Serious Case Review

‘Becky’

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1 INTRODUCTION

1.1 In May 2020 Surrey SSCP commissioned a review into the circumstances leading up to the death of an infant known within this report as 'Becky'. Becky is described by those who were involved in her care as a loved child. She was comfortable in the care of both parents, responding well to positive attention. She was clearly loved by her older sibling, who was noted to be '*very caring and careful… affectionate and loving towards her*'.[1] She was born prematurely but gaining weight. Despite this, practitioners remained concerned she could have ongoing medical or developmental needs. Becky died unexpectedly and the cause of her death is still subject to forensic investigation. 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. Shortly before her death, the local authority completed assessments under the Public Law Outline pre-proceedings process and concluded there were insufficient grounds to believe it necessary to initiate court proceedings under s31 Children Act 1989.

2 THE REVIEW PROCESS

2.1 The methodology used for this review closely follows the SCIE 'learning together' model. The relevant case records, minutes of meetings and assessments were made available to the Reviewer. In addition, relevant agencies completed internal 'information reports', reporting on areas of good practice as well as possible opportunities for safeguarding practice improvement. These were analysed and considered alongside relevant policy, case law and academic research to inform a learning event with frontline practitioners and managers from across partner agencies involved in supporting the family during Becky's life. Valuable learning was gained from that event and subsequent input from key practitioners who were unable to attend.

2.2 In addition, senior strategic safeguarding leads supported the completion of the report, via input through the SSCP's case review panel and liaised directly with frontline officers involved in the case to address outstanding queries. The Reviewer is grateful to all for such active engagement with this review.

2.3 The purpose of this review is to understand whether practitioners across relevant partner agencies recognised and responded in line with their statutory duties.[2] The review's focus is to ascertain:

- if practitioners properly understood the risks posed to Becky by parental conflict, including allegations of domestic abuse within the parental relationship (hereafter referred to as 'M' for mother and 'F' for father), including reports of domestic abuse, parental alcohol misuse and mental ill health;
- if interventions (including referrals to secondary services) were appropriate, timely and effective;

[1]This information is taken from assessment reports and discussions with practitioners.
[2]Expectations of inter-agency working to safeguarding and promote the welfare of children is set out in 'Working together to Safeguard Children' 2018 as the applicable guidance, unless otherwise stated. This guidance is available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

- whether the level of ‘professional curiosity’ exercised in respect of her parents’ ability to meet Becky’s needs was sufficient. Particularly in light of M’s disclosures that she used alcohol as a coping mechanism to manage depression and low self-esteem, arising from emotional and physical abuse by F;
- if the child protection and Public Law Outline pre-proceedings processes were applied correctly and if the child protection plan adequately addressed safety arrangements in respect of domestic abuse, mental health and alcohol misuse;
- whether there are any systemic issues that affected decision making or practice in the case.

2.4 The review also considered whether the local practice review, undertaken by the SSCP in July 2019 correctly identified the wider systemic issues that may have affected practice and what evidence there is of improvement to practice following those recommendations.

Family Involvement

2.5 The review author has been unable to speak with the parents because of on-going parallel processes.

2.6 The ongoing coronial and police investigation meant that it was not possible for the reviewer to meet with Becky’s family. The SSCP were, understandably, keen to ensure that any lessons could be learnt, and recommendations implemented without delay. The SSCP have agreed to meet with Becky’s parents and wider family, following the completion of coronial and police investigations, to share with them the report and recommendations. Panel members and practitioners were particularly keen to understand the parental views on barriers to their understanding of risk and effective engagement within the child protection plan.

Review limitations

2.7 This review has been commissioned (whilst the circumstances of Becky’s death were still subject to ongoing coronial and police investigations), following a request in July 2019 by the national Child Safeguarding Practice Review Panel[3] in order to identify if any improvements to practice might prevent or reduce risk of similar incidents. This meant that the precise cause and circumstances of her death were not yet understood. Where this may have had an impact on what conclusions could reasonably be drawn, this has been highlighted within the report.

2.8 Whilst the outbreak of Covid-19 prevented face to face meetings with practitioners over the review period, as set out above, this didn’t prevent their active engagement.

[3] Notification was given to the national panel of the SSCPs rapid review into the circumstances of her death in line with 16C(1) Children 2004.

3 FINDINGS AND RECOMMENDATIONS

Did practitioners properly understand the risks posed to Becky by parental conflict, including allegations of domestic abuse in the parental relationship?

