

WOLVERHAMPTON SAFEGUARDING TOGETHER

7 MINUTE BRIEFING: Child T



Background:

Mother was known to CSC and Mental Health Services - There was evidence of good communication between CSC (in and out of area) and acute and community maternity services, but poor communication between Perinatal MH Services & the Health Visiting Service

Social work assessment did not include information from all the relevant practitioners/professionals. Mother stopped her medication during her pregnancy. Mental health assessment tools were used frequently with a satisfactory result each time.

Background:

Mother has a diagnosis of Bi-Polar and has been detained four times under the MHA. Father has a diagnosis of severe and enduring mental health illness.

Parents relocated to Wolverhampton together but later separated following the birth of the baby.

What Happened?

Mother's Mental Health deteriorated significantly and was subsequently detained under the Mental Health Act. Baby had been left home alone for several hours – considered to be a near miss.

Key Learning:

There appears to be confusion of roles and responsibilities across Health and Social Care and blurring of services.

Key Learning:

Professionals need to analyse and understand the likely impact of enduring parental mental health difficulties [within the context of the parents' fluctuating ability to engage with / be concurrent with services].

Questions for you to consider:

Have I asked and am I listening to the right person with the expertise in that speciality for their assessment, OR am I making an assumption that I know the answer because I have some exposure and therefore insight into the issue?

What can you do to prevent reoccurrence?

Whilst professional and courteous challenge can be healthy and help to ensure agencies are accountable for their business and practice, it must be recognised and permitted that those with the expertise in their own specific areas know best.

