Children Board considered the circumstances of the children's deaths and agreed that a serious case review should be undertaken.

2. About the Author

2.1 The author in this review is Jonathan Chapman, he has no prior involvement with the case and is not connected to any of the agencies involved. He is a retired senior police officer, who had responsibility for strategic and operational safeguarding and was a senior investigating officer. He has undertaken serious case reviews, safeguarding adult reviews, MAPPA case reviews and domestic homicide reviews, with various boards across the country. He has also worked with Clinical Commissioning Groups, The Church of England, Local Authorities and the third sector on safeguarding matters.

3. Terms of reference and methodology

3.1 This case was referred to the National Child Safeguarding Practice Review Panel in November 2018. The panel deemed that the case did not fit the criteria for a national review, but a local review should be undertaken.

3.2 The Safeguarding Boards formed a panel to oversee the review process and to assist the author in identifying any improvements to safeguard and promote the welfare of children. The panel was constituted of the below organisations.

Warwickshire Children Services (CS)
Walsall Children Services (CS)
West Midlands Police
Warwickshire Police
Rugby Borough Council
North Clinical Commissioning Group
Warwickshire County Council Legal Services

3.3 The panel developed and agreed terms of reference for the case which included the identification of the agencies who had been involved with providing services to the children and family. These organisations were asked to provide an Individual Management Report (IMR) and chronology detailing their involvement. The organisations identified as being involved were: -

Black Country Women's Aid
CAFCASS
NSPCC
Rugby Borough Council Housing
South Warwickshire NHS Foundation Trust
University Hospital Coventry and Warwickshire
Walsall Children's Services
Warwickshire Children's Services
Walsall CCG/GP
Walsall Healthcare NHS Trust
National Probation Service (Black Country Cluster)
Warwickshire Police
West Midlands Police
West Midlands MARAC
West Midlands Ambulance Service
Warwickshire County Council Legal Services

3.4 The review panel identified a number of potential themes which organisations were asked to consider in their reports, and which formed the focus of discussion at the practitioner events. These were: -

- Where concerns were raised, was risk effectively identified? Were assessments undertaken when required, and were they effective?

- Was the cumulative effect of concerns raised considered, in particular the presentation of Alice at hospital and the presence of domestic abuse in the family?

- Was information appropriately shared between agencies, particularly when the family moved between areas?

- Following Alice's death was there appropriate consideration of the ability of Clare to care for Beth?

- To identify any areas of good practice in the case.

3.5 The timeframe that the IMR authors were asked to focus on was from 1st March 2014 to 1st February 2018. In addition, contributors were asked to consider any relevant information that was outside this scope.

3.6 There then followed two facilitated discussion events with frontline practitioners and managers who had been involved in the case. These discussions are reflected throughout the review.

4. Family involvement

4.1 Family members were informed of this review. The mother, Clare and her sister were both asked if they wished to contribute to the review but declined.

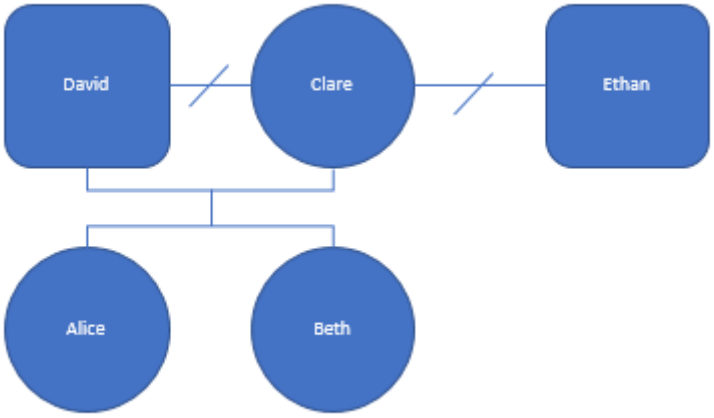
4.2 Clare's previous partner, David was asked whether they wished to contribute to the review but felt at the current time his involvement was too difficult for him. Ethan, Clare's subsequent partner, was seen by the review author.

4.3 Although Ethan had concerns regarding Clare's parenting and reported these to Walsall Children Services (CS), the police and NSPCC he said that he at no stage considered Clare was capable to causing harm to the children to the level which was ultimately proved, although he accepts fully that she has.

4.4 When considering how he interacted with agencies, Ethan feels that he wasn't listened to when making his concerns known and from his perspective they were not properly considered. When asked what more the agencies could have done Ethan said, "Paid more attention to detail and look into things more, she could put an act on (referring to Clare)". Where relevant Ethan's views have been included in the narrative of the review.

5. Background

5.1 Clare and David formed a relationship in 2014, Alice was born and while they were still together Clare became pregnant with Beth. They separated before Beth was born and Clare formed a relationship with Ethan. Ethan and Clare were still in a relationship when Beth was born.



6. Summary of Facts

6.1 Alice was born in October 2014 to parents Clare and David, at this time they were residing in Walsall. The pregnancy and birth of Alice was without any concerns, although Clare had presented on a number of occasions with anxiety concerning foetal movement.

6.2 The only event of note was that during the pregnancy the midwifery service notified Walsall Children Services (CS) in August 2014, that David had shared that he had suffered from anger issues. It would appear this was shared purely as information to note and did not require any further action.

6.3 Post-delivery contacts were made with the family by the midwifery and health visiting services in accordance with maternity post-natal pathway. Alice received her immunisations, although GP records would indicate that these were delayed. The delay was discussed in the GP surgery internal cause for concerns meeting but there was a decision that the delay did not constitute undue concern at that time.

6.4 In July 2015, Alice (10 months old) attended A&E department at hospital having been vomiting. It was disclosed by her parents that she had bumped her head four days previously. The case was transferred to the urgent care centre. The Multi Agency Safeguarding Team (MAST) was informed as was Walsall CS. Health visiting were requested to carry out a follow up check but despite attempts this was not successful.

6.5 In October 2015, Alice was taken to hospital A&E again, on this occasion she had an injury to her nose. Clare stated that this was caused by Alice bumping herself with a toy, which had caused bleeding, which had stopped by the time she had reached hospital. After being triaged Clare left the hospital with Alice, prior to being seen by a doctor. The department contacted Walsall CS and were advised to submit a referral for Early Help, which was done the same day.