3.1 Throughout the records there is clear evidence that practitioners were aware of the parental conflict, including allegations of domestic abuse and that practitioners were alert to the risks (including long-term impact) that domestic abuse can have on children. At each disclosure of domestic abuse, M was given information and urged to access specialist domestic abuse support. Agencies, particularly the police and the Midwifery Safeguarding Team proactively worked with partner agencies to put in place strategies to reduce risks and opportunities for trigger events, e.g. by developing a visiting plan for both parents whilst Becky was in SCBU.

3.2 There is also evidence within the case records that 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 both parents by the GP, police, SCS, Midwifery and the health visitor. Whilst thematic reports into SCR findings highlight that often cumulative risks of harm may be overlooked, this was not the case. There is evidence throughout the case records and assessment reports that practitioners were actively considering the voice of the child and impact of the parental behaviour on Becky and her older sibling.

3.3 In addition, the records reflect that emotional, physical abuse and coercive behaviours were identified as part of the parental relationship and that this risk persisted throughout the period Becky and her older sibling were subject to child protection interventions. Further consideration is given below to whether the interventions proposed under the child protection and PLO processes were sufficiently robust.

3.4 Case records suggest that F and the wider paternal family understood the risks posed to the children by M's alcohol use. F said M's alcohol misuse was a major trigger for disputes and whilst he disputed many of the allegations, he had physically assaulted M, he acknowledged he had caused damage to property during a dispute (witnessed by their older child). M also showed some insight into the risks associated with domestic abuse to herself and the children, in that she reported all concerns to the police, health and social care practitioners. However, did not accept additional support from specialist domestic abuse services.

3.5 In July 2020 the Child Safeguarding Practice Review Panel published a review into SUDI [4] reporting that of the 40 SUDI deaths reported to the national panel between June 2018 and August 2019, co-sleeping was a feature in 38 of the 40 cases. Parental alcohol and drug use were also common, as were issues related to parental mental ill-health. That review reveals families with babies at risk of dying in this way are often struggling with several issues, such as domestic abuse, poor mental health or unsuitable housing. It found that these deaths, often occur when families experience disruption to their normal routines and so are unable to engage effectively with safer sleeping advice. Having had the opportunity to consider findings from that review, practitioners from across partner agencies acknowledged, in discussions

[4] available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf

with the Reviewer, at the time insufficient attention was given to the possible impact the family's circumstances may have had on M's ability to follow safer sleeping advice. This is considered in more detail below. It should also be noted that, following a number of SUDIs in Surrey, the SSCP's Child Death Review Partnership are completing a thematic review of all SUDIs in Surrey that occurred between 2014-2020. The results of this thematic review will be published in Jan 2021, there will also be a multi-agency Surrey wide learning event to disseminate this piece of work.

Were interventions, including referrals to secondary services, appropriate, timely and effective?

3.6 CSC's case records suggest there may have been a delay in completing an assessment following notification by the MST in May 2018 of their concerns. However, this did not prevent or delay agencies from sharing information and working together (including with both parents) to understand the safeguarding risks for this family. Referrals by the GP, police and maternity services were all in keeping with expectations of the 'working together' guidance. Referrals were also made to specialist mental health maternity services, domestic abuse and specialist alcohol support services. Whilst active parental engagement was required to ensure the referrals to domestic abuse and alcohol dependency support services were effective, steps were taken by agencies to encourage participation, including through use of the Public Law Outline pre-proceedings process ['PLO'].

3.7 Having completed initial assessments, CSC in line with expectations under 'Working Together' guidance escalated the level of intervention so that safeguarding concerns would be monitored in line with the multi-agency child protection plan. CSC also commenced the PLO process.

3.8 Following Becky's birth the health visiting team assessed M as requiring a Universal Partnership ['UP'] health visiting service.[5] The Trust's internal case review identified that the family should have been assessed as requiring a Universal Partnership Plus ['UPP'] health visiting service. A UPP service enables support from the health visiting team and a range of local services (including Children's Services) to deal with more complex issues such as alcohol misuse and domestic abuse over a period of time. In reality the level of support offered was equivalent to that offered within the UPP, even if it was not recorded as such within Becky's health records, as there is evidence of regular visits, practitioner liaison and information sharing and attendance at core group and child protection conferences.

3.9 Referrals to secondary services were timely and appropriate, however, practitioners accepted safeguarding interventions may have been more effective had greater weight been given to inadequate parental engagement with specialist support. Many practitioners felt, given the numerous SUDI risk factors and Becky's fragility, tighter timescales for parental change (particularly in respect of M's alcohol misuse) should have been proposed.

