Waltham Forest Safeguarding Children Board

Child Safeguarding Practice Review

February 2023

Kubus

Review authors:

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Strategic Partnership Boards
SAFETY SAFEGUARDING WELLBEING

Contents

1. Introduction and circumstances for the review

1.1 Under Working Together 2018, the Local Safeguarding Children Partnership known as Waltham Forest Safeguarding Children Board agreed to a recommendation from the One Panel (multi-agency forum that takes referrals for local or statutory reviews and makes recommendations against the statutory criteria) to undertake a child safeguarding practice review (CSPR).

1.2 This CSPR concerns the unexpected death of a 15-week-old baby boy, who we are calling Kubus, as well as the services provided to Kubus 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).

1.3 It is imperative that Kubus and his family have their identity protected. The name Kubus was chosen by his mother and is the term of endearment she would use to refer to him. We have referred to mum as Agata and father as Pawel to maintain their anonymity.

2. Methodology and agencies involved

2.1 This review has been carried out using the Waltham Forest ethos of a Think Family approach with strength-based principles.

2.2 The review seeks to understand why things happened in the way that they did. Broadly this means 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 is to look for areas that relate to systemic issues, which will lead to changes in practice. The review is not about blame. Its focus is very much on learning and improving practice for the future.

2.3 Data was gathered from a variety of sources, including the review of existing documentation alongside data provided by front line practitioners and their managers / senior managers in the review team. We have used an evidence-based approach to support our recommendations, sought through a literature review.

2.4 A key part of undertaking a CSPR is to gather the views of the family regarding the services they received from agencies and share findings of the review with them prior to publication. The reviewers met with Agata to hear and understand her experience to ensure the voices of her and Kubus were reflected in the review

2.5 The final report has been authored by Dr Sabeena Pheerunggee, Named GP for Safeguarding, NHS North East London and Ghislaine Stephenson, Think Families Lead Nurse, Barts Health. The process has had oversight by the Independent Scrutineer / Chair of the Waltham Forest Safeguarding Children's board, Dave Peplow.

2.6 The review period is from September 2020 until 24 July 2021, covering the antenatal period as well as the 15 weeks of Kubus' short life. It should be noted that increased stress had been placed on health, social care and policing services due to the Covid-19 Pandemic, in which modified working practices were in place.

2.7 The review group comprised senior managers from all agencies involved with Kubus and his family in the 10 months before his death. The review group took part in a workshop with frontline practitioners who knew Kubus and his family. The professional, open and honest way all concerned conducted themselves throughout the process was noted and valued by the authors.

2.8 Agencies in attendance:

- London Borough of Waltham Forest
    - Safeguarding Team
    - Early Help Team
    - Housing Department
- North East London Foundation Trust (NELFT) – Health Visiting Services
- Metropolitan Police Service
- Hertfordshire Community NHS Trust

2.9 It should be noted that whilst the authors represent Barts Health NHS Trust and General Practice (Newham), apologies were received from the practitioners actually working with the family. Their input could have provided case context and nuance that may have generated greater understanding of some of the detail.

3. Background

3.1 Agata came to the UK from Poland as a teenager. She advised us of her exposure to domestic abuse as a child in Poland. This continued during her life in the UK in her family network and in her intimate partner relationships. Agata explained to us that domestic abuse was normal to her, and she did not believe that agency intervention would make a difference to her lived experience.

3.2 Information submitted to the review identified Kubus' Father, as being previously arrested for domestic common assault and discussed at a multi-agency risk assessment conference (MARAC). We know that he is also of Polish Background.

3.3 During the antenatal period, Agata and Pawel were living in a privately rented house of multiple occupancy (HMO) in Newham. Agata was receiving primary care in Newham and antenatal care from the high risk team at the Royal London Hospital, Tower Hamlets, due to severe high blood pressure in pregnancy.

3.4 At the time of his birth Kubus' parents had been evicted from the HMO in Newham; their landlady had told them they could not bring a baby back to that address. Kubus' mother and father were unaware of the law in relation to evictions during Covid-19. Whilst Kubus' mother was an inpatient, post-delivery, her partner had moved them into

an HMO in Waltham Forest. However, Universal Services (0-19) in Health had the old address in the neighbouring borough of Newham.

3.5 The first disclosure and reporting of domestic violence and abuse (DVA), in the postnatal period resulted in multi-agency involvement, despite which there was escalation of DVA which resulted in the relocation of Agata and Kubus to Hertfordshire.

4. Sudden Unexpected Death in Infancy (SUDI)

4.1 The Coronal report identified the cause of death as SUDI. Kubus died while sleeping on an inflatable mattress along with his mother and was sleeping on his stomach. This does not comply with safe sleeping guidance. In addition, the SCR process revealed that smoking and alcohol were present in the households that Kubus lived in.