6.6 The referral to Walsall CS was passed to a Children's Centre to follow up and the following day the attendance was reviewed by a Paediatric Liaison Nurse (PLN). The PLN sent a referral of the information to the health visiting team. It does not appear that this was received and therefore there was no follow up from health visiting.

6.7 In November 2015, Alice was seen by a nursery nurse for her 12 month checks, she was not brought to the appointment, so a visit was undertaken at home. Both parents were present, and no concerns were noted. The parents raised the October A&E attendance, although a different explanation was given, on this occasion they stated that Alice had fallen and hit her head on a skirting board.

6.8 In early December 2015, the police attended a report that Alice had been forcibly removed from her push chair by David. While police were attending, a separate call informed them that David was in possession of a weapon. On police attendance Clare had left the scene with Alice to visit her GP for immunisations for Alice. It transpired that there had been a dispute involving the parents and members of Clare's family. When finally located Clare expressed that she was scared of David and he was arrested on suspicion of child cruelty.

6.9 Whilst David was in custody Clare altered her account and denied that David had acted violently towards Alice. David stated that he had found evidence on Clare's phone that she had searched the web on the subject of 'how to kill yourself with a knife'. As a result of varying accounts, no further action was taken against David but the information regarding the website search was passed to Clare's GP. There followed a strategy discussion between Walsall CS and the police. On the basis of this discussion it was decided that a Child and Family Assessment was not required at this stage.

6.10 Since the October visit to A&E, the Children's Centre had attempted on numerous occasions to contact Clare, without success. This was finally achieved in

December 2015, when a relative of Clare informed Children Centre staff that she was concerned that David was isolating Clare.

6.11 Around the same time a member of Clare's family had contacted police stating that Clare had said that she was in grave danger. This was followed up by a further call from an anonymous female that 'there was a possible murder' at the same address. On police attendance members of Clare's family were outside the address. Inside the address Clare was with Alice, and David was present. Both David and Clare were spoken to separately and denied any dispute or incident had occurred. No further action was taken, police made a referral to Walsall CS.

6.12 Later in December 2015, Clare attended the appointment with the Children Centre where a family worker started to work with Clare, who agreed to an Early Help assessment. After the Christmas break Clare contacted the Children Centre and declined any further support.

6.13 In December 2015, in response to the alleged assault on Alice, the GP surgery submitted a safeguarding referral. This referral was mis-directed to the hospital safeguarding team instead of Walsall's Multi Agency Safeguarding Hub (MASH) and this resulted in the referral not reaching Walsall CS until February 2016, after it had been chased and re-submitted by the GP. The referral initiated an unannounced visit by the health visitor to the family address. The health visitor communicated with David through the letterbox, he stated that he was ill. David disclosed at this time that Clare was pregnant.

6.14 In early February 2016, Clare attended her GP and was seen by the Community midwife for her first ante natal appointment for Beth. She was asked about domestic abuse but made no disclosures. Clare was referred to the teenage pregnancy service. There was also a follow up to establish what Early Help support Clare was receiving.

6.15 At the end of February 2016, Walsall CS received a referral via a children's centre, from a member of Clare's family, to the effect that there was domestic abuse in the relationship between Clare and David and that he was isolating her. As a result of previous concerns and the recent referral a decision was made to undertake a Child and Family Assessment, under s17 1989 Children Act.

6.16 This assessment involved lateral checks with agencies and both Clare and David were spoken to alone. Alice was 18 months old at the time, she was seen and presented as a happy child. Alice was noted to interact appropriately with both parents. During discussion with David it was apparent that there was ongoing conflict between him and members of Clare's family. This had involved some spurious allegations being made, which included the fact that a murder had been committed at the family home address. Allegations like this were quickly resolved as

not being factual. The outcome of the assessment was that the case did not reach the threshold for further social care intervention. This decision was overseen and signed off by a manager.

6.17 In June 2016, Clare attended a police station with an Independent Advisor and made an allegation that she had been assaulted, in the family home, on five occasions by David. These offences were alleged to have occurred between December 2015 and May 2016. A referral was sent for the case to be heard at a Multi-Agency Risk Assessment Conference (MARAC)[1] and for an Independent Domestic Violence Advisor (IDVA) to support Clare.

6.18 On the day that Clare made the complaint to the police, she packed her belongings and left the family home. David located her that evening, in a pub with Ethan (who was her new partner). There was an altercation and David assaulted Ethan by punching him to the face. Alice was also at the pub but was not directly involved in the incident.

6.19 David was subsequently arrested for the offences. He was charged with the assault offence and bailed for other offences to be investigated. A condition of the bail was that he should not contact Clare.

6.20 The case was heard at MARAC in late June 2016 and appropriate safety measures for Clare and Alice were addressed. It was at this stage that Walsall CS first became aware of the assault allegations. It would appear that no referral had been made to them by police.

6.21 Through July 2016, the health visiting service made attempts to visit Clare but after several attempts it was established that Clare had moved in with a new partner, Ethan. Clare received continuing support from the IDVA and health visiting service.

6.22 At the beginning of September 2016, Walsall CS received a concern from David that Clare was sleeping on the floor and he had concerns over the behaviour of one of Clare's family members. No further action was taken on this referral.

6.23 Through September 2016, Clare attended hospital on two occasions with anxiety over reduced foetal movements. Tests revealed there were no concerns and on 9th September 2016 Beth was born. Clare and Beth were supported by a universal health visiting service, no concerns were noted.

[1] Multi Agency Risk Assessment Conference (MARAC) -
is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

6.24 At the beginning of October 2016, an anonymous referral which stated that Clare went out occasionally leaving the children in the care of other adults. There was very limited evidence of screening with other agencies with the staff in MASH speaking to Clare and a decision was made not to take any further action. It is the view of the Walsall CS IMR author that the rationale recorded did not provide adequate insight and understanding as to why this decision was made.

6.25 In early November 2016, Walsall CS received a further anonymous referral regarding Clare, to the effect the she was drinking heavily and leaving the children with strangers. This referral was followed up and enquiries made with other agencies, which did not support the information. Clare was spoken to and disclosed that she had been in conflict with a family member, who she believed may be responsible for the information.

6.26 In mid-November 2016, David appeared at court for the public order offence and the assault against Ethan. He was sentenced to a Community Order with Restraining Order made against him to prevent him having any contact with Clare for one year, except supervised child contact. Clare declined any further support from the domestic abuse services at this stage.