3.10 M expressed a wish to reduce her drinking to 'social levels' rather than abstain completely. The risks of alcohol use during pregnancy and in the post-natal period had been explained

[5] The Trust's information report confirmed both the duty health visitor who received the maternity concerns form from the midwives on the 15.08.18 and the allocated health visitor who undertook the visit to the family on the 06.06.18 allocated this to the UP service.

and M had demonstrated, by notifying her GP at the start of her pregnancy, she was aware of those risks. Despite her preference to reduce her alcohol use, she had also signed a written agreement as part of the PLO process to abstain from alcohol. It is understood that the requirement for total abstinence was to enable CSC to monitor compliance.[6] The specialist alcohol service acknowledged that an abstinence preparation pathway should have been agreed with M initially as part of her assessment for treatment. This would have set out clear expectations and, if those were not met, enabled them to push for a re-evaluation of risk to the children. However, they also explained for specialist services to be effective they need to develop collaborative relationships with their clients, meaning that often the focus for them is on harm reduction to afford them time and opportunity to build up a trusted therapeutic relationship.

3.11 Practitioners also accepted the risk of SUDI should have been made more explicit to Becky's parents and her maternal grandmother, given the number of high-risk indicators present. They agreed it would likely improve practice in the future if this is addressed separately within child protection plans and is a joint responsibility for all professionals. They reported SCS now have drug and alcohol workers within their child protection teams who are able to provide training and on-going case work advice, including on the increased risk of SUDI for this cohort.

Was the level of 'professional curiosity' exercised in respect of her parents' ability to meet Becky's needs sufficient? Particularly in light of parental substance misuse (alcohol) and domestic abuse.

3.12 There is evidence that practitioners working with M during Becky's pregnancy recognised that her low self-esteem and history of depression added to her vulnerability. For example, police notified adult social care and mental health services of the domestic abuse incidents, in addition maternity services secured her additional support through the Jasmine team. The Maternity Safeguarding Team should be commended for understanding risks associated with relying on M's self-reporting alcohol use and taking steps to ascertain the nature of this. They also clearly communicated risks regarding parenting capacity and increased risk for Becky in respect of SUDI and made clear to M and F the risks associated with this for Becky.

3.13 The consultant psychologist from the specialist alcohol service also identified M may experience post-natal depression as she had after the birth of her first child and questioned whether this might be heightened if Becky's development was affected by foetal alcohol syndrome.

3.14 Following Becky's birth, practitioners remained concerned that M's history of depression and alcohol misuse may impair her ability to safely care for Becky. Though it is noted that the health visitor's records could not evidence that all their required assessments had been completed, including consideration of M's mood, her case notes evidence that a post-natal depression screening was undertaken shortly after Becky's discharge from SCBU. M's mental health was also assessed by both the Jasmine team and an independent psychiatrist

[6] Practitioners reported it is far harder for the available testing mechanisms to differentiate 'safe levels' of alcohol consumption.

during this period; both these assessments concluded there would be no benefit of an onward referral to specialist secondary mental health support.

3.15 There is evidence that practitioners were concerned about the level of parental conflict, including allegations of domestic abuse within the family and M's minimisation of the impact of this on her self-esteem and wellbeing. Close monitoring was in place within SCBU and any concerns shared with partner agencies; these formed the basis of the safety plans when Becky was discharged from hospital.

3.16 As part of both the child protection and PLO processes M agreed to engage with specialist domestic abuse services, but never did. M was also frequently offered referrals by other agencies to specialist domestic abuse services and counselling but reported in March 2019 she was not ready to make contact.

3.17 A notable gap in professional curiosity was in respect of M's level of engagement with the specialist alcohol service and self-reporting that she was abstaining from or had significantly cut down her alcohol consumption after Becky's birth.

