Bristol Local Safeguarding Childrens' Board
Serious Case Review Baby X

Executive Summary

1. A Serious Case Review was carried out following injuries to 19 day old Baby X whilst he was in St Michaels Hospital, Bristol. Baby X was born at 32 weeks gestation. He was given a routine ultrasound brain scan at 16.45 on Friday and the results of the scan were considered to be normal. At 18.00 pm on Saturday a midwife discovered him breathing abnormally. Baby X was examined by The Senior House Officer and the Registrar. Baby X was noted to have a bulging fontanelle and dilated pupils. Bruising was identified on his left cheek and to the left chest wall. An ultrasound scan showed signs of bleeds on both sides of the brain and evidence of intra cranial swelling. Baby X was displaying cerebral dysfunction and continuous seizures.

2. On the following Monday a CT scan was viewed by a Consultant Paediatric Neuro-radiologist. His opinion was that baby X had extensive and severe brain injuries, there was bleeding present in all the areas of the brain and the brain was swollen. The results of a skeletal survey (x-ray) indicated that Baby X had a fracture to the right radius bone (lower forearm). The consultant felt that it was likely that the injuries were non-accidental.

3. Both parents were arrested by the Police 11 days later and both denied any responsibility for the injuries. They maintained the injuries to Baby X had been caused by staff at the hospital.

4. An internal investigation was carried out at St Michael's Hospital and a major police investigation was conducted. There was no evidence to suggest that anyone other than either or both parents caused the injuries to Baby X.

5. In accordance with HM Government guidance, 'Working Together to Safeguard Children', the Chair of Bristol Safeguarding Children Board (BSCB) appointed a panel of professionals to overview the review process. The panel considered the information from the investigations and individual management reviews from UBHT, North Bristol Trust (NBT), Bristol North Primary Care Trust (BNPCT), Avon and Somerset Constabulary, Bristol City Council Education Department and Bristol City Council Social Services and Health. A summary of involvement by the Connexions service was also reviewed.

6. Relevant information known to the agencies and professionals involved with both parents was considered. The mother was aged 19 at the time of the injuries and the father aged 17 years. There was a long history of statutory intervention with both parents who had complex family histories and special education needs. Both parents had difficult school careers which included school exclusions and experiences of being bullied.

7. The paternal grandfather of Baby X was convicted of the rape of one of his daughters in 1999 and received a 9 year prison sentence. This had considerable impact on the father then aged 11 and his behaviour became increasingly difficult. The individual management reports identify numerous incidents of ongoing violent behaviour including reported incidents of domestic disputes involving the mother and maternal grandmother of Baby X.

8. In 2001 the father was charged with indecent assault on an 8 year old boy. He was picked out in an identity parade but there was no independent evidence corroborating the allegations and he was acquitted.

9. In June 2003 the father was investigated when it had been alleged that he had assaulted a friend's 2 year old daughter. The child had presented with a broken collar bone and extensive bruising. He denied the allegations and was not prosecuted.

10. The review produced a chronology of agency involvement and individual agency reports. It highlights a number of incidents which could and should have prompted a multi-agency assessment of the father himself as a child 'in need' under s17 of the Children Act 1989. Despite the father having significant problems at school, intensive intervention by the Police, CAMHS and Social Services the analysis identifies a lack of inter-agency working and information sharing. The individual management reviews focus on issues raised after the injury and was therefore out of the scope of this review. However, they identify a number of recommendations relevant to their respective agencies to be considered and actioned. These are to be reviewed by the BSCB.

11. The conclusions and recommendations of the review focus on the lack of inter-agency working. They are presented within four themes; pre-birth assessment, information sharing, sexually harmful behaviour, and domestic abuse. These include recommendations that emphasis is placed on the importance of a shared culture of preventative work and early intervention across all agencies during training for the Common Assessment Framework and in individual agency's safeguarding children training.

12. As a priority it recommends that the BSCB should consider services available to boys and young men with sexually harmful behaviours and provide joint training for Police Officers and Social Workers to raise the level of understanding and ensure multi-agency procedures are followed.

13. The review recommends that the Police Child Abuse Investigation Team should have the lead in the investigations of all sexual offences involving a child as the victim or perpetrator, including non-familial cases. This would ensure consistent compliance with multi-agency procedures.

14. It is recommended that more effective responses to domestic abuse should be developed and systems and structures should be shared amongst all agencies with responsibility for safeguarding children. These should be based on agreed outcomes and should be monitored and evaluated. The review highlights the need for particular consideration of cases where the mother is pregnant and a number of domestic violence referrals are received.

15. The parents will be given a copy of this report and their comments and contributions will be circulated to the BSCB for information and consideration.

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Chair of Review Panel