4.2 SUDI is a descriptive term applied to any infant death that was not anticipated. Child Death Reviews 2019[i], exploring SUDI, identified that the major risk factors are well known and include families living within a context of background risks such as, deprivation and overcrowding and co-sleeping, domestic violence, smoking and alcohol and / or poor mental health. The advice on reducing the risks is evidence-based and well established. Despite this, the report states that 'it is apparent that while the safer sleep messages may be rigorously delivered by health professionals, many of those families who are most at risk are either unwilling or unable to receive or act on those lessons for a multitude of reasons.' 'And to bring about more effective working, we need to have a better understanding of the circumstances in which these babies are dying, how and why their parents are making choices about their infants' care and sleeping arrangements, and how practitioners are seeking to engage and work with families whose children are at risk.' This was further identified in the 2020 report 'Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm[ii]'.

4.3 Co- sleeping with an adult on a bed is a recognised risk factor for infant death, especially in babies under 6 months of age. The risk is greater if co-sleeping occurs on a sofa or a chair and if the adult has consumed alcohol. The possible mechanisms involved include accidental overlay and / or alterations in the baby's body temperature (overheating). Section 6.4 provides further narrative.

4.4 During the course of this review, we will explore in greater detail the contributing factors that are applicable to this family and the system level learning. These will include but are not limited to domestic abuse, housing, partnership working with a number of points for consideration for the Strategic Partnership.

[i] Child Death Reviews: year ending 31 March 2019

[ii] Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm

Identified impacting factors during the timeframe of the review:

5. Covid-19

5.1 The Covid-19 Virus was first noted in the United Kingdom in January 2020, with the first national lockdown being announced in March 2020, and various amendments to lock down measures in place until December 2021.

5.2 Due to the extraordinary circumstances presented by Covid 19 and the need to ensure adequate infection control measures, working practices were rapidly modified and heavily reliant upon virtual interactions with service users. Furthermore, staffing across the operational safeguarding partnership was affected due to the redeployment of staff, direct and /or indirect leave (i.e. shielding, bereavement, stress and anxiety). Therefore, caseloads for front line staff increased exponentially.

5.3 The balance between controlling infection rates universally, and the requirements for seeing a service user face-to-face, meant that by default, most services had to initially use a virtual / telephone contact model. This may account for the lack of face-to-face visits in the home from 0-19 universal and social services, consultation in GP surgeries and community health services. Thus, having an impact on visibility and disclosure of safeguarding concerns, creating the paradox of staying safe at home, while questioning if home is a safe place. One of the natural consequences of virtual / telephone contact is the lack of non-verbal cues and information the professional might receive during an assessment.

5.4 A study conducted by UCL [iii]gathered the views of 663 health visitors to understand how Covid-19 affected their work. The study reflects the working practices adopted in the borough during the period that this review covers. Health visitors were unanimously worried about domestic violence and widening health inequalities, due to the challenges placed by staff redeployment, inadequate PPE and increasing caseloads. A Nursing Times article [iv]reflects that urgent workforce planning needs to take place because "robust delivery of the work of health visitors with all families is an essential way in which governments can ensure more positive outcomes not only for children and families, but also for society"

5.5 Police data from the Office of National Statistics [v]from 2020, demonstrates domestic abuse cases flagged were on the rise with an 18% increase from the same period in 2018. Refuge, one of the leading domestic abuse organisations reported that calls to the UK Domestic Violence Helpline increased by 25% in the seven days following the announcement of tighter social distancing and lockdown measures by the government. During the same period, there was a 150% increase in visits to the Refuge website (as cited in 'The pandemic paradox[vi]' research).

[iii] UCL - The impacts of COVID-19 on Health Visiting in England
[iv] Nursing Times – survey shows 60% of health visiting teams affected by Covid-19 redeployment
[v] Domestic abuse during the coronavirus (COVID-19) pandemic, England and Wales: November 2020
[vi] The pandemic paradox: The consequences of COVID-19 on domestic violence

5.6 The impacts of the Covid-19 Pandemic are a significant feature throughout this review, affecting service delivery and sustained, modified ways of working the 'new norm'. We will explore further in other identified impacting factors discussed below.

Question to the board / areas to strengthen practice

Reflecting on the impact of Covid-19 to service delivery and quality outcomes, how does the partnership ensure that should we see another such crisis, we ensure that core services are maintained and provided with timely adequate resource to support their functions?