6.27 In early February 2017, David contacted Walsall CS and raised a concern that Clare had been involved in a road traffic accident and was now permanently confined to a wheelchair and she could no longer care for Alice, also that she was drinking heavily. It was very quickly established that this information was not correct and there had been no accident. Clare was spoken to and the matter of excessive drinking was discussed, which she refuted. She consented to checks being made with other agencies. David was updated with the result and when asked directly, stated that he had no concerns but wished for contact with Alice. He was advised regarding the private law route to achieve the contact he wanted.

6.28 In March 2017, Clare contacted police to complain that David had breached his Restraining Order by contacting her on social media. David was arrested. It was established by the investigation that the social media site had in fact been created by someone at the address occupied by Clare and Ethan. Ethan was arrested and Clare was interviewed for an offence of Perverting the Course of Justice. No action was taken against any person and the matter not progressed further.

6.29 In May 2017, there was an encounter involving Clare and Ethan with David. David made some threats towards a member of Clare's family. David then kicked the door of Clare's car, causing minor damage. David was subsequently arrested for breach of his Restraining Order. David appeared at court in June 2017 and was sentenced to a Community Order.

6.30 The case was again referred to MARAC due to the recent incident and Clare was supported by the IDVA and visits from the health visitor. The children were seen on a home visit and there were no concerns observed.

6.31 In June 2017, David raised a concern with the NSPCC, which was passed to Walsall CS. The report claimed that Alice and Beth were being exposed to domestic violence and excessive alcohol misuse by Clare, that the house and garden were not appropriate and that one of the children had sustained an injury. Lateral checks were conducted with agencies which indicated that there were no concerns over the children, and they had recently been seen by the health visiting service. A manager decided that due to the number of referrals made and the apparent conflict in the relationship between Clare and David, that a Child and Family assessment should be undertaken.

6.32 As part of the assessment David was seen and spoken to about his concerns, which mainly focused on his inability to have contact with Alice. Both children were seen and the description of them is one of happy, smiling infants who were clean and appropriately dressed. There were no concerns articulated by other agencies and the assessment was closed in July 2017, with the concerns being unsubstantiated.

6.33 During September and October 2017 there was an increase in allegations being made and this coincided with a private law case being initiated by David for contact with Alice, and the relationship between Clare and Ethan ending.

6.34 During August and September 2017, the NSPCC helpline received a series of calls and emails from David. These allegations were regarding Clare and her more extended family and appropriateness of them being involved in the care of children. Over this period the NSPCC shared information on five occasions with Walsall CS. The information did repeat some information previously received and was on occasions recorded as being difficult to fully understand. David was spoken to on a number of occasions to clarify the information.

6.35 One of the allegations from David was that a member of Clare's family had been arrested and prosecuted for carrying a weapon and that they are caring for the children. David was contacted and spoken to and the information reviewed by the team that had undertaken the recent assessment. It was agreed that the information did not alter the findings of the assessment. The allegation regarding the family member does not appear to have been addressed but there are no records from the police that there was an incident involving a weapon. During these conversations with David it became apparent that Clare had now also separated from Ethan.

6.36 In September 2017, David made an application for a Child Arrangement Order. CAFCASS were involved in initial checks and risk assessment in accordance with the

Child Arrangements Programme, in respect of Alice only. Around the same time Clare made contact with Rugby Borough Council regarding a move to that area, stating that she was fleeing domestic abuse.

6.37 At the beginning of October 2017, Clare reported to West Midlands Police that David had threatened a member of her family. It was established that this threat involved a Family Court hearing scheduled for later in October. David denied that this had taken place and there was no further action.

6.38 On 6th October 2017, Walsall CS were contacted by a male only calling himself 'E' (believed to be Ethan) alleging that there was a child at Clare's address with a 'big green bruise on her face'. On the same day a visit was made to the family address and there was no one home. The following day an anonymous call was made to Walsall CS reporting that Clare leaves the children with persons that they did not know when she goes out. Checks with the nursery and health visitor revealed that both children had been seen the previous day and there was no bruise evident on either child.

6.39 On 10th October 2017, the private law case for contact was heard at the family court. During the hearing there was conflict between Clare and David necessitating court security being involved. As a result of concerns raised by CAFCASS in relation to the risk presented by David and the presence of domestic abuse the court requested Walsall CS undertake a section 37 assessment, in respect of Alice only.[2]

6.40 On 15th October 2017, Ethan contacted both Walsall CS and police with concerns regarding the children. Walsall CS recorded that Ethan stated that Alice had a bruise as a result of being slapped by Clare the previous week. The police recorded that Ethan stated that Clare had been hitting Beth and she had 'lumps to her head and bruises' and that Alice had a slap mark on her face.

6.41 It would appear that both West Midlands Police and Walsall CS visited Clare at different times. On both occasions the children were seen and deemed to be fit and well ('in high spirits, smiling, laughing and appeared well fed'). When seen by West Midlands Police Beth, had a small bruise on her forehead. The explanation given by Clare was that Beth had recently started walking and fallen over. The officer accepted this as a reasonable explanation. Ethan, when spoken to for this review, stated that he saw Clare hit Alice whilst she was bathing her, and Alice struck her head on a tap. Both West Midlands Police and Walsall CS records would indicate

[2] Section 37 Children Act 1989 - A Section 37 investigation is an enquiry into a child's circumstances by a Social Worker. Under section 37 of the Children Act 1989 a court may direct a local authority to investigate a child's circumstances if it appears that a Care Order or Supervision Order would be appropriate.

Ethan reported this incident after a couple of days had elapsed and as a result of being refused access to see the children by Clare.

6.42 On 17th October 2017, Clare contacted West Midlands Police to state that Ethan was making threats to her on social media. The incident was recorded as a domestic abuse incident but there were no criminal offences and the case was closed. There were no referrals to other agencies.

6.43 In early November 2017, Clare was seen by a social worker from Walsall CS to initiate the s37 assessment. A history was taken, in which Clare alleged David's controlling behaviour and domestic abuse towards her over a period of time. Alice was at nursery at the time, but Beth was present and the interaction between Clare and Beth was witnessed as appropriate. Clare disclosed plans to move away to a location that David would not be aware of. Clare disclosed that David had threatened her and to 'snatch' Alice. Although recorded this disclosure does not appear to have been explored further.