3.18 The specialist alcohol practitioners supporting M did not initially notify CSC and the health visitor of M's non-engagement between October 2018-January 2019. Once she started to attend appointments in January 2019, they did form part of the core group, but did not clearly share concerns when M confirmed she continued to drink (up to two bottles of wine) whilst caring for the children.[7]

3.19 Practitioners involved in this case accepted another notable gap was the heavy reliance after Becky's birth on the parental self-reporting and presentation. During discussions with the Reviewer, practitioners understood the value of involvement by GPs and clinicians within child protection processes. Panel members reported there were clear mechanisms in place and SSCP audits evidence good levels of contributions from GPs. All partners supported improvements in practice that would see sufficient weight given to that information, particularly where the concerns require expert medical assessment. This would be consistent with the recent High Court judgment that '*as a matter of professional obligation, GPs do, and will continue, to provide the information required by local authorities for safeguarding investigations and case conference*s.'[8]

3.20 Practitioners involved in this review commented they now recognise M's pattern of help-seeking and apparent compliance alternated with denial of her problem drinking and reluctance to engage with specialist support services. Many of the practitioners highlighted the need to assess risks contextually and, in doing so, often must balance conflicting risks. There were many positive aspects to both M and F's parenting, and both cared deeply for their children. Practitioners were acutely aware that to have a positive impact they need families to be motivated to change and to share information with them openly. Panel

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[7] The health visitors case notes of core group meetings suggests the specialist alcohol service reported M's excessive drinking was restricted to when Becky and her sister were in the care of F, M had however confirmed that she drank whilst caring for the children.

[8] This would be consistent with the recent High Court judgment that '*as a matter of professional obligation, GPs so and will continue to provide the information required by local authorities for safeguarding investigations and case conferences'* [pg40] R (on the application of the British Medical Association) v Northampton County Council and others [2020] available at: https://www.judiciary.uk/wp-content/uploads/2020/06/BMA-northamptonshire-CO-3419-2019-Judgment-Final.pdf

members and practitioners involved in the case spoke of the improvements that the new multi-agency 'Family Safeguarding' model of delivery will bring. This aims to adopt a motivational approach to child safeguarding, working with families in a way that recognises the challenges they face and the strengths they may have.[9]

3.21 Whilst practitioners involved with Becky and her family very much regretted, with hindsight, the timing of the decision to cease PLO pre-proceedings process, they did not believe (given what was known at that time) there would have been sufficient grounds to continue this or escalate the case into proceedings under s31 Children Act 1989. The Children Act 1989 is clear that the paramount considerations must be the welfare of the child. There is also a 'no order' principle and a presumption that parental involvement in the child's life is in accordance with the child's welfare. A Court can only consider making a Care or Supervision Order if it is first satisfied that the 'threshold criteria' set out in Section 31(2) Children Act 1989 is met in respect of the child.[10] In order to obtain an interim care order or supervision order, it is necessary to demonstrate that there are reasonable grounds for believing the threshold criteria are met. In order to approve removal of a child from parental care under an Interim Care Order, a court must be satisfied that the child's safety demands immediate separation, and this is a necessary and proportionate response to the risks. The Court will consider alternative arrangements and available resources which would remove the need for separation. Given how rare and unpredictable such deaths are and the safeguards that were in place in this case to reduce risk, it is unlikely practitioners would have been able to evidence imminent risk to Becky or her sibling.

3.22 It is noted that the circumstances leading up to Becky's death are not yet fully understood, however the risk of SUDI had been identified by MST within their report to the ICPCC. The national Panel's review into SUDI[11] highlights the increased risk where there are concerns regarding domestic abuse, M's mental ill-health and alcohol consumption and a change in the family's living circumstances. Practitioners from across partner agencies therefore accepted during discussions this risk, however slight, should have been at the forefront of their minds and that it should have been made explicit within the child protection plans alongside the longer-term consequences of neglect.

3.23 Each year there are approximately 216 sudden unexpected deaths of infants in the UK. The Lullaby Trust[12] identify several modifiable factors which are associated with sudden unexpected death in infancy ['SUDI']. Their report, and associated guidance, recommends parents are aware that there is an increased risk associated with:

- Co-sleeping where either parent smoke, has consumed alcohol or taken drugs (including medications that may make them drowsy)[13];

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[9] See: https://www.surreyscp.org.uk/wp-content/uploads/2018/12/Effective-family-resilience-SSCB-Final-March-2019.pdf

[10] "that the child concerned is suffering, or is likely to suffer, significant harm; and that the harm, or likelihood of harm, is attributable to the care given to the child, or likely to be given to the child if the order were not made, not being what it would be reasonable to expect a parent to give to the child; or the child's being beyond parental control".