Identified impacting factors during the timeframe of the review:

6. Pregnancy care (ante, peri and postnatal)

6.1 Agata experienced a high-risk pregnancy due to a diagnosis of hypertension (high blood pressure). This meant her care was transferred to the Royal London Hospital, a tertiary centre and consultant–led, with increased frequency of antenatal assessment with doctors (secondary and primary care) and midwifes. This is opposed to low-risk pregnancies with the care being midwifery-led. In addition, she was assessed and monitored by the renal, cardiology and endocrine teams. This means that Agata had high visibility to numerous health professionals in the antenatal period. The reason is that hypertension early in pregnancy, in young women, is not common and can hold significant risks during pregnancy. While the medical management cannot be faulted, the psychosocial assessment by health was absent and not considered to be a potential contributing factor to her condition. This is a significant factor considering medical records do not reflect enquiry to facilitate disclosure of the domestic abuse, including coercive control she was experiencing in the antenatal period. This aligns with findings that victim / survivors of domestic abuse will have up to 35 encounters with health before disclosure.

6.2 Her perinatal experience at the Royal London Hospital was distressing due to her experience of racism from the midwifery team. This was a further contributing factor to not sharing her social circumstances. She advised us had she been asked about abuse and her circumstances, she would have disclosed but was reticent on what they would do, due to her previous experiences with services.

6.3 The table below demonstrates what best practice should be in the postnatal period, the adaptations in place due to Covid-19 and what actually happened for Kubus and Agata, and why this matters.

Postnatal time frame: **Prior to Discharge** Covid-19 service modification: **No change**		
What should happen?	*What happened?*	*Why does this matter?*
- Breast feeding facilitation and support. - Baby check - Maternal check (wound, blood pressure, bowels and bladder) - Check discharge address - Ensure car seat is available for transportation - Discuss safe sleeping / smoking / alcohol and the risk factors from the wider household - Discuss next steps regarding her hypertension	**Postnatal baby check**: - Bruise on right side of babies head - No escalation from midwife who noted bruise - No further documentation from other practitioners - No communication in the discharge summary to the GP. - Discharge summary does state home BP monitoring and escalation plan if not controlled - Failure to establish discharge address **Agata advised:** - she did not feel supported for breast feeding despite asking - No one rechecked her address or housing situation	The bruise could have been related to: - birth trauma - non-accidental injury from professionals or parents or another patient on the ward. A lack of professional curiosity meant there was no escalation and communication to the wider teams for assessment and monitoring. See further reasoning below Breast feeding has many protective factors for mother and baby such as: - child immunity - protective for SUDI (check literature)

Postnatal time frame: **Day 1** Covid-19 service modification: N**o change**		
What should happen?	*What happened?*	*Why does this matter?*
Midwife led new birth visit (at home)	Failed postnatal home visit, because Kubus and his family were no longer residing at the	Not having correct contact details creates: - a delay for new mums (which is a very vulnerable time especially during Covid-19 when there were a number of social distancing measures in place meaning wider social

	address documented in Newham. Significant because, best practice would be for the correct address and contact to be confirmed before discharge.	networks may not have been available to support mum) and the support they may require in the immediate postnatal period: ○ Maternal physical health ○ Child health ○ Breastfeeding ○ Psychosocial challenges ○ Safeguarding risks Additional workload to an already understaffed over stretched service, compounded by the challenges of service delivery during Covid-19.
Postnatal time frame: **Day 5** Covid-19 service modification: **No change**		
What should happen?	*What happened?*	*Why does this matter?*
- Community midwife visit for blood spot sample from baby - Review of baby including: ○ weight ○ feeding ○ jaundice - Postnatal review of mum including: ○ Wound healing ○ Mood / bonding ○ Blood pressure	Blood spot took place, however, the documentation on paper records was brief. There had not been a transfer of paper records onto the electronic record system (ERS), in line with Bart's process.	Blood spots detect 9 conditions and are essential to prevent disability and save babies' lives with early treatments and improve health outcomes. Inadequate documentation including incorrect contact / address details, plus failure to transcribe to the ERS system have the following implications: 1) If an issue was detected, how would the team follow up, to ensure timely and correct treatment? 2) Inability to establish how mother and child were progressing post-discharge, and if there were any health or social care concerns that needed monitoring and that would form part of the risk assessment and management process with future interactions 3) Organisational risk due to failure to adhere to professional standards for record-keeping, thus having medico-legal implications

Postnatal time frame: **Day 10** Covid-19 service modification: **Due to the infection control risk posed, assessments took place to establish if the home visits could be changed to virtual contacts**		
What should happen?	*What happened?*	*Why does this matter?*
Health visitor new birth home visit for: - holistic visit - review of mother and child - assessment of environment and safety - provision of advice on feeding, safe sleeping, vaccinations and adjusting to life as a new parent	Visit happened on day 14 and was virtual. The delay was due to: 1) Needing to make contact with Agatha and determine their new address. 2) Transfer of care from Newham 0-19 universal services to NELFT 0-19 universal services (commissioned at the time, in Waltham Forest)	Due to not establishing the discharge address, there were delays in service delivery because of the way systems are set up.

