Reflective learning Document

Child V

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Commissioned by RBWM Safeguarding Childrens partnership

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**The family (subjects of review)**

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| CHILD V |  |
| CHILD V MOTHER |  |
| Child V GRANDMOTHER |  |

**Overarching aim and principles of the Child Safeguarding Learning Review (CSLR)**

The purpose and underpinning principles of child safeguarding learning reviews are about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the review will reflect the current realities (the “view from inside the tunnel” SCIE) of any learning ("tell it like it is") and the context in which practitioners work. It will establish whether there are lessons to be learned from a case about the way in which local professionals and agencies worked together to safeguard children. It will identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.

We need to Improve inter-agency working and better safeguard and promote the welfare of children. Child Safeguarding Learning Reviews are not inquiries into how a child died or who is culpable. These matters are for Coroners and Criminal Courts respectively.

Legislation, Governance and accountability

Whilst such review processes are not formally governed, we expect to comply with the requirements set out in:

• The Children Act 2004 as amended by the Children and Social Work Act 2017

• Working Together 2018

• Multi-Agency Pan Berkshire Child Safeguarding Policy and Procedures.

As the accountable organisations responsible for its commissioning, the statutory safeguarding partners will receive updates on the progress of the review at meetings or via offline written briefings as required.

The independence of the facilitator, who is not an employee of any of the statutory partners, has been discussed by key partners and it is agreed their independence is sufficient to facilitate the learning review

**Incident leading to review**

Children’s social care services in Slough learned about the death of this baby on 8th July from Devon Police who reported that his mother and his Maternal Grandmother had travelled with him to Devon and had been there on holiday since 3rd July. The ambulance service was called to the caravan site by his mother saying that he was unresponsive from 6am that morning. The ambulance service reports indicate that both the mother and grandmother were intoxicated. The police toxicology confirmed that the grandmother was intoxicated, however the mother did present as if she was drunk, but her toxicology was negative. Attempts to resuscitate the baby resulting in a hospital admission where death was confirmed at 7.55am. A post death assessment showed that the baby appeared to be clean with no other marks other than a red cross painted on his cheeks. The mother provided a history of having put baby to bed at 11:30pm after watching football and he slept with her on the bed. She woke up at 5.45am to find the baby and not moving and she called for an ambulance. Devon Police reported that there was a double bed which was shared by the 2 adults and the Baby.

Child V’s mother had been known to a neighbouring Local Authority as a child and as a teenager. She had a very unpredictable and difficult relationship with her mother. She also had a history of depression and anxiety and a diagnosis of borderline personality disorder for which she was receiving care, from the local mental health services provider.

She also suffered a series of tragic losses. At 17, she had a baby who was adopted. Her brother died in a fall from a bridge approximately 6 years ago and her partner, who was the father of Child V, had died more recently following a fall from a balcony.

Mother was provided ante-natal care by the local hospital specialised midwifery team and mental health support by the local mental health providers who had liaised with the health visitor, however she failed to engage with prenatal mental health services.

It is Important to note no referral was made to children social care during the pregnancy or following the birth, as policy would have recommended. Policy indicates a referral should have been made because of a child being adopted in the past.

On 18th June 2021, Child V’s mother contacted the Emergency Duty Team as the maternal grandmother had evicted her and Child V. Temporary housing was provided in Slough, funded by RBWM, and Child V’s mother was reportedly happy with her accommodation. RBWM referred her to Slough Children’s Social Care services who had made several attempts to contact her to arrange for an assessment. It is believed that in that time Child V’s mother and grandmother took Child V and their 2 dogs to stay in a Caravan in Devon.

Police and health enquiries shared at the Joint Agency Review meeting (in Devon) indicated that both mother and grandmother were intoxicated when emergency services arrived on the scene. They informed health and police that they had consumed 10 pints of lager the previous evening, but they had not taken any drugs. All three slept together in a pull-out bed in the caravan. The JAR indicates that the grandmother was aggressive in the A & E department and that both she and Child V’s mother were arguing.