[11] Published in July 2020 after Becky's death

[12] Report into the evidence base into Sudden Infant Death Syndrome, March 2019 available at: https://www.lullabytrust.org.uk/wp-content/uploads/Evidence-base-2019.pdf

[13] The risk of SUDI is greatly increased in association with a combination of bed-sharing and smoking by either parent, even if they do not smoke in the bed. One case control study found the interaction between drug and alcohol use and co-sleeping increased the risk of SIDS by over 50 times. Under s1(2)(b) Children and Young Persons Act 1933 it is a criminal offence if it is proved that an infant has died as a result of suffocation whilst in bed with a person (aged 16 or over) and that person was under the influence of alcohol or prohibited drugs. NICE therefore advise that families where these are factors should be advised how to make co-sleeping safer in recognition that it can happen non-intentionally.

- The baby was premature, and/or of low birth-weight or with symptoms of foetal alcohol syndrome;
- Children born to women with an alcohol-related disorder diagnosed in pregnancy, indicating heavy drinking, have a significantly increased risk of SUDI. Binge drinking (defined as five or more drinks on one occasion) also increases the risk;
- Some products marketed for infant sleep, such as hammocks and nests or pods, are not firm and flat and so are not recommended for use by the Lullaby Trust, although their relationship to SUDI has not yet been established.

3.24 Local NHS policy[14] sets out that safer sleeping preventative advice is given at every new birth visit and, is particularly crucial, if a baby has a low birth weight or premature because of the increased risk of SUDI to that cohort. There is also evidence to support that children who are at risk of Foetal Alcohol Syndrome are at higher risk of SUDI. The Health Visitor remembered raising safer sleeping advice with M. This isn't documented within her case notes,[15] but this could be because the advice is held within the child's red book so it remains accessible to parents.

3.25 Growth in infancy is also associated with high childhood morbidity and mortality. Becky's weight remained a significant issue, such that it was monitored closely by the health visitor at each visit. It is understood that the health visitor recorded this within her 'red book'. Since Becky's death the NHS Trust responsible for health visitor provision has reviewed and ratified new faltering growth guidelines and provided flow charts as quick reference for staff to use during home visits, telephone contacts or within a clinic setting. The have improved information on their website to assist parents understand the importance of monitoring their baby's growth.[16]

3.26 During conversations with the Reviewer, practitioners reported that F and the wider paternal family understood risks in respect of M's alcohol misuse and became more vigilant. Practitioners did, however, accept that more should have been done to test whether earlier professional concerns that wider family members had '*colluded with and allowed the parents' habits and behaviours to continue unchallenged and no members of the wider family has ever raised any concerns to professionals regarding domestic violence between the parents or indeed, mother's excessive alcohol misuse*'[17] had been addressed.

3.27 When discussing learning in this case, practitioners were all very clear that safeguarding the welfare of children was their principle duty and were able to point to the support they could access, through specialist safeguarding leads or supervision if further guidance was needed in respect of a challenging case.

3.28 It is well understood, including from the findings of SSCP's own audit activity, that completing the safe sleeping assessment and a safe sleeping plan enables parents to understand the risks more comprehensively and put in place appropriate arrangements to prevent such tragic deaths.

[14] Clinical Guidelines for a new birth visit (Children and Family Health Surrey Oct 2018)
[15] As reported within the Information report prepared for the purpose of this report.
[16] See https://childrenshealthsurrey.nhs.uk/services/growth
[17] Taken from the Legal Gateway Planning meeting minutes

Were child protection and Public Law Outline pre-proceedings processes applied correctly and did the child protection plan adequately addressed safety arrangements in respect of domestic abuse, mental health and alcohol misuse;

3.29 Within the ICPCC practitioners identified a risk of physical harm to the unborn child arising from domestic abuse and M's excessive use of alcohol as a coping strategy. They also identified the potential for emotional harm to be experienced by the older sibling from the parental conflict, including allegations of domestic abuse within the relationship. M's capacity to provide good care to the children, the support she could rely on from wider family members and F's affection and close connection to the older child was also recognised. Despite this, both children were registered as likely to suffer 'neglect'. The rationale for choosing neglect rather than physical harm as a principle risk isn't clear.

3.30 The child protection plan required M to abstain from alcohol and engage with the specialist alcohol service. Previously M had told practitioners that she wished to cut down her drinking, but remain able to continue to drink alcohol in a social context. Despite strong encouragement she failed to attend appointments until January 2019 and there was no objective evidence to suggest she had abstained from alcohol. The child protection plan also required M to continue to work with the Trust's team, though by this time they had completed their assessment, concluding no further involvement was necessary.