Postnatal time frame: **6 weeks** Covid-19 service modification: **Primary care Visit - X1 face-to-face visit for baby for physical examination and documentation in the red book X1 face-to-face visit for mum to assess physical / mental / emotional health and wellbeing and explore any potential safeguarding challenges she may be experiencing**		
What should happen?	*What happened?*	*Why does this matter?*
- The 6-week baby check was delayed until 8 weeks (with first childhood immunisations) as part of infection control measures at the time. - The maternal check was now virtual, and should a physical examination be required, this would take place at the 8-week visit for baby	Kubus not seen until 10 weeks, due staff sickness / absence. The maternal check also happened at 10 weeks There was an absence of appreciative inquiry as to why they had come from Hertfordshire to the appointment	Staffing provision was significantly affected during Covid-19. Therefore, unavoidably impacting service delivery. In the case of domestic abuse, virtual and reduced face-to-face contacts remove opportunity to facilitate disclosure and support for mother and child. The absence of professional curiosity, create barriers between service users and professionals, as they may not feel important and cared for. It also fails to support the safeguarding ethos of making every contact count.

6.4 A child's life journey starts from the point of conception. The challenges faced by the mother in the ante, peri and postnatal periods reflect that services had not employed a professionally curious practice. Furthermore, it brings to question if the perinatal experience of discriminatory practice influenced the quality of care received by Agata and Kubus, in respect to escalation, investigation and information sharing of the bruise, and ascertaining correct contact details. In short, there is a snowball effect from the lack of professional curiosity, resulting in ill-informed risk assessment and onward care delivery.

Questions to the board / areas to strengthen practice

- Barriers to professional curiosity, workforce challenges, especially with the additional multi-factorial pressures created by Covid-19 - how do we overcome this?
- Despite having the question regarding domestic abuse on antenatal forms, how can we assure ourselves that 1) the question is asked 2) the question is asked in such a way that supports and facilitates disclosure?
- All partners have non-discriminatory values and policies to reflect this in practice. How, do we ensure that service users do not experience discrimination due to their protected characteristics, that may differ from those of the professionals working with them?

The barriers and operational challenges to having contemporaneous accessible electronic records should be explored, with a view to identifying solutions to prevent gaps in information sharing which can lead to risk and result in harm. This may require work between commissioners for maternity care and the clinical leads, in conjunction with secondary and community care.

Identified impacting factors during the timeframe of the review:

7. Housing

7.1 Migration has always and will continue to remain a significant aspect of living in London, in part due to the availability and cost of housing. During the antenatal and perinatal period, there was an absence of professional curiosity or understanding of Agata's living circumstances and any risks this may pose to Kubus. The housing in Newham and Waltham Forest were both privately rented HMOs. When professionals fail to understand the living circumstances of service users, this creates challenges to contextualising risk and the support offered. The significance, in the context of SUDI, complicated by domestic abuse, is the risk posed by overcrowding, environmental factors such as smoking, drugs & alcohol, damp & cold.

7.2 When living in unsecure tenancy this means that migration across boroughs and sometimes beyond the local area is highly probable. This is evidenced twice in Agata's and Kubus' circumstances; the first due to eviction, so moving to a neighbouring North East London (NEL) borough and the second due to needing a safe residence. Thus, seeing them moving to Hertfordshire. The wider implication of migration is access to

services because community health and social care services are commissioned at a borough level. Therefore, as previously referenced the quality and safety depends on effective, timely information sharing, otherwise there will be gaps in service delivery. This has been evidenced throughout.

7.3 Pawel and Agata were unaware of their tenancy rights and of the law in relation to evictions during Covid-19. They also did not know who to contact for support and guidance. The impact on housing circumstances during the pandemic was managed at government level under the Corona Virus Act. Instructions for landlords and tenants stated that rental evictions should not take place in this time, in addition to notice periods being extended. This was in place throughout the timeframe of this review. This brings into question how authorities support private renters to receive information about their rights. This may be more of a challenge for those who are not native to the UK. Had Agata and Pawel always resided in Waltham Forest they may have received information on their rights via the connecting communities' work that is alive in Waltham Forest, (the only London Borough to be part of a government pilot scheme which aims to connect communities and improve social integration.)

7.4 It is imperative to examine Agata and Kubus' experience when they moved to Hertfordshire to stay with Agata's mother and younger sister. She describes the property as small with the second bedroom being like a store cupboard. Agata told the reviewers she did not have a cot and was sleeping on an inflatable mattress in the lounge, with Kubus. She has no recollection of anyone asking her about safe sleeping or whether she had a cot for Kubus in Hertfordshire. In this residence the challenges of over-crowding, smoking and alcohol in addition to the absence of safe sleeping provision are significant risk factors contributing to SUDI. Furthermore, the review established absence of information sharing from Waltham Forest to Hertfordshire, thereby rendering the family invisible to universal and social services in Hertfordshire.