Police suspect overlaying but this has yet to be fully established. The police carried out a criminal investigation to establish if there are grounds to bring criminal charges in relation to neglect.

Rapid Review was completed within timescale and all partners were represented

**Is abuse or neglect of a child known or suspected?**

The group agreed that the consumption of large quantities of alcohol while caring for this young baby amounts to neglect. The group also recognised that the mother’s history of mental health problems, including post-traumatic stress disorder, anxiety, depression and personality disorder, and her recent and past traumas were predisposing factors to abuse and neglect. These factors were known to several agencies and should have triggered safeguarding referrals. The group agreed that there is always room for learning about vigilance in relation to these factors, and this needs to be addressed through traditional routes such as training and improvements in supervision. However, the group also agreed that that there is a need to carry out a more in-depth examination of why a number of professionals who were aware of these issues did not make a referral. Partners anticipate that a multi-agency focus on this is likely to lead to new local learning.

**Key lines of enquiry**

* Does the case highlight or could it highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified?
* Awareness about the dangers of co-sleeping and alcohol consumption when parenting a child needs to be continually promoted. A recent campaign developed by a local health provider in RBWM and targeting professionals in all agencies needs to be widely shared.
* Training for practitioners about these pre-disposing factors as a trigger for safeguarding referral and supportive action needs further exploration.
* The rapid review is informed by national concern about increased alcohol consumption during lockdown and the rise in cases like this nationally.
* Does the case highlight, or could it highlight recurrent, themes in the safeguarding and promotion of the welfare of children?
* The links between alcohol consumption, co-sleeping and sudden unexpected death in infancy (SUDI) needs to be widely promoted nationally, regionally and locally. The rapid review identified the important role of public health in leading on these issues.
* Does the case highlight, or could it highlight, concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children?

It is important to note prior to this practitioner event, Partners who provided services to this family and contributed to this rapid review, that happened days after the baby’s death had already identified areas for improvement and begun acting on recommendations immediately and could share evidence of good cross county working at the reflective meeting . However, all agreed that this is not a single agency learning issue and that there is a need for wider learning for all who work with all new families.

**Evidence of good practice**

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| At the reflective meeting it was evident this is the aim and ambition of this partnership, who have already developed, and are embedding and delivering training of the safer sleeping tool kit: [RBWM Safeguarding Partnership - Safer sleeping for babies](https://rbwmsafeguardingpartnership.org.uk/p/safeguarding-children/safer-sleeping-for-babies) and had a strong sense of commitment to the message. |

**Advice from National Panel:**

“Whilst it is your decision whether to carry out a local child safeguarding practice review (CSPR), as set out in Working Together (2018), we wondered whether it would identify further learning. It may be that some focused work around benchmarking against our national review could obviate the need for a review. If you decide to undertake a CSPR we would encourage you to be proportionate in scope and focus on key lines of enquiry appropriate to this case in particular focusing on the issues raised by the failure to refer the case to children’s social care”.

Specific areas of enquiry, including key areas of concern

The review (and by extension all contributors) have considered and reflected on the following:

**Mums’ previous history**

Information shared at the practitioner event highlighted areas for improvement. We discussed areas that have been implemented. Staff demonstrated the ability to be reflective around what could or should have been done differently. Some staff were really clear, that there should have been a referral for an assessment prebirth, as policy indicates.

Therefore, this is seen as a key learning point, the risks associated with giving up a child for adoption and the impact this can have on any subsequent pregnancies and motherhood. Failure to use the policy, therefore is seen as a missed opportunity for a joint assessment. This would have included the mother’s history as a child, detailing past interventions with social care, which would have identified the problems within the relationship. Alerting professionals to potential parenting risks, we can identify her childhood as experiencing adverse childhood experiences.

