



# **Oxfordshire Safeguarding Children Board**

## **Serious Case Review Baby L**

### **Report Author**

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## 1 INTRODUCTION

- 1.1 This serious case review has been carried out following the death of Baby L who died age eleven weeks, his father has been convicted of his manslaughter.
- 1.2 Baby L was born and lived in Oxfordshire with his mother, father and half-sibling. On 16th November 2014, South Central Ambulance Service received a call from a male (now known to be his father) reporting that his baby was not breathing. Baby L was taken to Great Western Hospital in Swindon Wiltshire and later transferred to a hospital in Bristol where he died on 18<sup>th</sup> November 2014. He was found to have significant internal injuries together with multiple fractures to his body and his father was charged with his murder. On 5<sup>th</sup> October 2015, a jury found his father not guilty of murder but guilty of manslaughter and he was sentenced to nine years in prison.
- 1.3 As a child had died and abuse was known to be a cause of death, this case met the criteria for a serious case review<sup>1</sup> and the chair of the Local Safeguarding Children Board made the decision to carry out the review on 2<sup>nd</sup> December 2014. An independent lead reviewer, Jane Wonnacott, was appointed to conduct the review and write this report.
- 1.4 Due to the ongoing criminal proceedings this report was not completed until April 2016.

## 2 REVIEW PROCESS

- 2.1 The lead reviewer worked with a team of senior professionals from within Oxfordshire to carry out the review. The full details of the review process and the lead reviewer are set out in appendix 1 of this report.
- 2.2 The period under review is from 1<sup>st</sup> December 2013 (Mother's pregnancy with Baby L) through to his death on 18<sup>th</sup> November 2014.
- 2.3 Information about agency involvement with the following family members informed this final report.
  - The mother of Baby L (known throughout this report as Mother)
  - The father of Baby L (known throughout this report as Father)
  - Mother's first child (known throughout this report as Half Sibling)
  - Baby L
- 2.4 All organisations which had contact with these family members were asked to complete a chronology and brief summary of their involvement including any relevant information prior to the review period. The lead reviewer then met with key staff along with a member of the review team in order to clarify what happened, factors that influenced practice at the time and any lessons for the future. The only exception to this process was the involvement of staff from Thames Valley Police. The policy of

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<sup>11</sup> HM Government (2013) *Working Together to Safeguard Children* was in force at the time of death. This has now been superseded by guidance dated March 2015

Thames Valley Police is that a member of their major crime investigation review team completes an individual management review and as part of this process conducts interviews with staff involved. Their individual management review has informed this final report.

2.5 Organisations that have contributed to this review are:

- GP records for Baby L
- Great Western Hospitals NHS Foundation Trust
- Thames Valley Community Rehabilitation Company
- Oxfordshire children's social care
- Oxfordshire Early Intervention Service
- Oxford City Council
- Oxford Health NHS Foundation Trust (health visiting)
- Oxford University Hospitals Foundation Trust (midwifery)
- Schools attended by Baby's L's half sibling
- South Central Ambulance Service
- South Oxfordshire and Vale of White Horse District Councils
- Thames Valley Police
- University Hospitals Bristol NHS FoundationTrust

2.6 Mother and Father were both offered an opportunity to contribute to the review. The lead reviewer met with Father and his comments, alongside other information received by the review team, have informed this report. Mother was contacted via letter and telephone. As no reply was received the review team respected her apparent wish not to be involved in this review process.

### **3 CASE NARRATIVE AND EVALUATION OF PRACTICE**

#### **History prior to Mother's pregnancy with Baby L**

3.1 Baby L was the second child of Mother and the first child of Father.

3.2 The review received no background information on Father prior to the review period apart from an indication that he may have experienced some disrupted relationships as a child due to the separation of his parents.