3.31 The child protection plan included a requirement that M and F '*take time to consider the impact on their children as a result of [F's] violent and abusive behaviour'*[18]. There was no clear action or outcome for practitioners to measure. The child protection plan placed the onus on M to report any breaches of bail conditions to police and notify practitioners of the outcome of the prosecution. The plan didn't engage directly with F to ensure he was aware of the risk posed by his reported coercive behaviours or require he undertook any perpetrator programme. Instead the midwife was instructed to put in place arrangements to prevent F's attendance at future appointments until bail conditions were lifted. Their report to this review confirmed this action was taken immediately, demonstrating effective safety planning good practice. It does not appear that the GP was notified of the outcome of the conference. Since this time further training has been made available to Child Protection Chairs and there are clear arrangements for spilt conferences where there is an allegation or concerns regarding domestic abuse.

3.32 Within the PLO pre-proceedings meeting it was agreed that the '*subject of domestic violence and what it means for both parents and children should be explored and incorporated into the Parenting Assessment… There must be no further incidents of domestic violence*'.[19] Within the PLO written agreement both parents were expected to complete DV awareness work, but no details of what this would entail, or deadlines were set.

3.33 Following the ICPCC, a core group was established, and subsequent meetings were conducted in a timely way, meeting the expectations set out in 'Working together' guidance. The PLO pre-proceedings process commenced on the day Becky was discharged from SCBU with a written agreement setting out the plan for assessments. Whilst a date was

[18] Taken from the ICPCC minutes
[19] Taken from the PLO minutes

given within the meeting for both the midway review and a final review date it does not appear these deadlines were met.

3.34 During this period further incidents of domestic abuse were reported, in addition F was reportedly turned down for support by the specialist perpetrator programme ‘steeping up’ as not meeting the criteria.

3.35 Both M and Becky’s maternal grandmother separately questioned the purpose of supervising M parenting and how long that will be required. The review heard that there were two occasions in which M and maternal grandmother disclosed breaches in the supervisory arrangements (M was left unsupervised with Becky and both M and maternal grandmother admitted using alcohol). Despite open nonconformity there is no evidence that this triggered a review of the child protection plan, nor a request by CSC for a further Legal Planning Meeting. Both would be required if practitioners believed the plan was unsuccessful. These incidents provided an ideal opportunity to reiterate safer sleeping advice and remind M and her mother of the increased risk of SUDI to Becky given her prematurity and the family’s circumstance. It is regrettable that these opportunities do not appear to have been taken.

3.36 It should be noted that all relevant partners engaged with the child protection process and PLO assessments. Subject to the issues identified above, assessments were largely completed within the agreed timeframes. Consideration was given within the parenting assessments to parental engagement with domestic abuse and alcohol support services and reasons given by each parent for this. Those assessments also drew on direct observations and core group reports, concluding that the practical care shown by both parents was to a good standard and that both parents understood practitioners concerns and accepted responsibility for ensuring the care they provided the children reduced risks associated with the ongoing concerns regarding M’s alcohol misuse and parental conflict, including allegations of domestic abuse. The role of the extended family network to monitor and support effective, safe parenting was also noted.

Were there are any systemic issues that affected decision making or practice in the case?

3.37 Thematic reviews into lessons from serious case reviews[20] highlight the importance of feeding back the outcome of any referral to the referrer and of ensuring that information given has been understood by all. There is always a risk that case responsibility can be diluted in the context of multi-agency working, meaning that families are signposted to other agencies for support with little or no follow up. In the main, however, agencies worked well in this case to explore the safeguarding risks posed to Becky and her sibling. The children’s voices, reported as the attachments they had to both parents and likely impact on their development and wellbeing of domestic abuse and parental alcohol misuse, was clearly recorded within assessments and during home visits by all practitioners. There was some delay to assessments, but there is no reason to suspect those delays inhibited good inter-agency working or contributed in any way to Becky’s tragic death.

[20] For example. ’10 pitfalls’ by Dr Karen Broadhurst, Professor Sue White, Dr Sheila Fish, Professor Eileen Munro, Kay Fletcher and Helen Lincoln available at: https://www.nspcc.org.uk/globalassets/documents/research-reports/10-pitfalls-initial-assessments-report.pdf

3.38 Systems could be improved to enable agencies to notify the most relevant agency of a safeguarding risk, rather than rely on a more complex chain of information sharing. For example, the delay by the specialist alcohol service in notifying MST directly that M was not attending, despite the referral coming from that service and agreement that health would lead the safeguarding investigation could be overcome by ensuring that information sharing agreements make clear practitioners are entitled to share concerns with all relevant safeguarding partners. In addition, the Police raised concerns within this review that there is no mechanism for the police to share information with health colleagues about attendances at domestic abuse incidents. Presently therefore it expected that the social worker will act as a conduit even where they are not leading investigations. In this case, notification of further police involvement in domestic abuse between the parents was overlooked because the social worker was under the impression that the MST were already aware.