**Learning point: understanding: Adverse Childhood Experiences**

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| Adverse Childhood Experiences (ACEs) are “highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person’s safety, security, trust or bodily integrity.” (Young Minds, 2018)  The experiences we have early in our lives and particularly in our early childhoods have a huge impact on how we grow and develop, our physical and mental health, and our thoughts, feelings, and behaviour.  Two important factors to think about when making an assessment and considering mental wellbeing are the quality of attachment relationships and their experience of ACE’s as a child. These are key considerations as part of an assessment, we need to be professionally curious of their history to understand how that will impact their ability to parent going forward. |

At the reflective meeting none of the professionals involved were able to give an explanation as to why a referral to social care had not been made. We reflected on the impact of the past adoption, and it was suggested that the length of time between the pregnancies could have masked the need for professionals, to make a referral as per policy. Arguably because the grandmother was a health professional, who reportedly was supportive of this pregnancy, appearing quite proactive, gave the impression of a strong, supportive family unit.

However, the assessments had not taken into account the mother’s own history and complex relationship with her mother as would have been expected. The history taken by midwifes did not take account of the fractious/troubled childhood or the earlier adoption and how this could impact on her parenting ability, events which would have been amplified by the baby’s father’s untimely death. Nevertheless, they acted appropriately regarding her current mental health situation and needs, leading to a referral as a priority.

Arguably this history could have been masked by the support she was currently receiving from mental health services and her mother’s support, her age and her presentation at the time of pregnancy. Her childhood history in of itself should have triggered professional curiosity and her mental health problems, coupled with her reluctance to engage with perinatal mental health services too, should have been a trigger for a referral to social care.

The referral was correctly made for the mothers’ mental health, however it only led to limited contact. Arguably If this had been coupled with a joint pre-birth assessment, this could have helped professionals gain a deeper understanding of the present risk.

The grandmother’s aggressive presentation in A&E at the time of death for Child V, led to a LADO referral regarding her, no professional concerns were identified about her ability to practice within her role as a nurse.

For awareness

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| Every local authority is required to have a Local Authority Designated Officer (LADO). They provide advice and guidance to employers and voluntary organisations that have concerns about a person who may have behaved inappropriately when working or volunteering with children and young people, or if information has been received that may constitute an allegation. |

**Understanding the impact of Covid**

Covid was not reported to be a factor in accessing services, professionals were able to share proactive methods for engaging with vulnerable families which highlighted areas of good practice, this family were not deemed to raise safeguarding concerns to services.

However, we need to reflect and understand how Covid restrictions impacted on the maternal pathway, this would have had a profound effect on all mothers and families who would not or could not have the delivery that they had planned for. This can lead to isolation and segregation post-delivery from family and friends. This was an abnormal and worrying experience for everyone, giving birth when staff were in masks, family and partners not being allowed to stay or join in prenatal visits. Further once discharged, restricted home visits, some were replaced with phone calls, leading to lack of professional oversight. The need for safe bubbles within the community and to understand who their support is, was often confusing. The partnership was responsive to this situation, however restricted face to face support from professionals. This cannot be sustained long term, Babies and families need to socialise.

Arguably families during Covid that wanted to remain under the radar, could do so. This case indicates there was an element of this, Mother sometimes presented as non-compliant, superficially engaged, and not accessing services offered to her. All professional’s need to be alert to this, for as long as restrictions are in place, we need to ensure every baby, regardless of need is seen physically. It is clear Covid has impacted on every new birth. Practice nurses and GPs are key to ongoing intervention, particularly in this case, as they will be the only ones who have on going care of the mother, therefore they need to ensure she keeps all appointments with mental health, and review her needs if she does not, for her physical and emotional wellbeing. Research shows after such a traumatic event she could be a risk to herself.

**Knowing the outcome what would you/could we have done differently?**

* Fractious relationship, was this fully explored?
* Toxicity and Alcohol abuse by Mother and MGM
* Referral for CP or CiN?
* What might have made a difference to this case such as early intervention

Midwives are well placed to act on mental health concerns and the risk of postnatal depression, the additional referral for prenatal services was timely, however it was less clear what happened when there was lack of engagement nor was there a proactive risk assessment. Midwifes need reminding of the referral process for mothers who have experienced a historic adoption in particular, and historic social care intervention. The importance of a joint assessment which could have led to joint proactive intervention, focusing on the lived experiences past and present. However, we cannot underestimate the legacy of suspicion of statutory services powers and consequent resistance to these (Gallagher and Smith, 2010; Beresford, 2016).