3.3 Mother had been known to Thames Valley Police from 2005 mainly due to incidents of domestic abuse. There were eighteen recorded incidents from more than one partner, many of which took place after the birth of Mother's first child. In relation to these incidents, there were inconsistencies in relation to the communication and recording of information within police and children's social care:

- Some were recorded by Thames Valley Police as sent and recorded as received by children's social care,
- Some were sent and recorded as sent by Thames Valley Police but not recorded as received by children's social care,

- In some cases there is no record of information about the incident being sent by Thames Valley Police or received by children's social care.
- 3.4 In the majority of incidents Mother was the victim of domestic abuse although on at least one occasion she was identified as the perpetrator.
- 3.5 Even though not all incidents of domestic abuse were recorded within children's social care, there was an opportunity for social workers to consider the accumulation of concerns in respect of domestic abuse and its impact on Half Sibling. Had an assessment been done that included other agencies it may have provided a basis for understanding potential vulnerabilities within the family at the point that Mother became pregnant with Baby L.
- 3.6 Since these incidents took place the MASH<sup>2</sup> system is now operational which means that there is a greater consistency in the way that information is shared and evaluated.
- The MASH team manager from children's social care meets regularly with a domestic abuse risk assessor from Thames Valley police to dip sample domestic abuse incidents that have not been shared.
  - There is regular communication between the relevant detective inspector and team manager in children's social care to review the domestic abuse pathway.
  - Risk assessors within MASH have access to children's social care records to identify whether the family are known or have been known.
- 3.7 Mother's GP records contain no information about domestic abuse and this influenced the quality of information sharing and assessment later on during Mother's pregnancy with Baby L. Domestic abuse notifications are sent to health visitors but not all share information systems with GPs and therefore there is no consistent and reliable information sharing route to GPs when a domestic abuse incident has occurred. The review team discussed the challenges associated with notifying GPs of domestic abuse incidents and this will need to be considered as part of an ongoing review of the effectiveness of the MASH system.
- 3.8 One incident of note is in February 2012, when Half Sibling's school contacted the police concerned that he/she was not in school and that Mother had been seen with a bruised eye the previous week. Before the police could attend, Half Sibling had arrived at school and the safeguarding lead advised the police that there was no longer any need for police involvement. Neither Thames Valley Police nor the school contacted children's social care and no action was taken regarding Mother being a potential victim of domestic abuse. It is significant that Half Sibling's school were unaware of any of the previous reports of domestic abuse and therefore did not see Mother's bruise in this context. The review team were informed that schools are now routinely informed of incidents of domestic abuse.

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<sup>2</sup> MASH is the Multi Agency Safeguarding Hub: a multi-agency team which identifies risk to vulnerable children and adults

- 3.9 The police call taker assumed that the school would be best placed to identify any concerns within the family and take the necessary action whereas, at that time, the school's safeguarding arrangements were not sufficiently robust. A new safeguarding lead in 2014 recognised gaps in the system and these were confirmed by an external audit. Action has now been taken to improve all aspects of the school's safeguarding practice and the most recent Ofsted inspection identified that the care given to the most vulnerable children is good.

#### **Summary evaluation: history prior to Mother's pregnancy with Baby L**

There is evidence from police and children's social care files that before her pregnancy with Baby L, Mother was a victim of domestic abuse from more than one partner and also that she had the potential for volatility and aggressive behaviour towards others. There were opportunities within children's social care to undertake an assessment of Mother's situation both in respect of her own vulnerability and the welfare of Half Sibling. A better use of chronologies, rather than cutting and pasting information from police notifications (which were often difficult to understand due to the use of jargon) would have helped in identifying patterns that needed further assessment.

The GP was unaware of any domestic abuse incidents and the fact that Half Sibling's school were not aware of any incidents of domestic abuse meant that they did not consider Mother's bruised eye in this context. A system for notifying schools is now in place and the Safeguarding Children Board will need to be assured that the domestic abuse information sharing system is effective for both schools and across the partnership.

#### **Mother's pregnancy and birth of Baby L**

- 3.10 Mother (age 26) and Father (age 20) met at a family party in October 2013 and Mother became pregnant soon afterwards. At this time Mother and Father were living separately, Mother in privately rented accommodation and Father in his family home with his young siblings.
- 3.11 The first significant incident in relation to Father is a conviction in December 2013 for a drugs related offence. He was given a Community Order with a curfew requirement, electronic tagging, an unpaid work requirement, a victim surcharge and forfeiture and destruction of the drugs. His offender manager became aware in January 2014 that his partner was pregnant but at that stage his unpaid work was noted to be "excellent" and there was no reason to believe that he would pose any risk to a child.
- 3.12 When Mother became pregnant with Baby L she was "booked" by the midwife on 31<sup>st</sup> January 2014, and from then received universal ante natal care. It was good practice that the midwife accessed GP records but the assessment was compromised due to there being nothing in the records to indicate any previous concerns regarding domestic abuse. Mother reported that she was in full time work with no housing

problems; she responded negatively to the routine enquiry regarding domestic abuse and the pregnancy was therefore deemed to be low public health risk.

