7 Minute Briefing: Rapid Review Sept 2021

Date: 3 November 2021

1. Background

This case relates to the death of 2.5 months old baby who was born prematurely and placed on a universal plus enhanced level of health visiting service. Routine in home was for baby to sleep in same bed as Mother and Sibling. Mother had been drinking that evening during a social visit with a friend. Baby found unresponsive in the early hours and declared dead by Paramedics at the scene. Child and family had no contact with Children's Services and Police prior to death. No safeguarding issues raised by health services prior to death.

2. Learning Point 1

Postnatal contact by Midwives was not carried out in the home environment so there was a missed opportunity to review where the baby was sleeping and offer appropriate advice. These checks were undertaken in the clinic.

Safe sleep was discussed with the parents by both Midwives and Health Visitors but a clinical setting does not allow for sleeping arrangements to be viewed and personalised advice to be given.

3. Learning Point 2

All practitioners need to ensure that they understand and can explain safer bed-sharing practices to women, their partner or main carers of babies. At each contact, practitioners should discuss safer practices for bed sharing and the risk factors/circumstances in which bed sharing with a baby is strongly advised against. Assessing the sleep environment and establishing safer infant sleeping habits with carers is key.

4. Learning Point 3

It is recognised that cut backs in funding to health visiting services over a number of years has resulted in Health Visitors having less time and capacity to visit and provide home visits and support to families.

5. Recommendations (1)

- A mapping exercise is to be carried out, to map the learning from this case with the learning and actions within the current SUDI Thematic Review Action Plan. In particular the panel requested that the exercise should focus on safer sleep messages around pre term babies and other risk factors.

- Midwifery and 0-19 service offer is to be taken to the Better Start Board to understand the current service offer and highlight the missed opportunities in this case.

6. Recommendations (2)

- Concerns regarding workforce capacity within the 0-19 team in Surrey have been escalated to Public Health. Public health have begun work on the design and transformation of children's community health services. This work will go on to inform the model of service delivery in the future

7. Resources and Reading

- Surrey Thematic Review of SUDIs 2020
- "Out of Routine" report published by the CSPRP in July 2020
- SSCP Safer Sleep 7 Minute briefing

The action plan resulting from these two reports is being progressed by the Surrey Better Start Board and learning will be disseminated across the system with reporting to the case review panel and CDOP for further scrutiny.