It must be remembered that this was at the peak of the COVID pandemic, with widespread use of services delivered online. In this instance several on-line conversations took place which arguably helped share information. The mother could hide behind the screen, perhaps preventing professionals from seeing the whole presentation. Any sign of depression or triangulation of body language, and interaction with the baby could easily be missed, although it clearly documented she consistently reported she was well, and not in need of additional help.

We also know the mother was capable of seeking help from Social Care when needed, such as the request for accommodation which lead to appropriate referral for intervention and assessment. Sadly, this happened just before the baby’s death. It is Interesting to note within days of her eviction from the family home the grandmother takes her daughter and grandchild on holiday. This event offers another insight into the conflict and confusion within this relationship.

In the Review of Child Protection in England, commissioned by the Department of Social Services, Professor Eileen Munro highlighted a growing imbalance in child protection work, with a focus on technical solutions, rules and procedures, rather than recognition of the importance of the skills to engage with families. She considered that the emphasis should instead be on 'building strong relationships with children and families with compassion' (Munro, 2011, 1.29) and on a more reflective practice. Devine and Parker found that when agencies were involved in investigations there was 'very little recognition or awareness of the stresses experienced by families as a result' (2015, p2). This applies to all partners who work in with the safeguarding arena.

**Learning points Postnatal depression**

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| Postnatal depression is thought to be caused by a combination of a number of different factors including having a vulnerability to experiencing mental health problems, a lack of a close, supportive network, having a poor relationship with a partner, partner’s recent death /adoption having experienced other recent stressful life events and hormonal imbalances. We know however, that many women and men experience postnatal depression without any of these vulnerability factors being present. Having a baby is a life-changing event which is exhausting, physically and mentally stressful and requires a huge amount of energy. |

**Reflecting on Suffering in silence pain of adoption**

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| The experience of sadness, helplessness, regret and resentment often experienced by a parent who has given up their baby for adoption can be really difficult for them to share with friends, family and professionals for a number of different reasons. Parents have talked to the author about a number of perceived barriers to being open and seeking support.  The lifelong impact of having a child adopted is not something that is covered in great detail in training or offered to all staff, therefore questions are avoided in history taken or not deemed relevant. In the author’s experience observing and contributing to good quality training to fully understand this lifelong impact should be available to all.  Despite a positive outcome for many, all adoptions are first created through loss.  As professionals we hope for a better and happier life for the adoptee than he or she would have had with his or her birth parents. However, we have to be aware of the birth mother’s feelings of grief and loss throughout points of contact with professionals and recognise the psychological impact the loss can present.  Whilst grieving the loss of a child, such as adoption, who is still alive, isn’t quite the same as grieving someone who has died, the feelings of loss are nevertheless very real. The feelings of grief and loss often continue throughout the birth mother’s life, resurfacing around the time of the child’s birthday or of expected milestones in the child’s life, such as when he or she would be old enough to start school or old enough to graduate from high school.  This mother has now experienced both, we need to ensure she receives the right support and intervention. |

**What might have made a difference to this case such as early intervention**

Clear guidance available recognises the importance of early referral to Children’s Social Care, so that where there are concerns for the future safety or welfare of an unborn child, appropriate assessments can be made in a timely way, and effective multi-agency plans can be put in place to support the parents and safeguard the child prior to the birth. We also know we have more time to share important messages prebirth, such as the safe sleeping message, which we know was shared on more than one occasion. However, in this case there was a hidden risk of alcohol misuse. There was no evidence shared at the practitioner event about who was her key support, or what daily life was like for her, she was known to suffer from depression and struggle with certain aspects of life, including use/abuse of alcohol, clear documentation of risk and lived experience is key to a robust holistic assessment and how its impacting on a persons mental health.

