Learning from the Serious Case Review – Baby L

A summary of the case reviewed

This serious case review was carried out following the death of Baby L aged eleven weeks. Baby L died as a result of significant internal injuries and multiple fractures, his father was charged with murder, convicted of manslaughter and is serving a prison sentence.

Baby L was born in Oxfordshire and has one older half sibling. His mother had been known to Thames Valley Police since 2005 due to a significant number of incidents of domestic abuse from more than one partner, as well as her being identified as the perpetrator on at least one occasion. Children's social care was aware of some (but not all) of these incidents; none were recorded in GP records.

Health professionals working with Mother during her pregnancy with Baby L were unaware of a number of stresses in the family including past experience of domestic abuse and threat of eviction. Following Baby L's birth, Mother and Father moved into accommodation together in Oxfordshire but twenty miles from their home area.

The injuries to Baby L were reported by Father who called an ambulance. Baby L was taken to two other hospitals outside of Oxfordshire. The immediate focus in hospital was on saving his life and the review has explored the degree to which effective safeguarding measures were in place both in respect of parental contact with Baby L and the protection of his half sibling.

How was learning achieved?

This review was carried out by an independent lead reviewer working with a team of professionals representing the agencies who had worked with Baby L. The review gathered together information about *what* happened in the case using individual agency chronologies and then sought to understand *why* actions were taken and any lessons for practice through discussions with practitioners who had worked with Baby L and his family.

Baby L's family were offered an opportunity to contribute to the review but the only person who wished to do so was Baby L's father.

Themes in common with other case reviews within Oxfordshire

Unlike many reviews, this case did not include extensive involvement by statutory agencies with Baby L's family. Two themes that do resonate with other reviews are:

- The need for curiosity about the families past history, relationships and current circumstances that moves beyond a reliance on self-reported information.
- The importance of thinking carefully about the role of the father in the family system.

Learning Points for practitioners

Oxfordshire

- Assessments in health organisations may be based mainly on self-reported information. Think carefully about whether there is additional information about family history available within health records for siblings, half siblings or parents that should be used to inform the assessment.
- Remember to include information about father's history in family health needs assessments.
- Think about the implications of an accumulation of domestic abuse incidents even where they are with different partners.

Oxfordshire & neighbouring areas

- When a child is admitted to hospital out of hours with serious injuries that may be non-accidental, practitioners in social care, police and health organisations should make sure that a strategy discussion takes place in order to plan next steps.
- Ambulance staff have an important role to play by informing police immediately where a child has experienced a paediatric cardiac arrest.
- There are challenges in managing serious injuries to children across local authority borders and practitioners need to be mindful of potential differences in custom and practice as well as being supported by effective protocols.

Key messages for the safeguarding system

Oxfordshire

- GPs are an important part of the safeguarding system and need to have information about domestic abuse incidents

If you do one thing take the time to...stop and think whether you are basing your assessment and understanding of what is happening solely on self-reported information.