- 3.13 Father is named on the booking form. During the pregnancy, the midwife became aware that he was on community service because he asked for a letter to his offender manager explaining that he had missed unpaid work due to an antenatal appointment. In the area of Oxfordshire covered by that midwifery team, community service would not be particularly unusual and this therefore did not raise any alarm bells.
- 3.14 In May 2014, Mother and Half Sibling were discussed at a “family at risk of homelessness meeting” attended by the community health practitioner for housing need<sup>3</sup>. The meeting noted that Mother had debts, had declined a referral to citizen’s advice bureau, and was awaiting the bailiffs. There is no indication that Mother’s pregnancy was known to any professional including health visitors.
- 3.15 On 4<sup>th</sup> June 2014 children’s social care received a notification from housing that Mother had been found intentionally homeless and was being evicted from privately rented accommodation. The notification was made because Mother had a child but children’s social care was not aware that she was pregnant. A letter was sent by children’s social care giving advice which was an appropriate response in the circumstances.
- 3.16 It was not until Mother’s 34 week appointment that the midwife recorded that she planned to move in with her sister after the baby’s birth. The midwife was not aware that this was because she was at risk of homelessness due to rent arrears as Mother said the move was because she needed support from her sister.
- 3.17 When the health visitor received notification of the pregnancy from the midwife Mother was scored as low risk<sup>4</sup> and at that time, due to capacity, health visitors were only able to do ante natal visits to mothers identified at risk levels 3 and 4. Previous concerns about domestic abuse would have been in Half Sibling’s paper notes and therefore not available to the health visitor for Baby L. The situation is now different as changes to commissioning arrangements now require five key visits by a health visitor during the child’s early years including one pre-birth.
- 3.18 When Baby L was born, the health visitor received an electronic notification and visited Mother at her sister’s house. Father was present at this visit and the health visitor could not therefore enquire about any concerns about the relationship including domestic abuse. Father was described to this review as being engaged, interactive and attentive to the baby. They informed the health visitor that they were being housed together in accommodation twenty miles away. The health visitor was rather concerned that Mother and Father were being re-housed so far away from their support systems but noted that they were excited to be moving in together. Father had obtained a full time job by this point and the location of the new

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<sup>3</sup> A health professional employed by Oxford Health, whose specific job is liaising with housing. The practitioner would routinely share information with health visitors.

<sup>4</sup> This risk rating was from the midwifery health and social assessment

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accommodation would involve him being out of the house for 12 hours a day. However, given the positive interaction with the baby by both parents, the health visitor did not believe there was any concern about their ability to care for the baby.

- 3.19 The main issue at this stage was an inability for health practitioners to have a holistic view of the family due to information recording systems within Health and a focus on an individual mother and baby rather than the family as a whole. Linked to this is reliance on self-report rather than an objective overview of previous information within the records. Other serious case reviews<sup>5</sup> have highlighted the problems for health visitors where they undertake new birth visits without easy access to information about previous children and in this case it would have been helpful to understand any potential vulnerability associated with the background of Mother and Father.
- 3.20 Baby L was taken to the GP on 11<sup>th</sup> November 2014 with a history of vomiting but there were no other symptoms and consequently a full physical examination was not carried out. The GP advised to bring him back within two days if he had not improved. Although Baby L may have sustained some injuries by the time of the visit to the GP there was no reason for the GP to have identified any cause for concern from the presenting symptoms.

#### **Summary evaluation: Mother's pregnancy and birth of Baby L**

During face to face meetings with parents there was no reason for professionals to have any cause for concern. Both Mother and Father presented as caring parents who were able to care for an infant. The impression is that Mother is a private person who does not readily share all aspects of her life with others and the systems across health organisations meant that no one professional had a full picture of the family circumstances.

- The midwife was not aware of the impending eviction.
- When health visitors were told of the impending eviction they did not know that Mother was pregnant.
- The GP records which were accessed by the midwife did not contain information about previous domestic abuse.
- The Health visitor for Baby L did not know of the domestic abuse incident which was noted within Half Siblings file.