Referring in a timely manner provides sufficient time for a full and informed assessment; avoids initial approaches to parents in the latter stages of pregnancy, as this is already an emotionally charged time; enables parents to have more time to contribute their own ideas and solutions to concerns and increases the likelihood of a positive outcome. Early assessment and intervention enables the provision of support services so as to facilitate optimum home conditions prior to the birth and provides sufficient time to make adequate plans for the baby's protection where this is deemed necessary and where the assessed risk is felt to be high. Clear analytical assessment will inform the long-term permanence and understanding of risk.

**What makes a good assessment**

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| Assessment is not an exact science, but can be made as sound as possible if it includes the following three elements: what research tells us about risk factors, what practice experience tells us about how parents may respond in particular circumstances and the practitioners’ professional knowledge of this particular family  The content of a sound assessment will be formed by looking at relationships –between parent/carers, between parents/carers and the child (whether born or unborn) – looking at how previous history shapes current experiences and the context within which people are living. |

**Circumstances of death and drunkenness particularly when caring for a young child?**

**Safe sleeping advice in addition to the safe sleeping toolkit**

We know safe sleeping advice was given; what we did not have was a clear picture of sleeping arrangements on a daily basis, or the amount of alcohol the mother drank, although we do have information that indicates she had a past history of alcohol abuse, which would be a risk factor.

We all agreed the final night of unsafe sleeping and alcohol use could not have been predicated, however early education and a reminder of potential risk factors may have led to making safer sleeping arrangements. Research suggests we need to repeat safe sleeping campaigns annually, to keep the message live and fresh for all new parents and carers, and I have seen clear evidence this happened across the partnership.

Previous UK data suggests:

* around half of SUDI babies die while sleeping in a cot or Moses basket.
* around half of SIDS babies die while co-sleeping.

However, 90% of these babies died in hazardous situations which are largely preventable

It should be born in mind that it isn’t helpful to tell parents what they must or must not do; instead, listen carefully and offer information appropriate to their needs. Having an open conversation can help them to understand why they should be very careful not to fall asleep with their baby after drinking or taking drugs. Drink and drugs also affect normal functioning and decision-making. Discuss the importance of planning care for their baby at such times, for example by asking a sober adult, relative of friend to help.

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| The safeguarding board has taken a vital role in ensuring that all agencies, not just in healthcare, are aware of the risk of sudden infant death syndrome (SIDS).  NICE Guidelines (NICE (2014) Clinical Guideline Addendum 37.1, Routine postnatal care of women and their babies) All practitioners who are in contact with carers with babies should discuss the risk of unsafe sleeping. It is recommended that baby's carer/s are advised not to bed-share or co-sleep particularly if alcohol has been consumed.    It is in no-one's interest to avoid this discussion with the baby's carer, either on the grounds that it is complex, or to wait until the mother reports that she has already slept with their baby in a bed.  Although many new parents/carers say that they will never sleep with their baby, about 50% of UK babies have bed-shared with a carer during their first three months. It is therefore important that ALL carers have a discussion about bed-sharing/ co- sleeping and consider how they will manage night-time care.  It’s good to see all professionals to work together to support families in taking steps to protect their babies. RBWM are actively delivering safer sleep messages to every parent with a new-born. |

We have historic records within social care showing the mother’s adolescent risk taking behaviour, including alcohol misuse. The Mothers history should have been included within the risk assessment prebirth. Best practice states these are questions all professionals should ask any mother at several points during her pregnancy for social and medical reason’s.

Arguably we know that staff at A&E were distressed at the level of drunkenness of the mother and MGM who were described as “still heavily under the influence on attendance”, which was some hours later. Alcohol was a factor in the argument which led to the mother and baby being made homeless. This is likely to be a factor throughout the mother and daughters’ whole relationship.

**Conclusion**

* Does the case highlight, or could it highlight recurrent themes in the safeguarding and promotion of the welfare of children?