Did the local practice review, undertaken by the SSCP in July 2019, correctly identified the wider systemic issues that may have affected practice and what evidence there is of improvement to practice following those recommendations?

3.39 The SSCP's learning review in July 2019 looked at what information was routinely provided to parents regarding the risks of SUDI and also those risks associated with parental alcohol misuse. This included information that was available to parents through the red book, leaflets provided by health visitors and on relevant websites. Health visitors had access to recent training on safer sleeping messages to give to parents through the Health Visiting Forum and in workshops on specific topics.[21]

3.40 In addition, SCR panel members confirmed within this review the SSCP ran an awareness campaign of the risk of SUDI in 2012. The impact of these campaigns was assessed through audit activity undertaken by the SSCP in 2016 and 2017. The most recent audit reviewed 50 cases and found that, whilst all had received red books which included pages on 'infant death- reducing the chances and the safe sleep assessment and action plan', only 18 had a fully completed safe sleep assessment (5 more were partially completed). Only 17% (4/23) of the fully/partially completed assessments identified risk factors, but only 1 had a completed action plan. The audit report also noted that '*Mothers who had the Safe Sleep assessment completed recalled the conversation quicker and were able to discuss more of the risk factors, more confidently in comparison to the women who did not have the assessment completed.*'[22]

3.41 The national panel's review into SUDI emphasised safeguarding work '*is not something that can be left solely within the remit of public health officials or relegated to the handing out of a health promotion leaflet. Rather, it needs to be embedded within respectful and authoritative relationship-based safeguarding practice.*'[23] This report stressed this is not just an issue for midwives and health visitors, but rather that all practitioners need a flexible and tailored approach to prevention that is responsive to the reality of people's lives. This means talking honestly with parents about how they will cope in different situations to ensure every sleep is

[21] For example, in December 2019 Dr Raja Mukherjee delivered a workshop on "What is Foetal Alcohol Syndrome and its impact"
[22] Taken from the Safe sleep re-audit report for Surrey SSCP, by Noreen Gurner, Specialist Nurse Child Death Reviews dated January 2017.
[23] See page 5 of the report: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf

safe. Their review identified the best local arrangements for promoting safer sleeping involve a range of professionals as part of a relationship-based programme of support, embedded in wider initiatives to promote infant safety, health and wellbeing.

3.42 Again, practitioners involved in this case recognised the opportunities for all professionals to re-enforce safer sleeping messages and test out whether those arrangements were being observed in practice, particularly where 'triple risk' factors[24] are present. The Triple Risk Hypothesis suggests that SUDI occurs due to a combination of factors including the infant is vulnerable (e.g. physiological abnormality of some kind'), the infant is at a critical period of development (e.g. first six months of life) and thirdly there are external factors that serve as a stressor to the infant (e.g. placed in the prone position or breathing is compromised by soft bedding.

3.43 Whilst practitioners universally welcomed a recommendation for further training to enable a multi-agency approach to safer sleeping and the reduction of SUDI, they asked that this also recognised additional difficulties that arise when there are issues of disguised compliance or non-engagement by parents in critical areas of any child protection plan. The SSCP confirmed they do currently offer training in respect of disguised compliance and 'working with conflict'. This could be adapted to provide core messages arising from the National Panel's review findings into SUDI and the heightened risk for families where there are concerns regarding neglect.

4 SUMMARY OF RECOMMENDATIONS

4.1 Surrey Safeguarding Children Partnership ['SSCP'] disseminate the learning from the National Panel's review and Surrey CDOP's own thematic review[25] into SUDI and revise their policy and practice guidance to ensure that where there are additional risk factors, such as parental alcohol misuse, mental ill health, domestic abuse or unstable housing conditions this risk is addressed directly within child protection plans and/ or PLO assessments.

4.2 Midwifery teams, health visiting services, specialist secondary support agencies and SCS where children are CiN or on CP plans should provide the SSCP with assurance that safe sleeping assessments and safety plans have been conducted. All partner agencies should give consideration to identifying the increased risk of SUDI where there is parental alcohol or substance misuse. CSC should ensure that preventative measures expected to be taken by parents and care givers are given distinct actions within any child protection plan, allowing practitioners working with the family to refer to this and reinforce the safe sleeping message. Practitioners working directly with the family and care givers need to continually test their understanding of the message and what measures they have put in place to keep the baby safe when sleeping.