6.44 During late October and early November 2017, Clare contacted West Midlands Police on two occasions to report Ethan being in the vicinity of her address. These incidents were noted in the context of previous domestic abuse incidents involving David. There were no restrictions to prevent Ethan attending the address.

6.45 On 13th November 2017, the Walsall CS social worker attempted to see Clare again to continue the s37 assessment. On attending the address, it was established that Clare had moved. There was information that there had been noisy parties and anti-social behaviour at the address, which neighbours had complained about.

6.46 The social worker spoke with Clare on the phone two days later and Clare confirmed that she had left the area and was staying with a member of her family in Warwickshire. Clare had made enquiries with Rugby Borough Council Housing, who in turn had confirmed the involvement of West Midlands Police and Walsall CS, as part of Clare's request for accommodation. Walsall CS confirmed that it was undesirable for Clare to remain in the Walsall area due to ongoing domestic abuse. Although not specifically stated by Clare, it was clear that Clare was seeking to relocate to Warwickshire. There was no notification made to Warwickshire CS by Walsall CS of the apparent relocation of the family.

6.47 During November 2017, David is seen on two occasions by the Walsall CS social worker for the s37 assessment. David stated that Clare had a transient 'party girl' lifestyle and that she had verbally and physically abused Alice, but this is not described or explored in more detail. David stated that he is unsure if he is the father of Beth but is willing to take a paternity test.

6.48 On 22nd November 2017, Clare was visited, where she was staying in Warwickshire by the Walsall CS social worker. Clare was not present, and the social worker was told that she had been in hospital overnight (not confirmed in hospital records). Both Alice and Beth were seen to be fit and well, with no concerns being observed.

6.49 On 7th December 2017, Ethan contacted the NSPCC to raise concerns about the care being afforded to the children by Clare. The address in Warwickshire was given. He claimed that she was hitting the children and driving a vehicle with both children in the car as an unqualified driver and regularly drinking excessively. This contact was not linked to previous concerns logged with the NSPCC by David, due to there being a different name and different address.

6.50 On 11th December 2017, Warwickshire CS received the concern from the NSPCC. The MASH initiated extensive enquiries with agencies to identify and locate the children. Contact was made on the phone with Clare, however Clare declined to discuss matters on the phone as she stated she had previously received hoax calls. Warwickshire CS made contact with Walsall CS and were informed that there was an ongoing s37 assessment. It was agreed that there would be no further action by Warwickshire CS as the case was open and allocated to a social worker from Walsall CS. The Warwickshire MASH fed back to the referrer, Ethan, that Walsall CS would be dealing with the information. Warwickshire CS also informed the Walsall health visiting service regarding the family now being in Warwickshire, although it was not clear if the arrangement was to be permanent.

6.51 The social worker from Walsall CS attempted to make contact by phone with Clare on three occasions in December 2017 and January 2018, messages were left but there was no response.

6.52 On 2nd January 2018, Clare attended a Warwickshire hospital with Alice, and reported that Alice had suffered a seizure lasting about 3 minutes. Clare stated that Alice had previously been well prior to the seizure and had not had any rashes, temperatures or coughs and colds. There was no previous history of seizures or illness noted. Alice was reviewed by paediatric medics, examinations and assessments all appeared within normal limits and a decision was made that Alice could be discharged. Clare was provided with written advice and encouraged to return Alice should she become unwell or have any further seizures.

6.53 On 4th January 2018, Alice was conveyed to the Children's Emergency Department by ambulance. Clare stated she had woken from sleep to find Alice "fitting". On arrival at hospital, Alice was described as floppy but on examination by the paediatric team is documented as being awake and having normal movements, but lethargic, although becoming more alert. It was found that Alice had oxygen

saturations of 82% in air (normal being over 92%), with some chest recession and crackle noises on examination suggestive of a lower respiratory tract infection.

6.54 Alice was admitted to a paediatric ward for treatment including intravenous fluids, intravenous antibiotics and oxygen therapy. Alice also underwent medical investigations to confirm the reason for her illness, including a chest X-Ray. The results were consistent with a respiratory infection and microbiology screening of nasal secretions isolated 4 types of viruses. Whilst an inpatient Alice was reviewed by four different paediatric consultants and all were consistent in their opinion of a respiratory infection being the cause of illness. The reason for the involvement of four paediatric consultants was due to changes in consultants' duties over the weekend.

6.55 Alice responded well to the treatment and was discharged home from the paediatric ward four days later, on the 8th January 2018 and did not require any further follow up care or appointments. It was noted that Clare was present throughout Alice's inpatient admission and attended to her needs such as nappy changes.

6.56 On 9th January 2018, Clare attended Rugby Borough Council offices regarding housing, she stated that she had no money to feed the children and disclosed the recent hospital attendance for Alice. Rugby Borough Council were concerned regarding Clare's circumstances and felt that she had been unusually 'blasé' regarding Alice's illness and on this basis, they made a referral to the MASH. The referral was passed to Warwickshire Family Information Service to provide further information about local support. Warwickshire MASH informed Walsall CS of this new information as they were the allocated team for the children.

6.57 On 11th January 2018, Clare contacted the Walsall social worker and informed them of her new address. The social worker immediately attended the address and spoke with Clare and saw the children. The home conditions were seen as sparse but appropriate. Clare spoke at length about David and Alice. She made various allegations about David and claimed that David and Ethan were working together to discredit her. The social worker discussed David's contact with Warwickshire CS and informed Clare that it is Warwickshire CS that will be dealing with Ethan's contact to the NSPCC.

6.58 Just after midnight on 15th January 2018, the ambulance service attended Alice's address on report of Alice having suffered a seizure. Alice was conveyed to hospital where on arrival she was found to be deceased.

6.59 Police had attended and secured the address. An examination of the address suggested that it was 'sparse' but there was adequate food and clothing. The flat was described as being cold.

6.60 Beth was examined at hospital and there were no concerns regarding her health.

6.61 On 17th January 2018, a child death and strategy meeting were convened by Warwickshire CS. Information was shared between Health, Police, Housing, Nursey and Walsall and Warwickshire CS. The meeting was chaired by a consultant paediatrician, this was the same paediatrician who had previously seen Alice in hospital. This meeting, on consideration of all the information, agreed that there should be a single agency assessment (s17) for Beth. This was allocated to a Warwickshire social worker who attended the meeting to ensure good continuity.