It is unlikely that a more joined up approach to information sharing would have changed the outcome of this case but it is possible that more consideration could have been given to the combination of potential stressors including:

- living in a very different type of community away from family supports,
- Father working long hours away from home,
- a relatively new parental relationship,
- Mother's history as a victim of domestic abuse,
- evidence of Mother's own volatility in interaction with other adults,
- possible issues in relation to financial management that had led to previous rent arrears.

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<sup>5</sup> For example Coventry LSCB (2014) *Daniel Pelka Deeper Analysis*



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## Agency actions following injuries to Baby L

- 3.21 The sequence of events from the time that Father called the ambulance on 16<sup>th</sup> November 2014 is significant as it raises a number of issues that had a potential impact on protecting Half Sibling and the criminal investigation into the death of Baby L. These issues are:
- communication between the ambulance service and Thames Valley Police,
  - the response of Swindon Hospital once non-accidental injuries were identified.
- 3.22 At 17.54 on 16<sup>th</sup> November 2014 Father called South Central Ambulance Service to report that he had been feeding Baby L who had coughed during the feed and it seemed as though something was stuck. Ambulance records note cardiac/respiratory arrest whilst feeding possibly due to aspiration. If procedures had been followed, a paediatric cardiac arrest would have been notified to the police by the emergency call taker. This did not happen and contributed to the delay in the police starting their investigations and securing the crime scene.
- 3.23 Baby L was taken to Great Western Hospital Swindon as this was the hospital nearest to the family home. On arrival resuscitation was started. Mother arrived at the hospital with Half Sibling who later left with Mother's sister and was therefore felt by hospital staff to be appropriately cared for by family members.
- 3.24 The possibility of non-accidental injury quickly formed part of the differential diagnosis but at this stage the focus and attention was on saving Baby L's life. Due to the severity of the injuries Baby L required a transfer to a regional specialist unit and at 22.24 the Bristol paediatric team arrived at Swindon to take over his/her care. At this stage the priority continued to be stabilising Baby L's condition and making sure that he/she could survive the journey to Bristol. He/she was transferred to Bristol and arrived there at 02.40.
- 3.25 Swindon hospital records note a discussion between the Swindon Consultant and the community paediatrician in Bristol<sup>6</sup> following which the Swindon Consultant contacted Oxfordshire children's social care at 01.45 to notify them that Baby L had been admitted with injuries and that the parent had been informed that the injuries were non-accidental. Half Sibling was thought to be with her aunt.<sup>7</sup>
- 3.26 The social worker in Oxfordshire emergency duty team did consider the safety of half sibling but felt that a "light touch" approach was best during the night and they did not make any direct contact with the family, but instead advised the doctor to call the police. After Thames Valley Police had received notification of the incident they called the emergency duty team who gave them information from the children's social

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<sup>6</sup> The community paediatrician is a specialist in safeguarding

<sup>7</sup> The Bristol community paediatrician does not recall this conversation and it is no record of the conversation in the notes.

care files regarding “a couple of low level domestic abuse type incidents that affected the eight year old half sibling”. Better practice would have been to have had a strategy discussion which set out a clear plan for parental contact with both siblings and for the emergency duty team to take active steps to ensure the safety of Half Sibling.

- 3.27 The Consultant was surprised to be asked to contact the police as, in the Swindon area; this would usually be done by children's social care. The paediatrician informed Wiltshire police resulting in further delay in Thames Valley Police being told.
- 3.28 A further call to Thames Valley Police was made by the on call paediatrician from Bristol at 02.57 and from this point Thames Valley police began their investigations.
- 3.29 At 03.35 Mother and Father arrived at Bristol hospital, safeguarding documentation was started and staff began to follow the hospital's non-accidental injury protocol including contact with Bristol children's services duty team.
- 3.30 Mother and Father remained with Baby L in the paediatric intensive care unit (PICU) until the morning ward round when all parents are asked to leave the ward temporarily due to the confidential nature of the information that is being discussed in an open ward. Staff were surprised when they did not return when allowed back into the ward as this was highly unusual behaviour for parents with such a poorly baby. For a while no one knew where they were and it later transpired they had gone home and returned to the ward some time later. This had implications for criminal investigation and the hospital have now reviewed their internal guidelines to clarify that where non-accidental injury is a possibility parents will not be asked to leave the unit.
- 3.31 During 17<sup>th</sup> November Father was arrested on suspicion of grievous bodily harm and later that day Baby L's life support machine was switched off. Father was later charged with murder and convicted on 5<sup>th</sup> October of manslaughter.

