Executive Summary – Baby J

1. This is an executive summary report of the Local Child Safeguarding Practice Review (LCSPR) of Baby J. It sets out the findings of the LCSPR initiated by the Enfield Childrens Safeguarding Partnership. Baby J was a seven-week-old baby boy who died in August 2025. His mother found him unresponsive after a period of co-sleeping. Despite emergency intervention, Baby J could not be resuscitated. The review identified several known and cumulative risk factors surrounding Baby J's care and daily lived experience.

2. About Baby J

2.1 Baby J was born prematurely and was described by professionals as a small and vulnerable baby. He relied entirely on the adults around him to recognise and respond to his needs and to keep him safe.

2.2 Baby J lived in a household where there were concerns relating to domestic abuse, parental substance use, poor home conditions, family conflict, unsafe sleeping arrangements and parental resistance to professional advice.

2.3 Both parents had experienced significant adversity in childhood. Mother had a history of mental health difficulties, trauma and vulnerability. Father was care experienced and had a history of violence, offending, substance misuse and sexual offences against a child.

2.4 Although many individual concerns were known to agencies, they were not consistently brought together into a clear understanding of what life was like for Baby J or what the cumulative impact of these risks meant for his safety and wellbeing.

3. The Review

3.1 The review considered professional involvement during the year prior to Baby J's death and examined how agencies assessed risk, shared information and understood Baby J's lived experience.

3.2 The review found a number of examples of good practice, including information sharing by health professionals, management oversight, safeguarding supervision and timely referrals when concerns arose.

3.3 However, the review identified significant areas for improvement relating to assessment of parenting capacity, multi-agency information sharing, safer sleep practice and understanding the lived experience of preverbal children.

4. Family Involvement

4.1 Both parents were informed that the review was taking place. Due to the ongoing criminal investigation, and following consultation with police, the parents were not interviewed as part of the review process. This limited opportunities to understand their experiences of services.

5. Recommendations

5.1 A set of recommendations have been identified for the Safeguarding Partnership to support better outcomes for babies and very young children exposed to cumulative risk.

5.2 Strengthening assessment of parental risk and parenting capacity
Assessments involving babies and very young children should explicitly analyse how parental trauma, mental health, domestic abuse, substance use, offending history, poor engagement and family support arrangements affect parenting capacity and the child's day-to-day safety. Assessments should move beyond describing adult issues to evaluating what those issues mean for the child, including whether risks are escalating or cumulative. Audit, supervision and management oversight should evidence that cumulative risk is analysed, fathers and significant adults are included, and the child's lived experience is central to decision-making.

5.3 Improving the focus on preverbal children's lived experience
Practitioners should routinely describe and analyse the lived experience of babies and preverbal children, including what the child sees, hears, feels and experiences throughout a typical day and night. Particular attention should be given to domestic abuse, unsafe sleep, substance use, poor home conditions and parental conflict. Audit and supervision should evidence analysis of emotional safety, routines, exposure to adult behaviour and environmental risks, with plans containing clear actions to improve the child's daily safety and wellbeing.

5.4 Embedding a system-wide response to safer sleep
Safer sleep should be understood as a shared safeguarding responsibility across all agencies, not solely health professionals. Practitioners should recognise increased Sudden Unexpected Death in Infancy risks associated with prematurity, parental smoking, cannabis or alcohol use, co-sleeping, unsafe bedding, domestic abuse, exhaustion, poor home conditions and rejection of advice. Audit should evidence that safer sleep advice is consistently reinforced, understood by parents and responded to where not followed, with concerns escalated and safety planning adapted to family circumstances.

5.5 Strengthening cross-border and multi-agency information sharing
Agencies should seek, share and analyse relevant information from other local authorities, police forces, probation, health services and specialist agencies before key safeguarding decisions are made, including decisions to close, step down or manage cases through assessment alone. Fathers, partners and other significant adults should be identified and their history, restrictions, current role and potential impact on the child fully considered. Audit and assurance activity should evidence that cross-border information is actively sought, informs risk analysis and decision-making, and that key agencies contribute to safeguarding discussions.

5.6 In conclusion, the review found that stronger assessment, professional curiosity, information sharing and multi-agency safeguarding responses are required when babies are exposed to cumulative risk. Practice needs to remain focused on understanding the child's daily lived experience and ensuring safeguarding responses are proportionate to the risks identified. The Partnership should assure itself that children are safer because practice has changed and improved, rather than solely evidencing completion of actions.