Questions to the board / areas to strengthen practice

- As a results of migration, every health encounter should confirm that the service user's address and contact number are up to date. This does not have to be an additional workload, because when we are confirming patient identity this can be part of the check. This is a system that is inbuilt with most corporate companies and forms part of their script when in contact with service users. For health, this can form part of a risk assessment and identify social housing issues which can potentially have wider physical and mental health implications as well as potential safeguarding concerns.
- How can the board gain assurance that operational systems are robust in ensuring they hold the most recent contact information for service users?
- A 'wicked' issue is that some people may be reticent to share new addresses for a number of reasons such as fear of needing to find a new GP, without understanding the impact of the community services that they will require due to commissioning. Therefore, awareness to service users could be considered to improve their understanding of the need to provide up to date addresses and contact details which will ensure they receive correct and timely service support when required.
- How are private tenants informed of their housing rights?

Identified impacting factors during the timeframe of the review:

8. Domestic abuse

8.1 Domestic abuse is well documented in pregnancy, which is why all pregnant women are routinely asked in their antenatal and postnatal appointments if they have experienced DVA. The impact of domestic abuse on the unborn and all children within relationships where domestic abuse is a feature has a strong evidence base that is documented. Recent research demonstrates that maternal stress causes an increase in the stress hormone cortisol. When excess cortisol crosses the placenta, this can have a long-term physical and psychiatric health impact on the offspring. Babies, children and young people, will also have a sustained cortisol response to domestic abuse. These are considered to be adverse childhood experiences (ACEs), a term originally founded in the United States following landmark studies[vii]. These found a significant relationship between the number of ACEs a person experienced and a variety of negative outcomes in adulthood including poor physical and mental health, substance use and risky behaviour

8.2 The first incident of abuse was reported to the police when Kubus was approximately 4 weeks old. Following Agata's engagement with services, she revealed the first incident of domestic abuse was in the second trimester of pregnancy. According to research[viii], this is the time that the developing foetus is sensitive to sound and would also be affected by increased maternal cortisol levels.

8.3 When we met with Agata she disclosed whilst the first incident of physical violence in her relationship was during the second trimester, she also shared that there were frequent arguments due to Pawel's drinking with another tenant in the HMO and his dislike of her leaving the house. When considering what domestic abuse is, the Serious Crime Act 2015 and the Domestic Abuse Act 2021 recognise coercive control as a form of domestic abuse. However, people affected by this may not recognise it as domestic abuse and only consider physical violence as abusive. While safeguarding training undertaken by all operational staff clearly states the different ways domestic abuse may occur, there often is still a failure to recognise and facilitate the disclosure of coercive control.

8.4 Her reason for nondisclosure of abuse and housing difficulties respectively was due to not being asked by health professionals, throughout the antenatal period. Her perinatal experience at the Royal London Hospital was distressing due to her experience of racism from the midwifery team. This was a further contributing factor to not sharing her social circumstances. She advised that had she been asked about abuse and her circumstances she would have disclosed but was reticent on what they would do, due to previous experiences with services. Earlier in the review, the authors noted the number of missed opportunities professionals had to ascertain the challenges Agata was facing at home.

[vii] Adverse Childhood Experiences (ACEs)
[viii] The Impact of Maternal Stress on the Fetal Brain – A Summary of Key Mechanisms

8.5 Review of primary care records have no evidence of psychosocial assessment in the postnatal visit. This could have allowed Agata to feel empowered to share her experience of DVA. There was an absence of professional curiosity when Agata stated she came from Hertfordshire, hence lateness to her GP postnatal appointment.

8.6 She called the police during the physical abuse she experienced postnatally in her instinct to protect her child. Pawel was assaulting her while holding Kubus and continued after he put Kubus down. While the police did go on to arrest Pawel and issue a domestic violence protection notice (DVPN), no steps were taken to arrange a health check to ensure no internal injuries to Kubus who was 4 weeks old.

8.7 A recent review by the national Child Safeguarding Practice Review Panel [ix](CSPRP) identified that perpetrators of physical abuse causing injuries in under ones are predominantly the birth fathers. The CSPRP have identified that evidence suggests that some men are very dangerous, but that service design and practice tends to render fathers invisible and generally 'out of sight'. In this case there was an absence of curiosity to question if dad had injured Kubus during the altercation, or in moments when he may have been alone with Kubus.