### **Summary evaluation: Agency actions following injuries to Baby L**

There is no information to suggest that there were any warning signs that Father would harm his child. However, there are lessons to learn about the way in which professionals should respond after a serious injury to a child in order to safeguard the child, their siblings and increase the likelihood of a successful criminal investigation.

There were delays in informing police by both the ambulance service and Swindon Hospital during this episode that could have had a direct impact on the investigation and it is fortuitous that there was a successful prosecution in these circumstances. The potential crime scene was not secured immediately and both Mother and Father were given warning of the hospital's suspicions before a plan for an investigation was put in place.

South Central Ambulance Service have conducted an internal inquiry and have identified that the failure to contact police was due to human error and have immediately issued a directive confirming the action that should be taken in such circumstances. The clinical commissioning group has followed this up and identified further action that needs to be

taken in respect of this.

The absence of an early strategy discussion meant that plans for half sibling and parental contact with both children lacked clarity. The emergency paediatric team at Swindon were particularly busy that night with three very sick children requiring the attention of the paediatrician and this impacted on the timeliness of the discussion with children's social care. At all times hospital staff were assured that Half Sibling was safe and was either with Mother and Father in hospital or latterly looked after by family members.

## 4 REVIEW FINDINGS AND RECOMMENDATIONS

4.1 This case has an extremely sad outcome yet there is nothing to suggest that any professional could have predicted that Father would kill his baby son. There are areas of practice that could be improved but there is no evidence to suggest with any certainty that had these improvements been in place at the time, Baby L's death would have been prevented.

### Finding One.

**The individual focus of health assessments and the fragmented nature of health records did not promote a holistic view of the family circumstances including potential vulnerabilities.**

4.2 In common with published reviews elsewhere<sup>8</sup> this review has identified challenges in ensuring that health professionals have access to relevant information and that information is shared between professionals, particularly those working for different organisations. In this case:

- Midwives at the time Mother booked for a pregnancy with Baby L did not have any information about her previous pregnancy with Half Sibling and it would not have been routine practice for this to be accessed,
- The health visiting team received the original booking form from the midwife; this form is based on self-reported information and will not highlight any undisclosed issues,
- Health visitors undertaking the new birth visits did not have information about previous children. This information is not routinely accessed unless issues or risks have been identified and is of significance as any information about previous domestic abuse incidents would have been on Half Sibling's file,
- It was positive that midwives accessed GP records although this was limited by the lack of information in the GP notes about previous domestic abuse.

4.3 The focus on the present without a full understanding of the whole family history meant that there was limited understanding of the social factors that might be

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<sup>8</sup> See for example Essex Safeguarding Children Board (2015) Child G ; Coventry Safeguarding Children Board (2014) Daniel Pelka Deeper Analysis

relevant in this case. An over reliance on self-report meant that any stresses associated with homelessness were not identified as well as any vulnerability stemming from previous domestic abuse incidents.

- 4.4 The national Healthy Child Programme<sup>9</sup> identifies the important contribution that fathers make and acknowledges that services may not do enough to support them. In this case, Fathers' relatively young age, the fact that it was his first child and exploration of the relationship between Mother and Father is not evident in the maternity notes and there is no prompt on the midwifery records to record whether Father attended appointments although the importance of involving fathers is stressed in training across the health community.
- 4.5 Health visitors were reassured by Father's presentation and described him to this review as "engaged, interactive and attentive". At the new birth visit both Mother and Father appeared to be caring competently for Baby L. The health visiting service in Oxfordshire uses the "promotional guide" as the framework for assessments required as part of the Healthy Child Programme. This guide specifies an assessment of family and baby using the "Framework for Assessment of Children in Need" and should therefore have included a holistic family assessment including the family history of both parents, as well as the circumstances surrounding Father's recent criminal conviction. There is no evidence that this took place in a systematic way. From discussion with health visitors it is not clear how consistently a systematic holistic assessment process is used and whether the supporting documentation is helpful. This is an area for review.

## **Recommendations**

**1a** Oxfordshire Safeguarding Children Board should bring the findings of this review to the attention of NHS England and ask them to identify what communication should be expected across health providers in order to ensure effective holistic assessment pre and post birth.

**1b.** Health providers should be requested to submit information to Oxfordshire Safeguarding Children Board about how they manage information sharing across services to promote holistic assessment and pre planning locally.