6.62 On 18th January 2018, a post-mortem examination took place. As there were no suspicious circumstances surrounding the death, the post-mortem was conducted by a paediatric pathologist as opposed to a Home Office Registered Pathologist. There were no injuries and no signs of abuse or neglect. Warwickshire Police completed their investigation and after consideration, the case was deemed a non-suspicious death.

6.63 It was recognised at an early stage that Clare would require support and Warwickshire CS allocated a family support worker in addition to the social worker. There was high level of contact with twice weekly meetings and other contact outside of the meetings. A family history was obtained, and it was assessed that Clare appeared to be meeting Beth's needs and was protective towards her.

6.64 During this period Clare was seen to be engaging well, registering Beth with a GP, seeking advice about the family court proceedings and dealing with funeral arrangements.

6.65 The police were contacted on two occasions by Clare. Both contacts concerned contact on social media by David regarding the death of his daughter. Neither incident was deemed to have breached his Restraining Order.

6.66 On the night of 1st February 2018, Clare contacted the health 111 line from a retail park to state that Beth was drowsy, ambulance service staff attended and found Beth to be unconscious. Emergency care was provided at the scene and Beth was conveyed to hospital, where despite the best efforts of emergency staff, she was pronounced dead.

6.67 Clare gave a history that Beth had slept through the night for the two days previously, which she considered unusual for her, and that she had eaten prior to her bedtime that evening. Beth was said to have woken at 21.30hours. Clare decided to get Beth reviewed at the Children's Emergency Department due to increased sleeping but stopped to get some petrol for her car. Whilst out in the car Clare noted that Beth did not seem to be breathing so she rang 111. Clare was advised in relation to

emergency care and an ambulance was dispatched. Despite best medical efforts Beth sadly, was found to be deceased.

6.68 The death of Beth, and the results of a further Home Office post-mortem examination of Alice, led the police to investigate both deaths. The investigation revealed that the cause of both deaths was believed to be third party interference with the normal mechanics of breathing. These findings initiated the investigation and subsequent prosecution of Clare.

7. Analysis of involvement

7.1 - Overview

7.1.1 This is an incredibly sad and unusual case. The murder of two children by a parent with just two weeks between the deaths is almost without parallel. The fundamental question that will be reflected on and indeed has been reflected on by all the professionals involved in this case is – Was there any indication at the time, or indeed in the past, that would have given any warning that the mother would kill one child and then go on to kill a second? If the answer is yes, then what could have been done to prevent the first and if not that, the second death?

7.1.2 This question has been considered in some detail by this review, but that pales into insignificance when compared to the reflection and consideration of every professional who was involved. The answer to the question is that there was nothing to indicate that Clare was capable of causing such harm to her children, both before and after the death of Alice. It therefore follows that in the given circumstances there was nothing that professionals could have reasonably done to prevent these untimely and tragic deaths.

7.1.3 That said, every case presents an opportunity for open and frank discussion and reflection to identify areas where improvements can be made. The below sections seek to identify some of these opportunities.

7.2 - Where concerns were raised, was risk effectively identified? Were assessments undertaken when required, and were they effective?

7.2.1 There were numerous concerns raised during the course of the case. Most of these concerns were raised by one family member regarding another. Often the same or similar concerns were raised with more than one agency. Some of the concerns could be considered to be extreme or outlandish and the challenge for agencies when assessing information is the ability to identify which information presented a real risk. There were, in fact, no concerns raised by professionals, but all were raised by family members.

7.2.2 In July and October 2015, Alice attended hospital with injuries to her head and nose respectively. There were reasonable explanations given regarding both occurrences. The first was followed up by the offer of Early Help, which was later declined by Clare. Walsall CS stated they were not made aware of the second, but their records would indicate that they were. The second visit was raised by the health visiting service with Clare, as she had not remained in the hospital to be seen by the doctor. During this discussion Clare gave a different account of how the injury was caused. This was not identified by the health visitor, although the hospital records would have been available.

7.2.3 These attendances at hospital were discussed at the practitioner event and it was considered that the offer of Early Help was appropriate. Had the knowledge of both incidents and potential differing account been recognised at the time it was felt that the circumstances warranted further exploration.

7.2.4 There were two s17 assessments undertaken by Walsall CS, the first in February 2016, which was initiated following concerns of domestic abuse in Clare and David's relationship raised by a member of Clare's family. The second was in June 2017, when there were a series of allegations made to the NSPCC. The Walsall CS IMR author comments that both these assessments were appropriately undertaken and at no point did the information gathered reach the threshold for consideration of a section 47 enquiry[3] or Child Protection Conference.

7.2.5 There could have been a more enquiring approach when some of the contacts were made by David and Ethan. This is identified in the Walsall CS IMR, with the author stating, '*Workers reflect on previous referrals in their summation of screening activity but not always with a sense that there may be a cumulative effects for the children and a wider sense of professional curiosity is not apparent'*. Whilst this may not have altered the outcome, it would have allowed a better understanding of the wider family dynamics and evidenced a more professionally curious approach.

7.2.6 When offences were disclosed, they were generally recognised appropriately as domestic incidents and following this appropriate support was offered to Clare. When Clare made the allegation of assault, she was appropriately afforded independent support. David, the alleged offender, was arrested for the assault and public order offences which flowed from the assault allegation. The domestic nature and risk presented by the offences was recognised and appropriate bail conditions were put in place. On David's conviction for the domestic related assault and public order offences, Clare was supported to obtain a restraining order. Breaches of the order

[3] Section 47 investigation - A section 47 enquiry is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of or likely to be suffering significant harm – Working Together 2018

were appropriately followed up. The case was appropriately referred to and heard at MARAC.

7.2.7 When the assault offences were reported and dealt with, consideration should have been given by West Midlands Police to the Threshold guidance to inform sharing the information with Walsall CS. The first notification they had was through the subsequent MARAC meeting. Although David was no longer in the family home, the allegation involved the offences of five assaults committed there, where Alice was resident. At this time, Clare was pregnant with Beth. This was also the first indication that Ethan was involved in the household and David had assaulted Ethan in the presence of both Clare and Alice. The sharing of the information would have allowed for consideration of these factors and what risks were presented by the allegations made and new relationship.

