Local Safeguarding Partners' response to the CSPR for Kubus
March 2023

INTRODUCTION

In 2022, under Working Together 2018, the Local Safeguarding Children Partnership, known as the Waltham Forest Safeguarding Children Board, agreed to undertake a child safeguarding practice review (CSPR) and in line with guidance, reflects the principles of a systems-based approach.

This CSPR concerns the unexpected death of a 15-week-old baby boy, who died while sleeping on his stomach on an inflatable mattress with his mother. As per her wishes, he is called Kubus in the review, which explores the services provided to him and his family during his mother's pregnancy and his short life, in which domestic abuse was a significant feature. The cause of death was recorded as sudden unexpected death in infancy (SUDI).

The review sought to understand why things happened in the way that they did. Broadly, this meant using Kubus' circumstances as a 'window on the system,' asking the question: What does Kubus' and his mother's experience tells us about how systems work? This systems approach focuses on multi-agency professional practice. The aim was to look for areas that relate to systemic issues, which will lead to changes in practice. Seven impacting factors were identified during the timeframe of the review relate to Covid-19, pregnancy (ante, peri & post-natal), housing, domestic abuse, cultural competence, fathers and documentation which are each explored further in the CSPR.

The review is not about blame. Its focus is very much on learning and improving practice for the future and will be applied across our services, including for adults.

PARTNERSHIP RESPONSE TO THE FINDINGS OF THIS CSPR

We continue to reflect on learning from the pandemic and will utilise the findings from this review in the event of any other crisis. Recruitment / retention is currently one of the partnership's biggest challenges and remains an area of ongoing focus across agencies.

We acknowledge that health visitors should be considered core services, which we will ensure features more broadly in the Babies, Children and Young People (BYCP) agenda through work taking place under the Health & Care Partnership and will consider whether BCYP should start before pregnancy in the ante natal period.

This review (and resources) will be shared with all Barts Health maternity services, primary care, health visiting services, endocrinology, cardiology and renal which will be accompanied by a mandatory learning session. This will cover all the relevant learning points, including asking the second question as well as appropriately asking about domestic abuse. We know that central to gathering information about a DVA incident, particularly involving non-ambulant children is asking the second question and triangulating all information effectively. This needs ongoing awareness, and forms part of our wider learning and improvement activity.

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We know that local health agencies have a range of fora at which learning can be shared, such as mortality and morbidity club and / or journal club and / or grand rounds and commitment will be sought to these being vehicles for sharing this review as well as ensuring appropriate representation by services.

Violence against women and girls (VAWG) remains a priority area for the partnership. We know the value that IRIS brings and will work to sustain commissioning for this service which continues to support primary care staff of all levels. We will also scope what learning we can take from IRIS and what other training is available from commissioned VAWG services that can be directed at wider teams.

The Board notes that the top five countries of origin for residents born overseas are eastern European and therefore the large amount of our residents who may be facing similar challenges to Kubus' mother. Use of an interpreter will continue to be promoted, including through the sharing of this review and findings. We will consider the discrimination that 'white other' cohorts experience and explore how this can be incorporated into wider inclusion and diversity and cultural competency programmes that are being rolled out across services.

We note the findings around documentation and recognise the need to seek assurances that accurate quality documentation is maintained. Our MASH Strategic Group is currently leading on collating relevant single agency audits relating to recording which will provide a measure in this regard to the partnership. Furthermore, we will ensure our next round of multi-agency audits continue to include a focus on documentation and supervision, to assist with any specific areas that require focus. We will also explore through our audits to what extent health services are included in partnership interventions, with a view to improving meaningful involvement / participation, particularly by primary care.

The Board understands the operational challenges that result in handwritten records not always being transferred accordingly. There is a need for health / midwifery teams to ensure adequate time / resource / systems are in place for staff to enable them to transfer records accurately on to the care record service (CRS). For instance, could this take place at one of the community hubs or simply uploading a picture? Some exploration of possible improvements will take place between commissioners for maternity care and the clinical leads, in conjunction with secondary and community care.

With regard to appropriate information-sharing across agencies, we are confident in the mature relationships and strong culture of collaboration that exist in Waltham Forest which should consistently facilitate effective information sharing. We know that getting this part of the system right was central to how these circumstances unfolded. This is an existing area of focus and we have recently refreshed our formal partnership sign up to the Pan London information sharing protocols. We will ensure that this is followed up with refresher awareness sessions throughout our programme of training. We will also explore how we might replicate aspects of other information sharing initiatives such as Operation Encompass into health settings.

We believe one of the main barriers to information sharing is the fragmented technological systems that lack interoperability. The Board notes delays with the planned roll out of the child protection information system (CPIS). Had phase 2 of CPIS been implemented during the timeframe of this review, then it is likely that the GP would have received pertinent information to prompt support / intervention by that

service. The Board considers whether this could act as a driver for increasing the pace of CPIS implementation for NHS England and will share the findings of this review with the relevant NHSE representatives.

We acknowledge the need to further improve the transfer of cases out of borough. This presents an ideal opportunity to learn from examples of good practice and where this has worked well, which can be shared across the partnership, celebrated and learned from.

Housing related issues have more recently emerged as an area of challenge for the partnership and will form part of the 2023 review of the Strategic Partnership Board priorities. We understand some of the findings about housing relate to an administrative system on discharge and requires cross referencing information accordingly. Steps will be taken to improve this process.

We have previously considered the complexity of houses of multiple occupancy (HMOs) through other strands of work, like modern slavery. We note that more can be done in this regard, and we are encouraged that the council's housing service has established a new early intervention pilot team to test proposals for a Housing Sustainment team. It is thought this would improve the wider system and enable more housing related prevention work such as training of frontline staff, new ways to inform residents on their options and manage expectations, increased advice, support and signposting, and the improved use of data. The pilot team of four will be based in one of the Family Hubs which will place them closer to those in most need as well as connecting them to multi-agency services / partners to better facilitate referrals and signposting. We will also explore as a partnership how we can get messages out to residents / professionals through the private rented sector and the various community participation networks, particularly for HMOs.

In Waltham Forest we have a well embedded 'think family' approach however the Board notes the oversight of Kubus' father's involvement in this review which is somewhat reflective of operational practice. This is changing with initiatives such as Safe & Together which places a focus on perpetrators in the context of domestic abuse. New projects being rolled out are considering fathers more so than ever, such as Family Hubs which are contemplating spaces particularly for them. Moving forward, all reviews will include reflections on the father/ co-parent / perpetrator chronologies.