Lessons Learned

Warwickshire Safeguarding

Alice and Beth's Story…

Alice and Beth were born outside of Warwickshire to Clare and David. Clare and David's relationship ended due to reports of domestic abuse. Clare then went on to form a relationship with Ethan which also came to an end.

Shortly after her relationship ended with Ethan, Clare moved to Warwickshire stating she was fleeing her previous partner. At this point, Alice was 3 and Beth was a little over 1 year old. Prior to the move Alice and Beth were known to their local Children's Services due to concerns raised separately by David and Ethan regarding Clare's lifestyle and her care of the children. At the time of Clare's relocation to Warwickshire, the other local authority's Children's Services had already initiated a section 37, following concerns over David's volatile behaviour at a family court hearing regarding contact with Alice.

Shortly after moving to Warwickshire, Alice was taken to hospital on two occasions after Clare had reported she had suffered seizures. On the second occasion Alice was admitted and remained in hospital for treatment of a respiratory infection. Alice responded well to treatment and was discharged four days later. Seven days after her discharge, Clare called for an ambulance stating that Alice had suffered another seizure. Alice was taken to hospital where she was pronounced dead.

A little over two weeks later, Clare contacted the NHS 111 line and stated that Beth appeared drowsy. Paramedics attended the scene and found Beth to be unconscious. Emergency care was provided at the scene and Beth was conveyed to hospital where she was pronounced dead.

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 Alice and Beth's deaths was believed to be third party interference with the normal mechanics of breathing.

What we have learned…

- Where possible more information should be achieved and explored when referrals come to the Multi Agency Safeguarding HUB (MASH) to better understand the nuances of the referral. An example of this is the referral received from the local housing team in 2018. The referral was good practice and extremely intuitive, raising concerns about Clare's attitude about Alice's admission to hospital, describing it as 'blasé'. When this was further investigated by police as part of the murder investigation, it was recognised that the referral did not fully convey the concern of the referrer.
  Learning for Practice: All professionals should exercise professional curiosity when receiving referrals. Do not be afraid to go back to the referee and ask more questions or seek clarification in order add to the richness to the information received and gain a better understanding of the family.

Lessons Learned (cont.)

Warwickshire Safeguarding

What we have learned (contd.)…

- Where a family moves between areas the new authority and relevant partners need to be informed.
  Learning for Practice: 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.
- 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.
  Learning for Practice: 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.
- 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.
  Learning for Practice: Professionals need to be confident to voice concerns and adopt the mindset of 'thinking the unthinkable' when approaching child death or child protection discussions.

What do I need to do…

Advice for professionals

1. *Familiarise yourself with the West Midlands Regional Safeguarding Networks Protecting Children who Move across Local Authority Boarders procedure.*
2. *Read Warwickshire Safeguarding's 7 Minute Briefing on Professional Curiosity.*
3. *If you have concerns about a child, call Warwickshire's Children's Social Care who will be able to discuss your concerns further and help to establish if a referral needs to be made to the MASH.*

Advice for communities

1. *Safeguarding is everyone's responsibility. Knowing the signs of child abuse can make it easier to spot and take action. Visit the NSPCC website for more information on the potential signs.*
2. *Talk about or report your concerns to Warwickshire Children's Social Care.*