Staff who attended the practitioner event, presented a clear understanding of the importance of the safe sleeping message with supporting evidence. There were no concerns this was an unaddressed issue or indicative of a recurring theme. Staff demonstrated a good understanding of the ongoing campaign. The author found evidence of pro-active practice, with a good understanding of safe sleeping. The message had clearly been given.

A wider campaign could only have enhanced the current program “who’s in charge” would not only re enforce the safe sleeping message but the use of alcohol to the general public, is also worth exploring related “You Tube” clips, to continue to raise awareness.

The links between alcohol consumption, co-sleeping and SUDI needs to be widely promoted nationally, regionally and locally. The rapid review identified the important role of public health in leading on these issues.

As professionals, we can give the message, but we cannot enforce or police it.

<https://www.bhamcommunity.nhs.uk/about-us/news/archive-news/whos-in-charge/>

* Does the case highlight or could it highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children?

Staff present at the practitioner meeting, and the information shared, highlighted many of areas of good practice between partners, instances of positive sharing of information, and joint working. We did identify, the historic information relating to the adoption policy was not followed when booking in maternity, it would be worth revisiting that policy and ensuring all professionals, that deal with prebirth assessments are reminded.

**Learning points**

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| Sudden unexpected deaths in infancy (SUDI) Analysis shows that: 80 per cent of babies were either in unsafe sleeping positions or environments with particular high-risk circumstances.  Learning includes; along with greater risk associated with placing a baby on the front or side to sleep, there is also a greater risk to babies who are in a room alone; rather than co-sleeping alone, it is co-sleeping when a particular high-risk circumstance is present which increases the risk to the baby; there is extensive data to show that breastfeeding has a protective factor in reducing SUDI. Recommendations include: ensure partners, (as you have shown within your tool kit) are adopting a practice model which encompasses reducing the risk of SUDI within wider strategies for promoting infant health, safety and wellbeing; you could have an additional focus on the risk of alcohol and new babies within awareness training that promotes respectful, non-judgmental care is delivered to all health and social care staff who work with patients or service users who misuse alcohol. |

**Risk associated with poor mental health**

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| Taking into consideration parental mental health. The Child Death Review Programme in Wales in their thematic review of SUDIs 2010 – 2012 asked “whether babies are being cared for by a parent with a mental health problem may have additional vulnerabilities or a potential for an increased risk of unexplained sudden infant death”.  Also worth noting:  It should be considered whether a parent suffering from depression is likely to be as responsive to their baby’s needs as they might wish to be. There was discussion around the risks of parenting if affected by prescribed medication, and particularly the perceived risks of co-sleeping in this situation.’ |

The effect of any bereavement can be immense, but with the sudden death of an infant, families can often feel the profound effect of shock and trauma. It is often the parents that have found their child unresponsive and begin the distressing process of resuscitation or witnessing medics attempting resuscitation. As a consequence, the grieving process may be more complex, intense and longer, although the actual experiences of grief may be similar to other bereavements.

After a sudden infant death, it can be more difficult to come to terms with why it happened because there may be no clear cause. Families can often struggle with not having a significant finding at post-mortem and the fact that the infant was well in the days leading up to their death. Parents often struggle with guilt for long periods. A sudden infant death commonly occurs at night and parents feel that they let their child down because they were fast asleep whilst their child was dying. The feeling of guilt may be further intensified for parents if an unsafe sleep environment is noted.

The author’s view is this baby’s death was unpredictable, even if enhanced support had been in place, parents can and will make unwise choices. This mother superficially engaged with services at a time when restrictions were in place, home visiting was limited, we have evidence she could ask for help when needed. The initial assessment did not raise concerns, she was already under mental health care for ongoing issues, a joint assessment would have enabled staff to evaluate her needs in more depth, a referral was in place just before the babies untimely passing.

The hospital confirmed the baby was well cared for, appropriately dressed, and well nourished, this appears to be a loved baby, the mother’s level of distress at the hospital, should be seen as significant grief.