8.8 The risk assessment required to determine if face-to-face visits were required was largely influenced by Covid-19 risk factors and staffing. However, this meant that there was an oversight to the risks the HMO placed in the context of domestic abuse. Virtual visits will only allow the professional the window of what they are told and can see on the screen. This creates a blind spot for professionals as they would not be able to ascertain other risk factors in the house such as alcohol, drugs, signs of modern slavery, the other residents etc. and the risks they may pose. In this case the other resident was an enabler for Pawel and his drug and alcohol use, in addition to being a port of access to the property. Therefore, when Agata went to use the bathroom on the first floor of the property she crossed paths with Pawel on the first floor, where his friend's room was, at which point he assaulted her. At this point, there was a DVPN in place and he should have not been at the property.

8.9 Research from the University of Lincoln in collaboration with academics in Poland [x] and Austria, revealed a level of normalisation of domestic abuse, often which developed in pregnancy, with alcohol being a strong contributing factor. Agata's shared lived experience reflects the findings from the research. Furthermore, her decision for not accessing the therapeutic marketplace for domestic violence offered by agencies was informed by her lack of understanding and miscommunication of the offers available.

8.10 Reflecting on our meeting with Agata, in which she provided her narrative and emotions, and drawing on the research from the University of Lincoln, we noted a commonality, these being:

- Prior understanding of DVA is derived from the home country
- Normalisation of DVA

[ix] "The Myth of Invisible Men"

[x] Polish women's experiences of domestic violence and abuse in the United Kingdom

- Lack of knowledge of services in the UK, and indeed fear about services
- Language barriers, and socio-cultural / religious and political context which may shape their understanding of their situation and perceptions about possible options

Questions for the board / areas to strengthen practice

- Boroughs with the Identification & Referral to Improve Safety (IRIS) service have a greater recognition and disclosure of all forms of domestic abuse in primary care, in comparison to boroughs that do not have this service. Therefore, the authors would recommend that IRIS provisions in primary care are commissioned and sustained.

- How do secondary care staff facilitate the disclosure of domestic abuse and are the current provisions in place working?

- For a non-ambulant child, who is unable to communicate and who is present during a DVA incident, what are the thresholds to determine if this child needs examination? Can we rely on the word of parents saying that the child was not harmed during conflict? Are their accounts accurate?

  Why we are asking this question:

  In this case what assurance do we have that the child was 'placed' when English is a second language? Do we need to consider the nuance of vocabulary and meaning in context?

  How do we know that when the child was being held during the altercation, there wasn't inadvertent injury?

  Do agencies as a matter of routine enquire / risk asses around time spent alone with the perpetrator, and what considerations are given for child protection medical in the non-ambulant and non-verbal child? What can we draw upon from the national review of Arthur and Star?

  We need to remember injury is not always visible i.e. shaken baby and fractures

- Within our current risk assessment strategies, do we consider the complexity of HMO and the other ports of access a perpetrator may have to the victim(s) / survivor(s)?

- Following an alert of DVA, is it best practice to continue with virtual assessment or would all measures be taken to facilitate face-to-face assessment due to the risk factors, irrespective of Covid-19?

Identified impacting factors during the timeframe of the review:

9. Cultural Competence

9.1 During the course of this review the lack of consideration to cultural competence and reasonable adjustment was explored. In doing so, we started by looking at the definitions.

9.2 Culture is defined by the Oxford English Dictionary as 'the way of life of the people, including their attitudes, values, beliefs, arts, science, modes of perception and habits of thought and activity'. With this in mind, the concept of cultural competence is having the knowledge and understanding with the application of reasonable adjustments to facilitate engagement with individual(s). In the context of cultural competence, we also need to examine the role of language and perceived understanding when English is a second language.

9.3 During the workshop session with professionals, the review found, from a language perspective, that Agata had a command of both written and spoken English, from being in the UK since her teenage years and was able to sustain employment and engage with services. However, when we met with Agata she shared that despite having a working knowledge of the English language she sometimes struggled to fully understand. This was reflected when we explored why she declined the support of Solace. She advised her understanding was that services on offer by the therapeutic marketplace was in unison with moving to a refuge and was not available if she went to live with her mum. She explained that as she was a first-time mum she wanted to be with her mother.

9.4 For a person where English is a second language, there may be communication difficulties in the way that language is understood, communicated, and expressed. Native speakers may not fully recognise the complexity and nuance of language and how the shade of meaning might seem small, but greatly affect how what is being said is understood. It is important to reflect and understand that professionals may also not be native English speakers and they may also fail to understand and be understood. Therefore, as professionals it is imperative to check understanding and reasonably adjust our communication until we are understood, and we understand.

Questions to the board / areas to strengthen practice

- Cultural competence ensures person-centred care and supports making safeguarding personal. Best practice would ensure that staff have an understanding of the cultures of the demographic that they work with at place. It would enable staff to have an understanding when English is a second language that information delivered and received needs to be checked to avoid miscommunication. Consideration should be given to the offer of an interpreter, due to nuance of language and what is understood.