7.2.8 In October 2017, Ethan reported to West Midlands Police and Walsall CS concerns over a bruise to Alice. Both West Midlands Police and Walsall CS visited Clare and saw the children, whilst this is preferable to no response at all, a more joined up approach would have been desirable. A concerning issue is that the Walsall CS records indicate that both children were seen and there is no mention of a bruise. The police records indicate that on their visit a bruise is noted on Beth's head. Clare gave an explanation that Beth had fallen, which was accepted. This lack of clarity in indicative of the uncoordinated action between the agencies. The West Midlands Police IMR author makes the point that the report should have been recorded as child abuse non crime, ensuring it would have been directed to MASH and been triaged more appropriately and a multi-agency approach considered. This would have given the opportunity for consideration of a medical opinion on the bruise seen on Beth and further investigation. There was also a slight difference in the information given by Ethan to West Midlands Police and Walsall CS. A more coordinated approach would have allowed for this to be more effectively investigated.

7.2.9 When interviewed for this review Ethan states he informed both West Midlands Police and Walsall CS that he had witnessed Clare striking Alice whilst bathing her and Alice striking her head on a tap. Ethan goes onto say that after making the reports he received no result from West Midlands Police or Walsall CS. It is clear that this incident warranted a more coordinated and investigative approach and would have benefited from more dialogue with Ethan.

7.2.10 In November 2017, the Walsall CS social worker attempted to visit Clare, but she had moved. There was information that Clare had left the property in an unsatisfactory condition and that there had been complaints about noisy parties and anti-social behaviour. When Clare was seen by the social worker she was challenged with this information and stated it was not true.

7.2.11 All the indications were that Clare was acting protectively towards the children and any risk or threat emanated from David and more latterly Ethan. This was the view of CAFCASS when they recommended the s37 assessment, that it was more focused on David and the alleged domestic abuse rather than any risk that Clare presented. This was borne out by the Walsall CS s37 report, which although not completed before Alice's death, it was to recommend staged supervised contact by David. There were no concerns raised regarding Clare as a parent.

7.3 Was the cumulative effect of concerns raised considered in particular the presentation of Alice at hospital and the presence of domestic abuse in the family?

7.3.1 The cumulative effect of the concerns being raised was considered appropriately when a Child and Family Assessment was undertaken in June 2017, the Walsall CS manager specifically referred to this when giving the rationale and this should be viewed as good practice.

7.3.2 There is good evidence of the risk and effects of domestic abuse being considered at various stages. The initial concerns of the abuse in the form of controlling behaviour being displayed by David, which manifested in Clare being isolated was raised twice by a member of Clare's family. On two occasions this was followed up and Clare denied that there was abuse in the relationship. It would not be unusual for a victim of domestic abuse to deny the abuse is taking place, particularly if there is coercion, but nevertheless support was offered to Clare.

7.3.3 Clare spoke about the abuse by David and more latterly Ethan, when she was separated from them, so any support was focused on ensuring that any risk to Clare and children was managed.

7.3.4 Alice was first taken to hospital on 2nd January 2018, with a seizure, after examination she was allowed home. Alice was re-presented at the hospital on 4th January 2018 and remained in hospital until 8th January 2018. She was allowed home with no follow up, having been diagnosed with a lower respiratory tract infection. All the indications were that Alice was suffering from a medical condition. Even after Alice's death an initial post-mortem did not give any indication that there should be any concerns. There were no other considerations, cumulative or otherwise which would have given cause for concern, at this stage. Clare was viewed as having acted protectively in moving areas to remove the children and herself from the threat of domestic abuse.

7.3.5 The panel for this review considered in some detail the medical information which was available at the time that Alice was in hospital between 4th and 8th January 2018, including the information which was subsequently gathered for the purposes of the prosecution. This information supported the view that there was no information available, at the time and without the benefit of hindsight, which gave any indication that the illness suffered by Alice was anything more than a medical condition.

7.3.6 During the course of this case there were a number of factors which if considered together may have given rise to a more enquiring approach. There were Alice's attendances at hospital with the bumps to her head, on one occasion a differing cause for the injury was given by Clare. The alleged occurrence of domestic abuse in the relationship with David. Allegations that Clare was leaving the children with strangers and driving unqualified with the children, Clare being difficult to contact by Walsall CS for the s37 report and the manner in which Clare presented at Rugby Borough Council for housing. Professionals when considering the history of a case need to apply an investigative mindset and be prepared to 'think the unthinkable'.

7.4 Was information appropriately shared between agencies, particularly when the family moved between areas?

7.4.1 In most areas' information sharing was appropriate, the allegation of assault has already been identified as an area which may have benefited from wider awareness. At the beginning of October 2017, Clare reported to West Midlands Police that she believed that David was going to harm one of her family members, this particular conflict was centred around an impending first hearing at the family court. David was seen and denied that this threat had ever been made. Considering the ongoing animosity and tension, other agencies could have been aware of this to assist with future assessment and to manage any potential risk at future hearings.

7.4.2 In early November 2017, the social worker undertaking the s37 assessment spoke to Clare who disclosed that she believed that David was going to harm her and take Alice. This disclosure was not explored fully enough to understand whether it had any basis and it was not shared with other agencies.

7.4.3 Agencies had received information which had been proven to be inaccurate and, in some cases, implausible. There was also an indication that Clare had been involved with Ethan in attempting to manufacture information to incriminate David. This said, all agencies need to be able to accept information on the basis that it is correct, or potentially correct until there is information to negate or disprove it.

7.4.4 In September 2017, there were indications that Clare and the children would move to escape domestic abuse by David. In November 2017 this was confirmed although Clare was obtuse regarding her intentions. At this time the s37 assessment had been started by Walsall CS and on receipt of the information that the family were in Warwickshire best practice would have been to notify Warwickshire CS and this is recognised in the Walsall CS IMR.