**1c** Oxford Health NHS Foundation Trust should ensure that health visitors have information about previous siblings where there have been any notifications of domestic abuse, child in need or child protection plans.

**1d** Oxford Health Foundation NHS Trust should review the implementation of the use of assessment tools and documentation. The Trust should provide evidence to the Oxfordshire Safeguarding Children Board that assessments carried out as part of the Healthy Child programme are fit for purpose in supporting the use of professional judgement to identify risks and vulnerabilities associated with social factors that may affect parenting.

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<sup>9</sup> The Healthy Child Programme is the national early intervention and prevention public health programme that sets out evidence based expectations regarding services to children through to adulthood.

## Finding Two.

**The delay in informing the Emergency Duty Team and Thames Valley Police of the serious injuries to Baby L was caused by an accumulation of factors. These were:**

- **The need to prioritise the acute medical needs of Baby L,**
- **Workload pressures within Swindon hospital and the ambulance service,**
- **Swindon Hospital managing a patient from outside their area,**
- **Inadequate access to specialist out of hours safeguarding advice within Swindon Hospital.**

- 4.6 As requested by the review team, South Central Ambulance Service carried out an investigation into the incident due to concerns about the delay in informing police of the incident. The conclusion of their investigation was that expected procedures had not been followed and that human error was the cause underpinned by workload pressures on that night. A new directive has been issued and the clinical commissioning group and the Oxford Safeguarding Children Board will wish to be assured that this directive solves the problem.
- 4.7 Once Baby L arrived at hospital the priority of both the team at Swindon and the retrieval team from Bristol had to be on keeping the baby alive. The possibility that injuries were non-accidental was correctly identified by the hospital team but there was a delay in contacting police and out of hours children's social care. This was within the context of a very busy emergency department that night as well as a consultant paediatrician managing three very sick children within the hospital. Nursing staff were not used effectively and they could have been asked at an early stage to make contact with children's social care.
- 4.8 There was no clear protocol that guided roles and responsibilities for safeguarding activity once the Bristol retrieval team arrived at Swindon and Swindon Hospital does not have a system of specialist safeguarding advice out of hours. It is notable that it was only when the Swindon consultant spoke to the community paediatrician in Bristol that the delay in calling children's social care was identified. The challenge of managing a coordinated response in such cases has previously been identified in Oxfordshire and is the subject of a Safeguarding Children Board protocol<sup>10</sup>. Similar guidance would have been beneficial in this case.
- 4.9 When the call was made to Oxfordshire children's social care by the Swindon consultant they were surprised to be asked to call the police as practice in the Swindon area is that children's social care make that call. There was also some further delay in that Wiltshire Police received the original call from the hospital, rather than this going direct to Thames Valley Police.

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## Recommendation

**2a** Swindon Hospital should provide assurance to the Clinical Commissioning Group and Swindon Safeguarding Children Board that adequate safeguarding advice is available to staff in Swindon Hospital out of hours and responsibility for communicating information across borders is clear.

**2b** Swindon Safeguarding Children Board should consider whether there is a need for guidance to underpin an effective coordinated response to serious/fatal safeguarding cases which take place out of hours across local authority and health boundaries.

**2c** South Central Ambulance Service should assure the Oxfordshire Safeguarding Children Board that as a result of the investigation into the circumstances surrounding Baby L they have reduced the likelihood of human error affecting their responses.

## Finding Three

**In order to manage interactions with parents where there are concerns about non-accidental injury, there needs to be early information sharing and a strategy discussion resulting in a plan which is shared with all relevant professionals.**

4.10 The review team discussed the issue of both parents being informed of possible non-accidental injury and leaving Swindon Hospital to travel alone to Bristol before police or children's social care were notified. In these circumstances doctors need to balance their responsibility to keep parents informed of all the possible diagnoses with the need to protect the child and siblings. It was not unreasonable for the parents to be told that non-accidental injury was one possible cause of Baby L's condition without any further details being given: the problem was that this was combined with the delays in any contact with police and children's social care explored above. Where parents are informed this must be combined with rapid discussion with the statutory agencies. In this case there had been no early formal strategy discussion to inform later work with the family. The first discussion should have taken place out of hours rather than in the hospital the next day.

4.11 The additional issue was allowing the parents to leave the Paediatric Intensive Care Unit in Bristol. Procedures within the unit have been amended to prevent a reoccurrence and the effectiveness of these procedures should be kept under review.