- Consideration to an Eastern European open access worker could facilitate with communication and understanding of culture

Identified impacting factors during the timeframe of the review:

10. Father

10.1 Very little was known about Pawel during the timeframe of the review and what was known was relayed by Agata, when she spoke to us, in addition to police records. In the antenatal health records, there was no mention of Pawel. This could be attributed to the restriction secondary to Covid-19. However, best practice would be to ascertain information to support person centred care. National and local reviews identify that it is not an unusual situation when undertaking child safeguarding practice reviews for fathers / partners to have little or no visibility. Making it difficult to ascertain if they are a positive factor or if they pose a risk to the child and / or mother and to what extent that may be.

10.2 In the new birth assessment, which was delayed due to the change of address, which was completed by video the only reference of father was in relation to his smoking and the risks to Kubus. Further risk factors in relation to Pawel were ascertained afterwards, when safeguarding procedures were underway. Intoxication was a contributing factor to the abuse which was established after police involvement.

10.3 Speaking to Agata, provided us with her insight into Pawel. She believes he is a good father to his son from a previous relationship and to Kubus. She maintained he would never hurt his children and paternal presence is important. Literature [xi] supports the importance of paternal presence is a core value held in the Polish community.

10.4 The NSPCC in 2017 [xii] highlighted that, professionals rely too much on mothers to tell them about men involved in their children's lives. If mothers are putting their own needs first, they may not be honest about the risk these men pose to their children. While it is evident Agatha did recognise the risk at the point of assault and therefore sought help from the police, she did have her own biases which would understandably be emotionally driven, especially during and after pregnancy when oxytocin (the bonding hormone) levels are raised. Previous studies regarding learning from SCRs[xiii], the Triennial Analysis of Serious Case Reviews and Lord Laming in his review into the death of Victoria Climbié, [xiv] indicated that it is important to maintain a respectful uncertainty of parents / carers. It is suggested that it is possible to do this without affecting the professional / patient / client relationship.

10.5 The NSPCC review highlights the reason for the assessment of fathers is to contextualise their experiences which may include poor parenting, exposure to abuse and neglect which could result in his adult social difficulties with alcohol, substance and healthy relationships. By understanding parental experience in the antenatal

[xi] Two worlds of fatherhood—comparing the use of parental leave among Polish fathers in Poland and in Norway

[xii] Infants: learning from case reviews

[xiii] Complexity and challenge: a triennial analysis of SCRs 2014-2017

[xiv] The Victoria Climbie Inquiry

period, it may allow for early signposting and support to change the narrative for their future child.

Question to the board / areas to strengthen practice

- The importance of including fathers in assessments, absent or living in the household should not be underestimated. How do organisations ensure visibility and ascertain further information on fathers / partners and households, to factor within assessments; to make safeguarding personal and provide the opportunity for both protective and risk factors to be effectively elicited?

- Given the 'think family' approach embedded in the work of the board, should future statutory reviews include more detailed chronologies and analysis of the father / co-parent / perpetrator? The authors recognise that this was an oversight in this review

Identified impacting factors during the timeframe of the review:

11. Documentation

11.1 Discrepancy in documentation in contrast to actual events is a theme. Prior to calling the police Agata was never asked about domestic abuse, however antenatal records suggest otherwise. When we met with Agata we explored all the possible ways and terminologies that could be used to enquire about domestic abuse. Agata was very clear that no professional had enquired in any way. Agata also stated that had she been asked she would have disclosed, although she was reticent about what would have been done. In Hertfordshire she did not have safe sleeping provision yet virtual assessment documentation advises Kubus was sleeping in a cot. These inaccuracies were substantiated from the coronal report and through conversations with Agata.

11.2 Reflecting on the challenges Covid-19 posed it could be hypothesised that the pressures staff were under during this period (both professionally and personally), meant they became unintentionally mechanical in their approach. Compassion fatigue is a well-documented phenomenon amongst front line staff with caring responsibility. However, it should be remembered that staff have accountability to a professional body as well as the public they serve.

11.3 Analysis of primary care records, demonstrate lack of request for collateral information from the GP and information sharing to the GP in relation to the Section 47 and MARAC. These took place respectively due to the initial reporting of physical assault and with the escalation of abuse and continued reporting to the police. The primary focus of the MARAC is to safeguard the adult victim. It will also make links with other fora to safeguard children and manage the perpetrator's behaviour. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an independent

domestic violence advocate (IDVA) who speaks on their behalf. The domestic abuse, stalking and harassment (DASH) Risk assessment that fed into the MARAC stated that Agata was isolated from friends and family and that Pawel's behaviour had been getting worse. The GP was oblivious to any safeguarding concerns until after the death of Kubus. Work will need to take place to ensure that in the future, systems and processes always remember to communicate with primary care and, there is full attendance and/or information from all services involved, in safeguarding meetings, including the GP. It is not possible to assess families and risk if there is key information missing. Furthermore, it prevents practitioners from proactively engaging with their patients to offer support.