7.4.5 Guidance is provided by the West Midland Regional Safeguarding Network policy on 'Protecting Children who move across Local Authority borders'[4]. There was some discussion as to whether Warwickshire were party to this guidance, but it is clear that whilst they are not party of the network, they are party to this particular policy. Nevertheless, included or not, the spirit of the guidance should be applied. Whilst the guidance is silent, specifically on cases being assessed under s37, it does identify cases which would be considered as a concern such as '*cases where there is a move which disrupts an assessment or planned work with a child or their family which is likely to identify safeguarding concerns or address a child's needs or evidence of repeated assessments.'*

7.4.6 The guidance is explicit on s47 enquiries, with which a parallel may be drawn and states that when a family moves during the course of a s47 investigation a strategy meeting should be convened within 72 hours to include the original and receiving authorities. It may be that the guidance should be reviewed to be explicit on s37 cases and this was made subject of a recommendation in the Walsall CS IMR. The same IMR also identifies that it would have been best practice for Walsall CS to inform Warwickshire CS of the presence of the family in their area.

7.4.7 Once the involvement of Walsall CS had been established the discussion between them and Warwickshire CS was that Walsall CS would hold the enquiry as the case was open to them. In January 2018, a social worker from Walsall CS visited Clare for the purposes of continuing the s37 assessment but informed Clare that the referral made by Ethan would be dealt with by Warwickshire CS. Warwickshire CS had in fact closed the case and informed the referrer, that Walsall CS would be dealing with the family. This indicates that there was continued confusion over who held responsibility for the case.

7.4.8 As there was no notification of the move between the two authorities, other agencies such as the health visiting service were not aware of the move and the fact that there should be discussion with their counterparts in Warwickshire.

[4] West Midland Regional Safeguarding Network policy on 'Protecting Children who move across Local Authority borders' - westmidlands.procedures - children who move across local authority

7.4.9 Following Alice's death a child death meeting/strategy meeting was convened. The meeting was convened in a timely fashion and it was well attended by professionals. The sharing of information was appropriate, and the discussion focused on the areas of risk on what was known from the case. The practitioner discussion was reflective on whether there could have been more of a focus on the hypothesis that Clare caused harm to Alice as a starting point, with information and evidence used to discount this. It was generally accepted that professionals in this case would use the experience from the case to adopt a more healthily sceptical but measured approach, but to introduce any direct measure for all cases was difficult and potentially detrimental.

7.4.10 The child death meeting was effectively chaired by a consultant paediatrician; this was the same paediatrician who had seen Alice during her stay at the hospital. This professional reflected that in future any meeting should be chaired by a professional not previously involved in the case. Although it is unlikely that the outcome would have been different in this case it does allow for detached challenge and fresh perspective. This was considered at the time, but resource and capacity did not allow for a paediatrician not involved in the case to be available.

7.4.11 The Warwickshire Safeguarding Partnership 'Best Practice Multi-Agency Protocol – Sudden Unexpected Deaths in infants and children under 18' (SUDC)[5] in relation to the child death meeting states that *'the lead paediatrician or their deputy should chair the meeting'.* Consideration, where the paediatrician has been involved in the case, should be given to using an appropriate deputy to chair the meeting. The Safeguarding Partnership's may wish to review the current guidance to reflect this.

7.4.12 The meeting held was both a child death review meeting and a strategy meeting. If the meetings are to be held together, it was felt that there should be a clear demarcation between the meetings. The guidance states that where the child death review meeting identifies child protection concerns it should become a strategy meeting, where this happens the recording should be clear to reflect this.

7.5 Following Alice's death was there appropriate consideration of the ability of Clare to care for Beth?

7.5.1 At the time of Alice's death, as far as professionals were concerned, they were dealing with the tragic death of a child, with no suspicious causes and a young grieving mother who required support. There has been no information revealed by

[5] Best Practice Multi-Agency Protocol – Sudden Unexpected Deaths in infants and children under 18 (SUDC) - https://www.proceduresonline.com/covandwarksscb/files/sudi_document_wark.pdf

this review or seen elsewhere, which suggests, that at that stage the case should have been viewed differently.

7.5.2 At the child death review meeting which followed Alice's death there is good evidence that appropriate information sharing took place, there is also evidence of professional challenge, with discussion about Clare's apparent reticence to effectively engage in the s37 assessment process. The meeting agreed that there should be a s17 single assessment undertaken. This was to assess the situation further, whilst supporting Clare through the loss of her eldest child, to provide emotional and practical support to enable her to continue to care for Beth.

7.5.3 An experienced social worker was allocated to the assessment at the earliest stage and Clare and Beth were supported by a family support worker. There was regular contact with Clare in the following weeks, who is said to have engaged well to achieve practical support.

7.5.4 During the first weeks of the assessment the focus, understandably in the circumstances, was Clare and Beth. The wider family network and Clare's previous partners were not spoken to at this stage, but this is not unusual in the early stages of assessment.

7.5.5 There was management oversight which reported *'the allocated workers had good communication with colleagues, other agencies and the family. They were considered to be child focused, organised, visited regularly, provided good quality emotional support'* (Warwickshire CS IMR). Although it was recognised that there was no recorded management oversight for the family support worker.

7.5.6 Historically there had been concerns raised regarding Clare's parenting of Alice and Beth, but these were made by either David or Ethan, in the context of conflict and other allegations, which had been discounted by other evidence. More latterly, Clare was seen as being protective in moving from the Walsall area, where the risk to her and the child was reduced.

7.5.7 The support afforded to Clare and Beth, after the death of Alice appears appropriate in the circumstances. There was no information or indications, at the time, that Clare posed a threat to Beth.

8. What are the learning points from this case?

8.1 Where a family moves between areas the new authority and relevant partners need to be informed. A decision needs to be made on when this is undertaken if the move is believed temporary according to the risk, but where there is an ongoing assessment or investigation this should be undertaken as soon as knowledge of the move is received.

8.2 Where possible more information should be achieved and explored when referrals come to the MASH to better understand the nuances of the referral. An example of this is the referral received from Rugby Borough Council Housing in January 2018. The referral was extremely intuitive, raising concerns about Clare's attitude about Alice's admission to hospital, describing it as 'blase'. When this was further investigated by police as part of the murder investigation, it was recognised that the referral information did not fully convey the concern of the referrer. This raises a learning point on ensuring that referrals fully articulate the views of the referrer. A point is also made by the author of the Walsall CS IMR that a more professionally curious approach by the Walsall MASH would have added to the richness of the information and understanding of the family.