## Recommendation

**3a** Oxfordshire and Swindon Safeguarding Children Boards should be asked to remind staff of the process for out of hours strategy discussions and be reassured that these are contributing effectively to the planning process.

**3b** Bristol Safeguarding Children Board should be informed of the swift response by

University Hospital Bristol in developing procedures for staff in the Paediatric Intensive Care Unit regarding parents leave the ward where non-accidental injury is being investigated and request that the new procedure is kept under review in order to ensure that it is workable in practice.

**Finding Four: Systems for reviewing accumulating information about domestic abuse with different partners were not effective in triggering an assessment within children's social care.**

- 4.12 Although outside the timeframe originally agreed for this review, consideration of documents in Thames Valley Police and children's social care revealed a significant history of domestic abuse or public order incidents linked with Mother. From 2006 onwards the chronology identified eighteen incidents of abuse (mostly domestic) and records indicate that twelve were not known to children's social care. Not all should have been shared (for example where a public order incident did not involve a child) and there are some incidents where records available from either Police or children's social care at that time may not give an entirely accurate picture as to whether information was shared or not.
- 4.13 Only one incident resulted in an assessment by children's social care and there is sufficient clarity within the chronology to indicate that enough information was known to have triggered an assessment on at least one other occasion. An assessment involving the wider professional network may have flagged potential vulnerabilities during Mother's later pregnancy.
- 4.14 There are however no recommendations made in relation to this finding as the practice context for working with domestic abuse in Oxfordshire is now significantly different as set out in paragraph 3.6. It is important to note that currently within children's social care where there have been three domestic abuse notifications in the year these will be reviewed by a senior social worker and this system would have ensured proper review of the accumulating concerns in this case.

**Recommendations**

**4a** Oxfordshire Safeguarding Children Board should ask Thames Valley Police, MASH and the Clinical Commissioning Group to consider the best method of ensuring that GPs receive necessary information where a parent has been the subject of domestic abuse and implement any changes necessary to current systems.

**4b** Oxfordshire Safeguarding Children Board should be assured that domestic abuse notifications are appropriately shared across the partnership and that the volume of notifications is managed effectively.

**4c** Oxfordshire Safeguarding Children Board should seek assurance from the domestic

abuse strategy group that the multi-agency training linked to the domestic abuse strategy is fit for purpose and having a positive impact on practice.

## 5 APPENDIX 1: THE REVIEW PROCESS

- 5.1 Following the death of Baby L on 18<sup>th</sup> November 2014 the Case Review and Governance Group of Oxfordshire Safeguarding Children Board agreed that the case met the criteria for a serious case review. This decision was confirmed by the Chair of the Safeguarding Children Board on 2<sup>nd</sup> December 2014.
- 5.2 The review was led by the independent reviewer and the review group. The review group were supported by the Oxfordshire Safeguarding Children Board administrator who attended every meeting and took notes.
- 5.3 The review group consisted of:
- Jane Wonnacott: Lead Reviewer
  - Detective Chief Inspector, Thames Valley Police
  - Senior Probation Officer, National Probation Service
  - Designated Safeguarding Nurse, Oxfordshire Clinical Commissioning Group
  - Senior Named Nurse, Oxford Health NHS FT
  - Partnership Development Manager, Oxford City Council
  - Senior Probation Officer/Relationship Manager, Thames Valley Community Rehabilitation Company
  - Social Inclusion Manager, Oxfordshire County Council
  - Safeguarding Support Officer, South Central Ambulance Service
  - Business Manager, Oxfordshire Safeguarding Children Board
  - Named Nurse Safeguarding Children, Oxford Health NHS FT
  - Lead Professional at Horton, Oxford University Hospitals
  - Social Care Manager, Oxfordshire County Council
  - Designated Nurse, Swindon Clinical Commissioning Group
  - Designated Doctor, Swindon Clinical Commissioning Group
- 5.4 The independent lead reviewer was Jane Wonnacott. Jane qualified as a social worker in 1979. She has an MSc in social work practice, the Advanced Award in Social Work and an MPhil as a result of researching the impact of supervision on supervision practice. She has published two books on supervision and co-wrote with Tony Morrison the national training programme for social work supervisors. Since 1994 she has been the author or chair of many serious case reviews and in 2010 completed the Tavistock Clinic and Government Office London nine day training



programme for panel chairs and authors. She has also attended the 2012 Department for Education serious case review training programme.