I recommend the report is shared widely across adult and Childrens partnerships particularly with GP’S and adult mental health services.

key learning Appendix

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| Key opportunities for intervention | Why is important | Key Learning |
| Adoption of first child | No referral to children social care as policy dictates with any new pregnancy.  Policies and procedures are an essential part of any organisation. Together, policies and procedures provide a road map for day-to-day operations. They ensure compliance with laws and regulations, give guidance for decision-making, and streamline internal processes. | Consistency in practice helps you understand what you are responsible for, what is expected of you, and what you can expect from your supervisors and co-workers, preventing missed opportunities |
| Why is it important to know about adverse childhood experiences?/troubled teenager /poor family relationship  Attachment | The increased public understanding that childhood adversity, including ACEs, can cause trauma and toxic stress—and, in turn, have a lasting impact a child’s physical and mental health—presents an important opportunity to turn this awareness into action.  Human babies are born dependent on their parents. They undergo huge brain development, growth and neuron pruning in the first two years of life. The brain development of infants (as well as their social, emotional and cognitive development) depends on a loving bond or attachment relationship with a primary caregiver, usually a parent. | <https://www.youtube.com/watch?v=95Q-mtI79m0>  <https://www.youtube.com/watch?v=WjOowWxOXCg>  What is a co-dependent parent?  A co-dependent parent is one who has an unhealthy attachment to their child and tries to exert excess control over the child’s life because of that attachment.  Over-involvement. For example, if a parent sees that something painful is happening in their child’s life, they may try to gain control by getting involved — often too involved, because the child’s pain is the parent’s pain   * Inappropriate caretaking. * Incorrect shouldering of responsibility |
| Death of partner in early pregnancy | Grief is a period of intense sorrow or mourning. It may last for a shorter period, although this is not always the case. Usually, it occurs after a specific and sometimes traumatic life event. Grief can act in much the same way as other stressors.  Grief can affect pregnancy through its impact on hormone balance and production. Pregnancy already has an effect on hormones. When pregnancy and grief take place at the same time, hormonal changes may have more extreme effects. | Foetuses can be susceptible to these changes. Disruptions in regular chemical production may have effects that last throughout a pregnancy. In extreme cases, these effects may impact the child’s life later on. |
| Did not access mental health team “Why don’t people get help?” | **Fear and shame**  One of the most common reasons for not seeking help is fear and shame. People recognize the negative stigma and discrimination associated with having a mental illness and don’t want to be labelled “mentally ill” or “crazy.” They may also have concerns about how such a label could  negatively impact their career, education, or other life goals.  **Lack of insight**  If someone has clear signs of a mental illness but says “there’s nothing wrong with me,” “I’m not sick,” or “I don’t need any help,” this signals a severe lack of insight.  Feelings of inadequacy having to admit something is “wrong” with their mental health. Further, they believe they “should be able to handle things” on their own without assistance and that they must be weak or inferior to have to ask for help.  **Distrust**  It’s difficult to consider revealing personal details to a doctor or counsellor. Many express concern about “telling a stranger” about their problems. Additionally, they worry that their personal information won’t be kept confidential. | Possible reason as to why she never took up the service, distrust, ACE, fear of failure  Are all questions professionals can ask in an early maternal assessment |
| Emergency Duty Team as the maternal grandmother had evicted her and CHILD V. | One of the most hurtful relationships between mother and daughter is the neglectful type. This sort of relationship leaves the daughter feeling as if she doesn’t exist. The mother always has her own agenda and despite how hard the daughter begs for her attention, the mother cannot see the effort. |  |
| Supporting mother post death of the baby | Mothers with personality/developmental traits and those with active psychiatric symptoms required a more extended treatment period in response to loss, suggesting the accumulation of negative factors in these patients; thus, more intensive and specialized care is necessary for these patients. Precise analysis of the coping style, attachment style, communication skills, and life history including relationship with the original family of the patients may have implications on the approach toward patients with complicated grief after perinatal loss. Studies with larger sample size are required to increase the reliability of the present findings, and future research should address the effects of the differential attachment and coping styles of patients with developmental/personality traits on the grief process. |  |