8.3 Professionals were confronted with a situation where there was conflict between parents and serious allegations being made, which were being investigated. Some of the concerns raised about Clare by both David and Ethan, could be easily refuted. The danger is that professionals can be prone to dismiss other information in the same vein. Professionals need to keep an open mind on all concerns being raised until there is clear information which negates it. The rationale for negating the concern needs to be clearly recorded.

8.4 Following Alice's death, all the information available from all professionals led to the belief that the death was unexplained as opposed to being suspicious. That her death resulted from medical reasons as opposed to third party intervention or trauma. On reflection at the practitioner's discussion, professionals who had been involved in the case felt that from this case they would exercise a more 'healthy scepticism' and explore the hypothesis that a parent may have caused the harm, to be able to develop it further or discount it. In this case it is difficult to see that, on the information available at the time, an assertion that Clare had caused the death would have been reached had this hypothesis been fully explored but having a mindset of 'thinking the unthinkable' when approaching child death or indeed child protection discussions is appropriate.

9. Recommendations

1. The Walsall and Warwickshire Safeguarding Partnerships should seek to: -

(a) Encourage professionals to adopt an investigative, questioning and professionally curious approach when considering the history of a case.

(b) Raise awareness with agencies that when making referrals to the MASH, they ensure that the referral accurately fully reflects the concerns of the referrer and that the MASH clarifies any information that is not clear.

2. The Walsall and Warwickshire Safeguarding Partnerships should be assured that all single agency actions identified by agencies in this review have been appropriately implemented.

3. The Walsall and Warwickshire Safeguarding Partnerships should seek reassurance that the West Midland Regional Safeguarding Network policy on 'Protecting Children who move across Local Authority borders' is understood and adhered to. They should consider reviewing the policy to include assessments undertaken under s37 Children Act 1989.

4. The Walsall Safeguarding Partnership should be assured that GP's are clear on the pathways and procedures for making timely referrals to Children Services.

5. The Walsall Safeguarding Partnership should be assured that where there are offences reported and investigated by West Midlands Police, that have an impact or are likely to have an impact on children (in line with the Right Help Right Time guidance), that a referral to Children's Social Care (MASH) takes place.

6. The Warwickshire Safeguarding Partnership should be assured that developments are made within the Multi-Agency Safeguarding Hub to ensure effective handing of referrals namely: -

(a) The MASH referral from to be amended to include the details of the person competing each section.

(b) To improve practice by ensuring that where the referral is out of timescales the reasons why are recorded.

7. The Warwickshire Safeguarding Partnership should consider the 'Best Practice Multi-Agency Protocol – Sudden Unexpected Deaths in infants and children under 18 (SUDC)' and whether guidance should be given to ensuring that Child Death Review Meetings are chaired by an appropriate professional not previously connected to the case.

8. The Warwickshire Safeguarding Partnership should work with partners to develop a process that where child death review meetings and strategy meetings are held together that there is a clear demarcation between the meetings and recording reflects this.

9. In the context that the deaths of Alice and Beth could not have been predicted, The Walsall and Warwickshire Safeguarding Partnerships should seek to use this review to convey to professionals that they should adopt a healthily sceptical approach to developing a hypothesis and considering all alternatives, despite them being 'unthinkable'.

Appendix A

Single Agency Recommendations

Walsall Children Services
Child Care Procedure Manual to be updated to included guidance on considering the social media use by parents during assessments
West Midlands regional Child Protection procedures to be reviewed to explicitly include reference to Section 37 reports
Continue to work with Walsall LSCB in embedding Professional Curiosity framework
Legal Services and Team Managers to be reminded that requests for Sec37 reports should be accompanied by a safeguarding letter from CAFCASS. If this is not received an explicit request should be made to CAFCASS
Warwickshire Children Services
Improved recording of Management Oversight on the case recording
Increased risk analysis in child death meeting.
Warwickshire Police
Compiling a checklist of agencies who would normally hold information on a family. The purpose of the checklist would be to prompt the SIO/OIC to consider all relevant sources of information in advance of any initial strategy discussion.
The development of a peer review network. The aim of the network would be to meet the SIO in the days following a SUDIC to act as a critical friend to ensure that all main lines of enquiry have been considered. The network would also provide reassurance and support to the SIO.
The development of a suspicious factor template to enable the SIO to contemporaneously record factors that could ultimately impact on decision making.
Form a police child death review group to share learning and best practice.
South Warwickshire NHS Foundation Trust (SWFT)
Undertake a review of the delay in the process of Paediatric Liaison Notification within the Health Visiting Service

The Trust to undertake an audit to review compliance with the Health Visiting Standard Transfer in to Area Visit (Warwickshire Health Visiting Standards 2017 – 2020) SWFT V4 2019
Learning themes from this case to be used in Level 3 Training
All staff to be reminded of checking meeting minutes and addressing inaccuracies in a timely manner.
Walsall Healthcare NHS Trust
Seek assurance that children that are triaged in ED and are sent to Urgent Care are appropriate and not safeguarding concerns
Improved communication of outcome of assessments between social workers and Health practitioners
Review of the Paediatric Liaison Nurse role to include Urgent Care
Black Country Womens Aid
Ensure that Notifications go to all agencies involved in supporting the family
BCWA is an adult focussed service and therefore BCWA needs assurance that an agency is assessing the children and working with the DVA service to ensure a whole family approach to protection and support
BCWA make victims aware of local DVA services and seek consent for continued support
West Midlands Ambulance Service
WMAS will continue to raise awareness of abuse and neglect, and all frontline practitioners to be trained to Level 3 in Safeguarding Adults and children to strengthen knowledge, understanding and information sharing via referrals within WMAS.
NHS Walsall CCG
Bruising and Injuries in Babies and Young Children (Learning Points, Paragraph 4) – Ensure that GPs understand the importance of bruising and other signs of trauma in babies and young children
To explore the response to GP Practices from A and E with the Head of Safeguarding at Walsall Healthcare Trust.
To ensure that GPs receive feedback and timely notification of meetings and child protection conferences

Safeguarding Training – To improve understanding of other agencies roles Explore opportunities for GP attendance at multiagency training
MARAC – To review the process with the MARAC Coordinator for informing GPs and including GPs in information gathering
Good Practice - Build on good practice with an audit of GP Practices use of Cause of Concern meetings and membership. Explore how information about families where there are safeguarding concerns is shared across Practices.