5.5 In considering the process for this review, account was taken of the principles set out within Working Together to Safeguard Children (2015) which specifies that:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works to promote good practice.
- The approach taken to reviews should be proportionate to the scale and complexity of the issues being examined.
- Reviews should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- Families including surviving children should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring the child is at the centre of the process.
- The final report must be published, including the LSCBs response to the review findings.
- Improvement must be sustained through regular monitoring and follow up.

5.6 Initial consideration of case materials by the Case Review and Governance Group had suggested that it would be most appropriate to focus in detail on the period 1<sup>st</sup> December 2013 to 18<sup>th</sup> November 2014. Agencies who had been involved with Baby L's family were asked to provide a chronology as well as a narrative report of their involvement which highlighted any emerging practice issues. No specific terms of reference for the review but the review group did identify questions to be considered during the review process. These were:

1. What opportunities were there to identify and respond to any vulnerabilities in respect of Father to Mother that may have impacted on their parenting capacity? In particular were there opportunities:
  - Within the school attended by Half-sibling?
  - By midwives during Mother's pregnancy?
2. If opportunities were not used effectively what factors prevented this from happening?

3. How far did agencies assess the implications for parenting of an accumulation of incidents of domestic abuse (linked to Mother), combined with other factors such as homelessness. Were there any factors preventing this from happening?
  4. How did the Haringey judgement affect the sharing of information regarding domestic abuse, how effective are triage processes and did this have any adverse implications for this case?
  5. Did information sharing across health agencies ensure that all health professionals had the necessary information to inform their assessment of vulnerability? If not why not?
  6. Did the actions of professionals from the point of injury onwards ensure that Half-sibling's safety was secured and the effectiveness of the criminal investigation. If not why not?
- 5.7 The agency reports were then considered by the review group and practitioners were identified who would be most able to help the review group understand the detail of what happened and the influences on practice at that time.
- 5.8 The only exception to this process was contact with practitioners in Thames Valley Police. The policy within Thames Valley Police is that an individual management review report (IMR) is completed all serious case reviews and the author of that report speaks to the practitioner involved.
- 5.9 Discussions with some practitioners were delayed due to the ongoing criminal proceedings and took place after the conclusion of the trial. This has contributed to a delay in completing the final report.
- 5.10 The independent reviewer met practitioners either individually or in small groups with the member of the review panel who had professional expertise in their area of practice. This approach allowed the lead reviewer to gain an overview of practice and cross reference information whilst ensuring that practice issues specific to one staff group were fully explored. A full list of practitioners is set out in Appendix Two.
- 5.11 Mother and Father were offered an opportunity to contribute to the review. Father wished to do so and was interviewed by the lead reviewer. Mother did not respond to correspondence relating to the review and the team respected her apparent wish not to be involved.
- 5.12 The lead reviewer met regularly with the review team to discuss the emerging information and the draft report. The report was discussed by the Case Review and Governance group on 22<sup>nd</sup> February 2016 and 7<sup>th</sup> April 2016 and presented to the full Oxfordshire Safeguarding Children Board on 12<sup>th</sup> July 2016.

## **6 APPENDIX TWO: PRACTITIONER DISCUSSIONS**

Discussions, either individually or group took place with the following practitioners in order to explore the context within which work with the family took place and reasons for the decisions that were made:

### **Childrens Social Care**

- Senior Practitioner/Duty Senior
- Emergency Duty Team Co-ordinator
- Assistant Team Manager, Multi-agency Safeguarding Hub
- Senior Practitioner, Children & Families Assessment Team South
- Assistant Team Manager, Children & Families Assessment Team South/  
Emergency Duty Team coordinator
- Team Manager, Children & Families Assessment Team South
- Social Worker, Assessment Team South

### **Early Intervention**

- Family support worker (level 3)

### **Oxford University Hospitals NHS Foundation Trust**

- Midwife

### **Oxford Health NHS Foundation Trust**

- Health Visitor
- Health Visitor / Community practice teacher
- Breastfeeding Support Worker

### **School**

- Headteacher, Infant school
- Assistant Headteacher, primary school
- Home school link worker, primary school

### **Great Western Hospital, Swindon**

- Named Nurse
- Named Doctor
- Designated Doctor