7 Minute Briefing: SCR "Becky"

Date: 2 March 2021

7 MINUTE BRIEFING

1 Background

In May 2020 the SSCP reviewed the death of an infant born prematurely but gaining weight. She was comfortable in the care of both parents and responding well to positive attention. Despite this, practitioners remained concerned she could have ongoing medical or developmental needs. At the time of her death she was subject to a child protection plan under the category 'neglect' due to concerns about parental alcohol misuse, mental ill-health and domestic abuse.

See **full published report** here.

2 Research

A **national review into SUDI** revealed families with babies at risk often struggle with several issues e.g. domestic abuse, poor mental health or unsuitable housing. Disruption to normal routines also makes it harder to engage effectively with safer sleeping advice. Recent SSCP audits found that only 18/50 cases had a fully completed safe sleep assessment and only 1 action plan. See also the **SSCP SUDI Thematic Review Report.**

3 Key Lines of Enquiry

- Practitioner understanding of risk posed by parental conflict
- Were interventions appropriate and effective
- Level of **"professional curiosity"** in relation to parents' ability to meet Becky's needs
- Application of Child Protection and PLO pre-proceeding processes
- Systemic issues affecting decision making
- Effectiveness and implementation of recommendations from Local Practice Review (2019)

4 Findings "Good Practice"

- Practitioners were aware of the parental conflict, including allegations of **domestic abuse** and alert to the risks and potential impact on the children
- Practitioners recognised that Mother's low self-esteem/history of depression added to her vulnerability
- The risk of emotional harm and physical injury for both Becky and her older sibling associated with domestic abuse was actively considered and regularly discussed with professionals and parents
- Risks posed by her mother's **alcohol misuse**, including an increased risk of SUDI were made clear to her parents.
- Interventions were in keeping with expectations of the 'Working Together 2018' guidance

5 Findings "What went wrong?"

- Lack of professional curiosity in respect of mother's **level of engagement** with the specialist alcohol service and overreliance on self-reporting.
- Insufficient attention given to the possible impact the family's circumstances may have had on her mother's ability to follow safer sleeping advice
- Importance of a whole team approach to safer sleeping advice

6 Recommendations

- Develop a SUDI prevent and protect practice model that recognises the continuum of risk of SUDI,
- Revise Safeguarding Procedures & seek assurance all partners align organisational policy so practitioners understand increased risks of SUDI
- Ensure practitioners understand their role in reinforcing safer sleeping advice and monitoring adherence to protect children where there are concerns regarding neglect or additional risk factors, such as parental alcohol misuse, mental ill health, domestic abuse or unstable housing.

7 SUDI – The Risks

- Co-sleeping where either parent smokes, has consumed alcohol or taken drugs
- Baby born prematurely, of low birth-weight or with symptoms of foetal alcohol syndrome;
- Children born to women with an alcohol-related disorder diagnosed in pregnancy,
- Some products marketed for infant sleep, such as hammocks and nests or pods
- SUDI is thought to be due to multiple factors coming together in a given situation. **'triple risk'** hypothesis
- the infant is vulnerable
- the infant is at a critical period of development (first six months of life) and
- external factors (e.g. placed in the prone position or breathing is compromised by soft bedding.)