11.4 The practitioner event revealed that there was an absence of information sharing, regarding the relocation to Hertfordshire (to Kubus' Maternal grandmother), from children's social care to NELFT. Also, communication errors occurred, with Waltham Forest children's services closing the case after the referral to Hertfordshire. (However, Hertfordshire did not receive the referral and were only aware of Kubus, due to inquiry following his death.) Consequently, NELFT were then unable to hand over and support local health visiting input, at her new address. The family were hidden from Hertfordshire's children's social care. If effective handover had taken place there potentially could have been support to address the overcrowding, safe sleeping arrangements, facilitation to re-register at a local GP practice in Hertfordshire, with the aim to reduce stress on Agata attending appointments to meet their health and social care needs.

Questions to the board / areas to strengthen practice

- How do we ensure that accurate quality documentation is maintained, irrespective of the challenges posed to staff?
- Are there adequate consistent quality supervision systems in place across all organisations to support staff, at various levels?
- How do we support staff with increasing workloads from reaching burnout and becoming mechanical in their approach?
- Are the information-sharing systems in place between safeguarding partners robust? What are the barriers to information sharing between agencies and within agencies (e.g. health visiting and primary care)? How do we ensure primary care and the information they hold are accessed from the beginning of any safeguarding process?
- Do we need to examine processes and pathways to ensure referrals are received and acknowledged prior to closing a case? How can this be embedded into practice?

12. Conclusion and recommendations

12.1 **"**The sudden and unexpected death of an infant is one of the most devastating tragedies that could happen to any family. Despite substantial reductions in the incidence of sudden unexpected death in infancy (SUDI) in the 1990s, at least 300 infants die suddenly and unexpectedly each year in England and Wales" as referenced in The Child Safeguarding Practice Review Panel's 2020 report into SUDIs [xv]

12.2 During the course of this review, the authors examined SUDI in the context of domestic abuse, during the Covid-9 Pandemic, examining key themes that have impacted the family, with consideration to the pathways to harm, prevention and protection framework as per the Triennial Analysis of SCRs report. [xvi]

12.3 One of the most important findings during the review has been the cumulative risk to mother and child with the varying health, social and environmental risk factors present from point of conception. This particularly relates to missed opportunities for disclosure of domestic abuse, challenges with housing, and paternal alcohol use, but also includes other risk factors such as mother's experience of domestic abuse and lack of trust in services. While isolation of victims / survivors is a common feature of domestic abuse, this was compounded by the Covid-19 Pandemic.

12.4 Following the government's public consultation on 'Transforming the response to domestic abuse' in 2018, the draft domestic abuse bill 2019[xvii] which set out 123 commitments to protect and support victims and their families from domestic abuse was passed as an Act of Parliament in 2021. The majority of provisions were to come into force during 2021 / 22. For the purposes of this review, Section 3 of the Domestic Abuse Act 2021 came into force on 31 January 2022 and specifically provides that a child (under 18 years old) who sees, hears, or experiences the effects of domestic abuse and is related to the victim or the suspect is also to be regarded as a victim. This is significant and brings into question how the safeguarding partnership will ensure that the systems in place support identification and referral for timely responses to reduce adverse childhood experiences created by domestic abuse for babies, children and young people. In essence this means that the adult parent / care giver needs services to be open and professionally curious to enable disclosures. The review established that both primary and secondary health services did not facilitate an environment safe for disclosure. The authors have reflected on the potential barriers which may be related to educational need, confidence and time. Therefore, they recommend sustained commissioning of evidence-based providers to support the health system, examples of providers are IRIS for primary care, Hestia for community allied health care and victim support in secondary care. The authors would like to be clear that these are suggested providers who provide an evidence-based trauma informed service, but commissioners would need to explore the wide range of providers on offer for sustained commissioning.

[xv] Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm
[xvi] Complexity and challenge: a triennial analysis of SCRs 2014-2017
[xvii] Domestic Abuse Bill

12.5 The authors were able to identify a wide range of lessons for practitioners across the partnership. Many of these examined systems working; communication and escalation pathways, in addition to risk assessment processes embedded during Covid-19, which may have contributed to reduced visibility and support. The authors' questions to the board / areas to strengthen practice have emphasised the importance of professional curiosity, robust record keeping, credence to fathers and acknowledging the role they have in the family dynamic. They examined the need for cultural competence and ensuring that all service users experience a safe, trusting environment, to be seen as an individual, to be able to speak freely and be listened and heard whilst being treated with respect. This is key because if not in place they create additional barriers and complexities to supporting families.

12.6 The authors hope the above recommendations are embedded into operational practice and strategic policy implementation promptly to ensure that fatal / life-changing outcomes are reduced from the findings of this review.