4.3 The CCG and relevant health agencies to provide the SSCP with assurance regarding the steps being taken to ensure they are able to meet best practice guidance in respect of Foetal

[24] Report into the evidence base into Sudden Infant Death Syndrome, March 2019 available at: https://www.lullabytrust.org.uk/wp-content/uploads/Evidence-base-2019.pdf.
[25] This is currently underway and due to be published in January 2021.

Alcohol Spectrum Disorder, particularly in relation to preventative interventions during pregnancy.[26] Consideration is also given to identifying the increased risk of SUDI where there is parental alcohol misuse. That preventative measures expected to be taken by parents and care givers are given distinct actions within any child protection plan so that all practitioners working with the family can reinforce their importance and monitor compliance.

4.4 All relevant agencies are to provide the SSCP with assurance that they have disseminated the learning from the National Panel's review into SUDI. The SSCP also seek assurance that partner agencies have aligned organisational policy and practice guidance with any revisions to the SSCP Safeguarding Procedures identified following implementation of recommendation 1 above so that practitioners from across health and social care disciplines understand the increased risks of SUDI to children where there are concerns regarding neglect and their role in reinforcing safer sleeping advice and monitoring adherence to this.

4.5 SCS are to provide the SSCP with assurance that they are monitoring the impact of the revised ICPCC practice guidance and training for Chairs to ensure that the importance of accuracy for factual accounts is properly understood and meetings facilitate engagement by both parents.

4.6 SCS should provide assurance to SSCP, perhaps through audit activity, that child protection and PLO plans identify specific activity required by parents to address concerns regarding domestic abuse and substance misuse. That plans also contain clear contingency plans if further incidents of domestic abuse or non-engagement with specialist support agencies are reported so that practitioners and families are clear about the outcomes and how adherence to the plan will be monitored.

4.7 When working as a team around the child all relevant agencies should share relevant information about parental capacity and motivation. For example when support services such as drug and alcohol misuse support services are working as part of a team around a child and families, information about parental abstinence and relapse, the possible impact of this on the safeguarding and well-being of children should be shared with the lead practitioner in a timely way, remaining mindful that during pregnancy this would usually involve the Maternity Safeguarding Team.

4.8 The SSCP to consider monitoring adherence to any revised information sharing guidance through audit activity.

4.9 In line with the national panel's review report the SSCP should consider developing a SUDI prevent and protect practice model that recognises the continuum of risk of SUDI, with support and interventions that are graded to reflect the needs of different families. This should provide practical guidance to all practitioners working with families where domestic abuse, mental ill health and substance misuse is a factor on the powers available within the existing legal framework to pro-actively gather evidence of compliance with child protection plans.

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[26] Best practice guidance is available from the BMA (at: https://www.bma.org.uk/what-we-do/population-health/drivers-of-ill-health/alcohol-and-pregnancy-preventing-and-managing-fetal-alcohol-spectrum-disorders). There is also draft NICE guidance regarding SUDI and post-natal care (available at: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 and draft Quality standards (available at: https://www.nice.org.uk/guidance/indevelopment/gid-qs10139/consultation/html-content-3) currently subject to consultation and expected to be introduced in 2021.

APPENDIX ONE: QUESTIONS FOR THE REVIEW

- Did practitioners properly understand the risks posed to Becky by parental conflict, including allegations of domestic abuse in the parental relationship (hereafter referred to as ‘M’ for mother and ‘F’ for father), including reports of domestic abuse, parental alcohol misuse and mental ill health?

- Were interventions (including referrals to secondary services) were appropriate, timely and effective?

- Was the level of ‘professional curiosity’ exercised in respect of her parents’ ability to meet Becky’s needs was sufficient. Particularly in light of M’s disclosures that she used alcohol as a coping mechanism to manage depression and low self-esteem, arising from emotional and physical abuse by F?

- Were the child protection and Public Law Outline pre-proceedings processes were applied correctly and if the child protection plan adequately addressed safety arrangements in respect of domestic abuse, mental health and alcohol misuse?

- Were there are any systemic issues that affected decision making or practice in the case?

- Did the local practice review, undertaken by the SSCP in July 2019, correctly identified the wider systemic issues that may have affected practice and what evidence there is of improvement to practice following those recommendations?